
Council Meeting

of

NEW JERSEY ADVISORY COUNCIL ON ELDER CARE

“Testimony concerning health care and caregiving for the elderly”

LOCATION: Francis E. Parker Memorial Home
Piscataway, New Jersey

DATE: February 10, 1999
1:00 p.m.

MEMBERS OF COUNCIL PRESENT:

Assemblywoman Carol J. Murphy, Chair
Senator Norman M. Robertson
Assemblyman Samuel D. Thompson
Assemblyman Louis A. Romano
Susan C. Reinhard
Ruth M. Reader
Theresa L. Edelstein
Vivian E. Greenberg
John Michael Heath
Renee W. Michelsen
Roberto Muniz
Joanne P. Robinson
Lennie-Marie P. Tolliver



ALSO PRESENT:

Irene M. McCarthy
Office of Legislative Services
Council Aide

Meeting Recorded and Transcribed by
The Office of Legislative Services, Public Information Office,
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey

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ASSEMBLYWOMAN CAROL J. MURPHY (Chair): We are going to begin today's program by hearing from Barbara Fuller, who is the New Jersey EASE Team Leader. Certainly this is something that has been discussed-- Roberto, is there any way we can turn the music off?

MR. MUNIZ: I was going to ask you.

ASSEMBLYWOMAN MURPHY: It was delightful during, and suddenly I heard it.

But we have talked about New Jersey EASE clearly, and Lou Romano, particularly, was someone who really wanted to hear more about how this is and how this is working.

So, Barbara Fuller, without further ado the floor is yours, and the music will stop in a minute.

BARBARA FULLER: Actually it's a nice background, so I would be happy if it continues.

Thank you for having me and Casey O'Connor, who is a member of our team, here today to talk about New Jersey EASE and especially care management, which is an essential part of New Jersey EASE.

New Jersey EASE -- and I know that you have been hearing about it. Some of you know it very well, such as Joanne, who has been a member of the Advisory Committee for many years, and some of you may just have been hearing about it for the first time during this task force (*sic*). But it is a New Jersey Department of Health and Senior Services initiative. It really began in 1996, at least the creation, and the goal is to create a single-entry system for senior citizen services in each of our 21 counties.

And it's important to say in each of the 21 counties because New Jersey EASE is not a boiler plate. It's not something that we bring to a county and say this is what you must do and you must do it this way. Each county has an opportunity to create its own system with certain State perimeters and guidelines, and I think that that's what made this initiative such a success, that counties have bought into it because they help create it. And, in fact, it's essential for them to help create it.

We at the State are not the experts, we are partners, and we approach each county as a partner. They have the expertise as far as what their services are, which are their strong agencies, which are their weak agencies, who can provide what in the county. We have developed expertise around the kinds of services that we think all older people and their caregivers require from hearings from Governor's conferences. We have been hearing this for a long time, and we have also lent technical assistance around developing certain tools that we can bring to the county that would be difficult to develop county to county and that we want to be uniformed throughout the state.

But the focus is really on the older person. New Jersey EASE, in many ways, is exactly a response to the older person who, for a long time, has been saying that services for older individuals in New Jersey are very fragmented, they are hard to use, they require phone call after phone call. You have to follow up every single phone call yourself and then keep after people. Family members we have had -- and I'm sure you have heard at your hearings -- talk about how fragmented things are in New Jersey.

So that was the beginning of New Jersey EASE really back in 1995 when we began to look at this. New Jersey EASE is also a response to the

increase that we know is coming in the older population that has already begun to come and acknowledgment that if we don't make our service system better, we are really going to look at chaos.

I think the other thing that really spurred New Jersey EASE along the way was an analysis in 1990 which indicated how much we are spending on keeping people in institutional settings -- State money -- and how little we are spending on keeping them in their homes or in the community. So all of these things came together to jump-start New Jersey EASE.

The focus of New Jersey EASE is really on the consumer in providing a comprehensive information and service coordination system, and that's important to say. We are not taking the place of providers of direct services to seniors. We are not a home care agency. We are not a counseling agency for mental health problems. We are an agency that gets information to individuals and then, if they require it, helps those individuals to take that information, make decisions for themselves, and then act on those decisions. So we are really an information and coordination group, and we use all other resources that are out there in the community.

Our goals are not a lot, but important goals. We want, first of all, to be able to inform older people of all of the information they need to make informed personal choices. We think that an individual's autonomy is essential in deciding what they want for themselves, what a family wants for a loved one if that person can't make a decision. And so the focus is really getting people the whole scope of information, not just what they are eligible for, not just what they can pay for or the State can pay for, but how can we

work together. This is all of the information. How do we put all of this together to make those informed personal choices.

Another goal is to really help people maintain their independence and dignity. So we are looking at how does a cookie-cutter system take programs that are not individualized and individualize them. How do we do an individual assessment on what a person really needs, not just what we can fit them into as far as a program. And how do we then take that plan and, if they need it, help them to connect with the services that they need. So we are really looking at individual -- what we call assessment and care planning as the key for helping people remain independent and to preserve their own dignity to take those services that fit in with their lifestyle, being sensitive to their culture, to their environment, to their family, and to their own preferences.

And I think a third goal, really, of New Jersey EASE is how do we help provide services which are efficient and cost effective. And that's not only for State dollars, but also individuals are going to be using their own money in many cases. How do we help them utilize their resources in the most efficient way possible.

So we have a number of goals, but the focus is really on that older person and how we individualize a service system and help coordinate it so that it doesn't feel so chaotic to that older individual.

We started with New Jersey EASE really in 1996 with a Robert Wood Johnson grant, and that grant was a three-year grant. It was a planning grant and a demonstration grant. It started with a year of planning, and we did a great deal in that one year, and I think you probably heard parts of this. One thing that we did was to develop a plan for consolidating all State services,

or over 20 State services, for seniors into one department, the new Department of Health and Senior Services. Now I can't say new anymore because it's been awhile. But for some people I still hear on the news Department of Health, and I keep on saying, "And Senior Services, please."

That Department really came into being when we realized that we couldn't ask a county to organize their services in a less fragmented way unless the State itself did something about the way we were going to support that county in doing it. So that resulted in the consolidation of, as I said, over 20 State services under one department, Department of Health and Senior Services.

The second thing that we did during that year of planning is to identify -- and this was through looking at other states-- What did five other states do that were exemplar states, and we identified certain services that were essential, and these are what we call our core services in New Jersey EASE. They include information and assistance, being able to call up or go into an office and getting comprehensive information; benefits screening, what is somebody eligible for; outreach, if a person is not able to come to the office, can we send someone to the home, can we send someone there when family is available, also, to work with them.

For those who need it and have more complex problems -- and I think most people do very well getting information, outreach, and benefit screening. They can take this information and run with it. But for individuals who cannot do this, there is care planning and assessment. How do we assess the individual needs? And this is really for somebody who has a more complex

problem or has diminished capacities to really handle that information and take it and put it together themselves.

So we do an individual assessment with a care manager who does this. We put together a care plan, which the person has to participate in and agree to. There is nothing like putting together a plan which falls apart, and often it falls apart because the person really doesn't want that. So you need to include that person in that. And then for those who need the help -- and I keep on saying this because not everybody will get this intensive kind of care management, but for those who need it, we need a county to be able to provide connections to the services, linkages; we need monitoring to make sure their services are in place; and then we need periodic reassessments. Has their situation changed, have the services changed, have their needs changed, and how can we reconfigure this care plan to meet their current needs? So we say to every county that we go into you need to provide this set of services.

We also say to a county-- During that year of planning, we worked over that year to develop certain tools. And Joanne was on one of those committees. Renee has been part of developing these tools. We wanted to make a State system that would be able to collect information statewide and be able to have a consistent level of expertise for the people who are delivering the services.

And the keys to those things included developing a comprehensive assessment tool, which we now call the CAT, which has had many lives, more than nine. (laughter) It's been revised a million times. But this is the first time that for all seniors one instrument, one set of information is collected. We are looking at developing a computer system that will be able to, with your

permission, convey that information from one agency to another so that they don't have to repeat it over and over again. And we've been working on this in developing the computer system.

We also ask each county to develop protocols. These are really guidelines around how they are going to work together and provide these services. Some agencies have such guidelines, many sort of wing it. It's sort of an art. We do this, we do that, we put it into the pot, and we figure it comes out well. We say that's great, but we really-- When a new person comes in, when you have staff turnover, when a new agency begins to work with you, they have to know what to expect and they have to develop guidelines for themselves, what can you expect from them, and what can the consumer expect, and that's the most important thing. So each county that we work with develops protocols for what they need to do.

We also emphasize training. Our county systems -- and I'll talk more about that -- have people who have master's levels in nursing and social work, we have people who are high school graduates. We utilize the people who are currently working for the county systems. We need to make sure that their expertise is at a certain level, so training is very important. We provide free training to the counties three days for their information and assistance specialist. We bring in a consultant, Pennsylvania Care Management Institute, which trains the Philadelphia Corporation on Aging to do four days of care management training; this is a baseline. And we are currently working with a geriatric education center from UMDNJ to develop a seven-day advanced care management training, which we'll eventually expect all care managers in New Jersey EASE to take.

We're also-- I just came up from a care management standards group which has been meeting over the past five months trying to develop the standards that we expect for care management in New Jersey EASE. So this is really a building process, but we are saying the quality of the service that we provide is very, very important. And the way that we do that will be assured by these different mechanisms.

So we have services, we have tools, and we have training. What we need from the county is really to develop their system. New Jersey EASE was a budget neutral initiative. There were no funds for implementation. We went to each of the counties initially -- and Susan and Ruth went -- to the Association of Counties, NJAC, and said, "Who will work with us?" We expected, initially, to work with one to three counties -- this was our hope -- and we found that 12 counties initially, back in 1996, volunteered to work with us.

We have been working with those counties four at a time bringing on New Jersey EASE, doing the training, doing the protocols, but really working with the county because we need them to develop their system. When we go into a county, we say to that county, "Who already in your county can work with you around information and assistance? Who can do care management? Is there any agency that goes out to the home? Can you bring them into this consortium, this cooperative?"

Each county has developed its New Jersey EASE system differently. So when we say these services have to be delivered, we have to use these tools, or we have to train these people, but the way you deliver them will be unique for your county because your county is a unique entity.

I never realized how different even county governments were until we started working with New Jersey EASE. And it took a number of months to realize how differently organizations are put together county to county, so that was a real awakening. It was very lucky that we decided that this would have to be a county-developed system because, if we tried to impose a given system, we never would have succeeded. They would have tarred and feathered us, and we would have been in Delaware working for the Delaware Office on Aging.

So we go into each county, we meet with the Freeholders, we get a resolution from those Freeholders indicating their cooperation. So far we have 20 of our 21 counties now that say that they will work with us. I won't mention the one that hasn't.

ASSEMBLYWOMAN MURPHY: There might be someone here who can work with that county.

MS. FULLER: If anybody is from Hunterdon County, tell them we really want to work with them. They have excellent services, and we are concerned that they may be the only county not in this system, and then it's not a statewide system. It is voluntary, however, so we can't sort of say you must. But maybe some of you can talk to your Hunterdon colleagues.

When we go in-- As I said, we meet with the Freeholders. We then conduct orientations for everybody in the world. We had over 200 people in Ocean County. All of the agencies that might be impacted by New Jersey EASE we invite them in to hear what we are doing. And it's a half day of orientation, so this is a very brief presentation.

We then begin to work, and our work takes about nine months with each county, and we work with four at a time. So far we are up and running in 13 counties, and they include -- and I can read them off because I know some people do want to know this. Our first 4 counties were Atlantic, Ocean, Union, and Morris. Our next 4 counties were Camden, Somerset, Monmouth, and Essex. Our last 5 counties, that we just brought on at the end of 1998, were Cumberland, Salem, Warren, Sussex, and Burlington. We sort of kept on riding all over the state. We are now working with Gloucester, Middlesex, Bergen, and Cape May. So we are Bergen to Cape May this time.

So we hope to finish our work, and when I say finish, I have to put parentheses around us finish setting up the core New Jersey EASE structure in each county by the end of 1999.

As I indicated, each county is unique. Atlantic County has one agency, an agency which has intergenerational services. They have 26 care managers. They go from soup to nuts. Those care managers provide everything: information and assistance, outreach, care management.

We go to Morris County and we have 20 different sites in Morris County that are known as access points. We have municipal Offices on Aging, we have the United Ways, we have some hospitals, we have VNAs, we have the Offices on Aging, veteran's disabilities. They provide over 20 individuals who do information and assistance in that county. When it comes to care management and outreach, there are four agencies that have divided the county up into catchment areas and they provide care management. One is a mental health agency, and another is a municipal Office on Aging, and one is a hospital-affiliated geriatrics service. It just varies greatly.

Monmouth County has a Department of Human Services. Under that is an Office on Aging which provides information and assistance. Their senior centers do outreach. They each cover a certain area and they do the outreach. When it comes to care management, their Division of Social Services, which is under the same department and is actually their county welfare agency, has designated certain individuals from their adult services unit that are specially trained in geriatrics, and so they do the care management and they divide the county. So you really have a tremendous array.

I think one of our concerns is that the system, at this point, although we are developing it, is very uneven. In Ocean County you have one and a half care managers -- no, two and a half care managers -- covering Ocean County. In Atlantic County you have 26. Being a budget neutral initiative has meant that counties have had to be very creative. Some of them have changed priorities in their expenditures of certain kinds of funds, social service block grant, and Older Americans Act funds. Some of them have gotten additional funds from their county. Some have already reorganized such as Atlantic County where they put many different funding sources together to get all of those care managers.

But I think one of our concerns is that as we become successful and as more people look to New Jersey EASE for care management, this system is going to become overloaded unless we can really put some dollars into developing that care management capacity. We refer to this as Phase I of New Jersey EASE, setting up the basic structure. I think Susan will be presenting on the new senior initiatives, which we really see as Phase II, how do we integrate State programs into this structure? This will be the important thing

because, if we are successful very quickly, our ratio of individual care manager to number of cases will just skyrocket, and we don't want that to happen. We want that individual care to be able to continue until a person realizes their care plan and what they want.

So that's a very quick overview.

Questions?

ASSEMBLYWOMAN MURPHY: Just one question. When you call with requesting information and needing the referral into care management, are you referred to an agency in that first initial phone call? I mean if there is-- A family service agency provides the program that you are requesting information or need, or are you referred to the care management program?

MS. FULLER: Okay, it depends upon the assessment of the person who answers that phone, and that's why the training is so important. They need to-- And there are specific questions on our assessment form around do you need help making this phone call? Should we be calling you back to find out whether you were successful in making this connection? If the person is able to do this, and it's assessed that they are and they say that they are, then for the most part you don't want to take that independence away from that person, so that person will be given the information.

If the intake person senses that it may not work out, then they will put that person in their tickler file and they will call back in a week, "Were you able to make this connection? How did it go?" If they find at that point that the person lost the telephone number, is flustered, doesn't remember making the phone call, that will then go to care management. If, from the beginning,

it's clear that that person can't do it-- And some people are shy, some people may have hearing losses, vision losses, language problems, cognitive problems, then that becomes clear in that initial assessment.

If there is a question about care management--

ASSEMBLYWOMAN MURPHY: Better to do it than not.

MS. FULLER: Right. They will send out an outreach worker, if that's different from the care manager, just to do it as screening to make sure that that person needs the care management.

ASSEMBLYWOMAN MURPHY: And what is the typical length of time that someone would be involved in the care management system or with a care manager?

MS. MICHELSEN: Actually that varies based on the individual. It can be anywhere from-- They are reevaluated, or reassessed, every six months. In the event that their needs change, say they become able to negotiate the services themselves, the services are in place and their situation is stable, then the case would be closed. Because, as Barbara said, otherwise it would become overwhelmed and we won't be able take on new consumers. But they can stay indefinitely if they continue to need that ongoing assistance. And we evaluate that by do they need a real intervention--

ASSEMBLYWOMAN MURPHY: Correct.

MS. MICHELSEN: --not just do they need you to call and say how are you.

ASSEMBLYWOMAN MURPHY: And if you are in the care of care manager, if I have called for a specific service, does the care management person deal with the agency to whom I may be referred, if it were family

service, for instance? Does the care manager deal them with family services? Are you holding the umbrella with the services surrounding the person is what I'm trying to find out.

MS. FULLER: Yes, yes.

ASSEMBLYWOMAN MURPHY: Okay.

MS. FULLER: Again if the person is able to make that call, it will be a follow-up call to the consumer. But if the person can't, then you call family services and make that referral and follow-up and find out the care manager or the counselor there and provide the information with the person's okay.

ASSEMBLYWOMAN MURPHY: Right.

MS. FULLER: I think one of the important things -- and I didn't mention this -- is that the care management and the information is provided regardless of income. The direct service may not be.

ASSEMBLYWOMAN MURPHY: Right.

MS. FULLER: If you can pay for that direct service or that counseling or that home care, then you may have to, but we feel that everyone should receive that information and coordination and help. This is not an income-limited program, it's for everyone.

ASSEMBLYWOMAN MURPHY: And does New Jersey EASE link in any way with any of the information and referral services? I know the United Way had them in different counties. Are you linked in any way with their first calls or any of that?

MS. FULLER: Yes, they are often a part of-- Many of the counties have developed information and assistance consortiums as part of

their entry point. So in Morris County, for instance, their United Way hot line is one of those entry points. That's true also in Union County. Some of the counties do not have a very developed program like that. In many cases that hot line will also serve as the after-hour emergency pick up. So that's a number that will be given for after hours.

ASSEMBLYWOMAN MURPHY: Thank you very much.

ASSEMBLYMAN ROMANO: Madam Chair.

ASSEMBLYWOMAN MURPHY: Yes, Lou.

ASSEMBLYMAN ROMANO: First of all, I will thank you again for the help that you have given in that particular case. May I ask why Hudson County is not in one of those counties that you read off before.

MS. FULLER: We have been waiting for really Hudson to develop its capacity in its lead agency, which is the Office on Aging. And so that is why. We intend to work with Hudson County starting probably this spring. We need a lead agency that has the capacity to really work on this project, and they have been working to develop their staffing.

What we found is that in a lot of cases-- In fact, they just hired their care manager. We found in a lot of cases that lead agencies have had to look at how to prepare themselves. What's-- The good thing has been that while we have been working with some agencies, we have also held what were called operations group meetings where all of the counties came and heard what was being done. So many of the counties had been able to prepare themselves and work more quickly by hiring some of the kinds of people that they need. And I think Hudson is just about there.

ASSEMBLYMAN ROMANO: Just one final point. I know it's in the gestation stage, if you will, putting everybody on target, but do you think we might ever look forward to the day where the social worker -- whatever the term they use in hospitals -- who fabricates the exit plan with the attending physician would be able to be -- how should I say? -- have that expertise, if you will, as a case manager at least to refer it to, let's say, another facility? Because obviously they can't handle that many individuals due to the number of people coming in and going out. But that they would know exactly what to recommend, ask those basic questions that could be referred to a care manager in that particular county.

MS. FULLER: Absolutely. I don't whether Theresa or Susan want to answer some of--

DEPUTY COMMISSIONER REINHARD: I'll just tell you that we are going to be-- I'll be presenting more on the senior initiatives and our intent to that, part of which came from working with Theresa in working with hospital discharge planners in conferences around the state. So I'll save that answer as part of the initiatives.

ASSEMBLYMAN ROMANO: I better wait till you make your--

DEPUTY COMMISSIONER REINHARD: Otherwise, I will just take over here. (laughter)

MS. FULLER: We're also looking at how we link those discharge planners up through computers so that they have the same resource directory, they have the same form, they can provide that information to the next agency for discharge. Because we know it's critical. I mean, that's the point in which people decide nursing home or community, and if we don't intervene at that

point by the time, we get to see-- The person is not there to get out to see. So we need to find those key points at which decisions are made that are critical to the future, and that discharge planning process is exactly where we've targeted.

DR. TOLLIVER: The other piece that is real important in the hospital relationship with the local agency is that while that client/patient has been in the hospital, there may be some dramatic change that's taken place. So those case notes can be passed back to the area agency, the New Jersey EASE site, so they know that they need to trigger more services. So there is a direct linkage.

MS. MICHELSEN: I think also the nice thing about New Jersey EASE is that it provides some data and experience for us to look at exactly what Senator Romano is--

ASSEMBLYMAN ROMANO: Thank you anyway, I'm still an Assemblyman and may not be that next year. (laughter)

MS. MICHELSEN: Assemblyman Romano. But I think, if you look at the counties that have New Jersey EASE for the longest time, you will see that that relationship has evolved where discharge planners actually call the care manager or where the patient or family actually says to the hospital social worker, "I have Renee who is my care manager in the community, maybe you should call her, here is her card." And that actually is sort of an evolutionary process that's beginning to happen.

ASSEMBLYWOMAN MURPHY: Roberto had a question and Joanne.

ASSEMBLYMAN ROMANO: I did, too.

DR. ROBINSON: Should I go?

ASSEMBLYWOMAN MURPHY: Jean.

DR. ROBINSON: Joanne.

ASSEMBLYWOMAN MURPHY: I'm sorry.

DR. ROBINSON: No, that's okay.

Do you have any sense, Barbara, of who makes a good care manager? Does it take a professional, or have the laypeople, I guess for a better word--

MS. FULLER: We have found for the most part that we think it's important that it be a professional. We'd like to develop that as a standard. To our great joy we have found that most of the counties have selected professionals. And by that I mean nurses who are individuals with bachelor degrees in related helping professions. They can be social workers or psychology bachelor's degrees. But we found that-- I think we feel strongly that a professional should be at that level. So this is something, you know-- We are looking at different Civil Service systems, we are looking at different agencies and different hiring practices, but if we can set a standard -- and this care management standards group is looking at staff performance and requirements. If we can set that standard, what we find is it gives the county tools to go to their boards or their Freeholders or their boards of trustees, if it's a nonprofit, and say, "For this program, this is the standard we need to hire for this." And so that has been happening, which has been wonderful. So we need to give them the tools that they need to advocate for expertise on staff.

ASSEMBLYWOMAN MURPHY: Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: I do appreciate your presentation, and it's obvious that I had a number of misconceptions about New Jersey EASE. First, I thought it was State funded, and, second, I thought it was simply an information referral system that you call up. I didn't realize that they went into care management, but they are going into care management, and so on. The Governor announced, I think it was last month, the implementation of a statewide New Jersey EASE number.

MS. FULLER: Yes.

ASSEMBLYMAN THOMPSON: How does this work when the person calling is from one of those counties that doesn't currently have New Jersey EASE? What happens in this case now?

MS. FULLER: That number is connected in each county. If they don't have New Jersey EASE, then it's connected right now to the Office on Aging, which--

ASSEMBLYMAN THOMPSON: In the county or--

MS. FULLER: In the county, right. What happens is that that 877 number is an umbrella number which then is fed in when you call from a given county. It bounces through the State line and back to an 877 number that has been set up in the county in a specific office. So the person calling from Middlesex County gets Middlesex County when they call that.

We've been trying to work that out. There is some exchanges--

ASSEMBLYMAN THOMPSON: But Middlesex County currently isn't prepared to provide the services of New Jersey EASE I gather from what you're saying.

MS. FULLER: Not fully, but they have been preparing. We are working with them now so that they will at least be able to provide the information, which every Office on Aging does. Every Office on Aging provides information and referral services and at least to do the connections to those agencies that are needed. They may not be able to do the intensive care management, but they are beginning to develop it.

DR. TOLLIVER: One of the things that we did prior to the Governor's announcing that statewide number was to bring together the information and referral staff from the counties that were not New Jersey EASE counties and gave them two or three additional days of training so that they would answer the phone appropriately, that they would be as much on target as was possible. So they have all received that training.

DEPUTY COMMISSIONER REINHARD: We should also point out that if you call in Middlesex County but want to talk to someone in Ocean County, they will do it for you.

DR. TOLLIVER: I also might add that we are certainly not opposed to having New Jersey EASE State funded. (laughter)

ASSEMBLYWOMAN MURPHY: Roberto.

MR. MUNIZ: I was under the same impression as Assemblyman Thompson. I thought that that New Jersey EASE was just a referral, not a case management program, which is really interesting to me.

MS. FULLER: I think that's what has been emphasized in the publicity for the program.

MR. MUNIZ: I'm concerned with how are we getting the message to everybody out there about the New Jersey EASE and the case management

program available to them. That's one concern. The other concern is actually a comment as to 21 counties handling the New Jersey program totally differently, most likely. Would that bring confusion to the people of New Jersey, or how is that handled?

MS. FULLER: For the consumer we are hoping that it looks the same, they are getting the same set of services, and they are being worked with by people who have the same training. It should not look different to the consumer. They should be able to access the same information and get the same set of services, and the people who work with them should hopefully be at the same level of expertise. It will look different in terms of the basic internal structure of this system.

ASSEMBLYWOMAN MURPHY: Roberto, if I can just say, as a Freeholder for 10 years and President of NJAC, the counties are uniquely different. But the system that each county builds -- and Norman as a Freeholder in Passaic can tell you-- The system that each county builds is one in which the human service agencies in that county work together. The point of New Jersey EASE is not only to give people the opportunity with one number to reach someone who can help them work this, it's that person who is doing the care management, or the assessment, to understand the nature of the agencies in the county. And you can't change the agencies and have them coordinate work together. They have developed a level of trust at any level, and turf is such an issue in human services. Turf is the most terrible thing that happens.

If the agencies have developed the compatibility to interchanging their services without worrying about who is bringing lunch and who is

bringing dinner, believe me, you don't want to disturb that. You simply want to get those services to the consumer. And if one county has worked out their stuff this way, don't mess with it, just make sure it keeps on working.

And, Lou, if your county wants to do it a different way, do it your way, just make sure it works. That's the issue.

MR. MUNIZ: My concern was basically if you are in Bergen County and I want to get some information in Ocean -- it's not necessarily for me, but it is going to be for my mom. I want to get some information from Ocean. How does that message get across? How can I get information from Ocean when I am in Bergen County calling a Bergen County number?

MS. FULLER: You will call Bergen County. They will transfer you because they don't know everything and they shouldn't answer questions about what is in Ocean County. They will transfer you free of charge on that 877 number to the Ocean County entry point, and you will be in touch with the Ocean County people who know Ocean County.

MR. MUNIZ: And the other question was, what are we doing to get the message across to New Jersey people?

MS. FULLER: We start with our orientations, we do a lot of press releases, we do a very large announcement, which the Governor often attends, to announce New Jersey EASE. But then we really work with each county to keep the information going. They have their unique ways. Some have newspapers that get to almost every senior citizen in the county. We keep that paper filled with information about New Jersey EASE. Many speaking engagements. We do statewide engagements, as well as the local people do

local speaking engagements. So there are a variety of things that we do do. I think I was getting a--

ASSEMBLYWOMAN MURPHY: Norm, has a question. Senator Robertson.

SENATOR ROBERTSON: What's the status of the program in Passaic County?

MS. FULLER: We think that we will-- We are waiting for -- also to organize. They have gone through a number of leadership changes around their aging services and human services, and we hope that within the next month or two they will have reorganized -- and this is the important thing, that the county be organized itself so that we can come in. So I would expect also to begin somewhere in the beginning of the spring for Passaic.

MS. GREENBERG: Barbara.

MS. FULLER: Yes.

MS. GREENBERG: One question. I take it that this is not run by computers, that when someone calls, a human being answers from the other end.

MS. FULLER: Right, absolutely. That's imperative. An individual has to answer. An answering machine is there after hours. It's not a 24-hour service, but there has to be a recording around where you call if it's an emergency.

DEPUTY COMMISSIONER REINHARD: I just want to-- A point of clarification. Barbara mentioned about care managers and how the difference in the numbers from county to county. I just want to clarify something. When Barbara says there is two or two and a half in Ocean County

and twenty-six in Atlantic County, there is a reason for that. Atlantic County already does the Medicaid case management, and the State sends the dollars to them already to do that. Plus, they have an intergenerational staff that is doing more than senior services. So they have a very different capacity than what other counties do and we recognize that.

The other part of that is the initiatives that I'll be discussing in a moment. A large part of that is to fund more case managers so that every county, as we bring them on line, will have a greater capacity, because if we don't, these initiatives simply won't work. They really build on the capacity of case managers.

MS. FULLER: Let me just mention that I've given you two brochures, one in English and Spanish. We have many, many more. Our new number-- We didn't want to throw out what we had. Our new number is on the back. And the slides that I gave you, which is really an overhead, is what we used to orient the counties. And we'd be happy to come to any group that you might have to do an orientation. We do a lot of speaking engagements to professional groups and county groups so we'd be happy to.

ASSEMBLYWOMAN MURPHY: Thank you, Barbara.

MS. FULLER: Thank you.

ASSEMBLYWOMAN MURPHY: We appreciate you being here and to answer another side of this.

Casey O'Connor is here. She is the New Jersey EASE Core Services Coordinator.

C A S E Y O ' C O N N O R: Are you tired of listening to care management?

ASSEMBLYWOMAN MURPHY: No, we are being managed quite well. (laughter)

MS. O'CONNOR: I'm going to give you a quick 101 cost and care management, and then I'm going to plug New Jersey EASE, always plug New Jersey EASE.

What is care management? I look around and I see people who could give some very good definitions of care management. Renee does it every day, and Joanne knows about care management, and certainly Susan knows care management. And if I asked them to define care management, the definition would be slightly different from person to person because the definition is often based on your discipline. Renee is a social worker and Joanne is a nurse. So we would be slightly different. The setting they worked in would determine how they might define care management, and the target population that they are working with would define care management.

If you are a nurse working in a hospital, probably your definition would contain something like, "The goal is to get these people out of here, to discharge people." And if you were working in a home care agency, the goal or the definition would sort of say things like, "We don't want them ever back in the hospital, to maintain them in the community." So based upon your discipline, based upon your setting, your population.

If I was working with a developmentally disabled person, it might be to teach them life skills. If I was working with an AIDS patient, it might be to decrease hospital admissions. So goals are different based upon your target population. But whether you are a nurse or a social worker, there are some

basic components in care management. We all sort of agree that there are these basic components in care management.

And the basic components are: Assessment. You look at that person and you assess the problem. Care planning. You take that information, what you know about that person, and you develop services for that person. Implementation. You take that plan and you implement it. You go out and find the services to meet those needs. You coordinate the services. You monitor the services, and you monitor the person because the person is not static. The person gets better, the person may get worse, the services may look good in January and may not look so good June. And then you reassess and reassess and reassess. So those components are always part of care management. We could throw a few more in, like case finding and screening and those kinds of things, but those are the basic components of care management.

And whether you are a case manager or a care manager, because that question always comes up, the process is the same. There is always this discussion about, "How come you call yourself a care manager?" I call myself a care manager.

Renee, what do you call yourself?

MS. MICHELSEN: I'm trying to switch over to care manager, but I, frankly, still say case manager.

MS. O'CONNORS: Okay.

To me they are sort of the same thing, and the reason I use the term care management has to do with looking at that person that I'm working with slightly differently than we have looked at them before.

I come from home care. I worked in homemaker agencies for years and years and years. And back then that old model was, you know, if he is a frail person, if he has cognitive and physical limitations, then this is a person that needs taking care of. This is a person that is helpless. We need to take care of him, we need to protect them, we need to provide them with security, with comfort. We need to make them comfortable, and that's how those terms like custodial care get developed, taking care of the helpless frail, older person.

And if you look in institutions and if you look in nursing homes, what does Medicaid pay for? They pay for custodial care. Well, care management, at least in my head, is the consumer-oriented model that says, "Hey, folks, because they are frail doesn't make them helpless." Frail does not equal helpless. And so what you need to do when you are working with a frail, older person is that you need to look at them differently. You need to look at their strengths. You need to look at them in terms of promoting independence, not dependence. You need to look at them as unique human beings, as unique people who have rights, values, preferences. And you need to take that into consideration at every step, from the time you meet them and you start doing that care plan, to what kind of services you are going to hook them up to, and what kinds of services you are going to provide them, and how are those services going to work.

So it's really important that you are promoting independence, you're promoting choice. Barbara talked about it. You're promoting dignity, you're preserving privacy. It's a different way of looking, and I guess care says that to me better than case management. And, in fact, the NCOA developed a care management standard several years ago to support calling it care

management. They said, "Care management is used because it conveys a process that is managing of care as opposed to managing of the case, or the person, recognizing the potential and the right to self-determination of the person receiving the care." So that's for me why we do care management.

And just a little background on care management because it's an older term, or case management, or care management. I mean the whole process of care management can be traced back about 25 years ago where it was really formulated when the Federal government decided to widen its view on long-term care and to look at community-based services. They started to develop options -- home-based options, for the elderly, demonstration programs. And each of those demonstration programs that were Medicaid/Medicare programs had care managers, and they were designed to test the theory, if we have frail, older people in the community who are cognitively and physically impaired, and if we give them a care manager to manage their services, and if we give them enough services at home that they can hook them up to, can we maintain them in their own home as independently as possible?

And the Feds were smart people. They were looking around, like we look around, and saying, "Hey, you know this older population is really moving along and the 80-plus population is growing at a faster rate. Are we going to be able to take care of these people over the long run? Are we going to be able to provide long-term care services for them?" Then they looked at the nursing home, and they saw the cost of nursing homes going up and they said, "Are we going to be able to use only this option?" And so-- And then looking at-- Thank God older people kept saying, "We want to stay at home,

we want to stay at home, we want to stay at home,” so all of these things started to come together.

The demonstration programs really formalize care management. And the other approach that the government took really increased the need for care management because they decided to develop all of these services. And it was a great move, only there was no plan. So what we ended up with was this fragmented system that took a genius to manipulate, that people at their best were faced with obstacles. But when you think about an older person, a frail, older person and you are thinking about a family who is facing the system for the first time, it's just overwhelming, awesome, impossible to negotiate.

And so care management came out of the need for somebody to help coordinate these services. In New Jersey today there are many agencies that provide care management services. Private, nonprofit, public agencies, the home health care, homemakers service, and many of those came out of the push for more home-based services. Many of them ended up with a care management component.

There are two basic care management models. There are a lot of different ones but two basic ones. One is the service management model, and the other is a service broker model. The service manager model is a great model; they have money. That care manager has access to funds and can authorize service. So they go and they do an assessment and they develop a care plan, and then they can go out and purchase service for that person.

The Medicaid waivers are service management models. The care manager does that assessment for that person and can go and purchase services. They are limited by a cap, a monthly or quarterly cap, saying you

can't spend any more than this, but you can spend this much money and you can spend it only on certain services. But you have money in your pocket to purchase these services. Whenever you hear about a service management model, you need to look at the target population because what you will find is it's a very narrow population.

CCPED has very strict guidelines. Not everybody can get into that program. Everybody is trying to get into that program, but not everybody can get in because they are strict. You have got to be over 65 years old, you have to pass a financial eligibility criteria, you have to go through a preadmission screening that says that you are nursing home eligible, and then you have to sit on a waiting list waiting for a slot. So they have all of these little gatekeeping techniques. Only certain people can get in because they are very clearly defined eligibility and there is only a certain number of slots. So it's very difficult.

The other model is the service broker model. They have no money, so they have to identify needs, develop a care plan, and then make referrals to other agencies, existing agencies, service providers, to implement the plan. They are smart, though. They don't have any money, but they are very smart. Because what service brokers learn very early on is that you need to know the system. You need to know how to get through that system. You need to know the eligibility criteria for every program there. You need to collaborate with all of these other agencies. You need to make friends. You need to have good, good working relationships, and that's what the service broker does. They make good relationships with other provider agencies.

Most programs and agencies are not such black and white. I mean most of them use a little bit of both. I mean, CCPED, that care manager can only purchase *X* number of services, so if they are going to get them home-delivered meals, they still have to be that broker and go out and get those services. And the person who may work in a county Office on Aging -- although they may be a service broker model, there are still some services within that agency that they can tap into or they're contracting out to a provider agency. So no model is totally clean.

But it's always good to have money in your pocket that you can go and purchase the services. The example of a service broker model is a county Office on Aging, more than a service management model for sure. And all county Offices on Aging are required to provide care management services. Some of them do it directly, some of them contract out for the services.

As Barbara said, 13 of the counties are now part of the New Jersey EASE system. And in all those counties, of course, the Offices on Aging are part of the New Jersey entity. Some of them have better developed care management components than others. Many of them have strengthened their components by joining and collaborating with other agencies or organizations within their county to build a stronger care management component.

Like in Monmouth County. Their Division of Social Services has this adult service unit that has general care managers, general meaning that they are not assigned to any particular program, and so they became part of the New Jersey entity and strengthened that model because they brought with them their care managers. So maybe the Office on Aging had two or three, but

now they had ten more from the Division of Social Services, so they had a stronger model.

Part of the problem in terms of care management, at least from my view in working as the New Jersey EASE team member, is that when we went into the counties, what we realized was that there was a lot of care management in there, but most of it was connected with a service of some kind. So you have to be part of that service to get the care management. And if you were discharged from that program, the care management stopped. So, for instance, if you came out of the hospital and you had home health aid service under a home care provider, you had care management. As long as that home health service was in there when they discarded you, the care management stopped.

And if you look at the other programs with care management, APS, respite has a component, CCPED -- all of those programs you have to fit into their slot in order to get care management. There is not a whole lot of general care management around. And that's part of what needs to be built in New Jersey EASE, that general care management. Because there are more people not in programs in terms of those care management programs than there are people in those programs. So when you think about all of those other people out there, folks who have come into the system for the first time, don't belong to any programs -- so New Jersey EASE is the provider of that care management.

When you think about people who are not eligible for any of those little service programs, they need help connecting to services. Families need help getting their elderly relatives connected to service. When you think about

the person that may be sitting on a waiting list waiting for CCPED, they need care management. And the person who may be discarded from the home health aid agency, they need care management.

So there is a whole group of people out there who don't fit into any service slots who still need care management. The hope is that Susan is going to talk about all of those initiatives and she is going to solve our problems. But we do need general care management for those people who don't fit into the service slots.

ASSEMBLYMAN ROMANO: I expect her to answer all of the questions. (laughter)

MS. O'CONNOR: Is that right? I hope so.

ASSEMBLYMAN ROMANO: I have a few that I'm holding for her.

ASSEMBLYWOMAN MURPHY: You going to hold your questions, Lou?

ASSEMBLYMAN ROMANO: I'll hold them for Dr. Reinhard.

ASSEMBLYWOMAN MURPHY: Are there other questions here?

ASSEMBLYMAN THOMPSON: I notice you took the easy way out here, care case management. (laughter)

MS. O'CONNOR: Yes, well, you know, I went to a conference in San Diego in December, and it was sponsored by the Society on Aging -- it was the American Society on Aging, and they avoided the whole issue. Every piece of literature they had said case care management.

I thought this was great because this really says it. What care management enables is the right person to get the right service in the right

place and the right time and the right amount and by the appropriate level provider. I think that just about says it all.

One other thing just about care management in terms of families. When I was at that conference in San Diego, I was waiting to get a bus to get a plane to come home, and I happen to walk into a session, a group of researchers from England, and they talked about how we need to widen the target population. Their target population for care management in England had been -- I think it was London, but I won't swear to it -- was the frail, elderly person who had physical and cognitive limitations, which is primarily our target group, too.

And they also worked with families who had frail, elderly people with cognitive and physical limitations. And what they found out was that they could provide less care management and be more successful in terms of keeping that person in their own home by supporting the family. And they really held that constant.

And what they said is the family was doing the bulk of the job. They were working and taking care of that person, but families needed somebody when the crisis hit, when that crossroads, you know, those decision places -- she is now incontinent -- that they needed somebody that they could call for educational purposes, for support purposes. That they were able to-- They were more successful keeping those elderly people home and it had nothing-- All of them, I think, were waiting for nursing home placements, so it wasn't that one was different from the other. But by talking families through the crisis by being there for them, by taking that telephone call, they in fact kept more family members home.

So I think that's another concept that needs to be looked at.

ASSEMBLYMAN THOMPSON: That's been evident in a good deal of the testimony that we have received.

ASSEMBLYWOMAN MURPHY: Absolutely so.

MS. O'CONNOR: You've asked all the care management questions.

ASSEMBLYWOMAN MURPHY: I think we are going to move on to Barbara Bristow, who is going to talk to us about care management in the private sector and how that is dealt with and handled in that arena.

Barbara, won't you introduce yourself. Thank you so much for coming today.

BARBARA BRISTOW: Oh, it's a pleasure to be here.

The name of my company is Senior Care Management, and we've had our practice for nine years -- we are entering our ninth year. And my partner -- she just left -- is right here, too. And we just came down, actually, from a meeting of our New Jersey chapter of care managers, and there are about 45 of us that are across the state now.

I'd like this to be interactive. I don't really want to just sit up here and tell you about care management because it sounds like you've heard quite a lot about it already. What kinds of questions are you interested in, in terms--

ASSEMBLYWOMAN MURPHY: How do people get in touch with a care manager? Why would they call a care manager, and what kind of things do you manage for them?

MS. BRISTOW: Okay.

DEPUTY COMMISSIONER REINHARD: That says it all.

MS. BRISTOW: Okay.

DEPUTY COMMISSIONER REINHARD: Good job, good job.

MS. BRISTOW: We're usually contacted by a family member, often a long-distance caregiver in our case, and it's because there has been a mental or physical decline in their parent and they're concerned about their parent and they want to know what kind of resources are available and what the options are. So this phone call often then initiates an assessment.

Our assessment process is that we go into the home -- we feel like a picture is worth a thousand words -- try and get as many involved family members there to meet with us, as well, of course, as the older adult. We go through an assessment, and that assessment process includes, first of all, looking at level of functioning. This is the most important thing. What can you do, what can't you do, what can you do of help, where do you not have the help that you need?

Then we look at mental health and physical health. We look at the support system that's out there, what family is available, what friends are available, who is doing what. We don't want to replace any of that. We want to build on that and support that. And then the last thing we look at, that is very important, is finances. What can you afford, what are you eligible for? Then from that we do a care plan.

ASSEMBLYMAN ROMANO: Excuse me, but I'm always of that old-fashioned mind. I'm Depression oriented. Who pays you?

MS. BRISTOW: Okay, our service, unlike what you previously heard from, is totally private. It is private pay. So the--

ASSEMBLYMAN ROMANO: When you say private pay, do you mean the person who comes to you?

MS. BRISTOW: Yes.

ASSEMBLYMAN ROMANO: Or by an umbrella organization?

MS. BRISTOW: The person who comes to us.

ASSEMBLYMAN ROMANO: Okay, thank you.

MS. BRISTOW: Sometimes it's adult children, sometimes it's the older adult. It's all private.

DR. ROBINSON: What are your fees like?

MS. BRISTOW: Our fees?

DR. ROBINSON: Yes.

MS. BRISTOW: Our assessment process, which takes about two hours, is \$200, and our hourly fee is \$95 an hour.

So, you know, let me just tell you who are care managers because you need to know this. We are part of the private, professional association of care managers. Most of us are licensed social workers, we are nurses, we are psychologists. All of us are licensed to practice at the independent level.

What else can I tell you about us?

Most of us belong to a national association. We have a code of ethics. We have rules that we follow in terms of our practice. There are different levels that you are certified at within the association according to your education and your experience.

MS. GREENBERG: I'd like to add, first of all, I know Bristow and McCurdy. I've referred to them and they do a great job.

Secondly, I would like to say that often those of us who are in the health professions forget that there are wealthy people out there also who are older, who are old, and need care. And they get just as confused by the system as anyone else and they need help. They need to know where the home health agencies are. They need to know about nursing homes. They need to know about assisted living.

And, fortunately, they can just take money right out of their pockets and pay people like Bristow and McCurdy. And the rich are different from the poor. I think Fitzgerald said that or something. But the rich are also people, and the system bamboozles them and confuses them. And these are the people that they can go to.

ASSEMBLYMAN THOMPSON: And I gather many of those don't qualify for programs because they have too much money.

MS. GREENBERG: That's exactly right. That's exactly right, Senator, yes. (*sic*)

ASSEMBLYWOMAN MURPHY: And the bulk of them have too much money to be able to be into the system, if you will, and not enough to be independently ready to do an awful lot of things there -- somewhere in that area in between. And the longer they live, the more dire the situation becomes but never dire enough to take care of them. So there is a concern.

When I did information and referral in Morris County some time ago, we had a lot of people from out of state call us seeking assistance for an (indiscernible). And that was in the '80s so that was before we all were noticeably older. People calling from out of state, particularly young working families or young working single women or men who had gone out of state to

take jobs and suddenly couldn't seem to get what they consider a coherent answer from the parent they called and wanting someone to help them figure out what was going on with the family. It was important that they could find a somebody.

MS. BRISTOW: Most of our cases don't have local family. If they have local family, it typically consists of two working professionals with young children. That's sort of the profile really of the family dynamic.

ASSEMBLYWOMAN MURPHY: How long a span of time do people usually contract you with?

MS. BRISTOW: You know, it depends. We have people who we will just do an assessment. We'll go in and do the assessment. The family might be more local or have more flexibility. They can follow through with the care plan that we are recommending, do the hook up of services, and it will be a one-shot thing. Other cases where we are involved until the person dies. I have to say most of our cases, once we are involved, we are there for the long haul.

ASSEMBLYWOMAN MURPHY: Norman.

SENATOR ROBERTSON: Quick question.

If I were interested in contracting for your services -- if I fit the profile of somebody who could benefit from your services, how would I know about your existence?

MS. BRISTOW: Well, we have an excellent relationship with our Office on Aging. We refer back and forth. So that's one way you can find out about us.

SENATOR ROBERTSON: So you have no problems with public entities being worried about referring businesses to private enterprises?

MS. BRISTOW: Yes, oh, yes. I'd say there is some of that.

SENATOR ROBERTSON: Yes, that's why I was curious.

MS. BRISTOW: Yes, I think that there is definitely some of that.

SENATOR ROBERTSON: Is there a licensing procedure in place now for the type of work that you do?

MS. BRISTOW: There is a--

SENATOR ROBERTSON: I realize you're licensed by virtue of your background.

MS. BRISTOW: Right.

There is two ways in which that happens. If you are of another discipline -- like I'm a social worker. I'm licensed as a clinical social worker. Our association has started a certification process, also.

SENATOR ROBERTSON: Well, the reason I asked that is that, you know, if there is some form of objective process in place, then perhaps it makes it a lot easier to develop lists of providers of service that can be used by our folks to refer folks who might not qualify under public programs.

MS. BRISTOW: Yes. You know we have a listing of all of our chapter members in a chapter brochure, and we hand that out continually.

SENATOR ROBERTSON: But you are not the 800 number -- public number -- that folks may be calling through the EASE Program or some other entry point.

MS. BRISTOW: Right.

SENATOR ROBERTSON: That's the thing I'm concerned--

MS. BRISTOW: We do have a number through our national association that is supposed to make referrals out to people in the states.

SENATOR ROBERTSON: Because that may be one of the things that we should consider is the way in which to integrate private sector providers of service into the overall--

ASSEMBLYWOMAN MURPHY: What would happen if someone called that 800 number?

MS. MICHELSEN: Perhaps I could speak to that. What we do now is-- I probably can speak for the public sector and case managers at large if they would allow me to do that, I imagine -- that we do use private sector care managers when we feel it is appropriate. The times when it's really appropriate is when the person not only has the funds to contract for such a service, but when the consumer needs more than we can provide. Such as they could actually drive somebody to Brighten Gardens, spend three hours and walk around with her and say, "Do you like this?" A public sector care manger can't do that.

DEPUTY COMMISSIONER REINHARD: Actually we can.

MS. MICHELSEN: Drive somebody? Well, that's a difference in agency to agency, though.

SENATOR ROBERTSON: But that's also direct providing -- excuse me, but through you, Madam Chair. That's--

MS. MICHELSEN: The private sector people have a lot more room in what they can do.

MS. BRISTOW: Flexibility.

SENATOR ROBERTSON: Well, no, but I guess my point was that that's more on the nature of the direct service providing as opposed--

MS. MICHELSEN: No, it's looking at options. Sometimes the private care manager can spend a greater amount of time with the person looking at those options than a public sector person can.

SENATOR ROBERTSON: That's really what--

MS. BRISTOW: You know we can take clients to the doctors.

MS. MICHELSEN: Right.

MS. BRISTOW: Be there, relate the clients' conditions.

MS. MICHELSEN: We're not going to drive somebody to an appointment.

SENATOR ROBERTSON: But I guess the point is at what point-- If the primary access point -- especially through an EASE Program where we are encouraging the use of an 800 number, 877 number-- If that's the primary point of access, how do folks wind up being hooked up with a for-pay, private sector, and that's case management as opposed --

MS. BRISTOW: I can only tell you--

SENATOR ROBERTSON: --to those private priorities being used as your resource for filling gaps.

MS. MICHELSEN: Well, sometimes they actually get referred from us to them if we feel that it's the more appropriate. Then you use a public sector care manager for a while, and then it seems like the things they need exceed what we can provide or are different than what we can provide.

Sometimes they get referrals from doctor's offices, from lawyer's offices--

MS. BRISTOW: I'd say primarily we get referrals in our practice from lawyers -- a lot of elder law. We've been in practice for nine years, and I am just telling you right now we are starting to get referrals from two local doctors. And it's just because we've had so many cases in common over time that they got it.

ASSEMBLYWOMAN MURPHY: But if I were to call that 877 number, do they ask questions about financial or financial planning, or have I done any or have I thought of this? Is that part of--

MS. BRISTOW: Is this our chapter number that you are referring to?

ASSEMBLYWOMAN MURPHY: Well, is it part of what would be done at New Jersey EASE--

MS. BRISTOW: Oh, okay, I'm sorry.

ASSEMBLYWOMAN MURPHY: --so that they could say-- No, but if I called New Jersey EASE, then they could say, "Well, really you probably wouldn't fit as well into this. These are some recommendations we would make of care managers for you."

DEPUTY COMMISSIONER REINHARD: Let me begin and then refer to Barbara because I think she is anxious to answer that question, too.

First, I want to note that Barbara Bristow was just in my office this week, and I am scheduled to go to her association and talk to them about how we can more formally link up. There is plenty of care management to go around. There is no competition as far as I'm concerned. But your point, Senator, is how do we make sure that we get that information now.

SENATOR ROBERTSON: We're realizing all our resources.

DEPUTY COMMISSIONER REINHARD: And that would be part of our training of the care managers in New Jersey EASE to know that this is a resource that they can turn toward.

The assessment that you are referring to, Madam Chair, is part of the CAT, the comprehensive assessment tool, where there is different levels. And so it depends on how far the person wants to go with us and to how far they want to go into their finances.

ASSEMBLYWOMAN MURPHY: Sure.

DEPUTY COMMISSIONER REINHARD: Did you want to add to that, Barbara?

MS. FULLER: Yes. I don't think that there would be an information and assistance person who would talk one time and then make a decision that this is appropriate for private care manager. Probably what would happen is that there would be a care manager who goes out, discusses the case in depth, looks at the resources but also looks at the need, and then, as part of a care plan, would discuss the possibility of a private care manager. That would be the responsible thing.

MS. MICHELSEN: That's exactly how it happens.

ASSEMBLYWOMAN MURPHY: And where would they receive, then, the referral to a private care manager? From the list of the people registered with the association?

MS. FULLER: Each county is asked to develop a criteria for the private, for-profit organizations that will be part of its information and referral resource directory. So that would be part of what they do around private care

managements -- management services. And I think that part of the criteria would be the relationship with a professional association as well as licensing or certification. But each county has to do that.

ASSEMBLYWOMAN MURPHY: Okay. It's scary.

SENATOR ROBERTSON: And I guess the reason that I'm bringing this up is that I can foresee a situation-- Well, two points really. Number one is that it seems to me that the need far outweighs New Jersey EASE ability, certainly now, to provide the services from the entry point in great depth or detail to some sort of a management plan resolution. And that if there is a private sector that is either available or could be encouraged to be developed that I almost wonder, is it wiser to do all of the in-depth analysis before making the referral, or to hook somebody up with somebody who could do that same in debt analysis from the get go?

MS. BRISTOW: You know, I think--

SENATOR ROBERTSON: Since you are only going to be able to do X number of them anyway.

MS. BRISTOW: I think it's hard because one of the things you have to get to is finances, and nurses and social workers, in my experience, don't feel real comfortable talking about this, but you must. But you can't start out there. You have got to start with what do you feel you need help with, what's your history, what's your diagnosis, and you work your way there.

So that's why it's hard to do in a real quick kind of phone conversation thing.

MS. FULLER: There is also-- They have the money, but the willingness to spend for what we think it would be important is certainly often

different from what the consumer thinks is important. So it really takes developing a relationship initially to be able to talk about the benefits of spending that money for yourself rather than leaving it for the seven grandchildren--

MS. GREENBERG: And that is one of the most important points because there are so many elders who have the money, but for all kinds of reasons, some of which have to do with the Depression, they do not want to spend that money on themselves.

MS. BRISTOW: And this is where, if you have involved family members, it's really critical to bring that person in because often--

ASSEMBLYMAN ROMANO: And/or they want to leave it to their children.

MS. GREENBERG: Yes.

ASSEMBLYWOMAN MURPHY: Yes.

ASSEMBLYMAN ROMANO: They don't feel comfortable unless they leave a buck.

MS. GREENBERG: That's right, that's right.

MS. BRISTOW: And that's why it's important to have the children involved in this process, too.

SENATOR ROBERTSON: And the other part-- The second point I wanted to make is that I can also foresee a situation where there will be inevitably a discomfort on the part of public entities to make private referrals, especially if your sector begins to develop more robustly. And whether or not we approach that by virtue of some form of certification so that lists can be

provided of providers in your area and -- things of that sort may be the sort of thing that we should consider.

DEPUTY COMMISSIONER REINHARD: I just want to throw a little loop in here because we are making too much of a distinction, in my opinion, between public and private. We have not gone far enough in the development of New Jersey EASE. I will probably shock my staff when I say this. Although I raised it earlier, there is no reason why New Jersey EASE can't charge for its services and provide private case management. It is done in other states. There is no way they are going to charge \$95 an hour. I don't see that happening. But I think there will be overlap, and they can and should move in that direction and then work collaboratively with independent case managers such as Barbara.

I do not believe that we will ever bump into each other. As you point out, Senator, there is such unmet need out there. There is such a need for case management that I do not believe we are going to be competing. The more important question is how we coordinate so that if Barbara has a client who can no longer afford her services, for example, that we get this person back. Because many folks will spend down to Medicaid and then become public.

The distinction between public and private in long-term care quickly evaporates within months as long-term care needs develop. I'm sure Roberto can address that, too. If you start to need a lot of home care or nursing home care, you spend your resources down very quickly and you become public.

ASSEMBLYWOMAN MURPHY: Yes.

DEPUTY COMMISSIONER REINHARD: So it's a real challenge to us on how to blend public and private sectors because people are not public or private.

ASSEMBLYWOMAN MURPHY: And do you think if we can work out a good way to blend it, you will have less resistance to that fact of -- or less insistence on saving the house to give to the kids so I hide it?

DEPUTY COMMISSIONER REINHARD: Maybe.

ASSEMBLYWOMAN MURPHY: Do you think that we will begin to bring people to the understanding that the best thing I can do with my house is to sell it and use the money to take care of myself so that you, my daughter, don't have to do this right away?

MS. GREENBERG: Eventually maybe.

SENATOR ROBERTSON: Another generation or two.

MS. GREENBERG: Yes, I think those of us who are new senior citizens, like myself, those of us who are in young old age approaching old old age, I think we think that way. I think we are a different generation than my parents, and I agree with you.

ASSEMBLYWOMAN MURPHY: But that's part -- to me that's -- And that's something we are going to have speakers on before we are done.

DEPUTY COMMISSIONER REINHARD: Good.

MS. BRISTOW: I mean what I see is everybody wants to stay home, nobody wants to go to a facility, and they will stay at home as long as the finances hold out, as long as they can keep the health-care situation together at home. And that's what we experience over and over again. And we often try to have, like, a short-term plan and a long-term plan for our clients:

you know, “This is your diagnosis, this is a progressive disease. You know you want to stay home, you’re really benefiting from being at home, your cognizant of your environment, you interact with your environment, let’s do this for now. There may come a point where it is so expensive to stay home and you are not reaping the benefits of being in that environment. Then placement is appropriate.”

So there is kind of a continuum that goes on. And the deciding point is health, function, and finances.

ASSEMBLYWOMAN MURPHY: Barbara, do you find assisted living is more frequently the referral that you will make in terms of options for living as opposed to any other kind?

MS. BRISTOW: I think that’s true, wouldn’t you say, Jan?

UNIDENTIFIED SPEAKER FROM AUDIENCE: Yes, certainly over nursing home now.

MS. BRISTOW: Most of our clients now--

UNIDENTIFIED SPEAKER FROM AUDIENCE: Because our clients can afford it.

MS. BRISTOW: And most of our clients have a dementia. So assisted living is perfect. They don’t need intensive, you know, kinds of medical stuff.

MR. MUNIZ: I was just curious, Madam Chair, if Barbara feels -- agrees with Susan that the competition may be limited or that it might be limited in the future between the public and the private sector?

MS. BRISTOW: I think it will be a continuum. I would love it if you could do what we do. I don’t think you will ever be able to do what we

do. You're going to have too many constraints on you just by the nature of it. And my experience-- I mean I worked for the State of New Jersey for 15 years. I'm a big advocate of good government, but there are limits. So I think that we can work in a complementary fashion.

ASSEMBLYWOMAN MURPHY: So you see the system being able to be drawn out and working from private to public.

MS. BRISTOW: Yes, I think there will be an area where we will probably have some overlay.

ASSISTANT COMMISSIONER READER: But I think--

MS. MICHELSEN: The biggest distinction that I sometimes see -- I'm sorry -- is that the private care managers can become substitute families where the public care managers--

ASSEMBLYWOMAN MURPHY: Cannot.

MS. MICHELSEN: --cannot.

ASSEMBLYWOMAN MURPHY: Absolutely.

MS. MICHELSEN: And that's really the distinction. They can get the call at 3:00 a.m. They have somebody that goes over. They can take somebody around to see different places and take them to the dentist and sit with them or broker for somebody to do that. It's a very different type of person that receives this service and a very different type of service.

MS. BRISTOW: And the expectation from the client is very different, too.

MS. MICHELSEN: Absolutely.

ASSEMBLYWOMAN MURPHY: So hands-on seems to be more private. Management seems to be public. But hands-on and presence is more of a private sector function.

ASSISTANT COMMISSIONER READER: But I think there is a second, very clear distinction, and that is that the public sector targets their services to those, as the Old Americans Act states, “In the greater social and economic need.”

ASSEMBLYWOMAN MURPHY: Right.

ASSISTANT COMMISSIONER READER: The Old Americans Act doesn't necessarily serve those who have a clear eligibility guideline, this amount you qualify, this amount you don't. It's much more (indiscernible) than that, but they still target their services--

ASSEMBLYWOMAN MURPHY: Right.

ASSISTANT COMMISSIONER READER: --to those who are in need. So I think that's another great distinction, and I would think and hope that the New Jersey EASE sites would clearly refer for private case management when an outreach worker or a care manager goes out to do an assessment and finds an individual who really does not fall in that category. So I think it's both what Renee is saying as to the level of service that they receive but also the level of the client.

SENATOR ROBERTSON: It even goes beyond that. The question is, are we structuring our public response to this issue in such a way as to encourage the development of a private sector that can reach numerically that many more people?

That's really one of the things-- Well, yes, but I've seen a lot of-- I mean, when the bureaucracy puts together the little boxes and people fit in the boxes or they don't. Because there are lots of agencies -- I can think of one offhand where-- If you call the DEP and you are doing a historical preservation project and -- "Oh, we can't recommend any architects, but we can send you a list of those who have experience in that area." That's the natural development of the public sector's look at competing private sector individuals.

I mean, right now you are at a stage where there are a limited number of providers for this sort of a service, and so you don't feel uncomfortable going from one verses another. You know it's not really a question. But that will hopefully happen sometime. And the question is, are we building that into our response?

MS. BRISTOW: I mean you're right, Senator. We get people who come, they've been to the Office on Aging, they have a list of all the nursing homes in the county. Now what do they do? Well, we're in and out of the nursing homes. We can tell them what we think are the positive points, what are the negative points. Maybe distance--

SENATOR ROBERTSON: But my point is you provide them with unique service.

MS. BRISTOW: --being local to a family member is the most important thing, so we can say, "Well then, this would be the best place," or maybe it's a dietary issue that's the most important thing.

MR. MUNIZ: But that's only to a target group of people. That's going to be to those people who can afford to do that -- to get the help from you.

What about all the millions of people who cannot afford it?

MS. BRISTOW: That's New Jersey EASE.

SENATOR ROBERTSON: That's my point. The more New Jersey EASE is taking up with those folks who can afford to pay for something privately, the less -- the fewer number of people will be--

ASSEMBLYWOMAN MURPHY: But that's why they clearly clear them or clear them as much as they can on the first go-rounds. As they get more expertise, I imagine that will come quicker to the assessment people as they develop more skill in dealing with people. But you're right.

MS. GREENBERG: For me personally in my private practice, because I do a lot of counseling with older families, the criteria I use is what Ruth said. If somebody has the money, they will go to Bristow and McCurdy or someone else. If someone does not, then I will look to your program.

SENATOR ROBERTSON: Yes, that's what I mean.

MS. GREENBERG: That's what it boils down to.

MR. MUNIZ: But that person should have the same services that Bristow can provide--

MS. GREENBERG: Well--

MR. MUNIZ: --whether they can afford it or not. Whether it's by the State or--

ASSEMBLYWOMAN MURPHY: No, they won't get the chauffeur service, that's for sure.

SENATOR ROBERTSON: That's a question of public resource.

MS. MICHELSEN: No, they are not going to get chauffeur--

MR. MUNIZ: But technically they should. Everyone should--

ASSISTANT COMMISSIONER READER: Are you saying this as a taxpayer? (laughter)

MR. MUNIZ: Probably.

ASSEMBLYWOMAN MURPHY: Not as a taxpayer, he wants to put it in the budget.

ASSEMBLYMAN THOMPSON: It sounds like a disagreement on whether Donald Trump should call New Jersey EASE or-- (laughter)

ASSEMBLYWOMAN MURPHY: Well, he should but--

SENATOR ROBERTSON: But the point is that they are going to at least have one visit to Trump Tower. That was my question.

DEPUTY COMMISSIONER REINHARD: Senator, can I ask you a question then since you raised it and I threw out a possible evolution for New Jersey EASE. Would you think it better for New Jersey EASE not to enter more into the private sector? Would you prefer to see it--

SENATOR ROBERTSON: No, not necessarily. What I'm concerned about and maybe I haven't articulated it well is that the service that is provided by your firm is itself a service.

DEPUTY COMMISSIONER REINHARD: Yes, it is.

SENATOR ROBERTSON: I'm talking about that service.

DEPUTY COMMISSIONER REINHARD: Yes.

SENATOR ROBERTSON: That is the same service only variations on the theme as New Jersey EASE seeks to provide. Now, there will

either be those folks who can afford it and can go to a private sector, and if there is enough of those-- I mean, you diagnosed a need or you've identified, rather, a need, and you created a product to meet that need.

Well, we know that that market and that need is huge, and the question is, while we are working with our various counties to put together a rather public and hopefully well-publicized public initial access line, are we, in the construction of our public response to this general problem, also encouraging the development of a private sector? So that when somebody-- I mean, I would have to understand more about it to come to a better conclusion, but it doesn't strike me that there has to be a very detailed analysis of somebody in order to refer them to the first person who is going to provide this service. If they have the money, regardless of whether or not we are comfortable asking about it-- Do they have the money to be able to afford it or don't they, and you can always put that in the tickler file for a week from now to see if they're so uncomfortable that despite their inclination you are going to make sure you get them help.

But if we assume on the public sector side all the initial responsibility of doing a detailed analysis of anybody who calls up when there is a private sector that could be doing it, then--

DEPUTY COMMISSIONER REINHARD: We're taking on more of the burden.

SENATOR ROBERTSON: We're taking on more burden than we should, and we will, as a whole system, public and private, be able to reach less people. That's what I'm concerned about.

DEPUTY COMMISSIONER REINHARD: That's interesting.

ASSISTANT COMMISSIONER READER: But I think--

SENATOR ROBERTSON: With this service.

ASSISTANT COMMISSIONER READER: The bottom-line issue, though, may still be a dollar one because if, when the first call comes, Barbara is the one that goes out to do that assessment, it's a couple of hundred dollars off the top. Whereas, if an outreach worker from the Office on Aging goes out that's--

SENATOR ROBERTSON: That's another person who can't be helped.

ASSISTANT COMMISSIONER READER: --a public service.

DEPUTY COMMISSIONER REINHARD: But that's my point. Why can't New Jersey EASE charge the \$300? That's the question and whether you would think that would be appropriate or not.

SENATOR ROBERTSON: My question is, if you have three case workers, care workers, whatever you feel like calling it-- (laughter) If you have a limited number of case workers, the cost is not \$300, the cost is to somebody else who can't get the help.

DEPUTY COMMISSIONER REINHARD: Yes, I understand what it is you're saying.

SENATOR ROBERTSON: Because of my point-- Whereas, you say--

ASSEMBLYWOMAN MURPHY: That's a capacity issue.

SENATOR ROBERTSON: That's a capacity issue. So the point is--

MS. BRISTOW: Let me say, once you get a waiting list, you're lost. I mean we have a 48-hour response time. If you can't do it-- Because you are dealing with people who are in crisis. I wish people would--

SENATOR ROBERTSON: It has to happen if it's a successful program. It has to happen.

MS. BRISTOW: --call in a playful way. We would love it. We could do a lot more, you know. It takes the pressure off of everybody. That's not what happens in this kind of practice. There is always a crisis, so they are going to keep calling until they get somebody who can help them.

DR. ROBINSON: Barbara, I'm wondering if anyone has looked systematically at outcomes of that kind of hand-holding approach in terms of cost and satisfaction. And I'm searching for where might be the cutoff point. You know, where should public sector services be obliged to go and then move on to private sector?

MS. BRISTOW: I don't know what to tell you on that.

DEPUTY COMMISSIONER REINHARD: She's too busy doing it. (laughter)

ASSEMBLYMAN ROMANO: I can't wait--

DR. ROBINSON: Are you a national association or--

ASSEMBLYMAN ROMANO: I can't wait to hear Dr. Reinhard, but you're forcing me to just make this point. I'm a former business administrator, so I have the sense of -- how should I say? -- being held criminally liable. And when you have a situation where a public employee is recommending someone, you'll be prepared, as I've been told to explain to the Attorney General, why you chose them, and it's just not a matter of you liked

the way they parted their hair. So when you have enough of these people, yes -- and that will be the Attorney General's Office to figure how many are on the list before you hand it out.

And here's the other part you have to remember. Whenever there is a need unmet by the public, the private sector will respond. In education, when you see vocational schools for beauty culture, for nails, or for this, it means that the public sector can't provide that so the private sector comes in and takes over. And in some senses it's a failure on the part of the public-- I'm not saying that the public should have a class in nail cutting. (laughter)

ASSEMBLYWOMAN MURPHY: With all of us getting old, someone's got to do it.

ASSEMBLYMAN ROMANO: But when we talk about computers, when we talk about programming, etc., that's the problem of the public sector who is not meeting it, by the way.

I can't wait to hear you talk.

DEPUTY COMMISSIONER REINHARD: Well, you really set me up, Assemblyman.

MS. BRISTOW: That is an issue we all have. We have malpractice in my agency. I also have home health aids. They are all insured. I spend a lot more time and money on insurance issues than I'd like to.

DEPUTY COMMISSIONER REINHARD: Good point.

ASSEMBLYMAN ROMANO: I hate to give away a good bill, but you should contact Assemblyman Moran and Assemblyman Impoveduto. They search the vineyards all the time to come up with a new license for the-- (laughter)

Am I correct on that?

ASSEMBLYWOMAN MURPHY: Listen, neither--

ASSEMBLYMAN ROMANO: You have to agree. I can just see this as a new license, so you contact them because they serve on the Regulated Professions Committee. The argument also is, well, if you can regulate manicurists, then they go through the whole thing about regulating movers, etc., etc. You'll just become another -- how should I put it? -- another group to be licensed.

DEPUTY COMMISSIONER REINHARD: Aren't you glad you came, Barbara?

MS. BRISTOW: I'm already licensed. (laughter)

ASSEMBLYMAN THOMPSON: He meant the agency.

ASSEMBLYMAN ROMANO: No, no, no. Particular to what you are doing here as a special license. Yes, you are a counselor, a social worker, and akin--

MS. BRISTOW: I don't know if I have enough room on my name tag. (laughter)

ASSEMBLYWOMAN MURPHY: That's right. You'll have to have two of them.

ASSEMBLYMAN ROMANO: And akin to this. For years I have been saying there should be some sort of a licensure for people who are financial consultants. You have a person who is a CPA--

ASSEMBLYWOMAN MURPHY: Well, there is. There is a--

ASSEMBLYMAN ROMANO: What is there? There is a national group--

ASSEMBLYWOMAN MURPHY: Yes, there is.

ASSEMBLYMAN ROMANO: --not mandated by the state.

ASSEMBLYWOMAN MURPHY: No.

ASSEMBLYMAN ROMANO: You could print up a card and say financial consultant and go in and lose somebody's money for them in two days.

ASSEMBLYWOMAN MURPHY: Oh, they do it all the time.

ASSEMBLYMAN THOMPSON: Maybe we ought to put in -- get in a license for licensors. (laughter)

ASSEMBLYWOMAN MURPHY: Okay.

ASSEMBLYMAN ROMANO: Let's move on to Dr. Reinhard.

ASSEMBLYWOMAN MURPHY: Roberto.

MR. MUNIZ: I can't wait to hear Susan, also, but, Barbara, a question.

Have you ever gotten a call from a person that doesn't realize that the call to you is going to cost money for your referral, and what do you do with that call?

MS. BRISTOW: We have an intake process we go through and everybody that calls gets a referral elsewhere if we can't help them.

MR. MUNIZ: Financially, if that person cannot afford it.

MS. BRISTOW: Or sometimes they are out of our encatchment area.

MR. MUNIZ: And who do you refer it to? The county government--

MS. BRISTOW: Office on Aging. Sometimes other colleagues, if it's another county other than one we serve. But always we give a referral.

SENATOR ROBERTSON: Do you visit them before you do it?

MS. BRISTOW: No, it's on the phone. We have a little intake process that we got through on the phone.

MS. EDELSTEIN: Barbara, are your fees flat regardless of income, or do you work on a sliding scale?

MS. BRISTOW: Ours are, yes. Remember we have no subsidy.

MS. EDELSTEIN: No, I understand. I just wondered whether your upper-end fees might subsidize some of the people who couldn't afford those.

MS. BRISTOW: No, it's flat. Frankly, I couldn't keep track of all that.

I want to mention one other thing because we also do guardianship and this is a big problem in this state, very big problem. There aren't enough people to do guardianship, to serve as guardians for people that don't have anybody. The people who often serve, attorneys, volunteers, I think are inappropriate. This is a real problem in this state. Our Office of the Public Guardian doesn't have sufficient funds to meet the need.

You know, once again, I think that the private sector could pick up here, especially social workers, nurses, psychologists, people who have a speciality in working with people and knowing needs when they see it. But this is a big problem in this state.

ASSEMBLYWOMAN MURPHY: Is this-- Now, surrogates can be guardians, but they are usually for people who are mentally incapacitated, are they not -- institutionalized?

ASSEMBLYMAN ROMANO: No, that's all part of the service.

MS. BRISTOW: Surrogate.

ASSEMBLYWOMAN MURPHY: The county surrogate.

MS. BRISTOW: We work with the county surrogate's office. They appoint us as guardian. I don't know that they ever--

ASSEMBLYWOMAN MURPHY: Okay.

MS. BRISTOW: --act as a guardian themselves.

ASSEMBLYWOMAN MURPHY: I thought that they did for institutionalized people. I think they do at Greystone.

Do they not, Peggy?

MS. NELSON: I don't know whether they act--

ASSEMBLYMAN THOMPSON: I think they appoint guardians.

SENATOR ROBERTSON: They are the ones that do the appoint.

ASSEMBLYWOMAN MURPHY: Okay.

SENATOR ROBERTSON: And some of them have volunteer programs where they do training and calling on people.

MR. MUNIZ: I just have to agree with you. I think it's so important that there are so many people with guardianship in nursing homes as well as the community, and they don't have any idea about how to take care of that person that someone entrusted in their lives, and so on. You know,

there is no follow-up, they never come and visit, they don't even know if they are receiving the right care that they are supposed to be receiving.

So I'm sure there are well-qualified people out there like social workers and like psychologists, like you said, that can be appointed as guardians, and even physicians. I'm not sure if a physician would be a conflict of interest.

MS. BRISTOW: Yes, I don't think they would probably want to do it, but--

DEPUTY COMMISSIONER REINHARD: Madam Chair, through you.

ASSEMBLYWOMAN MURPHY: Yes.

DEPUTY COMMISSIONER REINHARD: I want to emphasize, first of all, our gratitude for you to come and also to bring up that issue. It is one that we are aware of. The Office of the Public Guardian is within our department. Ruth's division is responsible for assisting the Public Guardian, who is a direct appointment by the Governor.

We know that it's tough to keep handling the increase in public demand, particularly for that service, and we would love to have more discussion of how we can stimulate the private sector, especially in this area. It has relevance all over the place. People sit in hospitals -- I should let the hospital people address this -- and cannot be discharged because there is no one to help make that decision, cannot have end-of-life decisions made--

ASSEMBLYWOMAN MURPHY: Right.

DEPUTY COMMISSIONER REINHARD: --because there is no one to help them. It's really a serious problem.

In nursing homes, you have the problem that you can't get someone into a hospital or back because there is no decision maker or they don't know how to deal with it. They are appointed, but they don't have enough training, I guess, to know how to really enact the role. So it's a very serious problem, and it's only going to get worse.

MR. MUNIZ: Or interest. They are not interested. They are appointed because they were practically appointed to do it but not because they want to.

MS. MICHELSEN: And often guardianship is considered the end of the line. I know the care manager-- Okay, a person who is guardianship that-- It's sort of assumed in the system that that's a knowledgeable person who will take wonderful care of that frail and incompetent individual, and that's often not the case. Who is supervising the guardian?

ASSEMBLYWOMAN MURPHY: Good issue, and so are living wills and end of life, and we discuss them.

MS. BRISTOW: Any other questions?

ASSEMBLYWOMAN MURPHY: Barbara, thank you so much -- both of you -- for coming and taking your time to be here today. We really appreciate it. As you can see, education is a big piece of what everybody needs.

MS. BRISTOW: Yes, well, you have an a formable task ahead of you and good luck.

ASSEMBLYWOMAN MURPHY: Oh, I have great help.
(laughter)

Thank you.

And now--

DEPUTY COMMISSIONER REINHARD: Without further ado.
ASSEMBLYWOMAN MURPHY: Absolutely.

DEPUTY COMMISSIONER REINHARD: I'd like to back up a minute into our first meeting, Madam Chair, when you called us together as a group to have that first discussion among ourselves with some experts that came to present and recall the presentation that Commissioner Fishman made at that time about how we are spending our dollars and why the Department became the Department of Health and Senior Services -- for just a minute, just to reframe us a little bit.

At that time he showed you some charts of where the public dollars are going and that 90 percent of public dollars in long-term care go to institutional care. Less than 10 percent go into home- and community-based care. And then he showed you some charts of other states that were doing far better. It was Oregon and I think we had Washington and perhaps Colorado to show that it is doable. It is definitely possible to change. This isn't a situation that is hopeless.

We also know from years of testimony from older adults that Ruth Reader has heard through various committees and organizations that she has had, through the public hearings that you have conducted relentlessly in December -- I can't believe you got all of that together in December -- that what older adults really want is independence, dignity, and choice. They want to remain in their homes for as long as feasible, and the family members who are assisting that need help to make that happen.

We have been hearing this for years. When the Governor convened the Department of Health and Senior Services, she asked us to make

that happen -- to do everything we could do to make that happen. We've been really trying hard to make that happen, and what we have found is that it takes a set of strategies. You can't do one thing. It's like nailing Jell-O to a board. If you hit it here, it is squished there, and so how do you do it. So we've come together -- the Governor has accepted recommendations from this Advisory Council, as well as what we have been as a Department trying to put together, and offer a beginning. This is a beginning agenda, and I want to emphasize that. There is much more to do.

But what it does do, we think, is have the essential elements to redirect our long-term care system from this unrelenting march toward institutionalization to one that rebalances more into home- and community-based care and institutional care. We should probably get to a 50/50, maybe even better -- much better than we are at 90/10. I should say that New Jersey isn't unique. We are probably like most states, so it's not that we are terrible, it's just that we can do a lot better.

So, before I give you any hand-outs, because you will get confused with the details, let me just say that what the Governor did was in her budget include by the end of three years \$60 million in new dollars that include State and Federal. The first year it's \$16 million -- I think it's 10.3 million and the rest is Federal dollars -- into these variety of techniques that we will put together with New Jersey EASE as the cornerstone and that care manager that you've heard so much about empowered to do the kinds of things that we all want to see happen.

There are a couple of pieces to this. The first one is what I would call choice counseling. How do you help people know up front and in a

preventative way as possible, or as Barbara has said, “When that crisis hits” -- how do you help people to know their choices so that they don’t automatically go to a nursing home if that’s not the right choice to be made? And we know that it often is.

We have New Jersey EASE, which you have heard a lot about this morning, and Barbara is one of the most talented members of my staff, along with Casey and the rest of her team. She has really done amazing work going from county to county and having that sensitivity as you have noted, Assemblywoman, to work with counties that are just so unique. So we have done a lot of fundamental work in constructing the infrastructure for this.

But we have to be able to build on that infrastructure. So we have New Jersey EASE where we hope this one number will start to get marketed. I think we should put marketing dollars in there so people do know that this is the place to call. Then, we have to have the places where people go, where seniors go, when they are in crisis. And that is generally in a hospital -- primarily in a hospital and in a nursing home. That tends to be the two places that they wind up where they have to make these choices.

We conducted over the past six months or so, with Theresa’s help, some regional meetings with hospital discharge planners to get a better sense of this. What is this link, this almost automatic link, between hospitals and nursing homes? Is it inevitable? Is it appropriate? What should we do as a state to change that or support the hospital discharge planners? They have pointed out, as Casey noted, that the case managers, or the discharge planners in hospitals are driven to discharge. That’s their title, discharge planner.

The easiest discharge is one that is a complete package of services, and a nursing home, especially a good nursing home like yours, is a very good package. It's far more complicated to discharge to an assisted-living facility or to home care or to alternate family care or some other mix of day care and respite care. That's complicated to put that kind of service package together.

What's your average length of stay now?

MS. EDELSTEIN: Seven days, six days.

DEPUTY COMMISSIONER REINHARD: Seven days, most of which the beginning part you are really very, very ill, so how are you ever going to do this this quickly? So we've given that a lot of thought, and we have realized that we shouldn't worry so much that the person be immediately discarded to assisted living, for example. That there should be time for a person to be discharged to a nursing home, start to recover, and then have another opportunity to see if that's where they should stay.

So beginning with the hospital end, the Governor has announced in her initiatives here a program of choice counseling in hospitals. So that we will have a counselor in every hospital in this state to work with discharge planners and work with every senior, not just those who are on Medicaid, every senior, to have an opportunity to talk to them about what their choices are. Perhaps not a full assessment; perhaps it will be, as you point out, kind of a screening assessment. We have to check that out. But to see what do you need now and what could you possibly need as you start to recover. So that is going to be put in place. We will probably do that through an RFP with some entity. We are not planning on hiring this many new State workers, and I think it's a function that we could pretty easily do through a subcontract.

On the other end, on the nursing home end, we will have a community choice counselor working in nursing homes, which we are already doing, to work with those that have been there about a month or two to see if this is where they want to be, if this is the choice that makes sense for them. And if not, if they are looking for another choice, we will help them make that transition, not just refer them, but literally, as you were pointing out, Renee, drive them around. Take them to an assisted-living facility, show it to them, literally bring them around, which is different than case management. This is a very specific function we are talking about here.

Now, we started doing this in March with about eight staff, this community choice counseling on the nursing home end, and by November we had worked with 300 people in nursing homes, and 200 of them left the nursing home. Forty percent of them went home, the rest went to a relative's home or to assisted living or foster care or other choices. That's a big success. Now, I don't mean that that's out of the universe of 46,000 people in nursing homes. We targeted the people that were supposed to only be there for a short period of time to see if they still needed it. If they needed to stay, we helped them do what they needed to do to stay, to fill out whatever paperwork they would need to stay. So that's the choice counseling end of it. Again that means hiring more people, and we're not sure if we are going to do that through an RFP or do that through contracting with more -- hire some more people from the state.

Once we have that choice to go out into the community, we have the assisted-living waiver that you've heard about, alternate family care and assisted-living waiver, so that the State will pay for Medicaid reimbursement

for those alternatives. They're mainly, and always will be, private, pay options. They are not going to be all Medicaid options, they shouldn't be. But there's got to be more in-home care. We have got to invest new dollars into in-home care and start priming that pump so that as people make more choices with new services, if it turns out that we do save dollars on the nursing home end, we will reinvest it into home- and community-based care if that happens. But we are not depending on taking dollars out of nursing homes. This is not the plan. The plan is new dollars for the home care piece.

The home care piece is very creative. We are very excited about this. We tried to look at the limits of what we have available. Right now all we have is CCPED, which you have heard a few times. The Community Care Program for the Elderly and Disabled is the only Medicaid waiver program for seniors by and large. There are these little, smaller programs, but that's the big one.

CCPED, as many have pointed out, is a box. You either get in it or you don't. And if you're in it, you only get seven things, that's all you can get. You can't get a personal emergency response system. You can't get chore services. You can't get your environment modified if that makes sense. There are only seven things. Those seven things are very good. They are homemaker; home health aid; they are skilled nursing; they are physical therapy; they are respite care; day care. They are good things. But we have had people have to leave their home because we couldn't modify their environment. It just doesn't make sense.

So the first thing we wanted to do was create programs that were move flexible.

Good bye, Senator. We will fill you in.

SENATOR ROBERTSON: Okay, thanks.

DEPUTY COMMISSIONER REINHARD: The second thing we wanted to do was to make sure that people who were not Medicaid had access to services. So we have designed, for the first time, a program that is sliding scale. This came directly out of these hearings. We kept hearing again and again and again that people would say, "You know, I could pay for this, but I don't know where to go." And it's not just getting the service. It's that ongoing care management that they need to help them monitor the situation.

So, under this new in-home care package, people could access the system, maybe pay completely private pay but have the care management that they have been looking for. And that's why I was saying there could begin to be some more overlap with what Barbara was describing. But we are not talking about super wealthy people here. The super wealthy people I think, by and large, are going to be calling Barbara and people like Barbara, and we'll help to continue that.

The third very innovative piece here is that we will pay family caregivers. Now, this is a very dramatic change, and I have to put some boundaries around this. We're not trying to make people become caregivers against their will. We are not trying to replace the contributions that family members are giving, but we are trying to make sure that if the family caregiver wants to be the primary caregiver and has to perhaps give up a part-time job to do that, that we will pay that person instead of a stranger basically.

We had specific cases in this experiment I was referring to with 300 people where there was one person that struck me. This is what kind of

made me go down this road. That the aunt was willing to have this person come out of the nursing home and stay with her, but she would have to give up her job to do this. We said no. We could have let a stranger do that and train them as an alternate family care provider, but since this person was a relative we said no, and so that person stayed in the nursing home.

That doesn't make any sense. We really should be more flexible about how we approach this. Now, the way this will work is the person -- the older adult is the person in charge here, will be working with Barbara's team, with the New Jersey EASE care manager at a very local level in a problem-solving way. This is extremely individualized, and the family member becomes involved if that's an appropriate thing to do. But the senior is the person in charge here. So that's the kind of mix of the in-home care services we want to do.

On the nursing home side, the last part of the initiative has to do with improving the quality of life, not just care, but improve the quality of life of people in nursing homes. We have gone to some wonderful models of something called the Edenizing philosophy in New York. This is a model that was developed by a Harvard-trained physician, Dr. Bill Thomas, who did this a number of years ago. He had been a physician in an emergency room, very much the hi-tech and the very medicalized model, and almost by accident wound up as the medical director in a nursing home. And this is the story that he tells.

He started off his career in the nursing home trying to cure everybody with pills and technology and realized that he was totally missing the boat. That what people really needed was care or treatment of loneliness

and isolation and a feeling of dependency that everybody was caring for them. That what they really needed was more opportunity to care for others, to be more reciprocal in their relationships with other people. So he thought about this. His wife was a social worker, so together they developed this model of really working as a whole unit with the community -- with the surrounding community to develop a more lively habitat, bringing in children, plants, animals, popcorn, whatever it takes to really change the nature of the environment.

In one facility -- we went to a nursing home whose occupancy rate was dropping. Instead of trying to fill it up, they closed that wing to be a nursing home and made it a kindergarten. The community was looking for space. They thought this would be a logical place. They renovated and they had two fall, scaled kindergarten classes going on when we were there. The children would walk through the lobby of the facility, interacting with those who wanted to interact, and there were formal opportunities for them to participate in arts and crafts or Valentine's Day if that what was going on, parties of all sorts. That was that particular facility.

The animals, it's not pet therapy. We've had that for years in our state. This is very different. The animals don't come and go, they live there. This is having pets that live there. They stay there at night, they're in your bed if that's what you want. It's very different than pet therapy. The community is very much involved sometimes by contributing the pets, by contributing the food, by bringing in plants and helping to take care of them but encouraging the residents to take care of them. That's a big part of this that residents are

caring for other living things and feeling more valued and more human, basically, than they have felt when they were in a dependent state.

This is something we are very excited about. The industry has been widely enthusiastic about this. I sent a letter last week, just a week ago. Thirteen homes as of yesterday had already said, "Please, we want to be in this mix." We are going to have an RFP to have at least ten nursing homes begin this process and work with those with an advisory committee. We're hoping to have Dr. Thomas come, perhaps even as early as the beginning of March, perhaps March 2nd I think we were trying to get him to come.

This will be a long process. This isn't something you can do overnight. You're involving your staff and your community. What we like about it is that people start to come in more into the facility. They come in because they are caring for the plants or the animals. And the grandchildren like to visit because there is a cat to pet or a dog there that they like and they bring presents. They bring dog food or they bring a toy for the dog. It's far more active in its environment, so we are very pleased about that end, too. So that's it in a nutshell. Back to the other pieces.

Our goal here with the home care-- I forgot to mention the respite care. We have respite care -- a million dollars more for respite care. That's on top of the million that the Legislature added last year. So it will bring it up to almost \$6 million now for respite care. But there is a whole section of that component, about \$250,000, that is going to be designed to provide more caregivers support training that we heard that people were looking for. Either having maybe a visiting nurse or some other professional go into the home and help the person develop the skills that they are looking for or allow them to go

to a course that might be offered by a home care agency or a nursing home with some of the training you would be doing for your aids here for the components that they are interested in. That's a very new idea that Ruth and her staff developed.

ASSEMBLYWOMAN MURPHY: Particularly important for Alzheimer's.

DEPUTY COMMISSIONER REINHARD: And the training for the dementia.

ASSEMBLYWOMAN MURPHY: Boy, that's good.

DEPUTY COMMISSIONER REINHARD: And we are also looking at the corporate world, bringing more training courses and support groups into the business world to help those who are the employed caregivers. But that's really just the beginning. There is so much more to do in the area of caregiving. It seems like such a small thing we are starting with, but it's a beginning to develop the protocols and some models and pilots to get that going.

ASSEMBLYWOMAN MURPHY: What about EAPs, Employee Assistance Programs?

ASSISTANT COMMISSIONER READER: That's one of the parts of the Governor's initiative allows us to hire a staff person to begin to do that corporate work. And one of the pieces of it will be to do a conference with EAP corporate people.

ASSEMBLYWOMAN MURPHY: May I suggest you invite United Ways to participate in that since many United Ways finance the agencies that do the EAPs.

ASSEMBLYMAN ROMANO: Is it my turn?

DEPUTY COMMISSIONER REINHARD: Sure.

ASSEMBLYWOMAN MURPHY: Lou, it's always your turn.

ASSEMBLYMAN ROMANO: I mean I patiently waited.

By the way, you're not a senior citizen, don't kid me that way.

(laughter)

MS. GREENBERG: Me?

ASSEMBLYMAN ROMANO: You, yes.

MS. GREENBERG: I am indeed and proud to be one.

ASSEMBLYMAN ROMANO: Nice try. You are only doing that for some sort of discount someplace. (laughter)

DEPUTY COMMISSIONER REINHARD: Take it as a compliment.

MS. GREENBERG: I am.

Thank you, Lou.

ASSEMBLYMAN ROMANO: Let me say this. One of the questions, or one of the comments I had, was while the brochure is fine, how do we get this all out? And I'm going to go through very quickly on this. Motor Vehicle when they send out licenses for somebody over a certain age should be in the envelope. Just the way they send you the piece in the envelope if you want a special plate. As a legislator, I get it first. (laughter)

ASSEMBLYWOMAN MURPHY: Absolutely.

ASSEMBLYMAN ROMANO: But that's the point. You have to get these out. I have an idea for that. All the other senior citizen groups who are able to leave their homes and come into a recreation center as such should

be called upon to act as mentors for other people that they know who are in the home and don't get out and should serve as a caregiver in the sense of providing them with the information of what is available. Many people do not know what you're talking about when you say New Jersey EASE. So the message still hasn't gotten out there.

I'm going to move along, and I'm going to give you a concept that I have. While you have care/case -- whatever you want to call it -- managers you have to have, for the want of a term, a super manager. You have to have somebody who has the right to look at a case in review and to sign off on the case without getting involved in cookie-cutter care here.

We have people--

You know my famous cases I keep telling you about, Madam Chairperson.

ASSEMBLYWOMAN MURPHY: Yes, I do.

ASSEMBLYMAN ROMANO: That for the want of one or two hours a day the family says, "No, we don't need anybody on the weekend. We need it during the day." The mother has dementia already, unable to control herself -- and somebody has got to be there during the day. For the want of-- If you say a sliding scale to pay for that because the people are not without money, but not with that sort of money to pick up 10 hours a week at the straight rate of picking up a health-care worker.

DEPUTY COMMISSIONER REINHARD: That's what that program is for.

ASSEMBLYMAN ROMANO: And if you have to give this care manager a polygraph once a year to make sure that they are doing everything

correctly, so do it. Private industry does it. Let's take New Jersey State Health Benefits. If you miss the rule in New Jersey State Health Benefits, it's cast in concrete, there's no changing. If you have a large company, you have a manager from the insurance company who has the right to come in and listen to the sob story that you forgot to enter this person into the health program at a certain time; that person has the right to sign off and predate the enrollment of that person, taken for the fact that, yes, I understand with my signature you can do it. Have a case manager, or care manager, who has the right by the very nature of the role for what I might call minuscule type of waivers where the State can put things together and say, "That person needs five hours more a week. Medicaid won't do it, and will you talk to me about an RFP going to the outside. I'll keep renumbering whoever you hired to do the Medicaid Concurrent Review, okay." That's one that's stuck right under here. (indicating)

What I'm trying to get at is, for the want of a glitch of an interpretation, is this babysitting? Oh, no it's not babysitting. No, it's babysitting. What are we doing here? That should be someone who has the right to draw upon money from whatever fund it is -- I know you're all limited by budgets -- but still giving the leeway to settle the situation.

DEPUTY COMMISSIONER REINHARD: That's right.

ASSEMBLYMAN ROMANO: And especially in my culture, I say Latin culture. We don't want our people in a nursing home unless it's the last resort. And so if you can hope and you have the extending family who has arranged all sorts of hours, all sorts of sleeping techniques so that the grandmother, the mother is covered all week long and you need five hours a

week for a homemaker to be in there, so be it, so be it. What are we doing here? Until we come to the realization we have to have faith -- have faith in our managers so that they can sign off, we're going to go through this problem every time.

Last but not least.

DEPUTY COMMISSIONER REINHARD: Can I tell you? You're right. That's what we're doing.

ASSEMBLYMAN ROMANO: You didn't tell me that one. I didn't hear that.

DEPUTY COMMISSIONER REINHARD: Well, you just said it a lot better.

ASSEMBLYMAN ROMANO: Who's going to stand with me? I didn't hear that definition?

DEPUTY COMMISSIONER REINHARD: Well, you did it a lot better.

ASSEMBLYMAN ROMANO: I'm talking about no constraints. And when you talk about priming the pump, that's what I'm talking about if you want to prime the pump.

DEPUTY COMMISSIONER REINHARD: That's right.

ASSEMBLYWOMAN MURPHY: That's right.

ASSEMBLYMAN ROMANO: This is the way people will not go into nursing home.

By the way, I shutter when I think of the evaluation or suggestions you're going to make to someone about coming out of that nursing home to stay home. I only hope, as I say again, this is not typical of the concurrent

review situation. Because I don't want to see anybody caught in the cracks or the floorboards that someone euhres this person -- because I asked you what the term is. What is that when you--

ASSEMBLYWOMAN MURPHY: Coerce?

ASSEMBLYMAN ROMANO: No, the name of the agency again. The elder care, the adult care, adult preventative--

DEPUTY COMMISSIONER REINHARD: Oh, APS, Adult Protective Services.

ASSEMBLYMAN ROMANO: Okay. I don't want to see the State assuming that role, not for being the person who adjudicates, but the person who is committing it. When I say the State, whoever they hire represents the State. I don't care who you hire.

Other than that I have to tell you I'm very proud--

By the way, how much are they going to pay the family caregiver?

DEPUTY COMMISSIONER REINHARD: That will vary.

You know, I mean it, you were very eloquent in a way that I wasn't. That is exactly what we're doing. The Governor said, "In these programs you should do whatever it takes to keep someone out of a nursing home to a limit." I mean there really is a point in time where that's not appropriate, even if the person wants it because there is no way you can arrange 24-hour care consistently in a snowstorm, in a this, and a that. You really have to do this individually. But we will hire a neighbor if it takes that to come into the home. That's why we are saying a family member, an aunt, whatever it takes that makes sense, and only the care manager and the older adult and family can figure that out. We can't figure it out from the State.

These will not be boxes. That's why I didn't want to give you this hand-out right away. It's got all these names, it's seamless. People should not care about any of these names. They are just names because they have to go on different waivers. What we'll give is a budget to the county Office on Aging or the New Jersey EASE site to use across all categories. And whatever it takes, pulling from the Respite Care Program, pulling from adult day care -- whatever it takes they can do.

ASSEMBLYMAN ROMANO: The other question tha we had in at the beginning -- and I don't know if there has been any activity on this -- is the insurance for those people who are taking some people into their home, what happens if they fall? Is this their ordinary homeowner's insurance because this be one of the situations they have to abide by. How does one cover these people taking people into their home?

ASSEMBLYWOMAN MURPHY: That was the other--

ASSEMBLYMAN ROMANO: We still have not come to the issue--

ASSEMBLYWOMAN MURPHY: No, we haven't gotten to that yet.

ASSEMBLYMAN ROMANO: --of the-- What do you call it? The ordinances on family boarding homes or whatever you want to call it.

DEPUTY COMMISSIONER REINHARD: We need a bill.

ASSEMBLYWOMAN MURPHY: That's another issue that we haven't covered.

ASSEMBLYMAN ROMANO: I rest my case.

MR. MUNIZ: Madam Chair.

ASSEMBLYWOMAN MURPHY: Just a second.

And I have spoken with some mayors, as I'm sure you have, about the concepts of home configuration for these kinds of things. And I've talked with a couple of planning board attorneys, and they are going to try and research and see what they can find out is whatever -- whatever within the law that we can tweak a little bit, and then we may have to sit down with the League of Municipalities.

MR. MUNIZ: I just wanted to tell Susan not to be too hard on the nursing home facilities, since I represent two of them, probably the best ones in the state, hopefully. But I have to tell you that the next meeting will be our chance to tell you about nursing homes, so we are going to get back on you.

DEPUTY COMMISSIONER REINHARD: Do you feel we are being hard on you?

MR. MUNIZ: No, I don't. And I have to agree with you that the Eden alternative, for example, is a great concept. We started in December and hopefully by March of next year we should be implementing the entire project in this facility as well as the other facilities. So that's an excellent program actually.

I was just concerned with their assisted-living facilities where the waiver that we currently have does not apply to those facilities that are not Medicaid or Medicare. I believe that there will be some facilities that will accept the waiver shortly, hopefully. Will there be a sliding scale for that also?

DEPUTY COMMISSIONER REINHARD: For people in assisted living?

MR. MUNIZ: Correct.

DEPUTY COMMISSIONER REINHARD: That's a good question. Right now we have a one price--

MR. MUNIZ: Sixty dollars.

DEPUTY COMMISSIONER REINHARD: --and there has been some suggestion that we level that according to the person's functional need, what their needs are. And we are very open to looking at that.

ASSEMBLYWOMAN MURPHY: Some mortgage bankers or money people who invest in assisted-living homes and others have called me and want to come and testify, too.

DEPUTY COMMISSIONER REINHARD: Good.

ASSEMBLYWOMAN MURPHY: But the fact that the bankers are becoming very wary of that-- They see a great many assisted-living facilities in the State of New Jersey, but they don't see any at an affordable level. So they wanted to come in and make a presentation to us.

DEPUTY COMMISSIONER REINHARD: Good.

ASSEMBLYWOMAN MURPHY: Also, I have had some calls from people who do long-term care. Some of these are private, but if that's who is out there selling them, we might as well hear from them. And I'm talking to some corporate people who do some long-term care programming within their corporations, and I thought we ought to hear from as many of these kinds of things. So please be thinking of people.

The viatical bill got out of one committee in the Senate and one committee in the House, so we are going to talk about viatical trusts -- not viatical wills, viatical trusts -- and we need to hear about living wills, end-of-life,

guardianship issues, insurance for alternate family care people, and financial care management.

What are people doing or not doing at any age, particularly to begin to understand that the cost of their aging will be their cost. And what are they doing or what are we doing as a public to do some education to people to say 30 years is not too late or too soon to be thinking about what you are going to do at 130 because you may get there. And I think we have to begin to educate people because it's going to take some time to get them to understand that putting 50 cents a week away for your pension is going to work about the same way it does for your Christmas club, you'll never have enough to go around. I keep trying, but it never adds up to any more. (laughter) But I think a lot of things like that.

Your thoughts, Sam.

ASSEMBLYMAN THOMPSON: I had two things for Dr. Reinhard.

One, you say for the first time we are going to be giving money to family caregivers. You cited a case and you said it doesn't make sense that we would pay a stranger, but not pay the aunt. The one concern I have here is-- Early on we got to figure on how many people are taken care of by a family member. What was the percentage, roughly?

DEPUTY COMMISSIONER REINHARD: We have 775--

ASSEMBLYMAN THOMPSON: No, percentage.

DEPUTY COMMISSIONER REINHARD: Oh, percentage. One in four households.

ASSEMBLYMAN THOMPSON: Very, very high. But that's-- Once we open the door -- and this is probably why it hasn't been done before -- how would we be able to say, "Well, we will give money to an aunt to take care of somebody," but what about the daughter taking care of the mother, and so on? In other words, every family member out there that's taking care of somebody -- if you start paying some, then I think you are going to find most all of them are going to say, "Well, if you pay them, then you got to pay us."

DEPUTY COMMISSIONER REINHARD: That's right.

ASSEMBLYMAN THOMPSON: And I think that's a lot more money than you have available to you.

DEPUTY COMMISSIONER REINHARD: Well-- You want me to respond to that now?

ASSEMBLYMAN THOMPSON: Yes.

DEPUTY COMMISSIONER REINHARD: I did mean daughters. You can't be a spouse by Federal law, and you can't pay a parent to care for a child. The Federal law allows this and other states are doing it. It's the first time in New Jersey, but there are several states that are doing this now. It has to be done by the care manager. We cannot be replacing the care that is going on now. We're talking more care above and beyond what is being done now.

ASSEMBLYMAN THOMPSON: Well, you're speaking of Federal law, and so on, and I assume that replies to Federal funds.

DEPUTY COMMISSIONER REINHARD: I'm talking about Medicaid.

ASSEMBLYMAN THOMPSON: Yes, yes. But I'm saying that once you open the door, the citizens of New Jersey are going to say, "We don't

care what you say down in Washington. I'm taking care of mother and you're telling me that if my niece here or somebody else takes care of my mother, you are going to pay them, but you're not going to pay me. I had to give up my job to stay home and take care of her, etc." I think you are going to have a lot of pressure that if you are paying any family member -- and every family member that's taking care of a family member is going to feel fair is fair, they're paid, I should be paid.

MS. MICHELSEN: Is it going to be based on the senior's income?

DEPUTY COMMISSIONER REINHARD: Yes, it's based on the senior's income. And we are starting this in the first four counties that begin with New Jersey EASE to test out those policies and reactions. If we fail, we fail and we will not continue.

Based on the experience of other states, I do believe it can be done. In fact, I was just presenting with Ruth this morning to the Home Care Council about these initiatives. We presented yesterday to the NJAFA -- a wonderful reaction. The nursing home industry is there and embracing this because in part they have a lot of housing and a lot of options. And some of these services we are talking about are provided in nursing homes like respite care and--

Is that you or me? (referring to beeper)

ASSEMBLYWOMAN MURPHY: I don't have that noise.

DEPUTY COMMISSIONER REINHARD: I shouldn't.

ASSEMBLYWOMAN MURPHY: I have another noise.

DEPUTY COMMISSIONER REINHARD: Okay. So they have been very open. But the Home Care Council has pointed out that there are

not enough nurses aids, homemakers, home health aids out there. I think we are going to have--

ASSEMBLYMAN THOMPSON: No, I recognize the problem.

DEPUTY COMMISSIONER REINHARD: --to rely on neighbors and other nontraditional forms of help to meet the growing demand, unless we are going to find homemakers out there to start training far beyond.

ASSEMBLYMAN THOMPSON: I think it's good to be moving in this direction. I'm simply voicing the problem I see.

DEPUTY COMMISSIONER REINHARD: I agree with you.

ASSEMBLYMAN THOMPSON: The second item I wanted to mention was where you spoke of the choice counseling. And as you described it, this would be something that would be taking place upon discharge from the hospital. That's how you--

DEPUTY COMMISSIONER REINHARD: Yes.

ASSEMBLYMAN THOMPSON: In this respect, while that is being done, again a need that has been brought out in previous testimony, is that we also need, at that time, to be counseling the people that are going to -- the caregivers.

DEPUTY COMMISSIONER REINHARD: Yes.

ASSEMBLYMAN THOMPSON: That this was one of the complaints that people-- They send them home--

DEPUTY COMMISSIONER REINHARD: Right.

ASSEMBLYMAN THOMPSON: --but they don't tell the caregivers anything about how to take care of them when they are going home. So if somehow or other that could be worked in with the choice counseling--

DEPUTY COMMISSIONER REINHARD: You're right, and we have to make sure we've got that. A 250,000 pilot was designed to do that, but we have to make sure they are going together.

ASSEMBLYMAN THOMPSON: That's what I said.

DEPUTY COMMISSIONER REINHARD: Right.

ASSEMBLYMAN THOMPSON: If they can be worked in together, it would certainly be very helpful I'm sure.

ASSEMBLYMAN ROMANO: What is the sliding scale that Renee is talking about?

DEPUTY COMMISSIONER REINHARD: One of the home care programs we are talking about, the Jersey Assistance for Community Caregivers, is a sliding scale program, so it's not a Medicaid program. It's a sliding scale program all the way up to full private pay.

ASSEMBLYMAN ROMANO: What would that pay for?

MS. MICHELSEN: It's those people that you were talking about that can't afford to pay \$18 for a home health aid an hour, but could pay \$10 or \$5.

ASSEMBLYMAN ROMANO: But this has nothing to do with this business of hiring a family member.

MS. MICHELSEN: No.

ASSEMBLYMAN ROMANO: Okay.

MS. MICHELSEN: It's one of the other options.

ASSEMBLYMAN ROMANO: And I had one final thing.

Ms. Fuller, you know, on the services that are provided under EASE, as I go down this, many of these programs that are here with the

individual community or county are controlled by budget dollars, aren't they? And even in the case of, let's say, home-delivered meals, this usually becomes the responsibility-- As in my own case, what they call the North Hudson Counsel of Mayors, they are paying for the meals. So what I'm really saying here is there are a lot of things listed here. What will happen to augment or to make sure that these-- Are you going to, let's say, massage, coerce, euchre some particular county or mayor to provide these services to make sure that they are there?

ASSISTANT COMMISSIONER READER: All of the above.

(laughter)

ASSEMBLYMAN ROMANO: That's why I'm just asking.

MS. FULLER: We're talking about access to those services. It still means that there may be waiting lists. And I think what the care manager will then be able to do -- and I think that we all know that we can't pay for all of the services that everybody needs, but the care manager will be able to look at the informal system. Is there a church or a synagogue that can help organize for a certain period of time while that person is on the waiting a list a group of people who can prepare meals on different days? Are there informal supports that people depend on but don't want to ask themselves, but if somebody else asked for them, they are willing to accept it? That can help to subsidize in a way some of these formal programs. Because I think that we all know that there will be waiting lists unless we are willing to tax ourselves a lot more, and that is not exactly where this citizenry is going.

So I think having the care manager and using that informal-- And our training really emphasizes-- Pennsylvania Care Management starts from

the assumption that you start with the informal support system. The lady who was the den mother, who all those years when her son was little -- you could ask that Boy Scout troop at this point to do their merit badges to help her, to do some of those services, those chore services that she might need.

So it starts with our care managers understanding the importance of the informal support system and how you utilize that, how you bring that into the service plan.

ASSEMBLYMAN ROMANO: You are going to teach them a multiplicity of strategies.

MS. FULLER: Right. Because we don't have just payment strategies for everybody.

ASSEMBLYWOMAN MURPHY: And that's what we learned with first call for help was exactly the same thing.

MS. FULLER: Right, exactly.

ASSISTANT COMMISSIONER READER: I had passed around a copy from the Older Americans Report, which has in it the new initiatives in the President's budget, in the Federal budget. One of them is 35 million more for home-delivered meals because across the country they are experiencing waiting lists on home-delivered meals. He also had a caregiver support program in his budget. So both the Governor and the President are seeing the needs of caregivers.

The other thing that we are saying to the county Office on Aging is that they need to be looking at prioritizing their service delivery system. And with their Older Americans Act dollars and Social Services Block Grant dollars there are options available to them as to what service they are going to

fund based on the priorities and the needs of the population in their county. So they may need to move away from some more social and recreational things and move towards more intense services. So those are local decisions.

ASSEMBLYWOMAN MURPHY: Since our last meeting, also, the National Organization of Women in Government had a workshop, day and a half seminar workshop, in Amelia Island, Florida. Susan was to have been there with me, but it was the Friday and Saturday before the budget or Saturday and Sunday, I guess, before the budget was presented by the Governor, so Susan didn't leave the state. But Marlene Verniero, who is the Medicaid waiver specialist in the Department of Health and Human Services, did come down with me. And New Jersey was a featured speaker because of the way we have moved forward with different kinds of programs -- some of which you are seeing here, some of which you have seen before -- in the area of dealing with the elderly and because the Governor had created this Council.

So Marlene and I were presenters speaking about the kinds of things that are happening, and I was very delighted to be able to speak about all of you and this Council and what we are doing. We have been asked, and Susan is working on this as an I, to work with the woman who is Executive Director-President of this organization. She is preparing an application for grant monies to do more of this.

There were seven states invited to be participants, or attendees, at this program. And all of them are going through exactly what we are going through. I must tell you it is really very interesting. I brought down a package that had 17 different kind of living alternatives which the State of New Jersey would invest dollars in for seniors -- 17 of them that we have. Some other

states have already done some, some of the other states are looking at, and some of them are not things, but other states are doing different things.

I was interested that Texas was the only state that spoke about something we have spoken about here. And some of the others didn't recognize it. And that is the diversity of our population, the language barriers, the mores that change what people will accept for a member of their family, and the value systems that come from different ethnic cultures that have shaped us and how we treat those older persons in our family. The Senator from Texas was the only person who spoke to this, and I really wanted to hug her because it's clearly-- It's going to be a need in some states and is not seen at all in others.

And when you think of the populations in different states, you suddenly think, oh, of course why would they and of course we would and of course Texas would. It's very interesting. There will be more coming from it. But we are a little bit ahead in some areas of other states, we are little bit behind others, but we are all searching for exactly the same solutions. It's kind of funny because I think sometimes we all feel we're out in the middle of that jungle all alone. And we are alone, but we aren't.

MR. MUNIZ: I understand that the next meeting is going to be in Hawaii and we are all invited.

ASSEMBLYWOMAN MURPHY: Yes. (laughter) I wanted to surprise you.

DEPUTY COMMISSIONER REINHARD: But you're still catering it.

MR. MUNIZ: I'm still catering it, that's fine. (laughter)

ASSEMBLYWOMAN MURPHY: Is there any other business anyone would like to bring up? Other items they want us to research speakers for?

MS. MICHELSEN: Dr. Reinhard, when do you think that these initiatives will be implemented?

DEPUTY COMMISSIONER REINHARD: It starts with budget, so it would be July. But many of the home care programs cannot be implemented until the Federal government approves the waivers, which generally we think about September or October.

DR. HEATH: What about the community choice counseling program?

DEPUTY COMMISSIONER REINHARD: That can be right away. In fact, we are trying to get the people trained now so that we can really have them in place July 1.

ASSEMBLYWOMAN MURPHY: And the nursing home initiative--

DR. HEATH: Hospital and nursing home?

DEPUTY COMMISSIONER REINHARD: Yes.

ASSEMBLYWOMAN MURPHY: The nursing home initiative has already begun.

DEPUTY COMMISSIONER REINHARD: Yes, and that's a matter of adding staff to that. The hospitals-- We have preadmission -- people who would do preadmission screening now or our long-term care field office staff who could start that now. They could do more than just ask the questions.

Right now, our long-term field office staff which are generally nurses -- they are nurses -- go in and it's like, "Yes, you're eligible. No, you're not." And if it's no, that's it. There is no discussion about what happens if you are not eligible--

DR. HEATH: You're talking about Medicaid eligible?

DEPUTY COMMISSIONER REINHARD: --for Medicaid to go into a nursing home. They are only called in to do anything if the person is going into a nursing home.

MS. MICHELSEN: And Medicaid eligible.

DR. HEATH: And Medicaid eligible.

DEPUTY COMMISSIONER REINHARD: And Medicaid eligibility.

MS. MICHELSEN: What if someone--

DEPUTY COMMISSIONER REINHARD: So we can take existing staff and have them go beyond no or even yes and talk more about what the possibilities are before we worry about expanding it any further.

MS. MICHELSEN: Is the hospital counseling program only for people that are Medicaid eligible?

DEPUTY COMMISSIONER REINHARD: No, we would like to have it available to every person who wants it. We have to work that out, but the policies would be around that.

ASSEMBLYMAN THOMPSON: I think maybe you're saying currently it is only for that, but in the future you're hoping to expand it.

DEPUTY COMMISSIONER REINHARD: Right.

Right now it's actually a mandate before someone can go into a nursing home if they are on Medicaid or expect to be on Medicaid within six months. We could expand that to *X* number of months, for example, in our policies, to broaden that to make it more available to others.

DR. HEATH: I'm sorry, the mandate is for community choice counseling, or the mandate is for the preadmission screening?

DEPUTY COMMISSIONER REINHARD: It's for preadmission screening.

DR. HEATH: Preadmission screening?

DEPUTY COMMISSIONER REINHARD: Right.

DR. HEATH: Which is yes/no.

DEPUTY COMMISSIONER REINHARD: Yes.

DR. ROBINSON: You know, I think one of the best features of everything you mentioned is that community choice counseling in nursing homes, just because in the hospital people are in such crisis--

MS. MICHELSEN: That they say yes.

DR. ROBINSON: Well, they say yes. You can't get in touch with the family, their function is down, so a lot of times decisions about nursing home placement are made when they might not be all that necessary. So that the opportunity to rethink that once in the nursing home and you start to recover a little bit and the family settles down is wonderful.

DEPUTY COMMISSIONER REINHARD: Right, thank you.

But they also need help, as the Assemblyman pointed out. It's not our desire to throw people out.

DR. ROBINSON: Right.

DEPUTY COMMISSIONER REINHARD: It's our desire to see what help they might need and help set up those services and then link them back up to the care manager in New Jersey EASE for an ongoing assistance.

ASSEMBLYWOMAN MURPHY: Yes.

MS. EDELSTEIN: I just wanted to make a comment that at our next meeting there are at least three hospital representatives that will be coming to speak to our group. And one of the things I think we should ask them more about -- because many of them have senior membership programs-- I think we should ask them more about what the function of those programs are and whether care management is a component, and if it isn't, how it could be. Because hospitals see a preponderance of older individuals in crisis, at least initially, and often get them into the senior membership program during that acute care stay. But the question that I think we should ask is, "Well, then what happens and what role can hospitals play in care management that could augment, or supplement, what New Jersey EASE does, what geriatric case managers do?" Because there are a lot of people in between New Jersey EASE economic situation and being able to afford a private geriatric care manager. That hospital may be able to serve on a sliding scale and have that service be more accessible.

DEPUTY COMMISSIONER REINHARD: We should do that, but I still want to keep pointing out that New Jersey serves people of all income levels and we'll do sliding scale.

MS. EDELSTEIN: Right.

DEPUTY COMMISSIONER REINHARD: That is the mission of New Jersey EASE so that we are not creating a two-tiered system, but for all older adults regardless of--

MS. EDELSTEIN: But to go back to the Senator's point, the more options you have for providing the service--

DEPUTY COMMISSIONER REINHARD: Absolutely.

ASSEMBLYWOMAN MURPHY: Absolutely.

MS. EDELSTEIN: --the more people you serve. So I think that it is something that some hospitals are already doing, and we've heard from some of them in the past hearings, but I think having three or four hospital representatives come -- and they all have some version of this going on, so I think it would be a good thing to talk to them about.

ASSEMBLYWOMAN MURPHY: Thank you very much, Theresa.

MR. MUNIZ: Just one last thing. A couple of years ago the Bonnie Kelly Institute, the volunteer ombudsman program, which I have great experience with-- I had one in my own facility, and I thought it was a great asset for the residents, as well as for me as the administrator of the facility. This is something that we can probably be looking into some kind of a care management program for nursing homes on a volunteer basis for those people that are looking to do something beyond what they do now, being retired and they want to volunteer their work in nursing homes to try to find places for those people that are there.

MS. EDELSTEIN: Or serve as guardians.

MR. MUNIZ: Or serve as guardians. Correct.

ASSEMBLYWOMAN MURPHY: Wouldn't it be wonderful to have RSVP or somebody pick up a program of training for guardians?

DEPUTY COMMISSIONER REINHARD: That would be great.

ASSEMBLYWOMAN MURPHY: A group of people who are at the age to perhaps have a little more sensitivity about--

MR. MUNIZ: Exactly.

ASSEMBLYWOMAN MURPHY: And you mentioned something else, but I forgot what it was. I'll come back.

DEPUTY COMMISSIONER REINHARD: I just want to add, when we were at NJAFA yesterday, which is June Duggin's organization, we met with the Housing Committee as well as the Long-term Care Committee. And there were a lot of suggestions that that committee made that perhaps they can come hear about housing.

ASSEMBLYWOMAN MURPHY: Okay.

DEPUTY COMMISSIONER REINHARD: Just in general. This is the No. 1 need of older adults, housing, and then, how do we get services and housing together in as a creative way as possible? And they had some ideas that I was not aware of that would be very good to hear from.

ASSEMBLYWOMAN MURPHY: Okay, very good.

Other ideas, other thoughts?

Doctor.

DR. HEATH: I had actually forwarded to your office a -- I'm trying to remember the exact title of it, but it was a county -- actually a city, a number of cities that had kind of gathered together resources.

MS. NELSON: We've ordered them.

DR. HEATH: I'm impressed.

MS. NELSON: They will be here by the next meeting.

DR. HEATH: Okay.

MS. NELSON: They weren't here by today and actually Carol--

DR. HEATH: I got a surprise for you then. (laughter)

ASSEMBLYWOMAN MURPHY: No, we have been going in different directions.

DR. HEATH: I'll have a surprise for you.

MS. NELSON: It looked good, we made some phone calls, and they are (indiscernible) for services based on county and area geography, I guess basically. But we ordered two completely different kinds. One on inner city and one on more rural to get a sense of what they are. I talked to Ruth and New Jersey does a-- If we can gain something from when they do it or if--

DR. HEATH: The reason why I found that -- it was in talking so much with providers, colleagues, physicians, but also nurse-practitioners, and physician's assistants, and some of the direct clinicians in an ambulatory care setting. One of the things that had come up was that institutional-based services obviously are very important, and oftentimes, in crisis, older individuals turn to institutions. But the routine, mundane, day-to-day care oftentimes takes place in ambulatory offices. And oftentimes the change in nature of the resources, especially in the face of a lot of competing demands on health-care provisions--

ASSEMBLYWOMAN MURPHY: Right.

DR. HEATH: A lot of physicians feel kind of behind the eight ball. It gets very overwhelming many times.

The proprietary, if I can use that term and not in a derogatory sense, but the proprietary case manager services oftentimes are very good and they link with physicians, and hospital-based systems may have hospital systems' loyalties, but oftentimes provider and hospital loyalty work well. But the opportunity they have, at least in one relatively concise place, a variety of services that kind of complements the one-stop shop with NJ EASE.

ASSEMBLYWOMAN MURPHY: Right.

DR. HEATH: And I thought this might be a resource that would be of interest.

ASSISTANT COMMISSIONER READER: Every area agency on aging has required to do a direct fee of services. So in each county that would be available. Some are more sophisticated than others, some are on the Web as well, but I will try and bring a couple from New Jersey as well to the next session.

ASSEMBLYWOMAN MURPHY: And speaking of on the Web, the nursing home criteria documentation is on the Web now. It's wonderful if you have access to the Internet. I saw it in the paper. I got the copy of the press release, and I went upstairs and tuned the machine on.

DEPUTY COMMISSIONER REINHARD: I'm impressed.

ASSEMBLYWOMAN MURPHY: I was impressed. I'm not usually quite so good. I fumble a lot, but I work at it.

But it was really very interesting to look on it. And to add to that, Peggy has pulled a lot of articles off the Web at different times, so if you find articles and things in there, it's because she is a busy person with great computer capacities at home as well as in the office. And I have received, have

not read yet, but will get for you, this Alliance for Aging research. One of the presenters at two Women and Government conferences I've been to has been someone from the Alliance for Aging research group, which is based in Washington, D.C. Just more information, more to put into the mix of the things that we have.

And I have given you a copy of the mission of the casino revenue funds, which is the annual report for November of 1996. But this kind of tells you where the casino funds started in terms of PAAD and some senior services and things like that. It's an interesting report, and they make recommendations that are not necessarily -- mostly PAAD recommendation that are not necessarily the purview of this committee, but all the money that is going to senior services around the issues of health and longevity, the kind of issues we are looking at. So information, information, information.

MS. GREENBERG: I just would like to say -- and thank you for the compliment, but I am 66.

I just want to say, because I won't be here for the next two meetings, what an honor it is for me to serve with all of you wonderful wise heads and-- You know, this is a new frontier. All of this is so new, and if we don't have committees like this to get into it and to brainstorm, we'll never be able to get out of the big storm of people that are coming our way. I won't be here in the year 2030, not many of us will, but it's committees like this that will be so essential then. It seems to me that the more I attend that more in awe I am of all of the good heads that sit here, and I thank you for asking me. And I just want that to be on the record because I won't see you again probably until April.

ASSEMBLYWOMAN MURPHY: We all feel the same way. It's been wonderful.

MS. GREENBERG: It really has.

ASSEMBLYWOMAN MURPHY: Don't tell Lou you're not going to be here in 2030 because he was counting-- (laughter)

Peggy has just said, if you send articles, things like that, to us that you want shared with the Council, we'll make the copies and we'll bring them the next time we come. Peggy actually makes the copies. We'd be happy to make those available to you.

Again, thank you to our Office of Legislative Services, our wonderful scribe, and to Irene, of course, who is ever faithful.

MS. MICHELSEN: And our next meeting is February 26th.

MR. MUNIZ: The 26th, at 10:00.

ASSEMBLYWOMAN MURPHY: Are we here or--

MR. MUNIZ: I believe so, yes.

ASSEMBLYWOMAN MURPHY: Roberto is the boss on that one. We're having a tour?

MR. MUNIZ: We're having a tour.

DR. HEATH: That's at 10:00.

ASSEMBLYWOMAN MURPHY: At 10:00. We will have a tour of this facility. There will be hospital people here. It will be a look at the other side, if you will. And we have heard from the caregivers and with the personal people at home. We've talked about systems and case management in New Jersey EASE, and now we are going to see two of the best facilities in the state.

MR. MUNIZ: And there will be breakfast next time.

ASSEMBLYWOMAN MURPHY: My goodness.

DEPUTY COMMISSIONER REINHARD: I'm sorry I won't be
here.

ASSEMBLYMAN ROMANO: God willing, I will be here.

(MEETING CONCLUDED)