



VETERANS HOME HEALTHCARE 180-DAY REPORT

Directed By Public Law 2007, Chapter 123
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The Final Report

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Executive Summary

This report responds to Public Law (P.L.) 2007, Chapter 123 signed by Governor Corzine on 03 August 2007. The Law directed the New Jersey Department of Military and Veterans Affairs (hereafter DMAVA) to evaluate resources, costs, and benefits of providing home healthcare aides for qualified veterans. The law further directed that the Department “shall evaluate the resources available and the costs and benefits of providing home healthcare services to elderly or disabled veterans through approved agencies, organizations, or other entities for the purpose of enabling these veterans to remain in their homes.”

The intent of this Report is to provide an introduction to home healthcare in New Jersey in order to generate informed discourse as to which direction State government should pursue. Given the complexity of home healthcare and the constraints imposed on the production of this Report, it would be prudent to only use this Report as the first step in developing future actions in the area of home healthcare for veterans. The data provided in this Report, while not statistically significant, will still serve to provide a rough estimate of the scope and costs involved in providing home healthcare for the veteran community, and so should stimulate informed discussion on this subject.

In order to answer the direction of P.L. 2007; Chapter 123 pertaining to “elderly veterans,” the decision was made to use the 525 veterans already on the waiting lists for the three state Veteran Memorial Homes (VMHs) as the population base to address for this part of the P.L. This Report acknowledges the fact that 525 veterans do not constitute a statistically significant number. Furthermore, since these individuals were already on a waiting list for the VMHs their condition of health might not be

representative of that for all veterans in the State. However, given the constraints imposed on this Report, it was felt that this survey would serve to provide a rough number from which the magnitude of the veteran home healthcare issue could be debated. In order to gather information on these veterans a survey was used as the methodology to garner information.

The second general veteran population identified for the Report in the P.L. was disabled veterans. There are approximately 48,932 veterans classified as disabled in New Jersey by the U.S. Department of Veterans Affairs (DVA). This represents nine percent of the total veteran population for the state. The DVA initially created seven Priority Groups for veteran compensation. This was later expanded by the DVA to eight priority groups, with Priority Group 8 having the lowest priority.

There are two Priority Categories of the eight Priority Categories that impact more directly on this Report than the others. The primary one is Category 4 which is the most restrictive and is reserved for Catastrophically Disabled (CD) veterans. Generally, veterans placed in this category are receiving Aid and Attendance or Housebound Benefits. For the parameters of this report, based on DVA data, it was safe to assume that these veterans are already receiving home healthcare.

The other category that bears more directly on this report is Category 5 which is reserved for veterans who are determined to be unable to defray the expenses of care needed. Again, for the parameters of this Report, based on DVA data, it was safe to assume these veterans are being compensated by the DVA for home healthcare services rendered.

Based on the survey of the veterans on the waiting list it was determined that roughly ten percent of that population desired home health care. This percentage was then applied to the veteran population as a whole and the following extrapolations were made:

- There are 526,651 veterans currently residing in New Jersey.
- Of this, approximately 248,530 are over 65 years old. Subtracted from this total is the number of veterans currently receiving home healthcare from the DVA; those already in the three state VMHs, those already on the waiting list, and those categorized as Priority 4 and 5 by the DVA. This then becomes the total number of elderly veterans who may be eligible for home healthcare, 221,373.
- For the purposes of this study, 10% of those eligible above was used for the projection of cost. This percentage was extrapolated from the veteran survey, which will be discussed in Section III. The percentage number equates to 22,137 veterans, hence this becomes “n” (n = 22,137).

Current costs for providing home healthcare services were obtained from the New Jersey Department of Health and Senior Services (DHSS). For this report, the figure \$2,143.00 was used for home healthcare. This equates to a visiting nurse coming once a month and a Certified Home Health Aide making two, two-hour visits a week, for a year for one veteran. It is understood that the home healthcare indicated above represents minimal custodial care and does not address any form of skilled nursing care. Based on this, funding projections were made and funding examples presented. Some example options:

EXAMPLE 1:

- Considered providing home healthcare as indicated above to 10% of the eligible veteran population.

- Considered supporting programs:
 - Hiring a DMAVA Home Healthcare program manager (Navigator),
 - Hiring six new Veteran Service Officers (VSOs),
 - Giving VSOs access to the DHSS NJEASE Program,
 - Publishing a “Veterans Guide” dedicated to Home Healthcare,
 - Funding a robust Outreach Campaign, and
 - Funding a Rutgers Veteran Home Healthcare Study.
 - Establishing a pilot program in 2 counties before fully implementing statewide.
- The projected cost for **five** years for this option equals **\$271,103,926.00***

*Figure does not include costs for expanding operational overhead required to administer a larger population.

EXAMPLE 2:

- Considered providing home healthcare as indicated above to 525 veterans currently on the waiting lists for the three Veteran Memorial Homes (VMHs).
- Considered supporting programs:
 - Hiring a DMAVA Home Healthcare program manager (Navigator),
 - Hiring six new Veteran Service Officers (VSOs),
 - Giving VSOs access to the DHSS NJEASE Program,
 - Publishing a “Veterans Guide” dedicated to Home Healthcare,
 - Funding a robust Outreach Campaign, and
 - Funding a Rutgers Veteran Home Healthcare Study.
 - Establishing a pilot program in 2 counties before fully implementing statewide.
- The projected cost for **five** years for this option equals **\$10,024,694.00.***

*Figure does not include costs for expanding the present DHSS programs.

EXAMPLE 3:

Considered providing no additional home healthcare services to veterans, but rather providing supporting programs to assist veterans in obtaining home healthcare through existing programs.

- As noted above, this would include such programs as:
 - Hiring a DMAVA Home Healthcare program manager (Navigator),
 - Hiring six new Veteran Service Officers (VSOs),
 - Giving VSOs access to the DHSS NJEASE Program,
 - Publishing a “Veterans Guide” dedicated to Home Healthcare,
 - Funding a robust Outreach Campaign, and
 - Funding a Rutgers Veteran Home Healthcare Study.
 - Establishing a pilot program in 2 counties before fully implementing statewide.

The projected cost for five years for this option equals **\$3,682,541.00**.

A synopsis of the recommendations for this Report which is Example 3 above is given as follows:

- Fund an expansive Veteran Outreach/Education Program on home healthcare.
- Establish a Governor’s Forum to increase cross-Department discussion and information sharing on home healthcare program availability in the State.
- Cross train all State Veteran Service Officers (VSOs) on the DHSS NJEASE Program and install access to this program on all VSO office computers.
- Contract a new or up-dated Rutgers Study on veteran home healthcare.
- Hire a DMAVA home healthcare “Navigator” and add six new VSOs to handle the increase.

Although it was not within the scope of P.L. directive, a recommendation was also made to fund the construction of independent living wings at the Menlo Park and Paramus State Veteran Homes as either new or rehabilitative projects. This would serve to provide a continuum for veterans from home healthcare to long term care. The

Vineland VMH has an independent living wing and this has proven to be enormously popular.

Home healthcare in New Jersey is a complex and expensive proposition. As demonstrated in this report, there already exists a myriad of home healthcare services available to veterans provided by numerous agencies, with often overlapping services. In order to insure veterans the availability of home healthcare, an overarching strategy must be developed to integrate home healthcare into the continuum of an overall health program for seniors and the disabled, which progresses from independent living at home to eventual residence in a long-term care facility.

Even within the limited scope of this small study it became exceedingly clear that based on current funding and resources, it is simply not possible to provide even minimal home healthcare for every eligible elderly veteran within the State of New Jersey. The funding for home healthcare would be additive, and would not be an option to closing the VMHs.

Finally, in considering future changes to programs and accessibility of veterans to home healthcare it must, in the end, be fiscally feasible and prudent. Ultimately, the cost must be affordable. There must be a fair balance that takes into account the New Jersey taxpayer, as well as those directly receiving the care under a home health system; a balance that assures a quality, efficient health care system, and does so for the long term.

SECTION I: Introduction

This report responds to Public Law (P.L.) 2007, Chapter 123 signed by Governor Corzine on 03 August 2007. The Law directed the New Jersey Department of Military and Veterans Affairs (hereafter DMAVA) to evaluate resources, costs, and benefits of providing home healthcare aides for qualified veterans. The law further directed that the Department “shall evaluate the resources available and the costs and benefits of providing home healthcare services to elderly or disabled veterans through approved agencies, organizations, or other entities for the purpose of enabling these veterans to remain in their homes.”

Furthermore, the Law directed the DMAVA to estimate the numbers of veterans that required home healthcare services, and make specific recommendations to the Legislature regarding the allocation of State funds necessary to meet these demands for each of the subsequent five State fiscal years.

The Law required that a written Report be submitted to the State Legislature not later than 180 days from the Law’s enactment (30 January 2008). Given this time limit, the decision was made to name this the 180-Day Veterans Home Healthcare Report.

Procedural Statement

Given the extent and complexity of veterans’ home healthcare, a Veterans Home Healthcare Advisory Committee (VHHAC) was formed. The VHHAC first met on 27 September 2007 at DMAVA and subsequent meetings were conducted throughout the period from September to January 2008. The Committee was composed of individuals from state agencies, private agencies and associations, and veteran organizations (see Appendix E). The Committee was instrumental in delineating the parameters for the

Report, examining home healthcare information, as well as providing general guidance for the production of the Report.

The Law specified the New Jersey Department of Health and Senior Services (DHSS) as a consulting partner with DMAVA for the production of the Report. Contact was made with the DHSS in September 2007 and continued throughout the production of the Report.

Construct of the Report

The intent of this Report is to provide an introduction to home healthcare in New Jersey in order to generate informed discourse as to which direction State government should pursue. Given the complexity of home healthcare and the constraints imposed on the production of this Report, it would be prudent to only use this Report as the first step in developing future actions in the area of home healthcare for veterans. The data provided in this Report, while not statistically significant, will still serve to provide a rough estimate of the scope and costs involved in providing home healthcare for the veteran community.

It became apparent early during VHHAC discussions that due to the complexity and magnitude of home healthcare in New Jersey that there was general confusion within the veterans' community and by legislative representatives on this issue. Therefore, since this Report was envisioned as a "primer" or "playbook" to inform the reader on the issue of home healthcare, a large part of this Report was constructed to be educational and informative in nature.

In order to complete the Report, it was necessary to define the two broad categories named in the Law. The first category was to ascertain "what is a veteran,"

since there is a discrepancy between the state and the federal definition of what constitutes veteran status. Secondly, we needed to clearly define the population of elderly and disabled veterans that would be addressed by the Report.

For the purposes of this Report, a Veteran is defined along federal guidelines as: “A person who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable.”

On the second issue concerning the population for the Report, it was determined that the sample size for the elderly population would be the 500+ veterans who were already on the approved waiting lists for the three Veteran Memorial Homes (hereafter VMHs), as well as an additional 200 veterans polled from the veterans’ organizations in the state. The procedure and results from this will be discussed in Section III. The disabled veteran population was taken from the rolls of the 49,000 disabled veterans identified by the U.S. Department of Veterans Affairs (hereafter DVA). This population will be discussed in detail in Section III as well.

Constraints of the Report

In order to provide perspective on this Report, a brief discussion of the constraints is appropriate. The Report was constrained by both time and resources, and is therefore not an exhaustive study of the issue of Veterans’ Home Healthcare. The Report was limited to completion within 180 days with no extensions approved. Additional funding was not provided for the completion of the Report, nor was additional personnel approved for employment to assist in the completion of the Report. The Department of Military and Veterans Affairs does not possess a research or statistical division. Therefore, the study does not meet normally accepted research standards. To

put this in perspective, the DMAVA contracted a similar study on this subject in 1995.

This study took two years to complete with a staff of 18 researchers, discounting clerical support, and cost in excess of \$78,000.00.

SECTION II: Discussion of Home Healthcare (An Overview)

Home Healthcare

Any serious discussion of Home Healthcare must begin with a definition of what constitutes Home Healthcare. Section II will attempt to portray a fairly comprehensive view of this extremely complex issue. Home healthcare can be part-time, intermittent care (both skilled care and custodial care), or full-time care (skilled or custodial care), provided to individuals in their place of residence for the purpose of promoting, maintaining, or restoring health; or for minimizing the effects of disability and illness, including terminal illness. Home healthcare must be ordered by a physician.

Most types of home healthcare services must be prescribed/ordered by a physician who writes the initial order for a nurse or therapist to evaluate the patient for home healthcare services. The physician establishes the goals of treatment/goals of care; orders which disciplines will be involved in the treatment process (e.g. nurses, physical therapists, aides, and so on), and also orders the frequency of visits by the various disciplines. Furthermore, the physician prescribes the length of time home healthcare will be provided in order to achieve the goals of care (...for example, the physician will order skilled nursing care 3 times per week for 3 weeks, then twice per week for 2 weeks, then once per week for 2 weeks, then if the patient is stable and the goals of care have been met, the patient may be discharged from home healthcare). The physician must sign the orders to begin the visits/treatments and authorizes and signs the orders to implement the Plan of Care that is written by the professional staff (nurses and therapists) after they have done a complete assessment of the patient and the patient's needs. The medical doctor periodically reviews the orders and updates

them, signs new orders, and revises the Plan of Care in consultation with the professional staff when the patient's condition changes, and functions as the leader of the home healthcare team.

The Sequence of Home Healthcare

Home healthcare services are comprehensive and coordinated, and are provided in a sequence which includes first Identifying the Need for home healthcare. Early identification by the patient, family, physician, or others of the patient's need for home health care services is the first step in providing home healthcare services. Once the need for home healthcare is established, a Physician's Order to Evaluate may be required. The veteran or family must obtain a physician's initial orders to have a home health agency staff person come into the home to assess the patient's need for home healthcare services. There follows an Evaluation by an RN or PT. This is a professional assessment (by a registered nurse or physical therapist) of the current health status and the functional potential of the patient. This results in establishing the Goals of Care, which include both long-term and short-term goals and a determination of what level of functioning the patient should be able to achieve by the end/termination of home healthcare services. The next step is writing the Plan of Care, which is the development of a written plan of care to include preventive, restorative, and maintenance therapies to be provided, including the amount, frequency and duration of treatments; the extent of the beneficiary's, family's, and interested persons involvement (for example, teaching PT exercises, learning to administer insulin, etc.); and specific, written orders that must be approved/signed by the patient's physician.

After the Evaluation has been done and the Plan of Care has been established, the staff must Provide Care. This is the very heart of home healthcare, and comprises the actual delivery of services by both the professional and paraprofessional staff in accordance with the plan of care and the physician's orders. Periodically, the professional staff must Monitor and Revise the Plan of Care. Health monitoring and regular reassessment by professional staff is done so that the plan of care and the services required may be changed, adapted, and increased or decreased in frequency and intensity as changes in the patient's status and function occur. The final stage of home healthcare is the Discharge. Discharge planning in all areas of care is coordinated with short and long-term goals. When the patient achieves the goals of care or reaches the targeted level of functioning, the patient will be discharged from home healthcare services.

Types of Home Healthcare

There are two overall categories of home healthcare: skilled care and custodial care. Skilled Care is a level of care that is medically necessary and includes preventive, rehabilitative and therapeutic services that can only be performed safely and correctly by a licensed nurse or a licensed therapist. Skilled care must be ordered by a physician.

Skilled Care provides Preventive, Rehabilitative, and Therapeutic Services that may include: Skilled Nursing Care – provided by either a registered nurse (RN) or a licensed practical nurse (LPN); Physical Therapy – provided by a licensed physical therapist (PT); Occupational Therapy – provided by a licensed occupational therapist (OT); Speech Therapy (Speech-Language Pathology) – provided by a licensed speech language pathologist. (ST); Medical Social Services – provided by a certified or licensed

social worker; either a certified social worker (CSW), a licensed social worker (LSW), a licensed clinical social worker (LCSW), or a Masters in Social Work (MSW);

Dietary/Nutritional Services – provided by a registered dietitian (RD); and Durable Medical Equipment (DME) – which may include walkers, wheelchairs, hospital beds, oxygen, etc., and may be provided as an adjunct to skilled care services.

Custodial care is usually “hands-on” maintenance care that assists a person with the **Activities of Daily Living (ADLs)**, to include bathing, dressing, feeding, toileting, assisting the patient to ambulate, changing diapers, changing bed linen, washing bed linen and patient’s personal clothing, preparing meals, shopping for food, light dusting, and vacuuming of patient’s bedroom, etc., performed by a paraprofessional such as a home health aide (HHA), a personal care assistant (PCA), or a homemaker/chore worker. There are two general types of custodial care: (1) Personal Custodial Care which is care that is provided by part-time or full-time certified home health aides (CHHA) or personal care assistants (PCA) who provide assistance with the Activities of Daily Living (ADLs) such as bathing dressing, toileting, feeding, or other personal care services, and (2) Non-Personal Custodial care that includes part-time help from homemakers, chore workers, or companions for house cleaning, food shopping, laundry, and other non-personal care services.

There are specific parameters for custodial care in New Jersey. For example, homemaker-home health aide services shall be performed by a New Jersey certified homemaker-home health aide, under the direction and supervision of a registered professional nurse. Furthermore, services include personal care, health related tasks, and household duties. In all areas of service, the homemaker-home health aide shall

encourage the well members of the family, if any, to carry their share of responsibility for the care of the beneficiary in accordance with the written established professional plan of care. Household duties shall be considered covered services only when combined with personal care and other health services provided by the home health agency.

Additionally, non-personal custodial care (or household duties) may include such services as the care of the beneficiary's room, personal laundry, shopping, and meal planning and preparation. In contrast, personal custodial care services may include assisting the beneficiary with grooming, bathing, toileting, eating, dressing, and ambulation. The determining factor for the provision of household duties shall be based upon the degree of functional disability of the beneficiary, as well as the need for physician-prescribed personal care and other health services, and not solely the beneficiary's medical diagnosis. The registered professional nurse, in accordance with the physician's plan of care, shall prepare written instructions for the homemaker-home health aide to include the amount and kind of supervision needed by the homemaker-home health aide, the specific needs of the beneficiary, and the resources of the beneficiary, the family, and other interested persons. Supervision of the homemaker-home health aide in the home shall be provided by the registered professional nurse at a minimum of one visit every two weeks for Medicare services, and once every 60 days for non-Medicare services, when in conjunction with skilled nursing, physical or occupational therapy, or speech-language pathology services. In all other situations, supervision shall be provided at the frequency of one visit every 30 days.

Supervision for personal care services may be provided up to one visit every two months, if written justification is provided in the agency's records. Finally, the registered

professional nurse, and other professional staff members, shall make visits to the beneficiary's residence to observe, supervise, and assist, when the homemaker-home health aide is present or when the aide is absent, to assess relationships between the home health aide and the family and beneficiary and determine whether goals are being met.

Home healthcare is highly regulated in New Jersey. Each type of home healthcare described above has its own set of statutes and regulations. There are basically three types of Licensed Agencies in New Jersey.

Types of Licensed Agencies*

The first type of licensed agency is a Home Health Agency (HHA), which typically provides “per visit” services. At a minimum, HHA's must provide at least skilled nursing (RN or LPN), Physical Therapy (PT), and certified home health aides (CHHAs). Generally, HHA's also provide Occupational Therapy (OT), Speech-Language Pathology (ST), Medical Social Work (MSW), and Nutrition Counseling/Registered Dietitian (RD). HHA's are approved for most payers, including Medicare and Medicaid. Note that certain private insurance companies may restrict use to agencies with whom they contract. The state requirements for HHA's indicate that these service agencies must be licensed as a Home Health Agency by the New Jersey Department of Health and Senior Services (DHSS); N.J.A.C. 8:42; N.J.A.C. 8:43E; see <http://www.state.nj.us/health/healthfacilities>. The Federal Requirements for HHAs are covered under Medicare, and certified by the Centers for Medicare and Medicaid Services (CMS) ; 42 CFR Part 484 Public Law; see <http://www.cms.hhs.gov>. The Home

Care Association of New Jersey notes that there are currently 51 Medicare-Certified Home Healthcare Agencies in New Jersey.

The second type of licensed agency are Hospice agencies. These provide comprehensive care to the terminally ill, including skilled nursing, social work, chaplains, certified home health aides, volunteers, and other services. These services are approved for most payers, including Medicare and Medicaid. Note that certain private insurance companies may restrict use to agencies with whom they contract. Hospice agencies are controlled by State Requirements and are licensed as a Hospice by the New Jersey Department of Health and Senior Services; N.J.A.C. 8:42C; N.J.A.C. 8:43E; see <http://www.state.nj.us/health/healthfacilities>. The federal requirements for Hospice are covered under Federal Requirements delineated by Medicare, certified by the Centers for Medicare and Medicaid Services (CMS) ; 42 CFR Part 418 Public Law; see: <http://www.cms.hhs.gov>. The Home Care Association of New Jersey notes that there are currently 58 licensed Hospice Agencies in New Jersey.

The third type of licensed agencies are Health Care Service Firms (HCSF). These agencies typically provide hourly services. HCSF's generally provide certified home health aides and nursing services. They may also provide therapies, housekeeping, companions, and/or other services. There are no minimum or mandatory services required by regulation. HCSF services may be approved by Medicaid, managed care, or other community programs. HCSF's cannot provide Medicare services. The State requires that HCSF's be licensed as a Health Care Services Firm (HCSF) by the New Jersey Department of Law and Public Safety, Division of Consumer Affairs; N.J.A.C. 13:45B (Subchapters 14 and 15). There are no federal regulations for

health care services firms; see <http://www.njconsumeraffairs.gov>. The Home Care Association of New Jersey notes that there are currently over 600 licensed Health Care Service Firms in New Jersey.

*Courtesy of the Home Care Association of New Jersey, Inc. www.homecarenj.org.

There have always been a number of uncertified and/or unlicensed individuals or companies that operate by calling themselves “Independent Providers” of home healthcare. In performing research for this Report, it has been noted that there are numerous offers on the Internet that encourage people to form their own home healthcare company and “reap the financial rewards.” These uncertified and unlicensed “home healthcare companies” are not regulated by, nor do they have to comply with, any State or Federal regulations regarding staff qualifications, quality assurance, or infection control issues, to name a few important considerations. It is beyond the scope of this Report to address the issue of veterans utilizing these uncertified or unlicensed home health agencies. Therefore, the eternal warning of *caveat emptor*, or “let the buyer beware,” seems to be appropriate here.

Description of Items and Services Provided by Home Health Agencies

There are standard items and services that one can reasonably expect will be provided by all licensed and certified private, federal, and state-sponsored home health agencies. This section will attempt to give a broad overview of these items and services, as well as the rationale for their inclusion.

Covered home healthcare services are those services provided according to medical, nursing, and other health care related needs, as documented in the individual plan of care, on the basis of medical necessity and on the goals to be achieved and/or

maintained. These covered home healthcare services are directed towards rehabilitation and/or restoration of the beneficiary to the optimal level of physical and/or mental functioning, self-care and independence, or directed toward maintaining the present level of functioning and preventing further deterioration, or directed toward providing supportive care in declining health situations.

The types of home health agency services covered include professional nursing by a public health nurse, registered professional nurse, or licensed practical nurse; certified homemaker home health aide services; physical therapy; speech-language pathology services; occupational therapy; medical social services; nutritional services; certain medical supplies; and personal care assistant services.

Nursing (RN or LPN) Services. The home health agency shall provide comprehensive nursing services under the direction of a public health nurse Supervisor/Director as defined by the New Jersey State Department of Health and Senior Services. These services shall include, but not be limited to, the following: participating in the development of the plan of care with other health care team members, which includes discharge planning; identifying the nursing needs of the beneficiary through an initial assessment and periodic reassessment; planning for management of the plan of care particularly as related to the coordination of other needed health care services; skilled observing and monitoring of the beneficiary's responses to care and treatment; teaching, supervising and consulting with the beneficiary and family and/or interested persons involved with his or her care in methods of meeting the nursing care needs in the home and community setting; providing direct nursing care services and procedures including, but not limited to: (1)

Wound care/decubitus care and management; (2) Enterostomal care and management; (3) Parenteral medication administration; and (4) Indwelling catheter care.

Additionally, nursing care seeks to implement restorative nursing care measures involving all body systems including, but not limited to: (1) Maintaining good body alignment with proper positioning of bedfast/chairfast beneficiaries; (2) Supervising and/or assisting with range of motion exercises; (3) Developing the beneficiary's independence in all activities of daily living by teaching self-care, including ambulation within the limits of the treatment plan; and (4) Evaluating nutritional needs including hydration and skin integrity, observing for obesity and malnutrition.

Nursing care also involves teaching and assisting the beneficiary with practice in the use of prosthetic and orthotic devices and durable medical equipment as ordered; providing the beneficiary and the family or interested persons support in dealing with the mental, emotional, behavioral, and social aspects of illness in the home; preparing nursing documentation including nursing assessment, nursing history, clinical nursing records and nursing progress notes; and supervising and teaching other nursing service personnel.

In the category of Certified Homemaker – Home Health Aides, these health services shall be performed by a New Jersey Certified Homemaker-Home Health Aide (CHHA), under the direction and supervision of a registered professional nurse. Services include personal care, health related tasks, and household duties. In all areas of service, the homemaker-home health aide shall encourage the well members of the family, if any, to carry their share of responsibility for the care of the beneficiary in accordance with the written established professional plan of care. Household duties

shall be considered covered services only when combined with personal care and other health services provided by the home health agency. Household duties may include such services as the care of the beneficiary's room, personal laundry, shopping, and meal planning and preparation. In contrast, personal care services may include assisting the beneficiary with grooming, bathing, toileting, eating, dressing, and ambulation. The determining factor for the provision of household duties shall be based upon the degree of functional disability of the beneficiary, as well as the need for physician prescribed personal care and other health services, and not solely the beneficiary's medical diagnosis.

Additionally, a registered professional nurse, in accordance with the physician's plan of care, shall prepare written instructions for the certified homemaker-home health aide to include the amount and kind of supervision needed by the homemaker-home health aide, the specific needs of the beneficiary and the resources of the beneficiary, the family, and other interested persons. Supervision of the homemaker-home health aide in the home shall be provided by the registered professional nurse at a minimum of one visit every two weeks when in conjunction with skilled nursing, physical or occupational therapy, or speech- language pathology services. In all other situations, supervision shall be provided at the frequency of one visit every 30 days. Supervision may be provided up to one visit every two months if written justification is provided in the home health agency's records.

State regulations also stipulate that a registered professional nurse and other professional staff members shall make visits to the beneficiary's residence to observe, supervise, and assist when the homemaker-home health aide is present or when the

aide is absent to assess relationships between the home health aide, the family, and beneficiary and determine whether goals are being met.

Therapists – Overview - Special therapies include physical therapy, speech-language pathology services, and occupational therapy. Special therapists/pathologists shall review the initial plan of care and any change in the plan of care with the attending physician and the professional nursing staff of the home health agency. The attending physician shall be given an evaluation of the progress of therapies provided, as well as the beneficiary's reaction to treatment and any change in the beneficiary's condition. The attending physician shall approve of any changes in the plan of care and delivery of therapy services.

Furthermore, the attending physician shall prescribe, in writing, the specific methods to be used by the therapist and the frequency of therapy services. Special therapists shall provide instruction to the home health agency staff, the beneficiary, the family, and/or interested persons in follow-up supportive procedures to be carried out between the intermittent services of the therapists to produce the optimal and desired results.

Physical Therapy (PT). When the agency provides or arranges for physical therapy services, they shall be provided by a licensed physical therapist. The duties of the physical therapist shall include, but not be limited to, the following:

- Evaluating and identifying the beneficiary's physical therapy needs;
- Developing long and short-term goals to meet the individualized needs of the beneficiary and a treatment plan to meet these goals. Physical therapy orders shall be related to the active treatment program designed by the attending physician to assist the beneficiary to his or her maximum level of function which has been lost or reduced by reason of illness or injury;

- Observing and reporting to the attending physician the beneficiary's reaction to treatment, as well as any changes in the beneficiary's condition;
- Documenting clinical progress notes reflecting restorative procedures needed by the beneficiary, care provided, and the beneficiary's response to therapy, along with the notification and approval received from the physician; and
- Physical therapy services which may include, but not be limited to, active and passive range of motion exercises, ambulation training, and training for the use of prosthetic and orthotic devices. Physical therapy does not include physical medicine procedures administered directly by a physician or by a physical therapist which are purely palliative. For example, applications of heat in any form, massage, routine, and/or group exercises, assistance in any activity or in the use of simple mechanical devices not requiring the special skill of a qualified physical therapist.

Speech-Language Pathologist (ST). When the agency provides or arranges for speech-language pathology services, the services shall be provided by a certified speech-language pathologist. The duties of a speech-language pathologist shall include, but not be limited to, the following:

- Evaluating, identifying, and correcting the individualized problems of the communication impaired beneficiary;
- Developing long and short-term goals and applying speech-language pathology service procedures to achieve identified goals;
- Coordinating activities with and providing assistance to a certified audiologist, when indicated;
- Observing and reporting to the attending physician the beneficiary's reaction to treatment, as well as any changes in the beneficiary's condition; and
- Documenting clinical progress notes reflecting restorative procedures needed by the beneficiary, the care provided, and the beneficiary's response to therapy, along with the notification and approval received from the physician.

Occupational Therapy (OT). The need for occupational therapy is not a qualifying criterion for initial entitlement to home health service benefits. However, if an individual has otherwise qualified for home health benefits, his or her eligibility for home health

services may be continued solely because of his or her need for occupational therapy.

Occupational therapy services shall include, but not be limited to, activities of daily living, use of adaptive equipment, and home-making task oriented therapeutic activities.

When the agency provides or arranges for occupational therapy services, the services shall be provided by a registered occupational therapist. The duties of an occupational therapist shall include, but not be limited to, the following:

- Evaluating and identifying the beneficiary's occupational therapy needs;
- Developing long and short-term goals to meet the individualized needs of the beneficiary and a treatment plan to achieve these needs;
- Observing and reporting to the attending physician the beneficiary's reaction to treatment as well as any changes in the beneficiary's condition;
- Documenting clinical progress notes reflecting restorative procedures needed by the beneficiary, the care provided, and the beneficiary's response to therapy, along with the notification and approval received from the physician; and
- Occupational therapy services shall include, but not be limited to, activities of daily living, use of adaptive equipment, and homemaking task oriented therapeutic activities.

Social Work (MSW). When the agency provides or arranges for medical social services, the services shall be provided by a social worker or by a social work assistant under the supervision of a social worker. These shall include, but not be limited to, the following:

- Identifying the significant social and psychological factors related to the health problems of the beneficiary and reporting any changes to the home health agency;
- Participating in the development of the plan of care, including discharge planning with other members of the home health agency;
- Counseling the beneficiary and family/interested persons in understanding and accepting the beneficiary's health care needs, especially the emotional implications of the illness;

- Coordinating the utilization of appropriate supportive community resources, including the provision of information and referral services; and
- Preparing psychosocial histories and clinical notes.

Nutrition / Registered Dietitian (RD). When the agency provides or arranges for nutritional services, the services shall be provided by a registered dietitian or nutritionist. These services shall include, but are not limited to, the following:

- Determining the priority of nutritional care needs and developing long and short-term goals to meet those needs;
- Evaluating the beneficiary's home situation, particularly the physical areas available for food storage and preparation;
- Evaluating the role of the family/interested persons in relation to the beneficiary's diet control requirements;
- Evaluating the beneficiary's nutritional needs as related to medical and socioeconomic status of the home and family resources;
- Developing a dietary plan to meet the goals and implementing the plan of care;
- Instructing beneficiary, other home health agency personnel, and family/interested persons in dietary and nutritional therapy; and
- Preparing clinical and dietary progress notes.

Durable Medical Equipment (DME). Medical supplies, other than drugs and biologicals, including, but not limited to, gauze, cotton bandages, surgical dressing, surgical gloves, ostomy supplies, and rubbing alcohol shall be normally supplied by the home health agency as needed to enable the agency to carry out the plan of care established by the attending physician and agency staff.

- When a beneficiary requires more than one month of medical supplies, prior authorization for the supplies shall be requested and received from the payor source. Requests for prior authorization of an unusual or an excessive amount of medical supplies provided by an approved medical supplier shall be accompanied by a personally signed, legible prescription from the attending physician.

- When a beneficiary requires home parenteral therapy, the home health agency shall arrange the therapy prescribed with a medical supplier specialized to provide such services.
- Provision of disposable parenteral therapy supplies, which are required to properly administer prescribed therapy, shall be the responsibility of the agency.
- Medical equipment is an item, article, or apparatus which is used to serve a medical purpose, is not useful to a person in the absence of disease, illness or injury, and is capable of withstanding repeated use (durable). When durable medical equipment is essential in enabling the home health agency to carry out the plan of care for a beneficiary, a request for authorization for the equipment shall be made by an approved medical supplier.

Personal Care Assistant (PCA) Services. Personal care assistance services shall be provided by a certified, licensed home health agency or by a proprietary or voluntary non-profit accredited healthcare service firm.

- Personal care assistant services are health-related tasks performed by a qualified individual in a beneficiary's place of residence, under the supervision of a registered professional nurse, as certified by a physician in accordance with a written plan of care.
- Personal Care Assistant (PCA) Services for the Mentally Ill - Personal care assistant services are health-related tasks performed by a qualified individual in a beneficiary's place of residence, under the supervision of a registered professional nurse, as certified by a physician in accordance with a written plan of care.

Rules and Parameters of Home Healthcare

Federal and New Jersey public law and legislative code place specific parameters on who may have access to skilled home healthcare. Some of these requirements are: (1) a patient must be under the care of a physician/patient must have an order for home healthcare from a physician; (2) the patient must require skilled nursing, physical therapy, occupational therapy, or speech therapy on an intermittent

basis; (3) care is medically reasonable and necessary; (4) the patient is “homebound.”

(For Medicare and for certain insurance plans, patients must be homebound to qualify for home healthcare services. This means that because of a physical condition or limitations, the patient cannot leave home without extreme difficulty or hardship.

Homebound status is not affected by absences from home for doctor’s visits or medical treatments such as dialysis or chemotherapy); (5) the patient’s needs can be met on an intermittent or part-time basis; (6) the patient resides in a home or facility that does not perform skilled care (e.g. a boarding home); and (7) a plan of care is developed and followed under the guidance of a physician.

Additionally, there are very real cost factors to consider when examining the parameters and making a determination of whether it is feasible to continue to provide in-home care for a person. For example, according to the VHA Handbook 1140.3, - “The total annual VHA costs for an individual veteran’s home and community-based care services, to include skilled home health care, homemaker/home health aide services, community adult day health care, and non-institutional respite services, will not exceed 65 percent (65%) of the monthly average per patient cost in the nearest DVA Nursing Home Care Unit (NHCU).”

This means that when the cost of providing home healthcare exceeds 65% of what it would cost to place the person into a DVA facility, it is cost-prohibitive to continue to try to maintain that person in their home.

Correspondingly, the State Medicaid program clearly states that “... [w]hen the cost of home care services is equal to or in excess of the cost of institutional care over a

protracted period (that is, six months or more), the Division (DMAHS) retains the right to limit or deny the provision of home care services on a prospective basis....The cost of Medicaid services provided shall not exceed the cost of institutionalization for the beneficiary.”

The Federal Medicare program, while not specifying a particular dollar amount or percentage, clearly also has guidelines. Medicare pays the home health agency a set amount of money for each 60-day period that the patient needs care at home. There is no ceiling on the number of covered visits, as long as the patient continues to meet the eligibility rules. Those eligibility rules include: the patient must be homebound; must have a need for skilled care; and must be under a Plan of Care established and periodically reviewed by the physician (physician orders must be re-signed every 60 days). Medicare does not pay for long-term custodial care at home; it only pays for custodial care while the person is receiving intermittent skilled care. When the skilled care stops, so does the custodial care, unless the patient makes other arrangements.

Who Pays for Home Healthcare*

There are several methods available currently for paying for home healthcare. The first is, of course, Self-Pay. That is, home care services that fail to meet the criteria of third-party payors must be paid for “out of pocket” by the patient or other party. The patient and the home care provider negotiate the fees.

The second method is Medicare. Most Americans 65 or older are eligible for the federal Medicare program. If an individual is homebound, under a physician’s care, and requires medically necessary skilled nursing or therapy services, he/she may be eligible for services provided by a Medicare-certified home health agency. Medicare Hospice

Benefit – Hospice services are available to individuals who are terminally ill and have a life expectancy of six months or less. There is no requirement for the patient to be homebound or in need of skilled nursing care. A physician's certificate is required to qualify an individual for the Medicare Hospice benefit.

The third major method of payment is Medicaid, which is administered by the states. Medicaid is a joint federal-state medical assistance program for low-income individuals. Patients must meet New Jersey Medicaid eligibility requirements.

Other methods of payment include the Older Americans Act (OAA). Enacted by Congress in 1965, the OAA provides federal funds for state and local social service programs that enable frail and disabled older individuals to remain independent in their communities. This funding covers home health aides, personal care, chore, escort, meal delivery, and shopping services for individuals with the greatest social and financial need who are 60 years of age and older. Services are provided through the local Area Agency on Aging (AAA), which will either provide services directly or in cooperation with local organizations.

The U.S. Department of Veterans Affairs (DVA) – All veterans who are enrolled in the DVA system are eligible for home healthcare coverage provided by the DVA. A physician must authorize these services, which must be delivered through the DVA's network of hospital-based home care units. (Other veterans may be eligible for home care services through the DVA, but they must individually establish their eligibility with the DVA by contacting their local New Jersey Veterans Services Officer (VSO) in the County in which they reside. Please see Appendix D.)

Social Services Block Grants – Each year states receive federal social services block grants for state-identified service needs. The government allocates these funds on the basis of the state's population and within a federal limit. Portions of the funds are often directed into programs providing home health aide, homemaker, or chore worker services.

Community Organizations provide another source of funding for patients. Some community organizations, along with state and local governments, provide funds for home health and supportive care. Depending on an individual's eligibility and financial circumstances, these organizations may pay for all or a portion of the needed services. Hospital discharge planners, social workers, local offices on aging (AAA), and the United Way are excellent sources for information about community resources.

Private Third-Party Payers – Commercial Health Insurance Companies – Commercial health insurance policies typically cover some homecare services for acute needs, but benefits for long-term care services vary from plan to plan.

Long-Term Care (LTC) Insurance is a relatively new concept within the insurance industry that provides for long-term, personal care needs generally not covered by health insurance or Medicare. LTC insurance was intended to protect individuals from the catastrophic expense of a lengthy stay in a nursing home. However, as the public need and preference for home care has grown, private LTC insurance policies have expanded their coverage of personal care, companionship, and other in-home services.

Managed Care Organizations (MCOs) and other group health plans sometimes include coverage for home care services. MCOs contracting with Medicare must provide

the full range of Medicare-covered home health services available in a particular geographic area. Most MCOs only pay for services that are pre-approved.

CHAMPUS – On a cost-shared basis, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) covers skilled nursing care and other professional medical home care services for dependents of active military personnel and military retirees and their dependents and survivors.

Finally, Workers' Compensation. Any individual requiring medically necessary home care services as a result of injury on-the-job is eligible to receive coverage through workers' compensation.

*The preceding is taken from the 2007 web site of the National Association for Home Care & Hospice at http://www.nahc.org/famcar_whopays.html

Issues Impacting on Home Health Care

There are several major societal and historic trends that presently impact on home healthcare. The most significant is the nursing shortage. As the Baby Boomers age and the need for health care grows, the United States is expecting a shortage of 340,000 registered nurses (RNs) by the year 2020. Fewer young people are entering the nursing profession, the average age of RNs is rising, and older nurses are leaving the profession. Additionally, U.S. nursing schools turned away 42,866 qualified nursing candidates from BSN and Masters programs in 2006 due to insufficient numbers of faculty members, clinical sites, classroom space and clinical preceptors, and due to budget constraints.

The second major issue confronting home healthcare is the certified home health aide shortage. Due to low wages, difficult working conditions, lack of health insurance coverage, and a loophole that prevents home health aides from receiving basic

minimum wage and overtime pay protection, there is a very high turnover rate and an increasing shortage of home healthcare aides.

One of the “hidden costs” of providing home healthcare is high transportation costs. High transportation costs, including the increasing price of gasoline and bus fares, also must be taken into account when estimating the cost of providing home healthcare.

Another parameter is the overall cost associated with healthcare. According to a recent Met Life survey, <http://www.metlife.com/Applications/Corporate/WPS/CDA/PageGenerator/0,4773,P8894,00.html>, it is estimated that the hourly cost to privately hire a home health aide (from one of the licensed Health Care Service Firms) to provide custodial care services in New Jersey is currently averaging around \$24 per hour. For individuals with Long-Term Care Insurance, the “usual and customary charge” for home health aides is also averaging around \$24 per hour. However, the individual usually receives a bill from the HCSF which they must first pay, then submit to the LTC insurance company for reimbursement.

Certificate of Need and Licensure

A significant constraint on the home healthcare agencies is the requirement for a Certificate of Need (CN). The CN process is controlled by the New Jersey Department of Health and Senior Services (DHSS) in the Certificate of Need and Acute Care Licensure Program. According to N.J.S.A. 26:2H-1 et. seq., (8:42-2.1 Certificate of Need*) and amendments thereto, a health care facility shall not be instituted, constructed, expanded, licensed to operate, or closed except upon application for and receipt of a Certificate of Need issued by the Commissioner of DHSS. Applications shall

provide the information required by N.J.A.C. 8:33 and N.J.A.C. 8:33L. The facility shall implement all conditions imposed by the Commissioner as specified in the Certificate of Need approval letter. Failure to implement the conditions may result in the imposition of sanctions in accordance with N.J.S.A. 26:2H-1 et seq., and amendments thereto.

*Taken directly from the Licensing Standards for Home Health Agencies-N.J.A.C. 8:42-New Jersey Department of Health and Senior Services –Certificate of Need and Acute Care Licensure Program

An Application for Licensure is the next step in the process for getting certified as a licensed home healthcare agency. Following acquisition of a Certificate of Need, any person, organization, or corporation desiring to operate a facility shall make application to the Commissioner for a license on forms prescribed by the DHSS in accordance with the requirements of this chapter. The DHSS shall charge a nonrefundable fee of \$2,000 for the filing of an application for licensure and each annual renewal of a home health agency. The DHSS shall charge a nonrefundable fee of \$1,000 for the filing of an application for the transfer of ownership of a home health agency. The DHSS shall charge a nonrefundable fee of \$250.00 for the filing of an application for the relocation of a home health agency. Any person, organization, or corporation considering application for license to operate a facility shall make an appointment for a preliminary conference at the DHSS with the Certificate of Need and Acute Care Licensure Program.

Once licensed each home health agency shall be assessed a biennial inspection fee of \$500.00. This fee shall be assessed in the year the facility will be inspected, along with the annual licensure fee for that year. The fee shall be added to the initial licensure for new facilities. Failure to pay the inspection fee shall result in non-renewal of the license for existing facilities and the refusal to issue an initial license for new

facilities. This fee shall be imposed only every other year, even if inspections occur more frequently, and only for the inspection required to either issue an initial license or to renew an existing license. This fee shall not be imposed for any other type of inspection.

After licensure, each agency is subject to State surveys. When the written application for licensure is approved and the building is ready for occupancy, a survey of the facility by representatives of the Certificate of Need and Acute Care Licensure Program of the DHSS shall be conducted to determine if the facility adheres to the rules in this chapter. The facility shall be notified in writing of the findings of the survey, including any deficiencies found. The facility shall notify the Certificate of Need and Acute Care Licensure Program of the DHSS when the deficiencies, if any, have been corrected, and the Certificate of Need and Acute Care Licensure Program will schedule one or more resurveys of the facility prior to issue of license. No health care facility shall accept patients until the facility has the written approval and/or license issued by the Certificate of Need and Acute Care Licensure Program of the DHSS. Survey visits may be made to a facility at any time, or to a patient's home, by authorized staff of the DHSS. Such visits may include, but not be limited to, a review of all facility documents and patient records and conferences with patients and/or their families.

Finally, a license shall be issued if surveys by the DHSS have determined that the health care facility is being operated as required by N.J.S.A. 26:2H-1 et seq., the Health Care Facilities Planning Act and amendments thereto, and by the rules in this chapter. The license shall be granted for a period of one year or less as determined by the DHSS. (See N.J.S.A. 26:2H-12.). This license shall be conspicuously posted in the

facility. The license is not assignable or transferable, and it shall be immediately void if the facility ceases to operate or its ownership changes. The license, unless sooner suspended or revoked, shall be renewed annually on the original licensure date, or within 30 days thereafter but dated as of the original licensure date. The facility will receive a request for renewal fee 30 days prior to the expiration of the license. A renewal license shall not be issued unless the licensure fee is received by the DHSS. The license may not be renewed if local rules, regulations, and/or requirements are not met.

It is important to note that no new Home Healthcare Agencies can be created/opened in New Jersey unless and until the DHSS issues a “call” for a CN for a new Home Healthcare Agency, and the “call” is published in the New Jersey Register. The “call” for a new CN for a home health agency is released County by County, not statewide, as the need arises. No new HHA’s can open unless one of the existing HHA’s gives up their CN, or goes out of business. The last “call” for a CN for Home Health Agencies in New Jersey took place around 1993-1994. The complete application for a CN can be found on the DHSS web site at <http://www.state.nj.us/health/> or at <http://www.doh.state.nj.us/forms/>. Since there are no current “calls” for a CN for new Home Health Agencies in New Jersey, there is no possibility of creating a new Home Health Agency within NJDMAVA at this point in time.

Licensing Standards for Home Health Agencies under DHSS can be found at N.J.A.C. 8:42.

Home Healthcare Services provided by the U.S. Department of Veterans Affairs (DVA), under the Veterans Health Administration (VHA)

The Veterans Health Administration (VHA) is the largest single provider of medical care in the United States. The DVA operates according to the federal government's fiscal year, which runs from October 1st to September 30th. To obtain DVA Healthcare Services, each Veteran must first be enrolled in their local DVA Healthcare System. To enroll in your local DVA Healthcare System, please contact your Veterans Services Officer (VSO) and he/she will assist you in this enrollment process. (Please see Appendix D for a complete listing of all VSOs in New Jersey.)

The DVA has divided America up into geographical areas called Veterans Integrated Service Networks, or VISNs. The two VISNs that serve New Jersey veterans are: VISN 3, covering northern and central New Jersey, and VISN 4, covering southern New Jersey.

Determine DVA Eligibility. The veteran must contact the DVA Eligibility Services Office to determine their individual eligibility to receive DVA healthcare services.

- VISN 3 – Eligibility Services at (973) 676-1000 x 3044.
- VISN 4 – Eligibility Services at 1-800-461-8262 x 4186.

The veteran must travel to a DVA clinic to be examined by a DVA physician as part of the determination of eligibility. The DVA physician will assess the veteran's medical/physical/psychological needs, and then fill out the DVA assessment form. New Jersey has DVA Outpatient Clinics in:

Brick	Hackensack	Paterson
Cape May	Jersey City	Sewell
Elizabeth	Morristown	Trenton
Fort Monmouth	New Brunswick	Ventnor
Ft. Dix	Newark	Vineland

Transportation. Veterans can arrange to be transported to the nearest DVA Clinic for this examination. Veterans in southern New Jersey can be transported to the Wilmington, Delaware DVA Clinic. Please contact your VSO to make transportation arrangements.

An Interdisciplinary Team from the DVA, consisting of physicians, nurses, social workers, psychologists, etc., will make the determination of whether or not the veteran requires home healthcare services through the DVA Home Healthcare System. This determination is based on an extensive set of DVA clinical criteria, as well as on the veteran's medical and psychological needs. This home healthcare is provided under the orders and authorization of a DVA physician. These orders must be renewed periodically, and when the veteran's medical condition changes.

The **DVA Home Healthcare System** provides skilled care such as nursing care, physical therapy, speech therapy, occupational therapy, dietitians, social workers and (most recently added), psychologists for counseling. The frequency of these skilled services/visits is determined by the physician's orders, as well as by the patient's medical condition.

Custodial Care. Homemaker-home health aide services are personal care and related support services that enable frail or disabled veterans to live at home by providing assistance with the activities of daily living (ADLs) such as bathing, dressing, toileting, food preparation, laundry, light housekeeping, etc. The DVA provides these custodial services up to six (6) hours per week (usually two (2) hours per day, three (3) days per week). The DVA provided certified homemaker-home health aide services to 1,075 veterans in FY 2006 and to 1,300 veterans in FY 2007.

The DVA is currently providing skilled home healthcare services to approximately 81 veterans, and unskilled (custodial) home healthcare services to approximately 1,215 veterans thus far in FY 2008, at a combined cost of approximately \$11,000,000. These numbers do not include veterans receiving home based primary care or home hospice care, since those are not considered either skilled or custodial. The DVA projects an increase in demand for home healthcare services of between 10% and 20% over the next five (5) years. However, this is a very inexact estimate due to current changes (as described elsewhere in this document), and the shifting needs in the veteran population.

Additionally, the DVA will provide Medical Adult Day Care for four to six (4-6) hours per day, two (2) days per week. Again, the veteran must be assessed by a DVA physician and authorized for these services. The DVA provided Medical Adult Day Care for 169 veterans in FY 2006; for 233 veterans in FY 2007; and is currently providing this for 175 veterans thus far in FY 2008. The DVA budget for Adult Daycare in FY 2008 is \$1,587,600.00, with a projected census of 210 veterans.

The DVA also provides Hospice (end-of-life) care at home for terminally ill veterans. Hospice services can be provided up to ten (10) hours per week. The DVA provided Hospice services to 16 veterans in FY 2006; to 56 veterans in FY 2007; and currently has provided Hospice care to 19 veterans thus far in FY 2008, with a projected census of 50 veterans, at a budget cost of \$329,944.50.

The DVA New Jersey Healthcare System (VISN 3) recently relocated a program, unique to the DVA, to Lyons called Home Based Primary Care (HBPC). HBPC is staffed by six (6) Nurse Practitioners, a part-time physician, and other professionals who go into

homebound veterans' homes to provide a "clinic visit" that the veteran would otherwise not be able to access. This care is provided to veterans who live within a sixty (60) mile radius of either Lyons or East Orange. This program "brings the DVA Clinic to the veteran's home."

The DVA purchases skilled home health services for veterans by contracting with existing licensed home health agencies throughout New Jersey; and provides certified homemaker-home health aide services (H/HHA) by contracting with existing homemaker-home health aide agencies. The DVA currently contracts with approximately 150 agencies throughout New Jersey, and anticipates that the FY 2008 budget costs for purchased H/HHA (custodial) services will be \$4,900,800.00; and the budget costs for purchased skilled care will be \$900,000.00.

The DVA-provided Respite Care can temporarily relieve the spouse or other caregiver from the burden of caring for a chronically ill or disabled veteran at home. Respite care is usually limited to 30 days per year, frequently offered in a 2-week increment, twice per year. The DVA budget for FY 2008 is \$30,000.00.

DVA Telehealth is the use of technology to provide and support the delivery of healthcare services, education, and administrative activities over a distance, using telecommunication technology and equipment (computers, video conferencing, etc.) for the direct benefit of individual patients. Telehealth includes actual physician-patient or nurse-patient interactions via telemedicine technologies and equipment. These Telehealth "visits" can monitor a veteran's blood pressure, weight, clinical status, and so on, and detect health problems in a more timely fashion, preventing poor medical

outcomes, emergency room visits, etc. The DVA Telehealth program currently has over 300 veterans participating.

While this is not, strictly speaking, home healthcare, mention must be made of the fact that the DVA has an on-campus, long-term care facility at Lyons, New Jersey, with a 266-bed census. A veteran must have at least a 70% service-connected disability, or a service connected disability for which nursing home care is needed to be admitted to one of these beds. The DVA has a **Contract Nursing Home (CNH) Program** to place veterans in local, community nursing homes, for which the DVA pays all costs for varying amounts of time. The projected budget costs for the Contract Nursing Home Program in FY 2008 is \$2,546,714.75. An additional \$50,000.00 per year is allocated for CNH emergency hospitalizations.

All enrolled veterans are eligible for a comprehensive array of medically necessary in-home services as identified in the DVA's medical benefits package (see Title 38 Code of Federal Regulations (CFR) 17.38(a)(1)(ix)).

Constraints of the DVA Home Healthcare Program - According to VHA Handbook 1140.3, dated August 16, 2004 (valid through the last working day of August 2009), entitled "Home Health and Hospice Care Reimbursement Handbook":

- "6f. The total annual VHA costs for an individual veteran's home and community-based care services, to include skilled home health care, homemaker/home health aide services, community adult day health care, and non-institutional respite services, will not exceed 65 percent (65%) of the monthly average per patient cost in the nearest DVA Nursing Home Care Unit (NHCU). DVA NHCU rates are available from the Office of Geriatrics and Extended Care (see subparagraph 6e for exemption)."

According to VISN 3, the DVA is currently (FY 2008) providing home healthcare to approximately 1,300 New Jersey veterans at a cost of \$11 million. The DVA does not anticipate the ability to significantly expand these services to encompass any additional veterans. See Appendix K for a more complete breakdown of the FY 2008 DVA budget for DVA-provided home healthcare services.

Home Healthcare Services provided by the New Jersey Department of Health and Senior Services (DHSS).

The Division of Aging and Community Services within DHSS offers a myriad of programs and services to New Jersey's elderly and disabled population. These services include:

NJEASE – The New Jersey Easy Access, Single Entry (NJEASE) is our state's senior service delivery system. A veteran's best first step to find out about and apply for in-home services is to call NJEASE toll-free at 1-877-222-3737. NJEASE connects each caller directly to the County Office on Aging in the County from which the call is made, or to the State Information and Assistance Senior Helpline, if calling from outside New Jersey. Both are reached by calling 1-877-222-3737.

The County Office on Aging serves as an advocate for senior citizens and is the central source of information and referral for services and programs for senior citizens within each County. Each Office on Aging usually distributes a directory of services and resources for older persons, as well as publishes a newsletter and other materials.

All seniors and their families, regardless of income, are eligible for NJEASE Information and Assistance, Outreach, and Care Management services. Eligibility requirements for other services and programs vary. The veteran may be entitled to

some of the listed services and programs if they have reached a certain age. Further, income and other requirements differ from program to program. It is necessary to contact NJEASE at your County Office on Aging or the State's Information and Assistance Senior Helpline to find out if the veteran qualifies for a particular service.

Information and Assistance – The provision of specific information or assistance, to or on behalf of older persons, which will link or enable individuals to obtain available services, benefits, or entitlements.

Benefits Screening – The completion and utilization of the current “Benefits Screening” section of the NJEASE Comprehensive Assessment Instrument.

Extended Assessment – The completion and utilization of the current Extended Assessment section of the NJEASE Comprehensive Assessment Instrument.

Outreach – A service, initiated by the service provider, which is designed to locate and identify specific older persons in need of specific services, and conducted to encourage and assist older persons to utilize particular benefit and/or program available to them.

Care Management – The development of a coherent care plan for arranging and coordinating the delivery of multiple services to vulnerable and/or functionally impaired older individuals.

Transportation – Conveyance of older persons to and/or from community facilities and resources for the purpose of acquiring/receiving available services, benefits or entitlements. Calculated on each one-way trip (per person).

Assisted Transportation – To provide an individualized linkage for functionally impaired or isolated older persons to enable them to utilize community facilities and

services, such as banks, stores, medical resources, and other necessary destinations which they are unable to access due to transportation and/or health barriers.

Newsletter – Providing timely, readable, relevant, service-oriented information through the form of a newsletter.

Friendly Visiting – An organized service that provides regular visits to socially and/or geographically isolated older individuals for purposes of providing companionship and social contact.

Telephone Reassurance – An organized service that provides regular telephone calls to homebound older persons to assure their well being and safety, and to provide social interaction and psychological reassurance.

Residential Maintenance – A service provided by volunteer or paid staff person for intermittent household and/or yard care to eligible older persons whose health and safety are threatened because they cannot perform these services by themselves, and/or are at risk of institutional placement.

Housekeeping – A service provided by a volunteer or paid staff person for routine basic upkeep and management of homes, for the purpose of enabling older persons to maintain themselves in their place of residence by removing housekeeping barriers.

Certified Home Health Aide – General support by certified and professionally supervised home health aides to maintain, strengthen, and safeguard the functioning of older individuals and families in their own homes during periods of illness or severe instability.

Visiting Nurse – 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.

Respite Care – Short-term or intermittent care, provided to older persons either in their homes or in other appropriate facilities, because of the absence or the need for relief of those persons normally providing care.

Hospice Care – 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.

Emergency – 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.

Homesharing/Matching – A living arrangement in which two or more unrelated people share the common areas of a house (the living room, kitchen, and often bathrooms) but each person has private sleeping space.

Housing Assistance – Assistance to persons in locating, obtaining, or retaining suitable housing.

Professional In-Home Education and Support – Provide individual education and support to unpaid caregivers at home so that they can improve their ability and effectiveness as caregivers and prolong their ability to provide care for an elderly or adult disabled individual.

Trained Volunteer Assistance – Provide well-trained, reliable volunteers affiliated with community and faith-based organizations who can respond quickly and courteously to caregivers' requests for help.

Caregiver Support Group – A group which meets on a regular basis, formed to help relieve caregiver stress and to provide peer support, education, and information to caregivers, both elderly and non-elderly, of older persons.

Adult Day Services – Social – A structured program for adults who require care and supervision in a protective setting for a portion of a 24 hour day, with emphasis on social and recreational activities in a group setting.

Adult Day Services – Medical – A structured program for adults who require care and supervision in a protective setting for a portion of a 24 hour day, with emphasis on the physically or cognitively impaired older adults.

Personal Care – Providing personal assistance, stand-by assistance, supervision, or cues for persons having difficulties with one or more of the following activities of daily living: eating, dressing, bathing, or toileting.

Adult Protective Services – Voluntary or court-ordered social, legal, financial, medical, or psychiatric services necessary to safeguard a vulnerable adult's rights and resources and to protect a vulnerable adult from abuse, neglect, or exploitation as carried out by the designated APS provider.

Legal Assistance – Legal advice, assistance, and/or representation provided by or under the supervision of a lawyer in order to protect and secure the rights of older persons.

Physical Health – Screening, assessment, and treatment activities which assist older persons to improve or maintain physical health by helping them to identify and understand their health needs and secure necessary medical, preventive health, or health maintenance services.

Physical Health – Dental – Services designed to provide assessment, diagnosis, or treatment in the care of the teeth or the mouth.

Mental Health – Services designed to evaluate older person's need or mental health intervention, determine the type of intervention needed, and/or provide appropriate intervention or treatment.

Counseling – Services designed to assist older persons by advising them or providing them with specific information so that they can make appropriate decisions and/or choices in the arrangement for, or delivery of, needed services.

Physical Fitness – Planned and structured activities aimed at improving or maintaining a person's physical health.

Education – Formally structured classes, lectures, or seminars which provide older persons and/or their caregivers with opportunities to acquire knowledge and skills suited to their interests.

Language Translation and Interpretation – Services for explaining oral and written communication to non-English-speaking, limited English speaking, hearing impaired, or other functionally impaired older persons.

Socialization / Recreation – Planned and structured activities and programs provided to well and functionally impaired older persons in order to facilitate social contact, reduce isolation, and improve personal life satisfaction.

Ombudsman – A trained interceder who acts on behalf of older individuals, their families, and other groups who have a complaint against an action or decision made by an owner, employee, or agent of a long-term care facility which may adversely affect the health, safety, rights, and/or welfare of older persons residing in long-term care facilities.

Money Management – A bill paying service that provides older or disabled people with volunteer assistance in budgeting, the processing of routine bills, check writing, managing financial matters, and/or reconciling bank accounts. The goal of the service is to provide guidance and non-intrusive bill paying assistance to maximize bill-paying capacity.

Caregiver Mental Health Counseling – Provides individual mental health counseling to help the caregiver with the normal anger, frustration, guilt, isolation, and depression that many individuals experience as caregivers.

Congregate Nutrition – The provision of nutritionally adequate meals which assure, at a minimum, one-third of the Recommended Dietary Allowance (RDA) to older persons at congregate meal sites.

Home Delivered Nutrition – The provision of nutritionally adequate meals which assure, at a minimum, one-third of the Recommended Dietary Allowance (RDA) to older persons in their places of residence.

State Weekend Home Delivered Meals – The provision of nutritionally adequate meals which assure, at a minimum, one-third of the Recommended Dietary Allowance (RDA) to older persons in their places of residence on weekends and/or holidays.

Nutrition Education – A program to promote better health through the provision of accurate nutrition and health-related information for participants of the congregate nutrition program, or other older adults in a group setting or homebound older adults.

Nutrition Counseling – Provision of individualized advice and guidance to older adults who are at nutrition risk because of their health or nutrition history, dietary intake, medication use, or chronic illness, about options and methods for improving their nutritional status.

The **Division of Aging and Community Services (DACS)** within DHSS also offers additional programs and services through the:

Office of Community Choice Options – Most seniors and people with disabilities in need of long-term care services prefer to get help in their homes or in a community setting, rather than in a nursing home. This office helps individuals learn about and access those services.

Community Choice Program – This program works with seniors and people with disabilities in hospitals or nursing homes who want to return home.

Pre-Admission Screening (PAS) – People seeking help from Medicaid to pay for in-home and long-term care services need to meet both financial and medical eligibility standards. PAS conducts clinical assessments.

Adult Family Care – Adult Family Care is a community program in which up to three people receive room, board, and other supportive health and social services in the home of another person. It is sometimes called adult foster care.

Alzheimer's Adult Day Services – The program partially subsidizes the purchase of adult day care services for persons with Alzheimer's disease or a related dementia.

Assisted Living – To make this option available to lower income individuals, the State administers this Medicaid waiver program.

Assisted Living Programs in Subsidized Housing – This program funds personal care, nursing, pharmaceutical, dietary, and social work services for individuals residing in publicly subsidized housing.

Assistive Technology – Assistive Technology refers to any item, device, piece of equipment, or set of products that is used to maintain or improve the functional capabilities of a person with a disability. Assistive technology can allow a person with disabilities to function more independently, thereby gaining self-confidence and increased functional independence.

Caregiver Assistance Program (CAP) – CAP is a Medicaid program designed to supplement the assistance an individual receives from his/her natural support network of family, friends, and neighbors, as well as from community agencies and volunteer groups. It provides thirteen (13) in-home services for eligible individuals.

Community Care Program for the Elderly and Disabled (CCPED) – The program provides case management, home health, homemaker, medical day care, non-emergency medical transportation, respite care, social day care, and prescribed drugs for eligible individuals living in the community.

Congregate Housing Services Program – This program provides supportive services to individuals who are elderly and disabled residing in selected subsidized housing facilities.

Global Options (GO) Nursing Facility Transition (NFT) – GO NFT is a new program for nursing home residents wishing to return to the community. It allows eligible participants to hire qualified family members, friends, or neighbors as service providers.

Jersey Assistance for Community Caregiving (JACC) – JACC is very similar to CAP, only for individuals with slightly higher incomes.

Social Adult Day Care – This adult day care option is for individuals who do not need medical attention during the day, but may need supervision to ensure their safety and well-being.

Statewide Respite Care Program – This program provides relief for unpaid caregivers by ensuring their loved ones are cared for while the caregiver takes personal time.

These programs and services can all be accessed by calling NJEASE at 1-877-222-3737.

The New Jersey Department of Health and Senior Services (DHSS) also oversees the **Area Agencies on Aging (AAA)** - the County Office on Aging. An Area Agency on Aging (AAA) is designated in each of New Jersey's twenty one (21) Counties to serve as the primary entity responsible for developing comprehensive, coordinated systems of community-based services for older adults. The role of the AAAs includes:

- Coordinating all programs on aging regardless of funding source, and serving as the central source for information and referral for services and programs.
- Preparing an Area Plan on Aging which includes an analysis of the needs and existing services with the County, and a comprehensive plan for the delivery of services to older people.

- Administering the annual allocation of federal Older Americans Act and state funds from the New Jersey Division of Aging and Community Services for projects and services within the County.
- Monitoring and evaluating projects funded under the Area Plan.
- Serving as an advocate to increase the public's understanding of the nature of the aging process and the aging individual.
- Advising local governments and the Division of Aging and Community Services of unmet needs, and recommending legislation where appropriate.
- The complete list of all New Jersey Area Agencies on Aging (AAAs) can be found in Appendix III.

See Appendix B for details on the costs/expenditures per client and per unit for AAA programs and services in 2006.

The Office of the Ombudsman for the Institutionalized Elderly (OOIE) – By statute, 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 New Jersey, and for promoting, advocating, and insuring the quality of care received, and the quality of life experienced by elderly residents of such facilities.

The Office of the Public Guardian for Elderly Adults – The Public Guardian serves as the guardian or conservator of last resort for those individuals aged 60 or 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.

The DHSS budget to provide all services comes from a variety of sources (see Appendix B). In 2004, the DHSS provided services to 496,968 clients at a total cost of \$85,593,262. In 2006, the DHSS provided services to 510,162 clients at a cost of \$88,035,834. It appears that there is relatively small annual growth rate in the DHSS budget for these services. DHSS has indicated that they would be unable to provide additional services to a large influx of veterans, since they currently must provide services to only their most needy clients, and when their annual funding is exhausted, they are unable to take on new clients.

Home Healthcare Services provided by the New Jersey Department of Human Services (DHS).

The New Jersey DHS, under the Division of Medical Assistance and Health Services (DMAHS), administers programs and services for the elderly and disabled under the State Medicaid Program. Reference is made to N.J.A.C. 10:60, the Home Care Services Manual, for details of the programs and services offered. The following is a listing of some of the programs and services that would be relevant to this report, that provide home care services to those individuals determined to be eligible:

- Home Healthcare Services – as described elsewhere in this report.
- Personal Care Assistant (PCA) services – as described elsewhere in this report.
- Early and Periodic Screening, Diagnosis and Treatment / Private Duty Nursing Services (EPSDT/PDN).

Home and Community-Based Services Waiver programs, which are administered by DHS through 42 U.S.C. § 1915(c) waivers, as follows:

- Home and Community-Based Services Waiver for Blind or Disabled Children and Adults.

- Home and Community-Based Services Waiver for Persons with AIDS and Children up to the age of 13 who are HIV-positive, known as AIDS Community care Alternatives Program (ACCAP).
- Home and Community-Based Services Waiver for Persons with Traumatic Brain Injury (TBI).
- Home and Community-Based Services Waiver for the Mentally Retarded and Developmentally Disabled (DDD-CCW) Individuals.
- Home and Community-Based Services Waiver Program for Medically Fragile Children under the Division of Youth and Family Services (DYFS) Supervision.

Home and Community-Based Services Waiver programs administered by DHSS:

- Community Care Program for the Elderly and Disabled (CCPED).
- Enhanced Community Options Waiver (ECO) which provides home and community-based services to aged or disabled adults.

Constraints of Medicaid Home Healthcare

The New Jersey DHS administers the State Medicaid program, but Medicaid does not have unlimited funds with which to supply care. Therefore, Medicaid has established the following restrictions on the provision of home healthcare:

“N.J.A.C. 10:60-2.6 - When the cost of home care services is equal to or in excess of the cost of institutional care over a protracted period (that is, six months or more), the Division (DMAHS) retains the right to limit or deny the provision of home care services on a prospective basis.”

“N.J.A.C. 10:60-6.5 – (Procedures used as financial controls for Model Waiver programs) “The cost of Medicaid services provided shall not exceed the cost of institutionalization for the beneficiary.”

Obtaining Home Healthcare through Medicare, Medicaid, and Private Insurance Companies.

MEDICARE. Medicare is health insurance for people age 65 or older; people under age 65 with certain disabilities; and people of any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Centers for Medicare and Medicaid Services (CMS) provides home health care services for persons covered under Medicare health insurance.

- Medicare Part A – Hospital Insurance (which most people get automatically without having to pay a monthly premium because most people paid Medicare taxes while working).
- Medicare Part B – Medical Insurance (for which everyone must pay a monthly premium, a co-payment/coinsurance, and a deductible)...provides home health care that is:

“Limited to reasonable and necessary part-time or intermittent skilled nursing care (RN or LPN) and certified home health aide (CHHA) services, and physical therapy (PT), occupational therapy (OT), and speech-language pathology (ST) ordered by your doctor and provided by a Medicare-certified home health agency. Also includes medical social services (Social Worker/MSW), other services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), and medical supplies for use at home.”

- Medicare Part C – Medicare Advantage Plan (offered by a private company that contracts with Medicare to provide all your Medicare Part A and Part B benefits).
- Medicare Part D – Medicare Prescription Drug Plan (PDP).

Medicare Eligibility Rules for Home Healthcare – The patient pays nothing (\$0) for home healthcare services as long as the patient meets the following eligibility rules.

The patient must:

- Be homebound (unable to leave home under normal circumstances).
- Need intermittent skilled nursing care (other than solely for venipuncture), physical therapy, speech therapy, or continuing occupational therapy.
- Be under a Plan of Care established and periodically reviewed (orders signed) by a physician.
- There is no ceiling on the number of covered visits, as long as the patient continues to meet the eligibility rules.
- Medicare pays the home health agency a set amount of money for each 60-day period that the patient needs care at home.

- Medicare does NOT cover personal assistance with fundamental tasks of life (such as bathing and meal preparation) or household services if these are the only home care services a person needs. Custodial care can only be provided during the time period a person is receiving skilled care services.
- The patient pays 20% of the Medicare-approved amount for durable medical equipment such as wheelchairs, hospital beds, walkers, oxygen equipment, etc.

Obtaining Home Healthcare if you have Medicare.

- Contact your family doctor/physician and explain your need for home healthcare services. Home healthcare must be ordered and directed by your physician. Your family physician will then call a local home healthcare agency with which he/she works, and will order an initial or evaluation visit, usually done by a registered nurse, to determine your need for home healthcare services.
- Contact your local home healthcare agency (found in the yellow pages under "NURSES"). You may speak with someone at a local home healthcare agency and they will explain their procedures to you, and will usually contact your family physician for you to obtain orders for an initial or evaluation visit by a registered nurse or physical therapist.
- Contact the Home Care Association of New Jersey, Inc., 485D Route One South, Suite 210, Iselin, New Jersey 08830; telephone number (732) 877-1100 to discuss your need for home healthcare. They will direct you to the appropriate resources.
- If you are in a hospital or awaiting discharge from another facility, the Discharge Planner or the Social Worker at the facility can assist you in obtaining home healthcare or refer you to a local home health agency. The Discharge Planner or Social Worker can also plan with your personal physician to have home healthcare start as soon as you return home.

MEDICAID. Medicaid is a federal-state entitlement program for low-income citizens of the United States. The Medicaid program is part of Title XIX of the Social Security Act Amendment that became law in 1965. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals. State participation is voluntary, but since 1982, all 50 states have chosen to participate in Medicaid.

Medicaid Benefits - Medicaid benefits cover basic health care and long-term care services for eligible persons. About 58% of Medicaid spending covers hospital and other acute care services. The remaining 42% pays for nursing home and long-term care. Participating states may offer the following optional services and receive federal matching funds for them:

- prescription medications
- institutional care for the mentally retarded
- home-based or community-based care for the elderly, including case management
- personal care for the disabled
- dental and vision care for eligible adults

Eligibility for Medicaid – Medicaid covers three major groups of low-income Americans: (1) Parents and Children; (2) The Elderly. Medicaid is the largest single purchaser of long-term and nursing home care in the United States; and (3) The Disabled. About 17% of Medicaid recipients are blind or disabled. Most of these persons are eligible for Medicaid because they receive assistance through the Supplemental Security Income (SSI) program. All Medicaid recipients must have incomes and resources below specified eligibility levels.

Medicaid Costs – Medicaid is by far the government's most expensive general welfare program. Combined federal and state spending for Medicaid takes approximately 20 cents of every tax dollar. The federal government covers about 56% of costs associated with Medicaid. The states pay for the remaining 44%. Although more than half (54%) of all Medicaid beneficiaries are children, most of the money (more than 70%) goes for services for the elderly and disabled. The single largest portion of Medicaid money pays for long-term care for the elderly. Only 18% of Medicaid funds are spent on services for children.

NEW JERSEY MEDICAID – The New Jersey Division of Medical Assistance and Health Services (DMAHS), within the New Jersey State Department of Human Services (DHS), operates the New Jersey State Medicaid Program. New Jersey Medicaid eligibility requirements are as follows:

- Must be a resident of New Jersey.
- Must be a U.S. citizen or qualified alien.
- Must meet specific standards for financial income and resources.
- In addition, a person must fall into one of the following categories: (1) Families with children up to age 18; (2) People who are aged, blind or permanently disabled; (3) Pregnant women; and (4) Children.

New Jersey Medicaid also has a number of special programs designed to meet the specific medical needs of certain groups of people who would not otherwise qualify for the program. One of these groups into which many veterans may possibly fall would be “Medically Needy programs for the aged, blind, or permanently disabled.”

New Jersey Medicaid provides two levels of home healthcare services, acute and chronic, provided by a certified, licensed home health agency, to Medicaid beneficiaries upon request of the attending physician:

- Acute Home Health Care – means concentrated and/or complex professional and non-professional services on a continuing basis where there is anticipated change in condition and services required.
- Chronic Home Health Care – means either long or short-term uncomplicated, professional and non-professional services, where there is no anticipated change in condition and services required.

Obtaining Home Healthcare if you have Medicaid

- Applicants must apply for Medicaid through the County Board of Social Services (CBOSS).

- See Appendix J for a complete listing of County Boards of Social Service in New Jersey.
- Applicants who are bedridden may request that a Medicaid caseworker come to the home to take the application.
- When you have obtained Medicaid and are in need of home healthcare, you must work within the framework of your local County Board of Social Services, and utilize your Medicaid Social Worker or your Medicaid physician and request home healthcare services through their offices.

PRIVATE INSURANCE COMPANIES - There is a whole host of private, commercial insurance companies that provide varying levels of home healthcare options to their subscribers. It is beyond the scope of this Report to itemize all the possible variations in benefit coverage, however this section will attempt to give a broad overview of the process a veteran must follow to obtain home healthcare services through private insurance.

Obtaining Home Healthcare if you have Private Insurance

- First, the insurance company must be contacted to determine if the policy provides a benefit for home healthcare; then determine what home healthcare services are covered under that benefit.
- Next, most major private insurance companies require pre-authorization of a request for home healthcare. This can be obtained in a number of ways.
- If the veteran is currently a patient in a hospital or some other facility, the veteran can request that the Discharge Planner or the Social Worker contact the local home health agency and his/her insurance company to determine whether or not home healthcare can be obtained.
- The Discharge Planner, the Social Worker, or the Intake Coordinator from the home health agency will obtain the required pre-authorization from the insurance company's Case Management Division.
- If a veteran is not in a hospital or other facility but feels that he/she needs home healthcare, the veteran should contact his/her personal physician to discuss this request. The physician will then have their office staff contact the insurance

company and/or the home health agency to obtain the required authorizations and begin home care.

- Most insurance cards have a 1-800 telephone number on the card which the veteran may call to obtain information about home healthcare coverage.
- Most insurance companies will require a physician's order and a complete diagnosis for the patient in order to authorize the start of home healthcare services.

Requirements for DMAVA to form a new Home Health Agency (HHA)

During meetings of the VHHAC, discussion revolved around the issue of making the DMAVA a provider of veteran home healthcare. This, in effect, would cast the Department as a new Home Health Agency in the State of New Jersey. In order for the DMAVA to develop a veterans-only Home Health Agency (HHA), coordination would be required with the DHSS to open twenty-one (21) "calls" for new CN's* for home health agencies, one in each New Jersey County. All current CN's are filled by existing Home Health Agencies. No new HHA's can open unless one of the existing HHA's gives up their CN, or goes out of business. The last "call" for a CN for Home Health Agencies in New Jersey took place around 1993-1994. The complete application for a CN can be found on the DHSS web site at <http://www.state.nj.us/health/> or at <http://www.doh.state.nj.us/forms/>. Since there are no current "calls" for a CN for new Home Health Agencies in New Jersey, there is no possibility of creating a new Home Health Agency within NJDMAVA at this point in time.

* Licensing Standards for Home Health Agencies under DHSS can be found at N.J.A.C. 8:42.

Opening a new Home Health Agency (HHA) is a huge business undertaking. Not only are there State and Federal requirements to be met (i.e. Certificate of Need [CN], State Licensure, and passing an initial CMS survey, etc.) but there are significant cash outlays for buildings (offices, parking spaces, etc.), furniture (desks, chairs, telephones, etc.), staff (administrative, nursing, office, personnel, business office, etc.), and equipment (medical supplies, nursing bags, BP cuffs, thermometers, dressings, tape, computers,

printers, chart covers, paper, shelving for storage of medical records, and developing/printing and maintaining specific forms – i.e. nurses notes, home health aide notes, doctors order sheets/multi-copy, therapy notes, billing forms, etc.).

To review some of the very basic requirements necessary to create a new home health agency, an organization would need to obtain a Certificate of Need (CN). As mentioned, the first requirement to form a new HHA is the receipt of a CN issued by the Commissioner of DHSS. In order to provide home healthcare services to veterans in all twenty-one (21) New Jersey Counties, the DMAVA would be required to obtain one CN per New Jersey County, for a total of 21 CNs. (N.B. – The DHSS has not issued a call for new CNs for home health agencies.)

Next would be the need for a License for each New Jersey County (21 Licenses). The License can only be issued after a survey has been completed of the HHA's physical location(s), ownership, Governing Body, policies and procedures, job descriptions, staff qualifications/licensure/ certification, etc., and all other regulations which can be found at N.J.A.C. 8:42.

Ownership of the HHA must be disclosed to the DHSS. Who would “own” a HHA developed by the DMAVA? An Organizational Chart, delineating the lines of authority, responsibility, and accountability, must be submitted to DHSS to ensure continuity of care to patients.

The Governing Authority of the HHA must assume legal responsibility for the management, operation, and financial viability of the HHA. The Governing Authority shall be responsible for services provided and the quality of care rendered to patients; adoption and documented review of written bylaws or their equivalent at least every two years; development and documented review of all policies and procedures; and establishment and implementation of a system to identify and resolve patient and staff grievances and/or recommendations, including those related to patient rights. This system shall include a feedback mechanism through management to the Governing Authority, indicating what action was taken; determination of the frequency of meetings (at least annually) of the Governing Authority, holding such meetings and documenting them through minutes, including a record of attendance; delineation of the powers and duties of the officers and committees of the Governing Authority; and establishment of the qualifications of members and officers of the Governing Authority, the procedures for electing, appointing, or employing officers, and the terms of service for members, officers, and committee chairpersons. Who in the DMAVA would assume this legal and financial responsibility for a HHA?

The Governing Authority must appoint an Administrator who is administratively responsible and available for all aspects of the HHA operations.

The Governing Body must also appoint an Advisory Group to review policy, evaluate programs, and make recommendations to the leadership for change or further study. Membership shall include at least one physician, the Director of Nursing, a consumer,

and a representative of PT services, and, if offered by the HHA, a staff member from OT, ST, MSW, and RD services. At least one member of the Advisory Group shall be neither an owner nor an employee of the HHA. Additionally, the HHA must establish written policies and procedures governing Pharmacy and Supplies.

The Director of Nursing shall be responsible for the direction of patient care services provided to patients, and shall oversee the operation of the Nursing Department. At a minimum, the HHA must have its own nursing staff (RNs, LPNs, and homemaker-home health aides) with current licenses/certifications, nursing supervisors, nursing schedulers, etc. The HHA shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of the person(s) responsible for training.

If a home health agency employs its own therapy staff (e.g. PT, OT, ST, RD, MSW), there must be a therapist in charge of this Therapy Department, as well as a therapy scheduling staff, and so on. The home health agency can also contract for therapy services with an outside therapy company, but the HHA is ultimately responsible for the performance of all therapists/professionals who visit the HHA's patient, therefore, these outside therapists must be routinely supervised.

The HHA must have a Written Agreement, or its equivalent, for services provided by contract or subcontract, signed and dated by the HHA and by the person or agency providing the service(s). These agreements must specify each party's responsibilities, functions and objectives, the time during which services are to be provided, the financial arrangements and charges, and the duration of the written agreement or its equivalent. These agreements must specify that the HHA retains administrative responsibility for services rendered, including subcontracted services.

A Policy and Procedure (P&P) Manual for the organization and operation of the HHA must be established, implemented, and reviewed at least annually. The P&P Manual shall provide a written narrative of the program, describing its philosophy and objectives and the services provided; a description of the Quality Assurance Program for patient care and staff performance; definition and specification of full-time employment; P&Ps for child and elder abuse/neglect; dealing with specified communicable diseases, rabies, poisoning and unattended, suspicious deaths, and so on.

A Personnel Department must ensure that all personnel who require licensure, certification, or authorization to provide patient care shall be licensed, certified, or authorized under the appropriate laws or rules of the State of New Jersey. In addition to handling credentialing, this department must ensure yearly health examinations for staff (Mantoux tuberculin skin tests, Rubella and Rubeola screening, etc.) are performed and documented, as well as maintaining all personnel records, staff education and mandatory training records, and routine personnel department functions (vacation, sick leave, discipline, hiring and firing, retirements, etc.).

The home health agency must establish a Medical Records Department which will develop written objectives, policies and procedures, an organizational plan, and a quality assurance (QA) program for patient's medical/health records. The QA program shall include monitoring of the medical/health records for accuracy, legibility, completeness, and accessibility. There are extensive guidelines for the maintenance of patient medical records in a home health agency. The patient's medical records must be maintained on-site or in a secured off-site location, and must be readily available to staff, physicians, other medical entities (e.g. hospitals, etc.). Therefore, there would need to be medical records staff members to maintain these medical records.

The Administrator shall ensure the development and implementation of an Infection Prevention and Control Program for the HHA. The Administrator shall designate a person who shall have education, training, completed course work, or experience in infection control or epidemiology, and who shall be responsible for the direction, provision, and quality of infection prevention and control services. The designated person shall be responsible for, but not limited to, developing and maintaining written objectives, a policy and procedure manual, a system for data collection, and a quality assurance program for the infection prevention and control services for the HHA, including a multidisciplinary committee which establishes and implements the infection prevention and control program. The HHA shall follow all Category 1 recommendations in the current editions of the listed Centers for Disease Control (CDC) publications, and any amendments or supplements thereto, incorporated herein by reference, including provisions for the collection storage, handling, and disposition of regulated medical waste.

The HHA shall establish and implement written policies and procedures regarding Patient Rights and the implementation of those rights. A complete statement of these rights, including the right to file a complaint with the NJ DHSS, shall be distributed to all staff and contracted personnel, and to all patients and their families. These patient rights shall be made available in any language which is spoken as the primary language by more than 10 percent of the population of the agency's service area.

The Governing Authority of the HHA shall have ultimate responsibility for the Quality Assurance (QA) Program. The HHA shall establish and implement a written plan for a QA program for patient care. The plan shall include a mechanism to ensure participation of all disciplines in QA activities and monitoring, and shall specify staff responsibilities for the QA program.

To provide for the financial viability of the HHA, a complete Billing Department must be established and maintained, which must comply with all the State, Federal, and private insurance rules and regulations regarding billing for home healthcare, including the most recently mandated computer equipment and programs for billing and filing reports with CMS and other entities.

In summation, the costs and requirements to open a new HHA under the auspices of the DMAVA would be staggering and beyond the scope or ability of this Report to calculate. In effect, an entire new Department within State government might be required that would focus solely on veteran home healthcare and would contain all the above-mentioned requirements.

The initial costs and outlays of time and money for staffing, offices, and overhead would be enormous, and would only serve to duplicate services that are already provided in both the private and the public sectors. Additionally, these monetary costs might be better spent in purchasing already-existing home healthcare services for New Jersey veterans in need of these services or expanding veteran educational and outreach programs, rather than creating an entirely new program.

SECTION III: Elderly and Disabled Veterans Studies

Introduction

In order to address projections for the populations of elderly and disabled veterans identified by the P.L., two different types of methodology were used. With the elderly veteran population, a survey was developed to ascertain base-line data which will be discussed in detail in this section. With regard to the disabled population, data was developed from existing census programs maintained by the DVA. By combining the results of these two processes, a final extrapolation was made to project costs associated with veteran home healthcare.

The Elderly Veteran Population

In order to answer the direction of P.L. 2007; Chapter 123 pertaining to “elderly veterans,” the decision was made to use the 525 veterans already on the waiting lists for the three state Veteran Memorial Homes (VMHs) as the population base to address for this part of the P.L. This Report acknowledges the fact that 525 veterans do not constitute a statistically significant number. Furthermore, since these individuals were already on a waiting list for the VMHs, their condition of health might not be representative of that for all veterans in the State. However, given the constraints imposed on this Report as mentioned earlier, it was felt that this survey would serve to provide a rough number from which the magnitude of the veteran home healthcare issue could be debated. In order to gather information on these veterans, a survey was used as the methodology.

Survey Framework and Construction

Several issues relevant to the aged veteran population were identified. One primary area of inquiry was determining what home healthcare services were currently being utilized, or had been utilized in the past, by those veterans on the waiting list. An adjunct to this question was who was currently providing those home healthcare services at the time of the questionnaire. Another area of interest was learning what home healthcare services these veterans needed to receive that would allow them to remain living at home. The third general area of interest was what DVA Eligibility Category were the veterans listed under, since these categories may give at least a broad indication of disability and hence need.

Survey Creation

In order to address the issues raised in the P.L., the DMAVA developed the survey questions. Since response time was critical, it was decided that the survey would be limited to one page which had ten (10) major questions with 75 sub-categories. The first two questions focused on what types of home healthcare services the veteran was currently receiving, or had received in the past. Twenty sub-questions were dedicated to finding out what types of services the veteran would need to receive to allow him/her to remain living at home. There were seven sub-questions dedicated to the issue of who paid for the home healthcare services. Finally, the survey addressed 13 sub-questions regarding VA categories and VMH-eligible non-veterans (e.g. veteran spouses, Gold Star Parents, etc.). A copy of the survey is attached as Appendix F.

Survey Distribution

Approximately 525 surveys were distributed to all the veterans currently on the waiting lists for the three VMHs. The surveys were sent to each of the three Veteran Memorial Homes (VMHs) since they retained the waiting lists for their respective facilities. The surveys were mailed out from the VMHs on 30 October 2007 with a requested response date of 20 November 2007. An additional 200 surveys were distributed to the largest veteran organizations in New Jersey (American Legion; Veterans of Foreign Wars; Disabled Veterans, etc.) through the Veterans Home Healthcare Advisory Committee (VHHAC). Surveys were given to the Veteran Organization Commanders to distribute to their members who were frail/elderly, etc. on 30 October 2007 at a VHHAC meeting, with the same response date as the mailed surveys. The Veteran Organization Commanders returned 56 surveys that they were unable to distribute. Therefore, a total of 669 surveys were mailed or given out to New Jersey resident veterans. Each survey had an enclosed, franked envelope with a DMAVA return address. This assured that the veterans who chose to respond would not have to pay for their response.

Analysis

The DMAVA received 177 responses back from the 669 surveys mailed which represents a 26% return rate. An additional five (5) surveys were received back long after the due date, and were thus not included in the computation analysis.

The following report tallies the responses received. Where the question permitted more than one response, the numbers represent the total number of individuals that selected that choice and not a percentage. Where there was only one response that

could be given to a question, the totals are given in percentages. Percentages .5 or greater were rounded up to the next whole percent. This survey does not include an analysis of the data, but a quick profile of those that responded suggests that:

- The majority (58%) are not now receiving services, but did at some time in the past (55%).
- Currently, 31% of the veterans responded that they are now receiving some type of home healthcare.
- Home Health Aide Services, Physical Therapy, and Skilled Nursing are the most prevalent services either received or are receiving now. This answered the second area of interest indicated in the Survey Construction paragraph above.
- Most responders pay out of pocket for their services, or Medicare pays for them.
- The DVA does not seem to have contributed substantially to services for this group.
- The greatest needs are for bathing, dressing, toileting, food preparation, housecleaning, laundry, food shopping, eating/feeding, transportation, and early dementia care. This answered the second area of interest indicated in the Survey Construction paragraph above.
- The need for “hands-on” personal care comprises classic Activities of Daily Living (ADL), and the other tasks are what is known as the Instrumental Activities of Daily Living (IADL).
- Forty-two (42%) percent indicated that they wanted 24-hour per day help, seven days a week.
- The next highest total is 13% who wanted help four hours per day.
- Sixty-one (61%) percent live at home; 20% are in another nursing home at this time.
- Most people that are receiving help are paying privately for it.
- They also receive help from their children, “other” (nursing facility, self, relatives), and then spouse.

- Fifty-two percent (52%) did not respond to the question regarding DVA Eligibility Category and 26% were unsure or did not know what their category was. This answered the third area of interest indicated in the Survey Construction paragraph above.
- Fifty-five (55%) percent indicated that they could stay home if healthcare services were provided.
- Veterans completed 68% of the questionnaires.

The Disabled Veteran Population.

The second general veteran population identified for the Report in the P.L. was disabled veterans. There are approximately 48,932 veterans classified as disabled in New Jersey by the U.S. Department of Veterans Affairs (DVA). This represents nine percent of the total veteran population for the state. The Veteran Health Care Eligibility Reform Act of 1996, Public Law 104-262 required the DVA “to establish and operate a system of a patient enrollment and created seven Priority Groups for disabilities.” “The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, Public Law 107-135,” expanded the seven priority groups to eight, with Priority Group 8 having the lowest priority. An explanation of these categories is attached at Appendix G.

There are two Priority Categories of the eight Priority Categories that impact more directly on this Report than the others. The primary one is Category 4 which is the most restrictive and is reserved for Catastrophically Disabled (CD) veterans.

Catastrophically disabled veterans must have a permanent, severely disabling injury, disorder or disease that compromises the ability to carry out the activities of daily living (ADL) to such a degree that the individual required personal and/or mechanical assistance to leave their home or bed, or requires constant supervision to avoid physical harm to self or others. The dependencies or disabilities must be judged as

permanent. Generally, veterans placed in this category are receiving Aid and Attendance or Housebound Benefits. It is safe to assume, for the parameters of this report, that these veterans are already receiving home healthcare.

The other category that bears more directly on this Report is Category 5 which is reserved for veterans who are determined to be unable to defray the expenses of care needed. Again, for the parameters of this Report, it is assumed that these veterans are being compensated by the DVA for home healthcare services rendered.

For the purposes of the Report, veterans in priority Categories 1-3 and 6-8 are accounted for in the overall number of veterans. Veterans in Category 4, because of their classification, are already receiving home healthcare of some type from the DVA, as are veterans in Category 5. However the DVA pays only 55% and 45% respectively for their care, therefore, the State of New Jersey is already helping to support their home healthcare needs. Therefore, the numbers for the veterans in Categories 4 and 5 were subtracted from the overall numbers of veterans considered above.

The Extrapolation of Data for Projections

In order to extrapolate rough numbers for this report, it was decided to use age 65 as the demarcation for elderly veterans. Sixty-five was used as the age for elderly veterans, since this is the point at which an individual becomes eligible for Medicare under federal guidelines. Using the numbers from the survey and data from the DVA, it was determined that there are 526,651 veterans currently residing in New Jersey.

In order to provide projections for elderly and disabled veterans, the next step was to then determine the number of elderly veterans. It was determined that there are approximately 248,530 veterans over 65 years old. Then from the total of 248,530 we

subtracted the number of veterans currently receiving home healthcare from the DVA (~1000), those already in the three state VMHs (~1000), those already on the waiting list (525), and those categorized as Priority 4 and 5 by the DVA (1,920/23,237 respectively). This then became the total number of elderly and disabled veterans who may be eligible for home healthcare, which equated to 221,373. It was determined from the surveys that 10% of those who may be eligible would avail themselves of home healthcare if it were available. This would equate to 22,137 veterans, hence this becomes “n” (n = 22,137), the number then used for the projection of costs. Since disabled veterans, apart from those indicated above, would be captured in the overall elderly population, their numbers are contained within “n.”

It must be noted that in researching veteran data for this Report, it became apparent that there does not exist a repository for accurate figures on the total veteran population requiring home healthcare. Furthermore, as indicated elsewhere in this Report, many state agencies traditionally have not collected veteran data on those individuals who use state programs.

Section IV: Funding Projections

Introduction

As projections for future costs are projected to provide additional home healthcare to veterans for this report, several factors must be noted. First, the exact figure for the number of veterans has not been determined, either at the federal or state level. Second, the State of New Jersey currently does not capture data on veterans enrolled in state home healthcare programs; therefore, it is safe to assume that many veterans are already receiving home healthcare benefits from the state. Third, there currently are no statistical models at either the federal or the state levels of government that can reasonably predict future home healthcare requirements for the veteran population. Finally, the numbers of the survey do not represent a statistically significant database.

Assumptions for the Funding Projections

In order to proceed with the funding projections, certain assumptions needed to be made pertaining to the projection of costs for veteran home healthcare as follows:

- The total number of veterans in the 65+ age group will, overall, continue to decline in the next five years by 1 percent to 2 percent each year. However, this would not affect the figures for ten percent of all the eligible veterans for the period of this report.
- The cost of providing home healthcare services will increase in the next five years by approximately 6.1 percent each year.

- There will be no change in current policies or funding levels at the DVA pertaining to veteran home healthcare. Similarly, the current policies and funding by the State for the State Medicaid program and Federal funding of the Medicare program would remain primarily as they are at the present time and for the foreseeable future (e.g. five years).
- The assumption made is that the majority of the veteran population considered for this Report as requiring home healthcare would fall under Medicare rather than Medicaid, due to the retirement programs and financial security for the World War II era veteran population.
- Less than 50 percent of low-income veterans enroll for veterans' healthcare.
- Less than 20 percent of higher-income veterans enroll for veterans' healthcare.
- Calculation of costs are based upon actual DHSS costs to provide these services in 2006. Costs are calculated upon the person receiving home health aide care (custodial care) two (2) days per week for two (2) hours per day, and having an RN visit once per month.

Costs for private agency home healthcare cannot be calculated because costs are dependent upon a variety of individual circumstances, including the type of insurance each person may have (e.g. Medicare, Medicaid, LTC policy, private insurance plans, and so on), as well as their financial status, family status, and their medical and/or psychological condition(s). It is beyond the scope of this Report to individually calculate costs for providing private home healthcare. The resources noted herein are suggested for further inquiry.

Funding Projections

- Projection to provide a certified Home Health Aide and a Visiting Nurse to 10% of all senior and disabled veterans statistically eligible (22,137).

Cost per individual = \$2,143.00

□ Projected costs for five years	Year 1 =	\$47,439,591
	Year 2 =	\$50,285,966
	Year 3 =	\$53,303,124
	Year 4 =	\$56,501,312
	Year 5 =	\$59,891,391

- Numbers rounded to nearest whole number
- Assumes a cost increase for services of 6% per annum
- Cost per individual numbers are based on DHSS 2006 funding
- Calculation found at Appendix H

□ **Total cost for the 5 years for 10% of all eligible veterans = \$267,421,384**

- Projection to provide a certified Home Health Aide and Visiting Nurse to the 525 veterans currently on the VMH waiting lists.

Cost per individual = \$2,143.00

□ Projected costs for five years	Year 1 =	\$1,125,075.00
	Year 2 =	\$1,192,580.00
	Year 3 =	\$1,264,134.00
	Year 4 =	\$1,339,982.00
	Year 5 =	\$1,420,381.00

- Numbers rounded to nearest whole number
- Increase per year equals 6% per annum
- Cost per individual numbers are based on DHSS 2006 funding
- Calculation found at Appendix H

□ **Total cost for the 5 years for 525 Waiting List Veterans = \$6,342,152**

One possibility to assist veterans in obtaining home healthcare might be to create a person who would serve as a conduit or point-of-contact for home healthcare information and assistance at the DMAVA. This person would be titled a home healthcare "Navigator" or "Ombudsman."

○ Projection to hire a DMAVA Veteran Home Healthcare "Navigator."

□ Principle Staff Officer 3 (R25) = first year	\$66,006
□ Projected costs for five years = Step 5:	\$66,957
Step 6:	\$69,598
Step 7:	\$72,239
Step 8:	\$74,879

- Contractually this bargaining unit is also expected to receive the following across the board wage increases: First full pay period JUL 08 = 3%
First full pay period JUL 09 = 3.5%
First full pay period JUL 10 = 3.5%

These increases have been computed into the figures above

- **Total cost for the Navigator for 5 years = \$347,681**

Once home healthcare awareness is raised in the veteran population, it can reasonably be expected that inquiries about these services would flood into VSO Offices. It would be reasonable to project hiring six additional VSOs to handle this increased workload.

○ Projection to hire six additional Veteran Service Officers.

□ One Veteran Service Officer 3 = first year	\$42,791
□ Projected costs for five years = Step 1:	\$44,288
Step 2:	\$46,316
Step 3:	\$50,035
Step 4:	\$53,958

- Contractually this bargaining unit is also expected to receive the following across the board wage increases: First full pay period JUL 08 = 3%
First full pay period JUL 09 = 3.5%
First full pay period JUL 10 = 3.5%

These increases have be computed into the figures above

- **Total cost for six new regional VSOs for 5 years = \$1,424,328**

- Projection to allow the current VSO computers access to the DHSS NJEASE Program

□ Estimated cost for initial fielding	Year 1:	\$65,990.00
□ Projected costs for annual licensing fee	Year 2:	\$30,000.00
	Year 3:	\$30,000.00
	Year 4:	\$30,000.00
	Year 5:	\$30,000.00

- **Total cost for implementing NJEASE Program for all VSO offices for 5 years = \$185,990**

- Complete calculations for this IT estimate can be found in Appendix I

In order to promote accurate information about home healthcare among the veteran population, a Veterans Guide dedicated solely to home healthcare would be one of the most cost-effective methods to get this information into the hands of veterans and veteran organizations. Currently, the DMAVA prints a Veterans Guide of 100,000 copies. This number became the basis for the extrapolations below.

- Cost to publish 200,000 copies of a Veterans Guide-type booklet dedicated to home healthcare. This is based on an initial run of 100,000 copies the first year and a run of 25,000 copies for the four succeeding years.

- This projection is based on the current run for the NJ Veterans Guide

- **Projected costs for 5 years/one run each year = \$150,000**

In order to raise awareness among veterans about home healthcare, a robust Outreach campaign should be initiated. The DMAVA has an on-going Outreach program, however, it does not include information on home healthcare. Additional funds should be allocated to increase the Outreach budget for inclusion of home healthcare information and contact numbers.

- Projection to conduct a premium Outreach campaign for one year.

- This projection is based on doubling the current Outreach budget for the DMAVA to “jump start” home healthcare awareness among veterans

- After the initial campaign; a sustained program would revert back to the current Outreach budget

- **Projected costs for a 5 years Outreach campaign = \$1, 500,000**

As indicated earlier in this Report, a comprehensive study of veteran home healthcare should be accomplished before funding decisions are made. Since Rutgers had produced a study for the DMAVA in 1995, it would be reasonable to have them either up-date that study or, using that study as a base, develop a new study.

- **Cost to commission a detailed follow-up Rutgers study of the veteran home healthcare issue =** **\$86, 000**

Funding Examples

EXAMPLE 1: Consider all the programs indicated in the section above (Navigator, new VSO Hires, NJEASE Program, Veterans Guide, Outreach Campaign, Rutgers Study) and provide the home health care to 10% of all elderly veterans eligible.

- **Projected cost for 5 years =** **\$ 271,103,926**
- PROs of Example 1
 - It would provide veterans with all the programs indicated above.
 - Would maximize home healthcare coverage for fully 10 percent of all eligible elderly veterans.
- CONs of Example 1
 - Considerable cost involved to implement in a fiscally constrained time in the state budget process.
 - Current existing programs at both the state and federal level cannot support this additional case load.

EXAMPLE 2: Consider all the programs indicated in the section above (Navigator, New VSO Hires, NJEASE Program, Veterans Guide, Outreach Campaign, Rutgers Study) and provide the home health care to for the 525 veterans on the waiting list only.

- **Projected cost for 5 years =** **\$10,024,694**
- PROs of Example 2
 - It would provide 525 veterans on the VMH waiting lists with all the programs indicated above.
 - The veterans identified could probably be absorbed by current home healthcare programs with the additional funding indicated.
- CONs of Example 2
 - Does not offer the same range of services to all elderly veterans.
 - Relatively expensive within the current budget climate.
 - Would serve to increase the number of veterans applying to the VMH if this were viewed as a portal to home healthcare services

EXAMPLE 3: Consider all the programs indicated in the section above (Navigator, new VSO Hires, NJEASE Program, Veterans Guide, Outreach Campaign, Rutgers Study) and provide no additional home health care funding.

- **Projected cost for 5 years =** **\$3,682,541**

- PROs of Example 3
 - Relatively low cost; can be funded under the current budget with some realignment of funds in the budget.
 - Parts of this option can be implemented almost immediately with a small allocation of funds.

- CONs of Example 3
 - Does not offer additional funding to directly support home healthcare to veterans.
 - Does not expand home healthcare services provided by the state.

SECTION V: Recommendations

Based on the information gathered and discussion among multiple agencies, state, federal and private, the following key recommendations are made which is consistent with Example 3 in Section IV above. First and foremost, efforts must be made to educate veterans about the totality of home healthcare services currently available. Ideally, this information will be provided before those services are actually required. It should be made clear to veterans that they must prepare for the contingencies of home healthcare with the same dedication and thoroughness that they apply to retirement planning. This educational program could take several approaches such as: increasing funding for Veteran Outreach Programs currently funded through the DMAVA. This Outreach, in the form of public service announcements (PSAs), needs to be multi-media to include radio, television, bill boards, newspapers, etc. It also needs to be on-going with predicable cycles of release. In support of this educational initiative, the DMAVA should consider the publication of a pamphlet or brochure completely dedicated to home healthcare. This publication could serve as a compliment to the New Jersey Veterans Guide currently published by the DMAVA. Another method for the dissemination of information would be conducting workshops targeted to specific population densities of veterans that concentrate solely on home healthcare issues and information. This could be accomplished using existing organizations and agencies (e.g. veteran organizations, family support groups, armories, senior groups, etc.).

Second, while this Report highlights the many home healthcare programs currently available from agencies of federal, state, county governments, as well as the private sector, these agencies rarely interact with each other and many times are totally

ignorant of the programs offered by their counterparts. Recommendation is made that a Governor's Forum be established at the Departmental level between the various state agencies that touch on home healthcare in New Jersey. This should be coordinated through the Governor's Office. As a suggestion, this Forum should include the Department of Health and Senior Services, the Department of Human Services, the Department of Labor, the Department of Transportation, the Department of Community Affairs, and the DMAVA. If successful, these meetings could be broadened to include county agencies and the U.S. Department of Veterans Affairs' Veterans Integrated Service Networks (VISN) 3 and 4. The sole agenda for this Forum should be the exchange of information on existing programs and the establishment of contact lists to assist in cross-talk pertaining to those services offered. Ideally, collaborations between Departments would result in a reduction in the duplication of services and hence a corresponding saving in program costs. This saving could then reasonably be applied to either increasing the number of individuals receiving services, or increasing the quality of service provided to those already enrolled.

This process has already started. As a result of the collaboration for this Report between the DMAVA and the DHSS, DHSS will now include questions pertaining to veterans as part of its NJEASE screening and in-take process. The DMAVA provided sample questions for this program to DHSS.

Third, cross-train the DMAVA Veteran Service Officers (VSOs). The DMAVA currently mans a VSO office in 17 counties of the state. These offices are often the primary portal through which veterans enter the sphere of Veterans Services. Similarly, the Department of Health and Senior Services operates the Area Agencies on Aging

(AAA) in each county. These agencies maintain the New Jersey Easy Access, Single Entry (NJEASE) data base for home healthcare services. Currently, these offices do not interface, nor do they share data bases. Recommendation is made to train each of the VSOs on the services provided by the AAAs. Research has indicated that an in-service would take approximately four days per each VSO. This first step could be accomplished immediately with very little funding. The future should look to enabling the VSOs to have read-only access to the NJEASE program, and eventually plans should be made to co-locate VSOs with AAAs in each county. This step would, of course, involve up-grades or new purchases of Information Technology (IT) equipment and costs in moving offices and IT data lines.

Fourth, contract for a new Rutgers Study similar to the one commissioned by the DMAVA in 1995. This is necessary for several reasons. Primarily, as indicated earlier, this Report was not construed to be a definitive study of veteran home healthcare, but rather a vehicle to illuminate the complexity of home healthcare in New Jersey and to stimulate discussion on this topic. Secondly, veteran demographics are rapidly changing due to the demands of the War on Terrorism, specifically Operations Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). In past conflicts, the majority of those enlisted in the fight comprised an age group of 18 – 25 year old men. Therefore, it could reasonably be expected that, except for those with catastrophic injuries, most individuals would not require home healthcare for roughly 40 years after discharge. However, with the current mobilizations of the National Guard and Reserve, personnel as old as 58 are now being sent into Theater. Moreover, a significantly greater number of women are serving in combat units in combat areas. This means that the demands

for home healthcare could be made by veterans within 5 -10 years of their discharge instead of the longer period normally seen from past wars. Similarly, different demands will be placed on the system by the impact of female veterans. For these reasons alone, a new comprehensive study should be underwritten. Recent inquiries indicated that a new study by Rutgers University Center for Social and Community Development (CSCD) would cost approximately \$86,000.00. This new study would be required for making any fiscal decisions pertaining to veteran home healthcare.

Fifth, consider new positions within the DMAVA. The most important of these new hires would be creating a position at the DMAVA for a departmental level point-of-contact for veterans' home healthcare. This home healthcare Navigator or Ombudsman would serve as the focal point for disseminating information on home healthcare to veterans and assisting veterans seeking home healthcare services by directing them to existing federal, state, county, and private home healthcare programs. This individual would be charged with maintaining contact with state, county, and federal agencies and their programs so that a constantly up-dated stream of information is available to any veteran or family member that seeks home healthcare services.

The Navigator or Ombudsman would be directly tied to the VSOs and would become an integral part of their day-to-day operations. Furthermore, this individual would be responsible for conducting the veteran workshops mentioned under the first recommendation. Again, as with the VSO training, this could be accomplished immediately with an exemption to the current hiring freeze and funding for IT equipment and data lines.

The next full-time manning issue to consider would be the requirement to hire six additional VSOs as regional representatives who would serve as veteran home healthcare points-of-contact. This would be required to help off-set the surge in inquiries to VSO Offices pertaining to home healthcare available to veterans, once awareness is raised among the veteran population.

Although not technically part of the Home Healthcare Study, recommendation is also made to fund independent or assisted living wings at the DMAVA Veteran Memorial Homes (VMHs). Currently, only the Vineland VMH has an independent living wing, which has proved to be enormously successful. This recommendation could be accomplished by either re-furbishing existing wings or building new wings at the Paramus and Menlo Park VMHs in order to provide one wing at each VMH for independent living rooms. This would serve as an ideal transition option for elderly veterans which would bridge the continuum from home healthcare to long term care. It would allow veterans to maintain an independent life-style while removing some of the burden for families. The conversion of one wing at each VMH would cost approximately \$1,950,000.00, with New Jersey's portion of the cost (65/35 matching funds) being \$682,500.00. However, this would entail a permanent loss of 64 bed spaces with a corresponding loss of revenue. Additionally, it would be extremely disruptive to the veterans living in the facility, as well as an enormous distraction to the operations of the VMHs involved. The best decision would be to build two new independent living wings, one each at the two VMHs (56 beds each VMH) indicated, and expanding the wing at the Vineland VMH to 56 beds. The estimated cost for this proposal would be approximately \$29,500,000.00, with New Jersey's portion of the cost being

\$10,325,000.00. Construction could be accomplished with no disruption to revenues or the operation of the Homes involved. Costs are based on 2007 construction costs.

These would be expected to increase in the “out” years. It must be noted that obtaining the 65% of construction costs from the DVA could not be accomplished during the five year projection window of this Report. However, New Jersey could elect to begin construction with the understanding of future reimbursement from the DVA.

Recommendation is made to establish pilot programs, one each in northern and southern New Jersey, for any program(s) selected. This would correspond to VISN 3 and 4 of the DVA and would allow for testing the integration of home healthcare programs across federal, state, county, and private agencies. Assessment can then be made as to the overall effectiveness of changes in home healthcare programs before committing large sums of funds statewide.

Finally, it must be noted that the proposed home healthcare programs were bundled into the Examples indicated above because it was felt that these Examples would provide a complete range of options to veterans and their families. However, any of the programs discussed in this Report can be implemented as a stand-alone initiative, and still would be of benefit to the veteran community. Furthermore, it must be recognized that several of the programs recommended in this Report were also recommendations delineated in the Rutgers Study of 1996 and the Rutgers Review of the Study completed in 1999 (see Section VI: References). These recommendations were never implemented; however, they are still viable options and were incorporated into this Report.

Closing Comments

Home Healthcare in New Jersey is a complex and expensive enterprise. As demonstrated in this report, there already exists a myriad of home healthcare services available to veterans provided by numerous agencies, with often overlapping services. In order to insure veterans the availability of home healthcare, an overarching strategy must be developed to integrate home healthcare into the continuum of an overall health program for seniors which progresses from independent living at home to eventual residence in a long-term care facility. Concurrently, this health care plan must be synchronized at every level from the federal government down to county and local municipalities. It is important that there be collaboration by the agencies at all governmental levels with all the players coordinating “best practices” in order to optimize the efficiencies of each, empowering and thereby also holding accountable people who are managing the integration of this care. This could be one method to improve efficiency and the cost effectiveness of a home healthcare system. We must also examine requirements that are involved in the existing rules and regulations to assess current requirements in terms of delivery to test and evaluate the effectiveness of a comprehensive integrated veteran home healthcare program.

Metrics must be developed to assess the effectiveness of an integrated veteran home healthcare system, which must also be linked to a cost-benefit analysis. The program can be tiered according to the retirement income of individuals, recognizing that the financial burdens will be very different among veterans based both on duty time served and post-military employment.

Even within the limited scope of this small study, it became exceedingly clear that based on current funding and resources, it is simply not possible to provide even minimal home healthcare for every eligible elderly veteran within the State of New Jersey.

Finally, in considering future changes to programs and accessibility of veterans to home healthcare, it must, in the end, be fiscally feasible and prudent. Ultimately, the cost must be affordable. There must be a fair balance that takes into account the New Jersey taxpayer, as well as those directly receiving the care under a home health system; a balance that assures a quality, efficient healthcare system, and does so for the long term.

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**VETERANS HOME HEALTHCARE
180-DAY REPORT**

SECTION VII: APPENDICES

Appendix A - Definitions

Activities of Daily Living (ADL) means the things we normally do in daily living including daily activities we perform for self-care such as bathing, dressing, toileting, feeding, grooming ourselves, working, homemaking, and leisure activities. The person's ability or inability to perform these ADLs serves as a measure of the person's functional status.

Acute Home Health Care means concentrated and/or complex professional and non-professional services on a continuing basis where there is anticipated change in condition and services required.

Administration on Aging (AoA) means the federal agency within the U.S. Department of Health and Human Services (DHHS) that serves as the focal point and advocate agency for older persons and their concerns.

Administrator means a person who is administratively responsible and available for all aspects of home healthcare facility operations, and:

- Has a master's degree in administration or a health related field, and at least two years of supervisory or administrative experience in home healthcare or in a health care setting; or
- Has a baccalaureate degree in administration or a health related field and four years of supervisory or administrative experience in home healthcare or in a health care setting.

Adult Protective Services (APS) means voluntary or court-ordered social, legal, financial, medical, or psychiatric services necessary to safeguard a vulnerable adult's rights and resources, and to protect a vulnerable adult from abuse, neglect or, exploitation as carried out by the designated APS provider.

Aid and Attendance (A&A) means a DVA benefit paid in addition to the monthly pension. A veteran may be eligible for A&A when:

- The veteran requires the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, toileting, adjusting prosthetic devices, or protecting him/herself from the hazards of his/her daily environment, OR
- The veteran is bedridden, in that his/her disability or disabilities requires that he/she remain in bed apart from any prescribed course of convalescence or treatment, OR
- The veteran is a patient in a nursing home due to mental or physical incapacity, OR

- The veteran is blind, or so nearly blind as to have corrected visual acuity of 5/200 or less in both eyes, or concentric contraction of the visual field to 5 degrees or less.
- A veteran cannot receive both Aid & Attendance and Housebound benefits at the same time.

Area Agencies on Aging (AAA) means the primary entity in each New Jersey County that is responsible for developing comprehensive, coordinated systems of community-based services for older adults.

Available means ready for immediate use (pertaining to equipment); capable of being reached (pertaining to personnel).

Branch office means a facility site from which services are provided to patients in their homes or place of residence, which is physically separate from the home health agency but shares administrative oversight and services which meets all requirements for licensure, and which has available a nursing supervisor or alternate coverage by a registered professional nurse. When the nursing supervisor or alternate is not on the premises, there must be a licensed nurse on the premises when the facility is open to the public.

Bylaws mean a set of rules adopted by the facility for governing its operation. (A charter, articles of incorporation, and/or a statement of policies and objectives is an acceptable equivalent.)

Calendar Work Week means the time parameters which constitute a work week for Personal Care Assistant (PCA) services. These time parameters are from Sunday at 12:00 A.M. to Saturday at 11:59 P.M.

Case Management is a process in which a professional nurse or social worker is responsible for planning, locating, coordinating, and monitoring a group of services designed to meet the individual health needs of the beneficiary being served. The case manager shall be the pivotal person in establishing a service package. Case management is defined as the process of on-going monitoring by DMAHS staff, of the delivery and quality of home care services, as well as the beneficiary/caregiver's satisfaction with the services. Case management ensures timely and appropriate provider responses to changes in care needs and assures delivery of coordinated services which promote maximum restoration and prevents unnecessary deterioration.

Certificate of Need (CN) Program is administered by the New Jersey Department of Health and Senior Services (DHSS) under the Certificate of Need and Acute Care Licensure Program. A CN is required before any medical facility or agency can begin operations. The CN process must be strictly followed and all the required documentation including a detailed application, a "track record review," an operational

survey and functional review must be performed, and construction requirements from both the DHSS and the New Jersey Department of Community Affairs must be met.

Chronic Home Healthcare means either long or short-term uncomplicated, professional and non-professional services where there is no anticipated change in condition and services required.

Cleaning means the removal by scrubbing and washing, as with hot water, soap or detergent, and vacuuming, of infectious agents and/or organic matter from surfaces on which and in which infectious agents may find conditions for surviving or multiplying.

Clinical note means a signed and dated notation made at each patient visit by each health care professional who renders a service to the patient. The clinical note shall include a written description of signs and symptoms, treatment and/or medication(s) administered, the patient's response, and any changes in physical or emotional condition, and may be documented in a flow sheet format. The flow sheet shall be supplemented by a narrative clinical note at least once a week and whenever there is a change in the patient's condition or care which cannot be clearly documented on the flow sheet. The clinical note shall be written or dictated on the day service is rendered and shall be incorporated into the patient's medical/health record according to the facility's policies and procedures.

CMS means the Centers for Medicare and Medicaid Services; the federal government.

Commissioner for this Report means the New Jersey State Commissioner of Health and Senior Services.

DACS means the **Division of Aging and Community Services** within the New Jersey Department of Health and Senior Services (DHSS). DACS is comprised of seven offices: the Office of Administration and Finance; Office of Area Agencies 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.

DHHS means the U.S. Department of Health and Human Services.

DHS means the New Jersey Department of Human Services.

DHSS means the New Jersey Department of Health and Senior Services.

Dietitian means a person who:

- Is registered or eligible for registration by the Commission on Dietetic Registration of the American Dietetic Association; or

- Has a bachelor's degree from a college or university with a major in foods, nutrition, food service, or institution management, or the equivalent course work for a major in the subject area; and has completed a dietetic internship accredited by the American Dietetic Association or a dietetic traineeship approved by the American Dietetic Association or has one year of full-time, or full-time equivalent, experience in nutrition and/or food service management in a health care setting; or
- Has a master's degree plus six months of full-time, or full-time equivalent, experience in nutrition and/or food service management in a health care setting.

Director of Nursing means a registered professional nurse who has at least one of the following qualifications:

- A Master's degree in nursing or a health related field and two years combined community health nursing and progressive management experience in community health nursing; or
- A Bachelor of Science degree in nursing or a health related field and three years combined community health nursing and progressive management experience in community health nursing.

Discharge Planning means that component part of a total individualized plan of care formulated by all members of the agency's health care team, together with the beneficiary and/or his or her family or interested person which anticipates the health care needs of the beneficiary in order to provide for continuity of care after the services of the home care agency have terminated. Such planning aims to provide humane and psychological preparation to enable the beneficiary to adjust to his or her changing needs and circumstance.

Division means the Division of Medical Assistance and Health Services (DMAHS).

DMAHS means the New Jersey Division of Medical Assistance and Health Services within DHS.

DMAVA means the New Jersey Department of Military and Veterans Affairs.

Documented means written, signed, and dated or computer generated, and authenticated if an electronic system is used.

Drug administration means a procedure in which a prescribed drug or biological is given to a patient by an authorized person in accordance with all laws and rules governing such procedures. The complete procedure of administration includes removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the prescriber's orders, giving the individual dose to the patient, seeing that the patient takes it (if oral), and recording the required information, including the method of administration.

Durable Medical Equipment (DME) means any medical equipment such as a hospital bed, wheelchair, walker, oxygen equipment, and so on, needed to provide care in a patient's home.

DVA means the U.S. Department of Veterans Affairs.

Field Security Cost means costs incurred by a home health agency in providing security personnel to accompany medical care staff of a home health agency during on-site visits to the patient's home.

Full-time means a time period established by the home healthcare facility as a full working week, as defined and specified in the HHA's policies and procedures.

Governing authority means the organization, person, or persons designated to assume legal responsibility for the determination and implementation of policy and for the management, operation, and financial viability of the home healthcare facility.

Health Services Delivery Plan (HSDP) means an initial plan of care prepared by DHSS during the preadmission screening (PAS) assessment process. The HSDP reflects individual problems and required care needs. The HSDP is to be forwarded to the authorized care setting and is to be attached to the beneficiary's medical record upon admission to a nursing facility or when the beneficiary receives services from home health care agencies. The HSDP may be updated as required to reflect changes in the beneficiary's condition.

Home and Community-Based Services (HCBS) means the array of supportive services that helps an individual live independently in their own home or community, rather than being placed into a nursing home.

Home Health Agency means a facility which is licensed by the New Jersey State Department of Health and Senior Services to provide preventive, rehabilitative, and therapeutic services to patients in the patient's home or place of residence. All home health agencies shall provide nursing, homemaker-home health aide, and physical therapy services. A home health agency can be a public or private agency or organization, either proprietary or non-profit, or a subdivision of such an agency or organization, which qualifies as follows:

- Is approved by the New Jersey State Department of Health and Senior Services, including requirements for Certificate of Need and licensure when applicable;
- Is certified as a home health agency under Title XVIII (Medicare) Program; and
- Is approved for participation as a home health agency provider by the New Jersey Medicaid or NJ FamilyCare program or the Medicaid agent.

Homemaker – Home Health Aide Agency or Health Care Service Firm means a proprietary or voluntary non-profit agency approved by the Department of Human Services, Division of Medical Assistance and Health Services to provide Personal Care Assistant Services and homemaker services under any waiver program approved by the CMS and accredited, initially and on an on-going basis, by the Commission on Accreditation for Home Care Inc., the National Home Caring Council, a Division of the Foundation for Hospice and Homecare, or the Community Health Accreditation Program (CHAP).

Homemaker-Home Health Aide means a person who:

- Successfully completes a training program in personal care assistant services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing as a homemaker-home health aide. A copy of the certificate issued by the New Jersey Department of Law and Public Safety, Board of Nursing or other documentation acceptable to the Division is retained in the agency's personnel file.
- Successfully completes a minimum of 12 hours in-service education per year offered by the agency; and
- Is supervised by a registered professional nurse employed by a Division-approved home health agency provider.

Hospice Agency means a public agency or private organization (or subdivision of such organization) that is Medicare certified for hospice care in accordance with N.J.A.C. 10:53A, and has a valid provider agreement with the Division to provide hospice services.

Hospice Service means a service package provided by a Medicare or Medicaid approved hospice agency to beneficiaries who are certified by an attending physician as terminally ill, with a life expectancy of up to six months. The service package supports a philosophy and method for caring for the terminally ill, emphasizing supportive and palliative, rather than curative care, and includes services such as home care, bereavement counseling, and pain control.

Housebound means a DVA benefit that is paid in addition to the monthly pension. Like A&A, Housebound benefits may not be paid without eligibility to pension. A veteran may be eligible for Housebound benefits when:

- The veteran has a single permanent disability evaluated as 100-percent disabling AND, due to such disability he/she is permanently and substantially confined to his/her immediate premises, OR
- The veteran has a single permanent disability evaluated as 100-percent disabling AND another disability, or disabilities, evaluated as 60 percent or more disabling.

- A veteran cannot receive both Aid & Attendance and Housebound benefits at the same time.

Instrumental Activities of Daily Living (IADL) means activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using the telephone. Limitations in IADLs are measured utilizing an IADL Scale.

Levels of Care means two levels of home healthcare services, acute and chronic, provided by a certified, licensed home health agency, as needed, to Medicaid or NJ KidCare fee-for-service beneficiaries, upon request of the attending physician.

"Acute home health care" means concentrated and/or complex professional and non-professional services on a continuing basis where there is anticipated change in condition and services required.

"Chronic home health care" means either long or short-term uncomplicated, professional and non-professional services where there is no anticipated change in condition and services required.

Licensed Practical Nurse (LPN) means a person who is licensed by the State of New Jersey as a practical nurse, pursuant to N.J.A.C. 13:37, having completed formal accredited nursing education programs.

Medicaid is a federal-state entitlement program for low-income citizens of the United States. The Medicaid program is part of Title XIX of the Social Security Act Amendment that became law in 1965. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals. State participation is voluntary, but since 1982, all 50 states have chosen to participate in Medicaid.

Medicare is health insurance for people age 65 or older, people under age 65 with certain disabilities, and people of any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

NJEASE means the **New Jersey Easy Access, Single Entry** toll-free telephone number, 1-877-222-3737, to put a veteran in touch with his/her County's Office on Aging/Area Agency on Aging (AAA).

Nursing supervisor means a registered professional nurse who has at least one of the following qualifications:

- A bachelor of science degree in nursing and two years combined community health nursing and progressive professional responsibilities in community health nursing; or

- Three years combined community health nursing and progressive professional responsibilities in community health nursing.

Nutritionist means a person who has graduated from an accredited college or university, with a major in foods or nutrition or the equivalent course work for a major in the subject area, and two years of full-time professional experience in nutrition. Successful completion of a dietetic internship of traineeship in hospital or community nutrition approved by the American Dietetic Association, or completion of a master's degree in the subject area may be substituted for the two years of full-time experience.

Occupational Therapist (OT) means a person who is certified as an occupational therapist and is registered by the National Board for Certification in Occupational Therapy and has at least one year of experience as an occupational therapist and complies with all New Jersey licensure requirements.

Older Americans Act (OAA) is federal legislation first enacted in 1965 that established the U.S. Administration on Aging (AoA) within the U.S. Department of Health and Human Services (DHHS), to serve as the primary vehicle for organizing, coordinating, and providing community-based services and opportunities for older Americans and their families.

On-Site Monitoring means a visit by DHSS staff to a homemaker agency, private duty nursing agency, provider of waiver services, or hospice agency to monitor compliance with state and federal regulations.

Performance Standards means the criteria established by the DHSS in order to measure the beneficiary/caregiver's satisfaction with the quality, quantity, and appropriateness of the services delivered.

Personal Care Assistant (PCA) means a person who:

- Successfully completed a training program in personal care services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing as a homemaker-home health aide. A copy of the certificate or other documentation issued by the New Jersey Department of Law and Public Safety, Board of Nursing is retained in the agency's personnel file.
- Successfully completes a minimum of 12 hours in-service education per year offered by the agency; and
- Is supervised by a registered professional nurse employed by a Division-approved homemaker/personal care assistant provider agency.

Personal Care Assistant Services means health related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered

professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care.

Physical Therapist (PT) means a person who meets all the applicable Federal requirements, and who is so licensed by the New Jersey State Board of Physical Therapy.

Physician means a person who is licensed or authorized by the New Jersey State Board of Medical Examiners to practice medicine or podiatry in the State of New Jersey. A physician can be a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners.

Plan of Care means the individualized and documented program of health care services provided by all members of the home health or homemaker agency involved in the delivery of home care services to a beneficiary. The plan includes short-term and long-term goals for rehabilitation, restoration, or maintenance made in cooperation with the beneficiary and/or responsible family members or interested person. Appropriate instruction of beneficiary and/or the family or interested person, as well as a plan for discharge, are also essential components of the treatment plan. The plan shall be reviewed periodically and revised appropriately according to the observed changes in the beneficiary's condition.

Plan of treatment means a written plan established and authorized in writing by the physician based on an evaluation of the patient's immediate and long-term needs:

- Initiated and implemented when the patient is admitted;
- Coordinated and maintained by the nursing service or the physical therapy service, if physical therapy is the sole service;
- Inclusive of, but not limited to, the patient's diagnosis, patient goals, means of achieving goals, and care and treatment to be provided;
- Current and available to all personnel providing patient care; and
- Included in the patient's medical/health record.

Primary Caregiver means an adult relative or significant other adult who accepts 24-hour responsibility for the health and welfare of the beneficiary. For the beneficiary to receive private duty nursing services under ACCAP, Model Waiver 3, ABC, or EPSDT, the primary caregiver must reside with the beneficiary and provide a minimum of eight hours of hands-on care to the beneficiary in any 24-hour period.

Prior Authorization means the process of approval by the Division for certain services prior to the provision of these services. Prior authorization also may be applied in other service areas in situations of an agency's continued non-compliance with program

requirements. In accordance with N.J.A.C. 10:60-2.1, if a patient is enrolled in an HMO, authorization for reimbursement is required by the HMO prior to rendering any service.

Private Duty Nursing means individual and continuous nursing care, as different from part-time or intermittent care, provided by licensed nurses in the home to beneficiaries under Model Waiver 3, ABC, and ACCAP, as well as eligible EPSDT beneficiaries.

Private Duty Nursing Agency means a licensed home health agency, voluntary nonprofit homemaker agency, private employment agency, and temporary-help service agency approved by the Division to provide private duty nursing services under Model Waiver 3, ABC, ACCAP or EPSDT. The private duty nursing agency shall be located/have an office in New Jersey and shall have been in operation and actively engaged in home healthcare services in New Jersey for a period of not less than one year prior to application.

Progress note means a written, signed, and dated notation by the practitioner providing care, periodically summarizing information about the care provided and the patient's response to it.

Public Health Nurse means a person licensed as a registered professional nurse, who has completed a baccalaureate degree program approved by the National League for Nursing for public health preparation, or post-baccalaureate study which includes content approved by the National League for Nursing for public health nursing preparation.

Quality Assurance means a program for the systematic monitoring of the various aspects of medical care to ensure that generally accepted standards of quality are being met, and the patient will have a positive health outcome.

Registered Professional Nurse (RN) means a person who is licensed by the State of New Jersey as a registered professional nurse, pursuant to N.J.A.C. 13:37.

SHIP- The State Health Insurance Assistance Program, in the Division of Aging and Community Services within DHSS. SHIP offices are located in each of the twenty-one (21) New Jersey Counties, and trains volunteers to assist Medicare enrollees who have problems or questions about their health insurance.

Signature means at least the first initial and full surname and title (for example, R.N., L.P.N., D.D.S., M.D.) of a person, legibly written either with his or her own hand, generated by computer with authorization safeguards, or communicated by a facsimile communications system (FAX).

Social Worker means a person who is licensed by the New Jersey State Board of Social Work Examiners and has a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education, and at least

one year of post-master's social work experience in a health care setting as per N.J.S.A. 45-15BB-1 et seq. and N.J.A.C. 13:44G. (CSW; LSW; LCSW; or MSW).

Social Work Assistant means a person who has a baccalaureate degree in social work, psychology, or sociology or other field related to social work and has had at least one year of social work experience in a health care setting.

Speech-Language Pathologist (ST) means a person who is so licensed by the Audiology and Speech-Language Pathology Advisory Committee of the Division of Consumer Affairs of the New Jersey Department of Law and Public Safety.

Staff education plan means a written plan developed at least annually and implemented throughout the year which describes a coordinated program for staff education for each service, including in-service programs and on-the-job training.

Staff orientation plan means a written plan for the orientation of each new employee to the duties and responsibilities of the service to which he or she has been assigned, as well as to the personnel policies of the facility.

Supervision means authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his or her sphere of competence, with initial direction and periodic on-site inspection of the actual act of accomplishing the function or activity.

TAG means The Adjutant General of the New Jersey Department of Military and Veterans Affairs.

VHA means the Veterans Health Administration

Appendix B – Costs for DHSS Programs and Services

(Taken from the DHSS “New Jersey State Strategic Plan on Aging - October 1, 2005-September 30, 2008”.) Costs for 2004 for programs and services provided by the Area Agencies on Aging (AAA).

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES

Over 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).

NEW JERSEY DIVISION OF AGING AND COMMUNITY SERVICES AREA PLAN CONTRACT SERVICES PROVIDED IN CALENDAR YEAR 2006

<u>Service</u>	<u>Units</u>	<u>Clients</u>	<u>Expenditures</u>
Information & Assistance	363,267	163,793	\$5,145,463
Benefits Screening	35,621	10,772	\$828,940
Extended Assessment	4,241	1,799	\$140,360
Outreach	76,682	40,556	\$1,584,212
Care Management	148,512	7,634	\$3,968,961
Transportation	887,981	18,208	\$5,751,760
Assisted Transportation	102,815	10,535	\$1,017,740
Newsletter	24	35,456	\$38,027
Friendly Visiting	23,754	1,673	\$205,884
Telephone Reassurance	259,223	2,352	\$352,278
Residential Maintenance	35,239	4,525	\$1,196,186
Housekeeping	77,710	1,793	\$1,530,839
Certified Home Health Aide	291,923	3,035	\$5,574,397
Visiting Nurse	8,694	928	\$283,594
Respite Care	83,698	1,401	\$1,596,249
Hospice Care	13,261	370	\$254,889
Emergency	11,670	1,847	\$521,958
Homesharing/Matching	904	107	\$34,273
Housing Assistance	1,702	616	\$87,398
Caregiver Support Group	959	1,222	\$129,714
Adult Day Services – Social	567,736	2,130	\$3,605,072
Adult Day Services – Medical	105,756	632	\$1,291,695
Personal Care	6,843	241	\$117,444
Adult Protective Services	211,454	4,830	\$5,116,099
Legal Assistance	26,550	6,897	\$1,520,333
Physical Health	39,855	18,277	\$1,062,708

Physical Health – Dental	7,713	1,673	\$571,583
Mental Health	10,257	1,626	\$766,836
Counseling	10,302	991	\$260,978
Physical Fitness	15,456	6,690	\$484,635
Education	34,793	35,093	\$967,020
Language Translation & Interpretation	8,348	5,094	\$139,219
Socialization/Recreation	39,509	12,540	\$1,207,385
Ombudsman	357	172	\$38,474
Congregate Meals	1,946,178	33,100	\$19,262,607
Home Delivered Meals	3,596,153	24,883	\$18,935,958
State Weekend Home Delivered Meals	336,058	7,301	\$1,810,359
Nutrition Education	1,629	35,770	\$289,988
Nutrition Counseling	2,675	3,170	\$157,729
Public Awareness	-0-	-0-	\$8,045
Caregiver Mental Health Counseling	259	67	\$30,692
Professional I-Home Education	785	173	\$60,975
Trained Volunteer Assistance	4,728	190	\$86,878
Total of All Services	9,401,274	510,162	\$88,035,834

SOURCE OF FUNDS FOR AREA PLAN CONTRACT SERVICES PROVIDED, 2004

Service Funds	Expenditures	Percentage
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%
Total Service Expenditures	\$85,593,262	100.00%

Appendix C – New Jersey’s Area Agencies on Aging (AAA)

(Taken from the DHSS web site http://www.state.nj.us/health/senior/sa_aaa.shtml)

An Area Agency on Aging (AAA) is designated in each of New Jersey's 21 counties to serve as the primary entity responsible for developing comprehensive, coordinated systems of community-based services for older adults. The role of the AAAs includes:

- Coordinating all programs on aging regardless of funding source, and serving as the central source for information and referral for services and programs;
- Preparing an Area Plan on Aging which includes an analysis of the needs and existing services within the county and a comprehensive plan for the delivery of services to older people;
- Administering the annual allocation of federal Older Americans Act and state funds from the New Jersey Division of Aging and Community Services for projects and services within the county;
- Monitoring and evaluating projects funded under the Area Plan;
- Serving as an advocate to increase the public's understanding of the nature of the aging process and the aging individual; and
- Advising local governments and the Division of Aging and Community Services of unmet needs, and recommending legislation where appropriate.

County Offices on Aging

Nationwide Toll-Free Telephone Number 1-877-222-3737

<p>Atlantic (609-645-7700 x 4700) Atlantic County Division of Intergenerational Services Shoreview Building, Office 222 101 South Shore Road Northfield, NJ 08225</p>	<p>Middlesex (732-745-3295) Middlesex County Department on Aging John F. Kennedy Square 5th Floor New Brunswick, NJ 08901</p>
<p>Bergen (201-336-7400) Bergen County Division of Senior Services One Bergen County Plaza, 2nd Floor Hackensack, NJ 07601-7000</p>	<p>Monmouth (732-431-7450) Monmouth County Division on Aging, Disabilities and Veterans Interment 21 Main and Court Center Freehold, NJ 07728</p>
<p>Burlington (609-265-5069) Burlington County Office on Aging 49 Rancocas Road PO Box 6000 Mount Holly, NJ 08060</p>	<p>Morris (973-285-6848) Morris County Division on Aging, Disabilities and Veterans 340 West Hanover Avenue, Ground Floor PO Box 900 Morristown, NJ 07963-0900</p>
<p>Camden (856-858-3220) Camden County Division of Senior & Disabled Services Parkview on the Terrace 700 Browning Road, Suite 11 W. Collingswood, NJ 08107</p>	<p>Ocean (732-929-2091) Ocean County Office of Senior Services 1027 Hooper Avenue, Building #2 PO Box 2191 Toms River, NJ 08754-2191</p>

<p>Cape May (609-886-2784/2785) Cape May County Department of Aging Social Services Building 4005 Route 9, South Rio Grande, NJ 08242</p> <p>Cumberland (856-453-2220/2221) Cumberland County Office on Aging and Disabled Administration Building 790 East Commerce Street Bridgeton, NJ 08302</p> <p>Essex (973-395-8375) Essex County Division on Aging 50 South Clinton Street 3rd Floor, Suite 3200 East Orange, NJ 07018</p> <p>Gloucester (856-232-4646) Gloucester County Division of Senior Services County Offices @ 5-Points 211 County House Road Sewell, NJ 08080</p> <p>Hudson (201-271-4322) Hudson County Office on Aging 595 County Avenue, Building 2 Secaucus, NJ 07094</p> <p>Hunterdon (908-788-1361/1362/1363) Hunterdon County Division of Senior Services 4 Gauntt Place, Building 1 PO Box 2900 Flemington, NJ 08822-2900</p> <p>Mercer (609-989-6661/6662) Mercer County Office on Aging 640 S. Broad Street PO Box 8068 Trenton, NJ 08650-0068</p>	<p>Passaic (973-569-4060) Passaic County Department of Senior Services, Disability and Veterans Affairs 930 Riverview Drive, Suite 200 Totowa, NJ 07512</p> <p>Salem (856-339-8622) Salem County Office on Aging 98 Market Street Salem, NJ 08079</p> <p>Somerset (908-704-6346) Somerset County Office on Aging Somerset County Office Building 92 East Main Street PO Box 3000 Somerville, NJ 08876</p> <p>Sussex (973-579-0555) Sussex County Division of Senior Services Sussex County Administration Building 1 Spring Street, 2nd Floor Newton, NJ 07860</p> <p>Union (908-527-4870/4872) Union County Division on Aging Administration Building Elizabeth, NJ 07207</p> <p>Warren (908-475-6591) Warren County Division of Senior Services Wayne Dumont Jr. Admin. Bldg. 165 County Road, Suite 245 Route 519 South Belvidere, NJ 07823-1949</p>
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Appendix D – New Jersey’s Veterans Services Officers (VSO)

Division of Veterans Services (DVS) – DMAVA

Gary R. Englert, Director – (609) 530-6962
Diane T. Donahue, Secretary – (609) 530-7049
Cheryl Henderson, Secretary – (609) 530-6975

Veterans Service Offices (DVS-VSO)

Chris Kulkosky, VSO Training Officer – (609) 530-7050
David Walther, VSO State Supervisor – (609) 530-6830
William Devereaux, Program Coordinator – (856) 853-0593

VSO Office by New Jersey County

Atlantic / Cape May

Christopher Wambach, VSO
Lonna Remsen, Secretary
1601 Atlantic Avenue, 7th Floor
Atlantic City, New Jersey 08401
(609) 441-3060 / 3061
Fax: (609) 441-3899

Burlington

Charles Piscopo, VSO
Bernadette Whitman, Secretary
555 High Street, Suite 6A
Mt. Holly, New Jersey 08060
(609) 518-2273 / 2274
Fax: (609) 518-2275

Essex/Union

Moise Abraham, VSO
Vacant, Secretary
1196 Chestnut Street
Elizabeth, New Jersey 07201-1053
(908) 820-3133 / 3134
Fax: (908) 965-2954

Mercer

David Joost, VSO
Theresa Tomecheck, Secretary
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Trenton, New Jersey 08625-0671
(609) 292-5880 / 5881
Fax: (609) 633-6852

Bergen

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125 State Street, Suite 109
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438 Summit Avenue, Room 302
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Middlesex/Somerset

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711 Jersey Avenue, 2nd Floor
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Fax: (732) 937-6417

Monmouth

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Sussex / Morris

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Salem / Cumberland

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Warren / Hunterdon

Monica Banca, VSO
Lisa Szymanski, Secretary
550 A Route 57
Port Murray, New Jersey 07865
(908) 689-5840 / 5845
Fax: (908) 689-5879
Route 31 County Complex Bldg 1
4 Gauntt Place
Flemington, New Jersey
(908) 284-6146

Appendix E – The Veterans Home Healthcare Advisory Committee

COL (Ret) Stephen G. Abel, DCVA – DMAVA – Chair
Hon. Jack Connors, Assemblyman, 7th District, D-Camden, Burlington – Bill Sponsor
Brigadier General Maria Falca-Dodson, DAG – DMAVA
Brigadier General Frank R. Carlini, Director, DVHS – DMAVA
Ms. Katheryn Wierzbicki, RN, BSN, QA Coordinator – DMAVA
Ms. Patricia Polansky, Assistant Commissioner, DHSS
Mr. Paul Langevin, President, Health Care Association of New Jersey
Ms. Sherl Brand, RN, BSN, CCM, President and CEO, Home Care Association of N.J.
Mr. Jack Donnelly, Esq., Office of the Governor
Ms. Keri Logosso, Esq., Office of the Governor
Dr. Marsha Rosenthal, the Rutgers Center for State Health Policy
Mr. Ray Zawacki, Adjutant, The American Legion
Mr. Robert Pinto, VFW State Commander
Mr. Albert Bucchi, VFW State Legislative Director
Mr. Daniel Flynn, Army DAV Adjutant
Ms. Virginia Dempsey, U.S. Navy DAV Commander
Mr. William Thompson, VFW State Adjutant
Mr. Frank Calandrillo, American Legion State Commander
Mr. Timothy Thomas, Senior Vice Commander, DAV

Advisors

Dr. Samer Nasr, Chief, Geriatrics and Extended Care, U.S. Department of Veterans Affairs, New Jersey Health Care System
Ms. Michelle Stefanelli, OIF/OEF Coordinator, U.S. Department of Veterans Affairs, New Jersey Health Care System
Ms. C. Denise Coutsouridis, MSW, State Veterans Home Liaison, U.S. Department of Veterans Affairs, New Jersey Health Care System

Administrative Support

Ms. Karen D. Wallace, DVHS, DMAVA

Printing Support

Ms. Maureen Turak, IASD, DMAVA

Appendix F: The Veteran Survey

QUESTION 1: ARE YOU OR YOUR LOVED ONE RECEIVING ANY HOME HEALTHCARE SERVICES NOW, OR HAVE YOU RECEIVED HOME HEALTHCARE SERVICES IN THE PAST?

Currently:

No:	58%
Yes:	31%
No response:	11%

Past help:

Yes:	55%
No:	36%
No response:	9%

QUESTION 2: WHICH HOME HEALTHCARE SERVICES ARE YOU/YOUR LOVED ONE RECEIVING OR HAVE YOU RECEIVED? (MOST INDIVIDUALS CHECKED MORE THAN ONE SERVICE.)

Home Health Aide:	82
Physical Therapy:	65
Skilled Nursing:	54
No Response:	31
Social Worker:	25
Transportation:	21
Occupational Therapy:	16
N/A:	14
Speech Therapy:	10
Home Maintenance:	9

Other: Full-time custodial care (6 individuals), Hospice 5), Assisted Living (1), Adult Day Health Services (2), Help with bathing (1), and Meal Preparation (1)

QUESTION 3: WHO PAID FOR THESE HOME HEALTHCARE SERVICES FOR YOU/YOUR LOVED ONE? (MANY INDIVIDUALS HAD MORE THAN ONE PAYMENT SOURCE FOR SERVICES.)

Out-of-Pocket (Paid Privately):	73
Medicare:	71
No Response:	37
DVA (US Dept. of Veteran Affairs):	21
Private Insurance Policy:	18
N/A	14
Other:	14

(DVA Disability, JACC program, Children, Donation, Hospice)

Medicaid:	5
Long-Term Care Insurance Policy:	2
Gloucester City grant for the Blind)	

QUESTION 4: WHAT HOME HEALTHCARE SERVICES WOULD ALLOW YOU/YOUR LOVED ONE TO REMAIN AT HOME? PLEASE CHECK ALL THAT WOULD APPLY TO YOU.

Bathing:	114
Dressing:	93
Toileting:	88
Food Preparation:	86
Housecleaning:	83
Laundry:	79
Food Shopping:	69
Eating/feeding:	65
Transportation:	64
Early Dementia Care:	62
Medication Administration:	59
Physical Therapy:	52
Adult Day Care:	51
Home Safety Improvements:	38
Meals-on-Wheels:	36
Yard Work:	32
Bill Paying:	25
Occupational Therapy:	25
No Response:	22
Oxygen-Respiratory Treatments:	17
Other:	7
Late dementia Care, feeding tube, skilled nursing, 24-hour care, nursing home, financial assistance to pay for live-in, Alzheimer's 24 hours supervision	
N/A:	2
None:	1

QUESTION 5: HOW MANY HOURS/DAYS OF HOME HEALTHCARE SERVICES DO YOU/YOUR LOVED ONE NEED?

Hours:	
24 Hours per Day:	42%
4 Hours per day:	13%
No Response:	18%
12 Hours per day:	8%
8 Hours per day:	6%
2 Hours per day:	6%
Other:	3%:
seven hours a day (1), six hours a day (3), one hour a day (1)	
Days:	
7 days per week:	50%
No Response:	24%
3 days per week:	11%
1-2 days per week:	6%

None/NA:	5%
Other:	4%
Night care (3), 5 days, M-F (2), wake time (1),	

QUESTION 6: WHERE ARE YOU/YOUR LOVED ONE LIVING RIGHT NOW?

At Home:	61%
Another Nursing Home:	20%
Assisted Living Facility:	10%
Other:	6%
Hospice (2), Rehab (2), NJ Vet Memorial Home (3), Family (3), Vets Boarding Home (1)	
No response:	3%

QUESTION 7: WHO HELPS YOU NOW WITH THE Activities of Daily Living (ADL's) (BATHING, DRESSING, ETC.?)

A number of individuals gave more than one response. The numbers represent the number of individuals who responded in each category:

Paid Help:	49
Children:	47
Other:	44
(Nursing Facility, Self, Sister-in-law)	
My Spouse:	33
No Response:	24
Friends:	11
Neighbors:	10
Church Members:	7

QUESTION 8: WHAT IS YOUR CURRENT DVA ELIGIBILITY CATEGORY?

No Response:	52%
Not Sure/Don't Know:	26%
Category Group 1:	7%
Category Group 2:	5%
Category Group 8:	4%
Category Group 7:	2%
Category Group 3:	1%
Category Group 4:	1%
Category Group 5:	1%
N/A:	1%
Category Group 6:	0

QUESTION 9: WOULD YOU/YOUR LOVED ONE BE ABLE TO REMAIN AT HOME IF HOME HEALTHCARE SERVICES WERE PROVIDED:

Yes:	55%
No:	28%
No Response:	13%
Other:	4%

QUESTION 10: ARE YOU A:

Veteran:	68%
Veteran's Spouse:	15%
Veteran's Widow:	10%
Other:	6%
(Conservator/POA (1), Family Member (10)	
No Response:	2%
Veteran's Widower:	0%
Gold Star Parent:	0%

Appendix G: U.S. Department of Veterans Affairs Enrollment Priority Groups

Veteran Priority Groups were established by the Veterans' Health Care eligibility Act of 1996, Public Law 104-262. The Department of Veterans' Affairs Health Care Programs enhancement Act of 2001, Public Law 107-135 expanded the original seven categories to eight. Those groups are as follows:

GROUP 1: Veterans with service-connected disabilities who are rated 50 percent or more disabled;

GROUP 2: Veterans with service-connected disabilities who are rated 30 or 40 percent disabled;

GROUP 3: Veterans who were former POWs or were awarded a Purple Heart, veterans with disabilities rated 10 and 20 percent, veterans awarded special eligibility for disabilities incurred in the line of duty;

GROUP 4: Veterans who are receiving aid and attendance or household benefits and veterans who have been determined by the DVA to be catastrophically disabled, although some catastrophically disabled veterans could be responsible for co-payments. Catastrophic disablement is defined as:

- Having a permanent severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that the individual requires personal or mechanical assistance to leave bed or requires constant supervision to avoid physical harm to self or others as defined in Title 38 Code of Federal Regulation (CFR) Section 17.36(e).
- Individual meets the specification of the below conditions.
- Amputation through the hand, forearm, elbow, humerus, forequarter, lower limb, great toe, foot, malleoli, above the knee, below the knee, hip, hindquarter.
- Disarticulation of the wrist, forearm, elbow, shoulder, ankle, knee, hip.
- Quadriplegia and quadripareisis.
- Dependent in 3 or more Activities of Daily Living (eating, dressing, bathing, toileting, incontinence of bladder and or bowel), with 3 of the dependencies being permanent with a rating of 1 using the Katz Scale.
- A score of 2 or lower on at least 4 of the 13 motor items using the Functional Independence Measure.
- A score of 30 or lower using the Global Assessment of Functioning.
- A score of 10 or lower using the Folstein-Mental State Examination.
- DVA Form 10-10EZ

GROUP 5: Veterans who are determined to be unable to defray the expenses of needed care; veterans receiving DVA pension benefits, veterans who are eligible for Medicaid programs, Veterans with incomes and assets below the DVA Means Test Thresholds.

GROUP 6: All other eligible veterans who are not required to make co-payments for their treatment. This includes veterans of the Mexican Boarder war period or of WWI; veterans seeking care solely for a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during the Gulf War, or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after Nov 11, 1998; and veterans with zero percent service-connected disabilities who are nevertheless compensated, including veterans receiving compensation for inactive tuberculosis; veterans seeking care for disorders relating to Ionizing Radiation and Project 112/SHAD; veterans seeking care for Agent Orange exposure during Vietnam service; Veterans seeking care for Gulf War Illnesses or for conditions related to exposure to Environmental contaminates during service in the Persian Gulf.

GROUP 7: Non-service connected veterans and non-compensable zero percent service-connected veterans with income above DVA's national means test threshold and below DVA's geographical means test threshold for the fiscal year ending on September 30 of the previous calendar year, or with income below both the DVA national threshold and the DVA geographically based threshold, but whose net worth exceeds DVA's ceiling (currently \$80,000) who agree to pay co-payments; and

GROUP 8: All other non-service-connected veterans and zero percent non-compensable service-connected veterans who agree to pay co-payments (Note: Effective JAN 17, 2003, DVA no longer enrolls new veterans in priority group 8).

It must be noted that the DVA has not up-dated its estimates of the effects of impairment since 1945, and has only begun to up-date its disability criteria in 1990. This process has yet to be completed.

Appendix H: Calculations for Home Health Care Services

COSTS FOR HOME HEALTHCARE

525 WAITING LIST VETERANS

5 YEAR PROJECTION

Type of Service	Base Cost Per Individual	Cost Year 1	Cost Year 2	Cost Year 3	Cost Year 4	Cost Year 5	Total Cost 5 Years
Certified Home Health Aide	\$1,837	\$964,425	\$1,022,291	\$1,083,628	\$1,148,646	\$1,217,565	\$5,436,555
Visiting Nurse	\$306	\$160,650	\$170,289	\$180,506	\$191,336	\$202,816	\$905,597
TOTALS	\$2,143	\$1,125,075	\$1,192,580	\$1,264,134	\$1,339,982	\$1,420,381	\$6,342,152

*Numbers rounded to the nearest whole number.

*Increase in service costs equals 6% per annum.

*Costs-per-individual numbers are based on DHSS 2006 funding.

COSTS FOR HOME HEALTHCARE

10 PERCENT OF ALL ELIGIBLE VETERANS

5 YEAR PROJECTION

Type of Service	Base Cost Per Individual	Cost Year 1	Cost Year 2	Cost Year 3	Cost Year 4	Cost Year 5	Total Cost 5 Years
Certified Home Health Aide	\$1,837	\$40,665,669	\$43,105,609	\$45,691,946	\$48,433,462	\$51,339,470	\$229,236,156
Visiting Nurse	\$306	\$6,773,922	\$7,180,357	\$7,611,179	\$8,067,849	\$8,551,920	\$38,185,227
TOTAL	\$2,143	\$47,439,591	\$50,285,966	\$53,303,124	\$56,501,312	\$59,891,391	\$267,421,383

*Numbers rounded to the nearest whole number.

*Increase per year equals 6%.

*Cost per individual numbers is based on DHSS figures.

*Population census decreased 1% per annum.

Appendix I: Information Technology (IT) Calculations

Cost Associated with Integrating DHSS NJEASE Program onto VSO Computer (Estimate)

The current New Jersey EASE Access (NJEASE) is a call-center-based program, which provides an easy way for older adults and their families to get information about home and community support services. NJEASE is a statewide toll-free telephone number that links to caller to their local county office on aging where they can find out about State and federal programs and benefits. Trained Information and Assistant Specialists screen callers to see if they are eligible for services and then connect them to the appropriate community agencies.

The Department of Health and Senior Services, Division of Aging and Community Services (DACS) is responsible for the NJEASE system. Because NJEASE does not have a statewide client-tracking system, DACS has been piloting in seven counties, a web-based client-tracking application, developed and hosted by Synergy Software Technologies, Inc. The application - Social Assistance Management System (SAMS), is an off-the-shelf application that will meet the DACS requirements for tracking client intake, service planning, care management, and service utilization/costs. The DACS is in the process of seeking approval from the State Office of Information and Technology (OIT) to deploy SAMS statewide to the remaining 14 county offices on aging and their 400 community provider agencies. Once OIT approves the statewide deployment, DACS will proceed with a Waiver of Advertisement to purchase licenses and subscriptions to Synergy's hosting service, AgingNetwork.com.

DMAVA is exploring the option to partner with DACS for procurement of the web-based application for its 13 Veterans Services offices and the Veterans Affairs Headquarters location for approximately 15 end users, to enhance delivery of veteran services and provide access to database information that is common between the two departments.

Estimated costs include:

- T-1 Frame Circuit for VSO \$384 @ 13 = \$4992 per month/\$59,904. per yr (existing infrastructure) *
- Personal Computer (PC) Win XP / Office 2003 - 15 @ \$1200 = \$18,000 (existing infrastructure) **
- SAMS 2000 / Licensing - Annual Service Fee \$2000 (est) @ 15 = \$30,000
- (IT) Staff assistance man-hours roll-out / set-up VSO's 7 hrs @ 15 = 105 x \$38 = \$3990 (est)
- Centralized On-site Training VSO staff end users = \$2000

Estimated Cost for initial VSO fielding of the SAMS program access is \$35,990 with a recurring annual licensing fee of \$30,000

* Note 1: this annual \$59,904 circuit fee is currently paid from the department telecommunications (3110) budget.

** Note 2: VSO Personal Computers and Software are existing assets.

**APPENDIX J - NEW JERSEY COUNTY WELFARE AGENCIES
AND BOARDS OF SOCIAL SERVICES**

Agency	Phone	Fax
Atlantic County Dept. of Family & Community Development 1333 Atlantic Avenue Atlantic City, NJ 08401-8297	609-348-3001	609-343-2374
Bergen County Board of Social Services 216 Route 17 North Rochelle Park, NJ 07662-3300	201-368-4200	201-368-8710
Burlington County Board of Social Services Human Services Facility 795 Woodlane Road Mount Holly, NJ 08060-3335	609-261-1000	609-261-0463
Camden County Board of Social Services Aletha Wright Admin. Building 600 Market Street Camden, NJ 08102-8800	856-225-8800	856-225-7797
Cape May County Board of Social Services Social Services Building 4005 Route 9 South Rio Grande, NJ 08242-1911	609-886-6200	609-889-9332
Cumberland County Board of Social Services 275 North Delsea Drive Vineland, NJ 08360-3607	856-691-4600	856-692-7635
Essex County Dept. of Citizen Services Division of Welfare 18 Rector Street, 9 th Floor Newark, NJ 07102	973-733-3000	973-643-3985

Agency	Phone	Fax
Gloucester County Board of Social Services 400 Hollydell Drive Sewell, NJ 08080	856-582-9200	856-582-6587
Hudson County Dept. of Family Services – Division of Welfare John F. Kennedy Office Building 100 Newkirk Street Jersey City, NJ 07306	201-420-3000	201-420-0343
Hunterdon County Division of Social Services Community Services Center 6 Gauntt Place, P.O. Box 2900 Flemington, NJ 08822-2900	908-788-1300	908-806-4588
Mercer County Board of Social Services 200 Woolverton Street P.O. Box 1450 Trenton, NJ 08650-2099	609-989-4320	609-989-0405
Middlesex County Board of Social Services 181 How Lane, P.O. Box 509 New Brunswick, NJ 08903	732-745-3500	732-745-4558 WFNJ 732-745-4555
Monmouth County Division of Social Services Kozloski Road, P.O. Box 3000 Freehold, NJ 07728	732-431-6000	732-431-6017 WFNJ 732-431-6267
Morris County Office of Temporary Assistance Program Services 340 W. Hanover (Morris Twp.) P.O. Box 900 Morristown, NJ 07963-0900	973-326-7800	973-829-8531

Agency	Phone	Fax
Ocean County Board of Social Services 1027 Hooper Avenue P.O. Box 547 Toms River, NJ 08754-0547 <i>*Northern Satellite Office Northern Ocean County</i> Resource Center 225 Fourth Street Lakewood, NJ 08701 <i>*Southern Satellite Office The Commons at Strafford</i> Business Park 325 Recovery Road Manahawkin, NJ 08050	732-349-1500 732-370-8854 609-978-2100	732-244-8075 WFNJ 732-473-0669 732-905-9797 609-978-2126
Passaic County Board of Social Services 80 Hamilton Street Paterson, NJ 07505-2060	973-881-0100	973-881-3232
Salem County Board of Social Services 147 S. Virginia Avenue Penns Grove, NJ 08069-1797	856-299-7200	856-299-3245
Somerset County Board of Social Services 73 E. High Street, P.O. Box 936 Somerville, NJ 08876-0936	908-526-8800	908-231-9010
Sussex County Division of Social Services 83 Spring Street, P.O. Box 218 Newton, NJ 07860-0218	973-383-3600	973-383-3627
Union County Division of Social Services 342 Westminster Avenue Elizabeth, NJ 07208-3290	908-965-2700	WFNJ 908-965-2758

Agency	Phone	Fax
Warren County Division of Temporary Assistance and Social Services Court House Annex Second & Hardwick Streets (501 Second Street – mailing) Belvidere, NJ 07823	908-965-2700	908-475-1533

Appendix K –DVA New Jersey Healthcare System Home Healthcare Budget

Community Care Program

Budget Justification – FY 2008

I. Contract Nursing Home (CNH) Program

We are currently spending slightly less than originally budgeted for FY2007; however this program is expected to grow for FY2008 because there is an increase of veterans without insurance who require sub-acute care. Also, the percentage of service connected veterans utilizing CNH indefinite placement has increased since our nursing home care unit beds are also in high demand.

There are currently 28 veterans in the CNH program; 23 of these are on indefinite contracts and the remaining 5 are on 40-day contracts. Our average per diem rate is \$206.63.

As of July 30, 2007, we have placed and/or maintained 81 CNH patients (including indefinite contracts) this fiscal year. Assuming this trend continues, we should place or maintain at least 100 patients in FY 2008. Our expenditures are projected as follows:

$\$206.63 \text{ (avg per diem)} \times 40 \text{ days (contract)} \times 80 \text{ patients} = \$661,216.00$

plus

$\$206.63 \times 365 \text{ days (indefinite contract)} \times 25 \text{ patients} = \$1,885,498.75$

Grand Total for CNH = \$2,546,714.75

II. Homemaker/Home Health Aid (H/HHA) Program

For FY 2007, we have provided H/HHA service to 1,220 veterans so far (as compared to 1,088 veterans for FY 2006 and 870 veterans for FY 2005). As of today, our census is 960. Providing H/HHA to all medically qualifying veterans, regardless of SC status, is mandated by Title 38-CFR 17.38. Given this, and the increase we have seen thus far, we can anticipate the census growing to 1,100 by the beginning of FY 2008.

Currently we are spending approximately \$40.84/visit/pt and with cost containment measures, we will be able to maintain that amount to \$408,400/mo.

$\$40.84/\text{visit/pt} \times 10,000 \text{ visits} \times 12 \text{ months} = \underline{\$4,900,800.00}$

III. Respite Program

For FY 2007, we have provided Respite service to 4 veterans. This program will continue to be available for those veterans who require respite care at home or CNH setting. In FY 2008 we anticipate to spend approximately: \$30,000.00

IV. Home Hospice Program

This program continues to allow veterans to receive appropriate end-of-life treatment so that they can attain a level of comfort that allows them to live life as fully as possible in the supportive and private environment of their home.

Currently we have 14 veterans in this program. For FY 2007, we have provided Home Hospice service to 42 veterans so far with an average length of stay of 43.13 days and per diem rate of \$152.99.

Since this is a mandated benefit for enrolled veterans, census is expected to rise, although not as dramatically as other community programs.

Assuming we have a census of 50 veterans enrolled for FY 2008, the cost would be approximately:

$\$153.00 \text{ (per diem)} \times 50 \text{ veterans} \times 43.13 \text{ days (Avg. \# of days)} = \underline{\$329,944.50}$

V. Adult Day Health Care (ADHC) Program

Great interest in the ADHC program continues as evidenced by continued calls requesting information and increased enrollment.

For FY 2007, we have provided ADHC services to 244 veterans thus far (as compared to 169 veterans for FY 2006 and 111 veterans for FY 2005), and currently have a census of 169 veterans enrolled. Assuming we have a census of 210 veterans enrolled for FY 2008, the cost would be approximately:

$\$630/\text{pt}/\text{mo.} \times 210 \text{ patients} \times 12 \text{ months} = \$1,587,600.00$

VI. Purchased Skilled Care Home Health Care (PSHC)

This new program has been added to Extended Care Service effective July 2, 2007. We are requesting **\$600,000.00** for FY2008. If necessary, additional monies will be requested.

VII. Contract Nursing Home Emergency Hospital

Approximately \$50,000 per year is needed for this program. Budget allotment will be assigned to this control point as needed. Funds will be obligated as invoices are submitted for payment.

Summary

CNH	=	\$2,546,714.75
H/HHA	=	\$4,900,800.00
Home Respite	=	\$ 30,000.00
Home Hospice	=	\$ 329,944.50
ADHC	=	\$1,587,600.00
CNH Emer.	=	\$ 50,000.00
<u>Purchased Skill</u>	<u>=</u>	<u>\$ 600,000.00</u>

Grand Total = \$10,045,059.25

APPENDIX L – Public Law 2007, Chapter 123

CHAPTER 123

AN ACT requiring the Department of Military and Veterans' Affairs to evaluate resources, costs and benefits of providing home health care aides for qualified veterans.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. a. The Adjutant General of the Department of Military and Veterans' Affairs, in consultation with the Commissioner of Health and Senior Services, shall examine and evaluate the resources available and the costs and benefits of providing home health care services to elderly or disabled veterans through approved agencies, organizations or other entities for the purpose of enabling these veterans to remain in their homes and communities and to avoid placement in a nursing home or other long-term care facility.

b. The Adjutant General shall make specific recommendations to the Legislature regarding the allocation of State funds necessary to meet the demand for veterans' home health care services for each of the subsequent five State fiscal years. The examination and evaluation of the Adjutant General shall focus on accessibility and cost effectiveness of care to be provided, while ensuring that the integrity of the department's nursing home and related missions are maintained. The Adjutant General shall make specific recommendations for working with the Medicare and Medicaid programs, and private insurance companies to provide these alternative to veterans.

c. In the report prepared, the Adjutant General shall describe items and services that may be provided as needed by a licensed home health care agency to provide preventive, rehabilitative, and therapeutic services to patients in the patient's home or place of residence. The department shall itemize and estimate the cost to provide each service and shall estimate the number of veterans in need of home health care services for each of the subsequent five State fiscal years.

d. Each State department or agency shall provide the Adjutant General with such resources as may be necessary for the completion of the examination and evaluation required by this section.

e. Not later than 180 days after the date of enactment, the Department of Military and Veterans' Affairs shall submit a written report to the Legislature, pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), on the findings and recommendations of the Adjutant General.

2. This act shall take effect immediately and shall expire 30 days after the submission of the final report to the Legislature.

Approved August 3, 2007.