
Public Hearing

before

NEW JERSEY ADVISORY COUNCIL ON ELDER CARE

“Testimony concerning health care and caregiving for the elderly”

LOCATION: Center for Health and Fitness
Vineland, New Jersey

DATE: December 15, 1998
10:00 a.m.

MEMBERS OF COUNCIL PRESENT:

Assemblywoman Carol J. Murphy, Chair
Senator Robert W. Singer
Assemblyman Samuel D. Thompson
Assemblyman Louis A. Romano
Ruth M. Reader
Theresa L. Edelstein
John Michael Heath
Renee W. Michelsen
Joanne P. Robinson
Bernice B. Shepard



ALSO PRESENT:

Irene M. McCarthy
Office of Legislative Services
Council Aide

Hearing Recorded and Transcribed by
The Office of Legislative Services, Public Information Office,
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TABLE OF CONTENTS

	<u>Page</u>
Assemblyman Nicholas Asselta District 1	1
Paul S. Cooper Chief Executive Officer and President South Jersey Health System, Inc.	2
Ann Hubbard Caregiver	9
Sharon P. Blase Family and Consumer Sciences Educator Rutgers Cooperative Extension of Cumberland County	12
Lester Corson Representing Community Care Program for the Elderly and Disabled	17
Edward C. House Resident Medford Leas Continuing Care Retirement Community	18
Lewis L. Coriell, M.D., Ph.D. Resident Medford Leas Continuing Care Retirement Community Chairman Committee of Health Care Issues	18
Frank Solis Chair State Legislative Committee American Association of Retired Persons	25

TABLE OF CONTENTS (continued)

	<u>Page</u>
Julian Brown Secretary State Legislative Committee American Association of Retired Persons	25
Thomas A. Cavalieri, D.O., F.A.C.P. Chairman The Department of Medicine University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine, and Project Director New Jersey Geriatric Education Center, and Chair New Jersey Commission on Aging	29
Anita Chopra Director Center of Aging The University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine	33
Raymond Gage Member Alzheimer's Association	38
Geraldine Kijowski Caregiver	40
Nina Bobkovf Caregiver, and Social Worker Cumberland Manor	44
Dorothy Cheeks-Wilson Caregiver	47
Loretta Brickman, R.Ph. Pharmacist	50

TABLE OF CONTENTS (continued)

	<u>Page</u>
Margaret Klauder Program Director Cumberland County Adult Medical Day Care Center, and Representing New Jersey Adult Day Services Association	54
Wallace Corneu Caregiver	57
Frank Byrne Director of Public Policy New Jersey Association of Non-Profit Homes for the Aging	58
Dolores Spotafore Private Citizen	62
Alicia Gedhetti Caregiver	63
Luke Fannon Representative Senior Care Centers of America	67
Shantel Williamson Caregiver	68
Lloyd Kellner Caregiver	69
Mario Simone Program Coordinator Senior Citizen Information and Assistance Outreach Program of Cumberland County	72
Misono I. Miller Executive Director Cumberland County Office on Aging & Disabled	75

TABLE OF CONTENTS (continued)

	<u>Page</u>
Patty Small Private Citizen	79
Yvonne Crouch Executive Director Hospice Care of South Jersey	81
Nancy Ivey Nursing Supervisor City of Vineland Department of Health	84
Adeline Eagan Caregiver	89
Gloria Hluszak Caregiver	91
Louise Rolling Caregiver	94
James Rolling Caregiver	95
Ilana Crowther Respite Coordinator Holy Redeemer Visiting Nurses	96
Gussie Little Caregiver	98
Joan Crow Client of Gussie Little	99
Janice Pizzuto Program Coordinator Virtual West Jersey Health System	101
Nancy F. Maliszewski-Curlett Member Alzheimer's Association	103

TABLE OF CONTENTS (continued)

APPENDIX (continued):

Page

Statement submitted by Sharon P. Blase	1x
Statement plus attachment submitted by Edward C. House	5x
Statement submitted by Lewis L. Coriell	14x
Testimony submitted by Julian Brown	18x
Testimony submitted by Thomas A. Cavalieri	20x
Statement submitted by Margaret Klauder	26x
Statement submitted by Misono I. Miller	27x
Statement submitted by Nancy Ivey	29x
Letter addressed to Assemblywoman Carol J. Murphy from Janice Pizzuto	34x

TABLE OF CONTENTS (continued)

APPENDIX (continued):

Page

Letter addressed to The Advisory Council on Elder Care for the Future from Sandie Severt Statewide Respite Care Program Cumberland County	36x
Testimony submitted by Paula J. Ring, R.N., B.S. Executive Director Homemaker-Home Health Aide Service	37x
Letter addressed to Sandie Severt Statewide Respite Care Program Cumberland County from Anthony Olivio	41x
Statement submitted by Patricia B. Giancaterino Caregiver	42x
Testimony submitted by Marcella Freed Caregiver	43x
Statement submitted by Joe Heving	44x
Testimony submitted by Michelle A. Harman Executive Director Alzheimer's Association - South Jersey Chapter	45x

TABLE OF CONTENTS (continued)

APPENDIX (continued):

Page

Testimony submitted by Piper Bicanich Program Coordinator Alzheimer's Association-South Jersey Chapter	50x
Statement submitted by Peter Darpino Caregiver	51x
Letter from Thomas W. Averell	52x
Letter addressed to Rick Greene from Paul L. Talla Caregiver	54x
Letter plus attachment addressed to Kathy Licardo Senior Care of Haddon Heights from John B. Eastlack Caregiver	55x
dmt: 1-51 rs: 51-105	

ASSEMBLYWOMAN CAROL J. MURPHY (Chair): Ladies and gentlemen, if I may have your attention, we are going to begin the hearing. While all the members of the Council are not here at this time, we do anticipate Commissioner Fishman being here. He is opening a program in another part of the state, but he will be here as soon as he can. Susan Reinhard called from the Department of Human Services -- Department of Health and Senior Services. She is in a meeting at the moment, but she will be here, also. And I believe Assemblyman Romano will be here because he is that kind of person, and he did call us a couple of times. He really did. He is coming from the New York City area. His District is right bordering New York, so he has quite a drive ahead of him. He is a very assiduous person. I'm sure that he will be here.

I would like to welcome you. This is the third public hearing that the Advisory Council on Elder Care has held, and we are very pleased to be here in Vineland at the Center for Health and Fitness. And we have been honored this morning. Assemblyman Nick Asselta, who represents this District, had asked if he could welcome us to Vineland. And I am more than thrilled to ask you all please to say good morning to Assemblyman Nicholas Asselta, your Assemblyman. (applause)

ASSEMBLYMAN NICHOLAS ASSELTA: Thank you, Assemblywoman Murphy, and thank you for bringing the Advisory Council down here.

I just want to welcome everyone to the 1st Legislative District in Vineland. And obviously this is something that is very needed for us, for this

Council to get out there and get some outreach going and listen to what you are saying and what your needs are.

I'd like to first introduce and first thank Misono Miller, the Office of Aging in Cumberland County, for all of her work to get this particular meeting together. I'd like to introduce Paul Cooper, CEO and President of South Jersey Hospital System, that in which we are in their building today using their facility.

Paul. (applause)

P A U L S. C O O P E R: I also want to add our welcome. Welcome to South Jersey.

ASSEMBLYWOMAN MURPHY: Thank you.

MR. COOPER: We are pleased you're at the Center for Health and Fitness. This is part of our wellness program that we've had since 1986. So it's been a long time, but your topic here is very important as well. This is really, you know -- affects everything you're talking about. We also have a respite program, for how many years?

UNIDENTIFIED SPEAKER FROM AUDIENCE: Ten.

MR. COOPER: Ten years. This topic you are discussing is very dear to our program.

Welcome, and have a good conference.

ASSEMBLYWOMAN MURPHY: Thank you very much. Thank you very much, Mr. Cooper.

Just a couple of notes as we proceed. This is the last public hearing at which we will be taking testimony from individuals, and then we will, as a Council ourselves, be working on our progress report to be made to the

Governor before or on the 1st of January. Then we will be reconvening for hearing professionals on certain specific issues at the State House as we have hearings on addressing some of the questions we have gathered from hearing all of the public speak to us. We will be continuing to keep people informed as to the progress of the Council. But it is clear to us that we have a lot of work we need to do in order to make sure that we are giving the correct information to the Governor, to the Legislature, and moving forward to direct some programmatic areas so that we can address this need for the constituents of the State of New Jersey. And we appreciate your being here.

We have probably 60-some people who have requested the opportunity to speak to us today. And it's clear that between now and 2:00 we probably won't have time to hear from everybody individually. What we will be doing, however, as we move along, is asking three, four, five of you to get together and decide who will speak to represent all of you. We will accept any written testimony, and it will be read by all of our members. I've got people here who do their homework. But I'm afraid that between now and 2:00, when Commissioner Fishman will be announcing a program for your County right here in this building and all eyes will be on him, that I don't think between now and 2:00 we will have time to perhaps hear every single person individually. So I hope you will allow us that leeway since this is a day in which we are trying to do a great many things.

The first person who will be testifying before this Council today is Assemblyman Nick Asselta.

Nick-- Sorry. Assemblyman.

You may have to turn the mike on. I don't know.

ASSEMBLYMAN ASSELTA: Thank you again, Assemblywoman and Chairwoman Murphy, for bringing this public meeting down here to Cumberland County, and thank all the members for coming. And I know Senator Singer and Senator Robertson and Assemblymen Romano and Thompson will be here shortly.

I just want to begin very briefly because there are so many speakers, and I just want to let you know that there is legislator intent of legislators up here and just allow the public to know that legislators in this particular state have been very supportive of senior issues. This has been evidenced -- we have seen through the legislative intent in which the PAAD Program was restored in the last few months and many other initiatives that have taken place over a long, long period of time.

This Legislature cares about senior issues, cares about veteran's issues, which are interrelated by the way, and cares about young children and their education. And I think that has been the focal point of this Legislature, at least since I've been involved.

A couple of quick brief comments. I was very fortunate enough, my first two years in the General Assembly, to serve on the Commission on Aging and working with people like Ruth Reader and Commissioner Fishman, and has also formed and taken over, since Congressman LoBiondo has moved on, a Senior Advisory Committee. And what that Committee has done over a quarterly basis has brought to me issues, particularly in my District, that seniors have. And I have been able to take those issues and take them to the legislative process and allow people like you to listen to some of those issues. And briefly, I just want to mention a few that are very, very important.

1. Obviously, the PAAD Program is critical to our seniors, and the financial viability of it and probably expansion of it must be looked into. More people need to be on that Program than ever before, particularly in this District. And if you know the situation down in Cumberland and Cape May County, we do have the highest unemployment rate. We do have the needs, and the services must be met, hopefully, in this area.

Other pieces of legislation I just want to make you aware of. Assemblywoman Murphy has sponsored, with myself, an Alzheimer's bill that will create some resources to provide care for Alzheimer's patients as we move forward in the next century. I have seen this disease just wreck havoc with people. I have seen it quickly take people's ability to comprehend and basically render them very, very useless. And it is very, very difficult for me to understand why we can't provide the resources to provide the care to these people. And I will be working very, very hard in this next legislative session to make that happen.

A few other issues I'd just like to bring to this Council's attention would be a prompt-pay bill, that is ready for the Senate to be voted on Thursday, that will provide the resources to hospitals, the medical care that they so sorely need, and for HMOs to pay our hospitals in a 30-day cycle. Hospitals in this area, as Mr. Cooper can attest, have been struggling financially to pay their bills, and HMOs have played a real, real role in making that difficult -- for them to operate. That, in turn, passes those services down to our senior citizens who now can't get some of the services these hospitals offer. That is something the Legislature can act on Thursday, and hopefully they will.

In the future, I see a major program that I think can be enhanced is the meals-on-wheels program. The meals-on-wheels is just such a valuable program when you go out there and you see how these seniors totally are appreciative of meals that are brought to them. I think this program needs to be enhanced, needs to be putting more money into this program, and allow this particular program to operate at the discretion of the counties on a weekday or weekend basis. Right now it is basically relegated to weekdays, and I think counties need the flexibility to offer that particular program on the weekends, and more resources need to be provided to provide that.

I just want to end my testimony by saying that there is no more important issues that we face in the Legislature today than senior issues. We will all be there someday. We need to ensure that in the next century that senior issues, their needs and concerns, are met. It is extremely important to me and, I know, many members on this Council.

And I want to thank you for bringing this Council here this morning, and we are truly appreciative here in Cumberland County for you being here. Thank you once again.

ASSEMBLYWOMAN MURPHY: Thank you, Assemblyman. Thank you for your support and assistance.

I'm going to ask the members of the Council to introduce themselves around the table. We will begin over here with Joanne Robinson.

DR. ROBINSON: Hi, I'm Joanne Robinson. I live in Burlington County, so I'm a southern New Jerseyan. I am an assistant professor of nursing at Rutgers University. I'm here representing the New Jersey State Nurses Association.

MS. GREENBERG: Good morning. I'm Vivian Greenberg. I'm a clinical social worker. I specialize in the stresses and strains of adult children who are caring for their elderly parents. I write about the subject. I've written books, and I lecture. And I am looking forward to your testimony this morning.

Thank you.

ASSEMBLYWOMAN MURPHY: Thank you, Vivian.

MS. EDELSTEIN: Good morning. I'm Theresa Edelstein. I'm the Director of Continuing Care Services at the New Jersey Hospital Association.

ASSEMBLYMAN THOMPSON: Good morning. Assemblyman Sam Thompson, 13th District. That's Middlesex and Monmouth. I am also on the Assembly Health Committee.

ASSEMBLYMAN ROMANO: I'm Assemblyman Lou Romano from the 33rd. That's northeast Hudson County. As I look around here, I don't see that many that came from Hudson County at our previous meeting. In Neptune, everybody there was from Hudson County. (laughter)

By the way, Nick Asselta had mentioned-- He said when we get there we will all be senior citizens. Well, I'm a senior citizen today. (laughter)

Thank you.

ASSEMBLYWOMAN MURPHY: That's why Nick is working-- That's why Lou is working with me -- Lou -- because he and I are both senior citizens -- looking at the graying of America.

I am going to pass out summaries from the Alzheimer's Association of some commentaries over the last meetings.

I'm sorry, Dr. Heath.

DR. HEATH: Good morning. I'm not a senior citizen yet, but I am looking forward to it, I guess. John Heath. I'm a geriatric physician. I help in the Geriatric Training Program within the UMDNJ system.

MS. SHEPARD: Good morning. My name is Bernice Shepard. I am a true southern New Jerseyan now. I live here in Bridgeton. It's good to see everybody here this morning. I'm a private citizen -- old, of course. I'm learning about caregiving because I need a nanny caregiving, something I didn't have before. So I'm having a new experience. And if we live long enough, all of us are going to get there at some point, so you might as well prepare for it now. It's not easy, especially if you're an old independent like me. I want to run the world. I sometimes question God. I mean why are you doing it like this? So I've done that over the years and it's a part of me.

But I am so happy just to be out this morning. You know I had to hold on to every car to get in here. And I'm sorry I've missed the meeting.

I apologize, Chair.

ASSEMBLYWOMAN MURPHY: That's quite all right.

MS. SHEPARD: But I just could not help it.

But I feel good this morning, anyway. And it's good to have you all here, and I'm glad to meet all of-- I see so many people I know, I do feel right at home.

Thank you very much.

ASSEMBLYWOMAN MURPHY: Thank you for being here, Bernice. We appreciate it. (applause)

ASSISTANT COMMISSIONER READER: Good morning. I'm Ruth Reader, Assistant Commissioner of Department of Health and Senior Services, Division of Senior Affairs.

MS. MICHELSEN: Hello, I'm Renee Michelsen. I'm a social worker. I'm a Manager of Senior Services for Atlantic Health System Hospitals in Union, County of Passaic, Essex, and Morris. I am also the representative of Morris County Senior Service Providers Group as the Chairperson of that group representing agencies serving the aging in Morris County.

ASSEMBLYWOMAN MURPHY: Thank you very much, Renee.

The next person who-- Oh, the speakers will be given five minutes, and I will be setting the timer. So if you hear a little beep or I kind of wave, please understand that I am giving you the signal that we are running out of that time.

Myrtle Pedrick will be represented by her daughter Ann Hubbard, I believe. And is Ann Hubbard here today?

Ann, would you like to come forward and testify?

Thank you very much, Ann. If you would like to begin.

A N N H U B B A R D: Yes.

This has been really great for us, my husband and I, because we were always taking care of my mom by ourselves. And then someone told us about this home health care, so I looked into it. And there is a lady with my mother right now. If there wasn't, I wouldn't be able to be here today because my husband went to Cow Town. He likes the flea markets.

And they are very good, the home health aides. They come, they give her a bath. I have them five days during the week. On the weekends, my husband and I have full care of her. We change her diapers, wash her. She has little things on her feet where she is always kicking, like a blood blister. Then the doctor has to come and take care of that and put bandages on. On the weekend, I have full care of her feet, and you have to use saline solution to, you know, keep it clean and to help heal it.

And, well, just without this program, you know, we wouldn't be able to go anyplace together, my husband and I. I'm 66, he's 75. My mother is 91, and I won't put her in a nursing home because I don't think nursing homes give them that good of care. Some of them may, others may not. But at home she is always clean, her diapers are changed, she gets fed. It takes sometimes 45 minutes just to feed her. In nursing homes they don't do that. If they get fed they are lucky. They'll say, "Well, do the best you can, Mrs. Pedrick." Well, the best she can is nothing because she can't feed herself. Her hands just can't come up and feed herself.

And I guess that's about all I have to say.

ASSEMBLYMAN ROMANO: Madam Chair, if I might add.

ASSEMBLYWOMAN MURPHY: Yes.

ASSEMBLYMAN ROMANO: Which program? You said without this program. What are we talking about now?

MS. HUBBARD: Home health aides.

MS. MICHELSEN: Do you get it through a particular program like CCPED or--

MS. HUBBARD: Through Millville, in Millville.

MS. MICHELSEN: What agency do you get it from?

MS. HUBBARD: Cindy Chapman is in charge of it.

MS. MICHELSEN: From the Medicaid Waiver Program.

MS. HUBBARD: Yes, okay.

MS. MICHELSEN: From the Medicaid Waiver Program.

MS. HUBBARD: Okay.

ASSEMBLYWOMAN MURPHY: Okay.

ASSEMBLYMAN ROMANO: And what does your mother have?

I mean the way you spoke--

MS. HUBBARD: Alzheimer's.

ASSEMBLYMAN ROMANO: Alzheimer's, okay.

MS. HUBBARD: Yes.

ASSEMBLYWOMAN MURPHY: Thank you very much for coming this morning, Ms. Hubbard. We appreciate your taking the time and all of your caring.

Bella Figarsky, a senior who is accompanied by her daughter, Selma Galligar, and a case manager, Cindy Chapman.

UNIDENTIFIED SPEAKER FROM AUDIENCE: We are having trouble with this microphone.

ASSEMBLYWOMAN MURPHY: Is it on?

UNIDENTIFIED SPEAKER FROM AUDIENCE: Yes, it's on, but I think if people speak directly into it. If they try, we'll do better.

ASSEMBLYWOMAN MURPHY: Bella Figarsky. (no response)
Bella is not here.

UNIDENTIFIED SPEAKER FROM AUDIENCE: No, she was unable to make it.

ASSEMBLYWOMAN MURPHY: Okay, thank you very much.

Craig Johnston, caregiver. Craig Johnston. (no response)

Sandra Stimson. Sandra is the Director of the Summit Ridge Nursing Home, West Orange, an Alzheimer's facility. (no response)

Ilana Crowther, Respite Coordinator from Atlantic County. (no response)

My goodness. Frank Byrne, New Jersey Association of Non-Profit Homes for the Aging. (no response)

Sharon Blase, family and consumer science educator, Rutgers Extension, Cumberland County.

Thanks, Sharon. I'm glad you are here. I was beginning to feel kind of funny.

SHARON P. BLASE: My name is Sharon Blase, and I am employed as a family and consumer science educator with Rutgers Cooperative Extension here in Cumberland County. As an educator with Rutgers Cooperative Extension, I have developed and also conducted training classes for seniors, caregivers of the frail elderly, and home-maker health aides providing care for the frail elderly. My extension classes have focused on caregiving issues faced by caregivers including long-term care and home care decisions, financial management for retirement, living wills, and financial management strategies for caregivers, and also nutrition and food safety education for seniors.

I'd like to share with the New Jersey Advisory Council on Elder Care some issues and concerns that seniors and caregivers have shared with me

on things that they are concerned about presently and also in the future. They are concerned about an adequate supply of qualified home care services which they can afford within their present and future income. Currently, some caregivers are paying \$12 per hour for a companion to provide respite care for a family member and \$15 to \$20 an hour for a homemaker-health aide to provide basic care for their family member. These home care services are not covered by the family member's health insurance program, and they do not qualify for Medicaid coverage. These costs will continue to rise in the future, and they are concerned about how they will afford these costs with their present financial assets.

They are concerned about finding home care workers who they feel they can intrust with the care of their parent and/or spouse in their own homes. Many are faced with the problem of adjusting to different home care workers caring for their parent and/or spouse due to agency scheduling of workers. Caregivers are also faced with the problem of orienting home care workers to their parent and/or spouse's needs, and they have to take time off from work to coordinate these home care services.

Second, they are concerned about being able to provide care for their parents and spouses requiring nursing home services. Currently, some caregivers are paying \$175 or more per day for a semiprivate room in a nursing home. Caregivers are exhausting the financial assets of their parents and spouses to pay for this care, which is not covered by their health insurance plans. Nursing home costs continue to rise, and many caregivers and seniors will be unable to obtain this care unless they spend down their assets and qualify for Medicaid. Caregivers and seniors are concerned that no ceiling

exists now in New Jersey to limit the daily cost of nursing home care at this time. In the future, the cost for nursing home care will escalate dramatically in New Jersey and also across our country.

They are concerned that a senior citizen on Medicaid can only keep \$35 a month from their Social Security check for personal needs. This places an economic burden on the caregiver who attempts to provide for the expenses that exceed this amount that is now permitted by Medicaid and Social Security. This amount needs adjustment as costs in the marketplace rise for the caregiver and seniors.

Caregivers who are now part of the sandwich generation are attempting to provide care for their parents in their parents' home or in their own at considerable emotional and financial expense on their families and households. The typical caregiver today is a woman working outside the home caring for her own family, in addition to caring for a frail parent or their own spouse. Some women and men beyond retirement years are continuing to hold full- and part-time jobs to meet the expenses of caregiving.

These caregiver pressures are intensified in households consisting of only one parent, which is common today. The current situation of both parents working outside the home will only increase in the future, thus, placing additional demands on those who will have caregiver responsibilities in addition to full employment.

If an individual is forced to give up their employment to assume caregiver responsibilities on a full-time basis, they will find it difficult to earn a pension or save for their own retirement. Family leave for caregiving responsibilities is a luxury that few workers can afford today because they need

their income and benefits to live on while they are caregiving. Statistics reveal that family leave is a benefit used by only a few today because of the impact it has on the caregiver's income.

Insurance for long-term care is available, but only if you have the income to pay for this type of insurance. Caregivers and seniors are concerned that if they purchase long-term care insurance, it will not meet the cost of home care and nursing home care in the future. Few caregivers have the opportunity to participate today in long-term care insurance programs that are provided by their employers. In the future, the inclusion of long-term care insurance in employer's benefit packages will be an important consideration to meet the cost of home care and nursing home care.

I will provide the rest of my information to you in the written form, but I would like to thank the Council for the opportunity to share with you some concerns of residents of Cumberland County concerning caregiving.

ASSEMBLYMAN THOMPSON: Would you repeat for me the topics that you cover in your training programs that you present?

MS. BLASE: The topics that I cover in my training programs deal with financial management for retirement planning, also for caregiver training. And we have focused on a special program that deals with financial management strategies for caregivers, which helps them in handling the record-keeping aspects that is necessary when you are handling the finances of your parent or your spouse.

ASSEMBLYMAN THOMPSON: Do you cover all of these topics in one evening, or do you have different courses, etc.?

MS. BLASE: These programs are offered over a period of time. Also, if I was able to share more information that I have, you know, regarding this-- We have done programs in cooperation with the area Office on Aging and other agencies here within Cumberland County. And I believe this is an important need in the future.

ASSEMBLYMAN THOMPSON: One of the things that have frequently come out in the hearings we've had is that caregivers do need more training, more information, and so on. So I was particularly interested in what you're doing here and how do you get the word out about your training program and what kind of response do you get in terms of--

ASSEMBLYWOMAN MURPHY: And, Sharon, if you have written information on all of that, we would be happy to have it and invite you to come to one of the professional hearings that we have in the State House so we can question you at length.

We have 60-some people today, Sam.

ASSEMBLYMAN THOMPSON: Okay.

ASSEMBLYWOMAN MURPHY: So if you don't mind, we will take and read what we have and then ask you to -- invite you to come again.

MS. BLASE: I would be happy to share with you-- And basically, our information is shared through the media of Cumberland County and newspapers and also in networking with agencies. So I thank you very much for your questions.

ASSEMBLYWOMAN MURPHY: Yes, we are very interested because many of the things you are discussing -- Sam is correct -- have been identified as needs. Have you submitted the testimony?

MS. BLASE: I will give it to them.

ASSEMBLYWOMAN MURPHY: There is a folder right there, a bin I guess you could call it -- small basket on the end of the table.

We have been joined by Senator Singer.

Senator, would you like to introduce yourself and say--

SENATOR SINGER: Good morning. I'm Senator Bob Singer. I'm from Ocean, Monmouth, and Burlington counties. I'm the Assistant Majority Leader of the State Senate, and I sit on both the Health Committee and the Regulator Professions Committee. And I thank you for inviting me down here today.

ASSEMBLYWOMAN MURPHY: We're delighted you're here, Senator.

When I asked for Lester Corson, apparently he did not hear me call him forward.

Lester, would you like to testify now?

LESTER CORSON: Yes, I'm here to represent CCPED.

If it wasn't for this kind of help I'd be bed bound. I'm paralyzed from the neck down. I had a broken neck. I also have poliomyelitis syndrome. And if it wasn't for the health caregiving outside like it is, I'd be stuck in a nursing home now. I wouldn't be here, and if it wasn't for my girl here today -- this is my girl Friday. She dresses me, cleans me, and gets me out of bed. I have to have a lift to get me out of bed and into my motorized chair. I've had a little independence that way, but she follows me around. Wherever I go she is right there. And if it wasn't for the support of this type of State health, it would be impossible for people like me to be out of a nursing home where

the care is not as great and it costs more to keep somebody in a nursing home than if I had a personal attendant keeping me at home.

And my wife has Parkinson's disease. She can't take care of me right and my son works all the time, so he can't take of me. So by this I can stay home and keep the family together. And I appreciate all your help that you do, and I hope you continue this help and not stop it.

ASSEMBLYWOMAN MURPHY: We're delighted that you took the time and the energy to come here this morning and speak to us, Mr. Corson. It's very important, and we're very grateful that you have come here. And to your wonderful aide and to your wife who came with you also, thank you, again.

Thank you.

Elga Mitowski. Elga Mitowski. (no response)

William Sweeten. William Sweeten. (no response)

Sissy and Mike Weiss. Sissy and Mike Weiss. (no response)

Edward House.

EDWARD C. HOUSE: With Dr. Coriell.

ASSEMBLYWOMAN MURPHY: With Dr. Lewis Coriell, please.

Thank you.

LEWIS L. CORIELL, M.D., Ph.D.: I'm Dr. Lewis Coriell. I am a resident of Medford Leas, one of the nation's leading Continuing Care Retirement Communities, or CCRCs, located in Medford, New Jersey. I want to thank Len Fishman and Carol Murphy and all of you people for getting together this advisory panel. It's very important.

The mission of Medford Leas is to provide a retirement community for aging adults that include long-term comprehensive care, with attention to their emerging needs and their social, intellectual, and cultural enrichment. The goal, which continues to be achieved, is to provide a homelike atmosphere among friends and employees who are genuinely concerned about the welfare of each patient.

Medford Leas' philosophy of health care, which is reflected in the positive, caring attitude of the staff, states in part, and I quote from the mission: "Individuals are entitled to live their lives at the highest level of dignity, independence, and quality possible as they have the right to make their own choices and decisions regarding health care. Nursing care will be held to the highest standards, maintaining optimum physical status, even if the patient is bedridden for a long time. If a resident becomes terminally ill, Medford Leas will provide palliative, supportive care according to the patient's wishes, administering to the spiritual and emotional needs, as well as the physical."

I have attached a descriptive page about Medford Leas to this; however, let me describe briefly how our managed care system functions in practice by describing my own experience. I have lived independently in my spacious, fully equipped town house in Medford Campus for eight years, free of the responsibilities of home and grounds maintenance but protected for the rest of my life by extensive contract for health care and nursing services should they become necessary.

My unit is one of about 400 existing partial- and full-service units. An additional 110 units are currently under construction at our place. I have

the option of managing my own meal preparation, transportation, and housing or having such provided through Medford Leas at a nominal additional charge. Other medical-care system focuses on preventive medicine, maintaining wellness, and optimum treatment of established health problems. A full-time physician and geriatric nurse-practitioner serve as my primary caregivers, making decisions about appropriate diagnostic studies, medications, and treatment.

If I become ill or need nursing care to recover from surgery, I will move temporarily to one of the 67 beds in the nursing unit on Medford Campus, returning to my town house when fully recovered. If I wish, I can move to a smaller full-service unit where more services are provided. If I need assistance with daily activities, a companion, provided through Medford Leas, will assist me in my home. If my need for assistance increases, I will move to one of the 61 assisted-living units located on Medford Leas Campus. If I need long-term nursing care, I will be transferred permanently to one of the 67 nursing beds.

I suggest that you consider the implications of the three Medford Leas success stories in your deliberations.

1. A recent review of managed care information for New Jersey found that Medford Leas residents required only one-half the average annual hospital days verses comparable facilities in New Jersey. There are three contributing factors to this: first, need for hospitalization being precluded during early detection and treatment resulting from medical care knowing the residents' needs through frequent contact; two, having more surgery recovery

services, such as IV care, available on the site; and three, refusing to hospitalize a patient merely to qualify for Medicare reimbursement.

2. An enhanced degree of wellness is maintained through extensive exercise and general fitness programs. Regular outdoor activities will offset the tendency for seniors to suffer vitamin D deficiency, muscle deterioration, general apathy, and depression where adequate outdoor facilities are not available. A daily two-mile walk can cut the mortality rates in half for men over 60.

Medford Leas successfully provides a respectful, integrated, holistic continuum of health care for residents from the time they join the community through the rest of their life.

I am Chairman of our Committee of Health Care Issues, one of some eighty volunteer resident committees which bring health, financial, social, musical, political, educational, environmental, historical, and other issues and programs to our residents. These are all volunteer people who have experience in this. It has been meeting for 14 months, that is, our Committee, and was organized as a result of the growing concern of many residents at the lack of substantive action by the administration and Congress in dealing with our country's deteriorating health-care delivery system. Mr. Ed House is on our Committee, and he will summarize our current findings in regard to the delivery of health care in Washington, D.C.

ASSEMBLYWOMAN MURPHY: Mr. House, you are going to have to move along because he leaned on one of your minutes there.

MR. HOUSE: Okay. I'll try to move along. I have my testimony -- prepared testimony. I'll try to read quickly and summarize, perhaps, as we go along.

My name is Edward C. House, and I became a resident of Medford Leas earlier this year. As Dr. Coriell indicated, many of our residents, and I among them, are growing quite concerned about our country's ailing health-care system in general. And our Committee has drafted an opinion piece, a copy of which I have attached for your future review if you wish, to underscore the need to develop a comprehensive cure for the country's sick health-care system overall. Of course, that includes the implications and interface with all of the states and our state in particular.

While our piece focuses on the Federal level, I think there are four basic principles that I would like to underscore and point out and comment on here today, briefly, that apply to the state as well and need to be incorporated into any long-term strategy that has developed relative to health-care reform. The four are:

first, equal access. All Americans should have access to essential, high-quality health care at an affordable price;

second, quality health care. Health-care reform should focus on assuring the delivery of high-quality, cost-effective health care with adequate consumer protection;

third, system integration. Our complex, archaic health-care delivery system must be simplified and integrated;

fourth, control of for-profit managed care. A way must be found to control the chaos that currently exists from our having entrusted health-care delivery to for-profit managed care organizations.

Let me expand briefly on these four points, recognizing the time limitation and certainly the fact that any one of these provides enough challenges and complexities to fill a paper, if not a book.

First, with respect to equal access. We believe it to be a fundamental right that every citizen of our country have access to essential, high-quality health care at an affordable price. Use of the word essential conveys the need to determine what should separate essential health care covered by insurance from what I can call luxury health care, which should be paid personally. Ours is the only major country in the Free World that has yet to provide some form of universal health care for its citizens. Millions of our New Jersey residents continue to have inadequate access to health care. They are included in the 40 million-plus Americans who have no health-care insurance. We must find a way to address this.

Second, quality health care. Access and price dominate the health-care debate. Few talk about quality. In a 1998 presidential task force, it was reported that the main impediment to health-care quality is not managed care's denial of care, but rather good old-fashioned mistakes by doctors and hospitals. The prestigious Institute of Medicine recently noted in the *Journal of the American Medical Association* that there are no real exemplary models.

Let me go on recognizing the time is very close.

ASSEMBLYWOMAN MURPHY: Yes. Since it just rang, yes, it sure is. (laughter)

MR. HOUSE: Can I have just a couple of minutes?

ASSEMBLYWOMAN MURPHY: You can have one more minute.

MR. HOUSE: Okay, let me do it very quickly.

I would like to commend that Department's nationally recognized leadership role with regard to quality, as reflected in the Consumer Bill of Rights and the HMO report card system, where consumers have information to compare services provided. I encourage you to expand and enhance these efforts, including implementation of appropriate quality assurance measures. The oversight that is provided by the Department should include regular tests for the consumer's perspective of the services being provided to confirm that the intended processes and information are flowing smoothly. Some find it hard to believe that high quality is cost effective. However, it is, as I can attest after 20 years of quality management consulting experience that it can be. The key point is that high quality results when a knowledgeable person does it right the first time.

System integration I think is the other point. And the fourth is the control for, for-profit managed care. I think I would only add just one final comment, and the full text is here available for your review. Just one point, besides thank you, would be to suggest that you use as a benchmark in judging the kinds of recommendations and proposals that go into your report and judge them against the one benchmark of Will this step we're considering move us closer to the goal of providing every citizen in our state with access to essential high-quality, cost-effective health care at an affordable price?

I'd be glad to answer questions or provide assistance.

Again thank you very much for your efforts that are very profound.

ASSEMBLYWOMAN MURPHY: Thank you very much.

SENATOR SINGER: Madam Chair, just a couple of brief question to the gentlemen.

First of all, is there an entrance fee or is there no entrance fee to get into Medford Leas?

MR. HOUSE: Yes, there is a substantial entrance fee to get in.

SENATOR SINGER: It's approximately what?

MR. HOUSE: The range is, let's say, depending on the size of the facility -- ranges from, let's say, roughly in the \$30,000 or \$40,000 range up to over \$200,000.

SENATOR SINGER: Right. And what is the monthly, what is the monthly maintenance?

MR. HOUSE: The monthly again varies per individual. In the partial care facility, it's about \$2000 per -- for a couple, or half of that for an individual. In the book here it's a little more than that.

SENATOR SINGER: Thank you.

ASSEMBLYWOMAN MURPHY: Thank you very much.

MR. HOUSE: Thank you for the opportunity.

ASSEMBLYWOMAN MURPHY: Thank you for being here, too.

Frank Solis, AARP State Legislative Committee Chair. Frank.

FRANK SOLIS: (speaking from audience) Thank you, Madam Chair. The presentation will be made by our Secretary, Julian Brown.

ASSEMBLYWOMAN MURPHY: Thank you.

Julian.

JULIAN BROWN: Thank you.

I am the Secretary of the New Jersey State Legislative Committee of the AARP. We have one and a half million members in New Jersey, and each and everyone is concerned with elder care and managed care. We applaud the promulgation of HMO regulations and urge that these strong regulations be extended to all forms of managed care. The recent Health Care Quality Act provides additional protections that have been sought. The recent release of a managed care report card on providers is a step in the right direction to help consumers make better choices. The recent release by the Commissioner of Health on the performance of hospitals that deliver cardiac surgery services is another step in the proper direction.

The AARP State Legislative Committee supports the State in its role of appropriately regulating the total health-care delivery system. However, we would like to point out that the quickest way to wilt laurels is by sitting on them. Thus, we are happy to see the Elder Care Advisory committee (*sic*) seeking more and more improvements in our health-care system.

The continuum of health-care delivery for the elderly in the state includes family practitioners, specialists, hospitals, rehab centers, adult day care, home health care, visiting nurses services, assisted living, and nursing homes. We support the State and, in particular, the Commissioner of Health and Senior Services in their role of policing the health-care delivery system and of protecting the elderly.

One area requiring more attention is assisted living. The trend toward assisted-living facilities is limited by cost and level of care available in

the facilities. One must have the financial resources and also have a level of self-sufficiency. Perhaps increasing the level of care would ease the load on other elements of the continuum and make subsidization feasible.

The more seriously ill require a different level of care such as nursing homes, long-term care, home health care, or visiting nurses. Both the Federal and State governments are reducing reimbursement in these areas. These areas should be closely monitored and audited to make certain the financial reductions are accommodated by increases and efficiencies and not by unacceptable lowering of quality of service.

There should be a higher degree of coordination between the Health and Insurance Departments. If such interaction were available, the HIP debacle could have been avoided. Employers should be encouraged to take advantage of existing State tax incentives to include elder care as part of their employees benefit plan. Consideration should be given to strengthening regulations governing alternate family care. There is a viable alternative for aging within one's community while preserving independence and assets.

The AARP State Legislative Committee urges the Legislature to:

1. Establish a permanent funding source for charity care.

Apply all savings from the application of Medicaid managed care to programs for the uninsured.

Use proceeds from the tobacco settlement to restore cuts made by the Federal and State governments.

Provide protection to health-care programs by ensuring that in mergers or acquisitions, the financial reserves of nonprofit tax-exempt health-care providers and insurers are applied to maintain or improve the health-care

delivery system and not be absorbed by for-profit corporations. This is covered by bill S-466 and A-652, which should be approved in the Senate without delay and sent to the Governor.

We thank you for the opportunity to speak on behalf of the State Legislative Committee to be heard in this very important effort.

Thank you very much.

ASSEMBLYWOMAN MURPHY: We appreciate you being here very much, Julian. Very well said.

SENATOR SINGER: Madam Chair, just if I might say a few brief comments.

First of all, we look forward to someone telling us what the permanent funding source should be for charity care. We haven't found it yet. (laughter)

Secondly, both Senator Robertson and myself, I think I believe on this Thursday, will be introducing legislation that will require that in assisted-living facilities at least 10 percent be Medicaid eligible in all new facilities being built and any expansion of existing facilities would have to meet that same requirement. As you know, right now, nursing homes require 65 percent Medicaid. We are going to look at the earmark of 10 percent. I am hoping my colleagues here might consider doing that on the Assembly side to do that. We took the 10 percent level because we don't want to discourage building of new facilities. We want to implore them to understand there is a need for Medicaid-eligible people to go into assisted living. So I hope you are going to look at that piece of legislation.

Lastly, I wish that bill would pass a little sooner because, as you know, with Allegheny going bankrupt, the first for-profit acquisition of a hospital, Rancokis (phonetic spelling), fell by the wayside. So as you know right now there are no for-profit hospitals in the state.

One last comment that I hope you take a look at. One of the reasons why managed care Medicare is failing in the state, and you know many providers are pulling out, is unfortunately only the truly ill seniors are buying into that, which means their dollars and cents are costing them because the well seniors are not. Secondly, seniors unfortunately are using the \$1000 maximum for prescriptions and, once that is used up, making that switch, because they are able to switch as much as they want.

So I think we have to take a look at the problematic things we've created by it. Why many companies are pulling out of the Medicare market for managed care and again have not been successful in it because a lot of the stumbling blocks. As a matter of fact, I'm getting calls in my office continually why AARP is not signing more people up for their insurance plan in the state.

Thank you.

MR. BROWN: Thank you.

ASSEMBLYWOMAN MURPHY: Thanks very much for being here.

Elizabeth Morgan, AFC Program Coordinator. Elizabeth Morgan.

Dr. Thomas Cavalieri.

Thank you very much.

THOMAS A. CAVALIERI, D.O., F.A.C.P.: Hi, how are you?

ASSEMBLYWOMAN MURPHY: Fine, thank you.

DR. CAVALIERI: Assemblywoman Murphy and distinguished members of the Advisory Council on Elder Care: I thank you for the opportunity to testify before you today. I am a geriatrician and academician with The University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine, and the Director of the New Jersey Geriatric Education Center.

My purpose today is to speak to you about the need to support geriatric education and training not only of physicians, but health-care and human service professionals and paraprofessionals, community servants, and those individuals who are gatekeepers who come in contact with the elderly every day and often are the first to notice a problem, and lastly, training of caregivers themselves, many of whom are thrust into the caregiving role without any preparation for its demands, stresses, or even the skills required.

It has been well documented that there is a significant shortage of trained health-care professionals to care for our growing elderly population. The Department of Health and Human Services, in its national agenda for geriatric education, documented that no single health profession has an adequate number of providers with the requisite education and training to care for the older population.

In a 1996 report of the Alliance for Aging Research, it was reported that the U.S. has one-third the needed number of primary physicians with geriatric training and less than one-fourth the number of academic faculty to train present and future doctors on the principle of geriatrics. It is estimated that by the year 2030, more than 36,000 physicians with geriatric training will be needed to care for the more than 65 million older Americans.

Despite these articulated needs, money for graduate medical education is in serious jeopardy in the current health system. Our capacity to deliver training and education is limited by lack of funding to support geriatric fellowship positions, which prevent our ability to train much needed geriatricians to care for the elderly.

The newly evolving health-care system requires that the workforce of professionals and paraprofessionals, who come from multiple disciplines, possess the skills and knowledge needed to properly care for our elderly as they grow older and sicker, choosing to age in place, while maintaining their sense of dignity and self-esteem. New Jersey EASE, a model and potentially groundbreaking initiative, which has been created to help the elderly and their caregivers navigate the complexities of the health-care delivery system, must be supported by ongoing education and training of community-based agency personnel.

In acknowledgment of the need for training and education about how best to care for our growing elderly population, I would like to propose the following for your consideration:

1. Support the efforts of the New Jersey Geriatric Education Center in training health-care professionals of multiple disciplines through an annualized State budgetary appropriation. The New Jersey Geriatric Education Center, one of more than forty-three programs nationwide initiated through Federal funding from the Department of Health and Human Services, has a proven track record in providing education and training in gerontology for health-care professionals of multiple disciplines in order to enhance the care provided to older Americans.

This program grew out of an unidentified need to address the national workforce crisis and prepare health-care professionals to better care for the rapidly growing elderly population. The Federal intent has been for the states to eventually assume financial support of the Geriatric Education Centers. During its eight years of operation, the New Jersey Geriatric Education Center has provided training on geriatrics and gerontology to more than 7500 health-care professionals across the state through a variety of sponsored educational programs.

Our current Geriatric Education Center represents a unique collaboration of the six schools of UMD, Rutgers University School of Social Work, and the Department of Health and Senior Services. Its focus is on fulfilling two major training needs identified by the Department of Health and Senior Services: health promotion, where we deliver training on a county basis, and care management, where we support the efforts of New Jersey EASE.

Based on its history, the New Jersey Geriatric Education Center has proved to be a successful and well-respected model for educating health-care professionals of multiple disciplines. The future financial support from a Federal perspective is uncertain, and it is our hope that consideration will be given to support the New Jersey Geriatric Education Center.

Let me end by making a few other final suggestions: second, consideration should be to fund a geriatric medical fellowship at each of the three UMDNJ medical schools to assure continued training of geriatricians to care for New Jersey's elderly; third would be support the creation of an endowed professorship at each of the UMDNJ medical schools to assure that geriatrics is well represented, once again to train geriatricians statewide; fourth

would be support the development and continuation of special training programs for family caregivers who are responsible for providing hands-on care for their loved ones.

In closing, I cannot emphasize enough the importance of training and education as a most cost-effective means of meeting the challenges of caring for the elderly population across the service continuum and within the true interdisciplinary context. It is only through continued education and training that quality and successful outcomes can be achieved so that the elderly can receive the care they deserve by those who often are the best and most eager caregivers but least prepared to respond to the needs of their aged family members.

Thank you very much.

ASSEMBLYWOMAN MURPHY: Thank you very much, Dr. Cavalieri, and I do hope that your testimony is in writing for us.

DR. CAVALIERI: Yes.

ASSEMBLYWOMAN MURPHY: Thank you very much. We appreciate that.

Lorraine Miano, AFC Unit Manager, discussing respite for caregivers. (no response)

Anita Chopra, C-H-O-P-R-A. Anita.

Thank you very much.

ANITA CHOPRA: Madam Chairperson and distinguished members of the Council, my name is Anita Chopra. I'm a geriatrician, a physician specializing in caring for the elderly, and associate professor of clinical

medicine at UMDNJ-School of Osteopathic Medicine, where I serve as the Director of Center for Aging.

The Center for Aging is multidisciplinary, multidepartmental center of excellence in clinical services, education, and research. It's comprised of more than 35 staff -- including 14 geriatricians, three geriatric psychiatrists, two neurologists, three nurse-practitioners, and a social worker -- working as a team of clinicians to provide primary care and consultative services to the elderly individuals, many of whom are frail and have complex medical problems.

Our services span a continuum ranging from ambulatory programs, which offer comprehensive geriatric assessment and dementia of (undiscernible), to acute care services in three hospitals in long-term care setting where we provide care in subacute units, nursing homes, adult medical day care centers, assisted-living facilities, and continuing care retirement communities.

I'm here today to talk to you about the problems that the elderly and caregivers face in the current health-care system and make recommendations about what we can do in New Jersey to improve access, continuity, and quality of care.

In my role as a clinician, educator, and administrator, I have been both privileged and challenged to provide care to growing numbers of elderly who come to the Center for Aging for evaluation and treatment, many of whom are at risk. As a geriatrician, I have committed myself to caring for older individuals, and for more than 14 years, I have provided care to patients in ambulatory, home care, hospital, and long-term care settings.

I am familiar with the problems of older Americans, many of whom have multiple chronic illnesses, use four or more medications, have limited financial resources, and may be lacking formal, as well as informal, supports. Many are unfamiliar with community resources and do not know where to turn for assistance. Their lives are complicated by medication regimes, seeking transportation to medical appointments, and making choices due to functional and financial limitations.

As a physician, I see individuals seeking to maintain their independence despite diminishing functional and cognitive levels. I see families and caregivers under stress due to daily challenges of providing care for someone at home. Many times physicians unfamiliar with the needs of the elderly focus on medical diagnosis of the patient, failing to address their functional status and caregiver stress.

I see choices people are forced to make. A choice between buying food or purchasing needed medication. A choice between remaining at home or placement in an institution because there is no one to help. I see the older individual who has switched from traditional Medicare to managed care and therefore cannot access the specialist services he or she needs, or who now has to travel to the next town instead of going next door to get lab work done.

My heart goes out for those elderly individuals who are depressed or have behavior problems as a result of their dementia but cannot access needed mental health services because they are unavailable or, more frequently, not covered by their health insurance.

As a physician, I experience the daily challenge of providing comprehensive care yet feel that I cannot spend enough time with my patients.

As a geriatrician, I see the all-important link between the medical, psychosocial, and community-based interventions needed to preserve the older individual's function and independence. I know intuitively and programmatically that care management is the key to negotiating the system and instituting early intervention measures to prevent complications and contain costs.

None of us can deny that reform of our health-care system should be a priority. Demographics alone dictate the changes for the new millennium. All we'll be is one of the most advanced nations in the world. We have failed to address the chronic care needs of our elderly and disabled population. Somehow we must come to realize that nonskilled or custodial care, which if provided in the home, can reduce caregivers' stress, allay costly institutionalization, and in the long term, attain cost savings if coupled with care management. In March 1999, the President's bipartisan Commission on Medical Reform voted these as its recommendations.

The hope is that the Commission will map out a preliminary direction for health-care reform. Those of us who are health-care providers realize that many of the changes needed in our health-care system must be dictated by Federal mandate.

However, on a State level we are in a position to initiate significant changes that can serve as an example to others. New Jersey has already undertaken major steps that can provide the foundation of health-care reform. The consolidation of New Jersey Department of Health and Senior Services in 1996 was the first step in positioning us to move ahead in restructuring our system of care and reducing fragmentation and duplication. The initiation of New Jersey EASE, Easy Access, Single Entry, and anticipated to be on-line in

all 21 counties, will permit us to assess and identify needs of elderly individuals and develop a plan of care to fulfill those needs.

Through alternatives to institutionalization, such as assisted living, alternate family care, adult medical day care, and Statewide Respite Program, New Jersey has sought to support its elderly in the least-restricted alternative while preserving dignity, choice, and self-esteem. These values are to be applauded. In consideration of health and long-term care framework, which has already been put in place in New Jersey, I am making four recommendations.

First, provide funding to support care management for high-risk elderly through partnership between New Jersey EASE care managers and regional geriatrics centers, which offer team approach to comprehensive evaluation and management of older individuals. Partnership and care has become increasingly important in providing quality care. Communication between New Jersey EASE community-based care managers and teams of geriatricians, geriatric psychiatrists, nurse-practitioners, and social workers, which provide comprehensive geriatric evaluation, is the key to successful care management of elderly individuals who are at risk for institutionalization.

ASSEMBLYWOMAN MURPHY: If I can ask you just to capsule just those four, we have been--

MS. CHOPRA: Okay. I'll just take one minute.

ASSEMBLYWOMAN MURPHY: Just one statement on each of them, please.

DR. CHOPRA: It's imperative that health-care professionals working with compromised elderly have the appropriate knowledge, training,

and time to perform a comprehensive assessment and evaluation. The type of care management linkage with New Jersey EASE assures continuity between medical assessment and community-based care management.

My next recommendation is expand access to assisted living for individuals on limited incomes by requiring a percentage of Medicaid residents for facility.

ASSEMBLYWOMAN MURPHY: Thank you.

DR. CHOPRA: Third, I encourage linkages between assisted-living facilities, assisted-living programs, and academic centers in geriatric care to insure health promotion, disease prevention, and quality of care as elderly individuals age in place.

Fourth, increase funding for adult medical day care and respite care services to ease caregiver burden and encourage caregiving at home.

I appreciate this opportunity to have testified on elder care issues today. I leave you with the thought that there is no easy solutions to our health-care crisis. Health-care reform and preparing for long-term care needs of growing numbers of elderly in the new millennium is a complex and costly proposition. New Jersey is in a unique position through New Jersey EASE, its new alternative to newest institutionalization, and a network of strong geriatric centers to forge new linkages and to emerge as a leader in health-care reform. Let's not miss the opportunity to set an example for our nation.

ASSEMBLYWOMAN MURPHY: Thank you very much.

DR. CHOPRA: Thank you.

ASSEMBLYWOMAN MURPHY: Ray Gage, Respite Coordinator, Alzheimer's Association.

Doctor, is that testimony in writing for us to have? Is that to be left here for us to distribute the testimony?

DR. CHOPRA: Yes.

ASSEMBLYWOMAN MURPHY: Thank you.

RAYMOND GAGE: What was my title again? (laughter)

ASSEMBLYWOMAN MURPHY: What I had written down was Respite Coordinator and involved with the Alzheimer's Association.

MR. GAGE: Well, I don't know about the respite. I am Ray Gage. I live in Bridgeton, New Jersey. My wife was diagnosed with Alzheimer's roughly 12 years ago now. She died last November, and I remarried this July. I do not have a lot to say, but I just wanted to point out and sort of reaffirm some of the things that were said.

One of the things I ran into some 12 years ago -- it's not the same problem today -- is this comprehensive geriatric health evaluation. At one time there was a program that the State had with a mobile unit that would come into the South Jersey area and made it easy to get this geriatric health-care evaluation. There wasn't any in South Jersey until more recently now that Kennedy Hospital and some program in that area up there now. But still, when you think of people that are down in lower Cape May County and lower Cumberland County, it's a long way to go to get there. And, of course, now there is a lot of programs available in Philadelphia, the major hospitals.

The other thing that I ran into with my wife was the specialized training for home health aides. There are very qualified home health aides. In my own case, though, we found it difficult to find the one that was able to provide the proper care because of her mental confusion. And I think it's

important that when someone is going to be dealing with an Alzheimer's patient that they have some specialized training in that regard.

Another item was special care units, or Alzheimer's units, in nursing homes. There is few of them around. We looked pretty far into Pennsylvania, a couple of hours away. It became necessary for her to be institutionalized. We were ready to go into the Veteran's Home in Vineland, which has an excellent special care unit, but there was some wait there in that they don't have many spots for females. But we did find an excellent unit in the Cape May Courthouse at the Courthouse Convalescence Center. They do have a specialized unit. My experience with the nursing home there was excellent. I ran into several people from the State on different inspection teams that were down there, and they did a good job keeping things in order.

So I think that the State is doing a great job in lots of ways. And as I have seen progress in the last few years, there are more services available than there used to be. I think that's basically what I wanted to tell you today and be part of this group that's bringing things to your attention. There is a lot more professional people here than myself that can offer some really good suggestions to you. I appreciate your help.

ASSEMBLYWOMAN MURPHY: Well, I don't know if there is anything more professional than having been there and done it, Mr. Gage. Thank you very much for coming today.

MR. GAGE: You're welcome.

ASSEMBLYWOMAN MURPHY: We appreciate it. (applause)

Rose Marie Repp. (no response)

Geraldine Kijowski.

GERALDINE KIJOWSKI: Hi, my name is Geraldine Kijowski. I didn't realize there was going to be all these people. I thought it was going to be a little bit less formal. But my story is really personal as a caregiver. I have a lot of notes, but I write big, and I've been scribbling trying to make it down into five minutes.

But I have been the prime caregiver for my mother, Eleanor, who is 84 years old. For me trying to keep my experience brief is very hard. I've been with the support group, Ray Gage, and Alzheimer's, and they know that I can be rather lengthy.

My story begins five years ago, and it was a holiday trip to Pennsylvania that my sister and I took my mother to the doctors, and she was diagnosed with Alzheimer's. We had previously gone through this disease with my mother's brother who ended up in a nursing home for five years and had died the year before.

We knew we had a big problem on our hands, not only with the disease, but knowing my mother was in complete denial of her brother's illness and did not want to listen to anything about Alzheimer's. She felt this was not a disease that could be in our family, our family was too good for this. She was a very healthy, concerned person, loved to walk, exercise, ate healthy, very strong willed, independent, loved her family and friends, and loved her church.

A decision had to be made on how we would care for her, which was really difficult being her personality type. The decision was that she would move here to New Jersey. So in 1994 my life changed as I knew it. Foolishly I thought I could make a difference. There was just my husband and I, and I

had a little dog. I felt that she could be with me, and she would have her privacy and that I could make a change.

I had to do more changing than I thought. First, I had to quit my job. The move from her family and home and friends was the shattering of her life. She always took care of other people, helped to solve other people's problems, this couldn't be happening to her. She became paranoid. It was everybody else and not her. I foolishly thought that I could get help from my sister because I had always been there for her, but that did not happen.

The situation I put myself and my husband through has changed who I am and how I viewed family and friends. The challenge has been, besides taking care of my mother, trying to take care of a home, keep a marriage intact, making time for my other family and friends. I was doing everything to keep things normal under an abnormal situation. Things I thought I could never do became real, even the small thing as giving my little dog insulin four years ago, and it's been four years since he became a diabetic and we had the choice of putting him to sleep or giving him medication. I never wanted to become a nurse, but that's what I feel like I am.

Caregiving has left me emotionally and physically drained. Alzheimer's has so many changes, it seems there is no end to the day-to-day problems. I learned that love is doing what people need, not just what they want or what we want. Guilt is so destructive. Through these years, I found help through books and the Alzheimer's support group, organizations like the National Family Caregivers Association, which Suzanne Mintz has spoken many of times, and I have been involved with a survey that they have been conducting -- two surveys, one every six months, that they published in 1998,

and the third phase I just finished will be published in 1999. And I have some literature on that I can leave.

I tried day care for my mother; that didn't work. The Statewide Respite Program was actually my salvation. I've been involved with that since 1995, and it is a wonderful program. Because the amount given of \$3000 a year time was very precious and I had to wisely choose how I was going to spend it; because I knew that as the months went on at the end of the year I would have nothing left; because of the amount of time that I was trying to use wisely, I had to end up hiring somebody that cost us money so that I could do other things.

My mother became so sick that Hospice was called in, and we had Hospice for six months. Then she became stable, and they left me alone again. This May I had to put her in a nursing home, and I've had to go through paying and through the Medicaid process, which was very-- In one way it felt degrading, but I realized that none of us can afford the long-term care. She is in Millville Nursing Home.

I just wanted to say that I think that in these days of living longer, living farther apart, sometimes having to care for ourselves, we ourselves need to be aware of what happens to anyone, not just the elderly. We have to be open-minded. The doctors cannot just diagnose our problems and leave us to go home and try and handle the problems. They have to start giving us information so that we can help ourselves, and we have to work as partners, not enemies, with our families and with our doctors. I just feel that most of the Respite Program could be expanded for moneywise and also for the

amount of people that need to be taken care of in this Program. Because we as caregivers need as much help as we can get.

And just as a last thing, I want to thank the State for giving us our caregivers luncheon at the Resorts. It was really nice. Everyone that went enjoyed it, and I just want to personally thank Sandie Severt who takes care of the Respite Program. She is very patient, understanding, and goes way out of her way to help all of us.

ASSEMBLYWOMAN MURPHY: Thank you, Mrs. Kijowski. We appreciate you being here today. Thank you. (applause)

Nina Bobkovf. Nina Bobkovf.

Good morning.

NINA BOBKOVF: Good morning. My name is Nina Bobkovf. I am a resident of Millville, New Jersey, and I work for Cumberland County, Cumberland Manor, which is 196-bed skilled nursing facility. I've been there for 21 years. I'm a licensed social worker.

I came here at the request of Sue from the Alzheimer's Association. I thank the Alzheimer's Association and also all of you distinguished members of this Elder Council for allowing all of us to speak our minds about our concerns. I would also like to speak as an only child and a daughter of immigrants. So I would like to do this as two parts because I feel for my clients because of what I have been through personally.

At the age of five, my parents, who spoke very little English, had a tragic accident. My father had a tragic accident because he did not understand what the words not in order mean. To make a long story short, by the age of 16, I was in Ed Selman's (phonetic spelling) office in Millville

because my parents were dying and I had no help and I didn't know where to get it. So I thank legislation in New Jersey and legislators and people in political offices for the extension of their help and for their foresight in planning such assistance for people who really need it.

We did obtain assistance, but it was very difficult. Thank God times have changed. There were very few services in Cumberland County, and it was difficult to coordinate those services for my parents. It was only through social workers and kind nurses and good doctors who gave me information and a lot of resourcefulness on my own part that I was able to coordinate services and keep my parents alive.

My father has since passed away, in '84. My mother continues to need care, and I have cared for her in my home and coordinated her medical services all of my life. This leads me to the reason that I am here as a licensed social worker, because my heart is open to my clients who come to me, and many are here testifying, to help coordinate services that they need. If you have not lived through standing alone, being the sole caregiver of a demented individual or someone who is rapidly declining mentally or physically or declining with an insidious disease, and you do not understand that, you are lost. You are lost. And when you think your best isn't good enough, it never is because you really are always blaming yourself and feeling as a failure when you don't have someone's support, especially with my clients with Alzheimer's disease.

To come here, I interviewed several of my clients and I asked them what is it that you really need, and they said early education, immediate education as to the stages of the disease, as to what to expect, as to the services

that are out there, as to the cost of these services. You've heard testimony on the importance of New Jersey EASE from Dr. Cavalieri and Dr. Chopra. Please, I implore you, read their testimonies, dissect them, ingest them, study them. Those were two exceptional testimonies.

My clients tell me, in addition, we need very strong case management, the coordination of services. I gave you a little personal biography because I know this from myself. If you do not have someone that you can build a rapport with and that you can trust to come to day or night when you need help, you are lost. So, therefore, regional case management and offices on aging -- and we have one of the best here in Cumberland County run by Misono Miller. I think applause here is needed. (applause) We have a very competent loving networking of professionals here in Cumberland County, and I really do believe that's one of the greatest assets here in this county, clients tell me so. So coordination of services is essential.

Additionally, there are three things that clients desire:

Concrete services in terms of, especially, respite care, home health care, medical adult care specialized for Alzheimer's, and Alzheimer's specialty care in nursing homes. In speaking, you know, for a nursing home with 66 people on one unit, it is very difficult to care for Alzheimer's behavioral problems. People need instrumental care such as Helping Hands. It's a program out of Washington, D.C., which our Lady of Lords has used in Camden County.

The coordination of volunteers to provide assistance with instrumental services such as bill paying, transportation to doctors' offices, etc., etc., that other programs can't do.

And also psychosocial, well-being services that could offer people reassurance. They offer people confidence in what they are doing and a follow-through on the coordination of their services for their specific case.

So I thank you very much for this honor to testify here today.

ASSEMBLYWOMAN MURPHY: Thank you very much for coming, Ms. Bobkovf, and for extending your professional life to us. (applause)

Thank you.

MS. GREENBERG: Excuse me a moment, Nina. Thank you, and I want to say to you your best is good enough, obviously, and thank you for the presentation.

MS. BOBKOVF: Thank you very much, and thank you for your book.

MS. GREENBERG: It's a pleasure.

ASSEMBLYWOMAN MURPHY: Dottie Wilson, Alzheimer's Association.

DOROTHY CHEEKS - WILSON: Good morning. My name is Dottie Cheeks-Wilson. My name is Dottie Cheeks-Wilson and I am from Atlantic City. A year ago this month my mother was diagnosed with Alzheimer's. And the biggest problem I faced was the lack of information. I know nothing. I'm learning very slowly. We have taken advantage of adult day care, home health aid. Unfortunately, the home health aide is not working out. It is again one that she is not familiar with Alzheimer's. She has to provide personal care, and my mother, at this point, does not need the personal care, the bathing, things that way. Part of the CCPED Program

requires a home health aide, and part of their job is to provide personal care. With that, comes the battle that she does not want someone in her home bathing her when she doesn't need them to do that.

I've taken a leave of absence from work to find resources that I'm comfortable with that I can leave her alone. I'm hoping to go back to work full-time, some time after the new year. I've turned my life around by moving into her house, which means -- excuse me (witness crying) -- which means my life has been put on hold. But I ask that the State continue with the programs there, and if the information could be put out there available to us, we may be able to find the things that we do need to avoid having to give up your job and more or less give up your life for the life of your parent, which is not what she wants. And she is still at the stage where she realizes what is going on, and she is fighting. She is denying that she can't do for herself, but having taken off and being home with her, I know that if I'm not there to fix the meal and give it to her, she is not going to eat.

Which is how it was kind of brought to our attention she would end up in the hospital all the time. She had stopped taking her medication, she had stopped eating, and I don't know if she simply forgot to or if she just gave up. I honestly don't know, and not knowing the disease and slowly learning about it -- excuse me-- (witness crying)

I just ask that the State continue their support of the programs for the elderly. Some of the other problems I've had is the fact that I am going from out of state to this state, not knowing what's going on. She is a Medicaid patient, then she is not a Medicaid patient. She's eligible for PAAD one month, the next month she's not. Through the CCPED Program she is now

again on Medicaid, but not medical Medicaid. She does have supplemental insurance through AmeriHealth, but now those premiums are being deducted from her Social Security check, where at one point they were not. So there is a lot of confusion there on my part because I'm not sure exactly what I'm looking for or how to find out about these things.

So I think the most important thing to me would be information and the availability of it.

I apologize, and I thank you for allowing me to testify this morning.

ASSEMBLYWOMAN MURPHY: Dottie, thank you for--

MS. CHEEKS-WILSON: You're welcome.

ASSEMBLYWOMAN MURPHY: --making that extension. It's not easy at all.

ASSEMBLYMAN ROMANO: Madam Chair, if I may. I don't have the number here, but someone should give her a number for the EASE Program.

ASSEMBLYWOMAN MURPHY: Right, because it's in Atlantic County.

ASSEMBLYMAN ROMANO: Plus I have another comment for you.

MS. CHEEKS-WILSON: Yes.

ASSEMBLYMAN ROMANO: By the same token, contact PAAD. I don't understand it and I don't want to make a protracted discussion here how your mother is one day eligible for PAAD and on the next month not eligible. Something is wrong here.

SENATOR SINGER: It's a yearly income.

ASSEMBLYMAN ROMANO: Right, yearly. So it shouldn't be shifting in between.

MS. CHEEKS-WILSON; Right, and I say she's on a fixed income that has not changed, yet--

ASSEMBLYMAN ROMANO: Was she eligible for the PAAD Program financially?

MS. CKEEKS-WILSON: Yes, she has been on PAAD.

ASSEMBLYMAN ROMANO: There is no reason, then, for it to change.

MS. MICHELSEN: Joanne, she is on CCPED, so she has a CCPED case manager. You need to utilize that person more heavily.

MS. CHEEKS-WILSON: All right, thank you. Thanks again.

ASSEMBLYWOMAN MURPHY: Thank you, Dottie.

MS. CHEEKS-WILSON: You're welcome.

ASSEMBLYWOMAN MURPHY: Harold Bobrow and Loretta Brickman who are here, pharmacists. And I know they had a flat tire this morning on the way here.

I'm glad that you got here.

LORETTA BRICKMAN, R.Ph.: So are we.

ASSEMBLYWOMAN MURPHY: I'm sure. Thank you very much for coming.

MS. BRICKMAN: It's our pleasure.

On behalf of Harold Bobrow and myself, I would like to thank Assemblywoman Carol Murphy and the other members for this Council for

giving us the opportunity to address you this morning. As pharmacists, we work with the elderly on a daily basis. We strive to obtain optimal health care outcomes for our patients. Unfortunately, we encounter many obstacles along the way. These obstacles very often create unnecessary frustration and anxiety for the elderly, the caregiver, and even ourselves. It is for this reason that we come before you today. We believe many of the issues that cause such frustration and anxiety and, in some instances, even prevent appropriate treatment in a timely manner can be overcome.

Pharmaceutical Assistance to the Aged and Disabled, PAAD, and Medicaid have greatly benefitted senior citizens, but these programs need to go to the next level. I'm sure all of you must be thinking of the added costs involved and the fact that we are looking to conserve government spending. If we were to include disease state management into our current programs, we would improve the quality of life of our senior citizens and, in many instances, even reduce the amount of medications they receive. For some disease states, hospital visits would be reduced. Diabetes and asthma are only two areas that we are bringing to your attention. There are others, but we need to begin somewhere. Don't focus just on the dollars spent or saved by these funded programs, think of the time lost and dollars spent by family members when they need to stay home from work because of an acute problem that could have been avoided. Many of these family members are government employees.

PAAD and Medicaid have been lifelines for many senior citizens. If not for these programs, many elderly would have to decide whether to put food on the table or take the medication they so desperately need. It is our obligation to ensure these programs continue. We have all been following the

disturbing events currently unfolding with some HMOs in New Jersey. Even before the State had to actually take over two HMOs, several others had already notified the State that they intend to eliminate the State-funded programs from their plans. We can't sit back and watch the events unfold. It could be disastrous. Act now. Carve out the medication portion of the plans and allow the State to continue to run these programs as they have for many years.

The Health Care Financing Administration, HCFA, has just implemented the Prospective Payment System, PPS, for Medicare residents in nursing homes. Unfortunately, HCFA has decided to include medication in the same grouping of services as laundry, maintenance, etc. The overall concept is for the nursing homes to develop shared risk with all service providers. The profit for these facilities will depend upon the amount of dollars they can retain after paying for all provider services. The concept follows the current thinking of managed care. It is important to note that other critical provider services such as physicians, nurses, rehabilitation, etc., have been carved out of the overall pot of funds and addressed individually. Unfortunately, this has not happened with the pharmacy provider. We all realize how important it is to maintain and even reduce health-care costs wherever possible but not at the expense of the resident. That is exactly what will happen. New York ran a pilot program and proved exactly that. Nursing homes made medication decisions based on cost, not on therapeutic substitution. Proper cost containment decisions are made when therapeutic efficacy and cost are weighed appropriately. The pharmacy provider can assist

the nursing home to accomplish this goal but not when such costs as laundry and maintenance are factored into the equation.

Unfortunately, just as PPS is being implemented, New Jersey has decided to reduce aid to nursing homes. The result of these two simultaneous initiatives could be catastrophic.

Regulations governing assisted-living facilities and group and boarding homes are under the Department of Health. The practice of pharmacy governing the pharmacy provider delivering services to the residents of these facilities falls under the Board of Pharmacy. Unfortunately, sometimes the regulations addressing these facilities and pharmacy providers are not consistent and create areas of concern. It is important to develop regulations in each agency that support the other and enhance the resident's quality of life. Currently, the Board of Pharmacy is planning to develop a separate subchapter in their regulations to address pharmacy services provided for these residents. We suggest both agencies should work closely together during this process. It might also be beneficial to reevaluate and possibly reclassify pharmacies that provide these services to these facilities and nursing homes off-site to be included in the definition of an institutional pharmacy. Such reclassification would benefit the facilities and their residents enormously, while addressing many inequities for their provider.

It is interesting to note that most private, third-party prescription plans do not address or even recognize the special needs of a resident in a nursing home or assisted-living facility. With only one exception, these plans do not consider the need to provide any dispensing system other than the

conventional vial. We, as pharmacy providers, are obligated to provide several different systems. All of these are more time consuming and costly.

Harold and I understand the purpose of this commission (*sic*) is to address the needs of the elderly. By bringing this issue to your attention, we are highlighting an urgent area of concern. As we all know, more pharmacies are owned by fewer and fewer providers. Such a phenomenon is occurring for many reasons: increased regulations, decreased reimbursement, decreased profitability. Such scenarios require providers to take drastic measure to survive.

Unfortunately, many of these measures are not beneficial to our patients. Pharmacists are required to increase their workload at an alarming rate while their support personnel are being drastically reduced. This cannot be allowed to continue. Adequate reimbursement must be attained to be able to render the level of professional services that pharmacists have been known to provide. Legislation should be introduced to require third-party plans pay for dispensing systems that aid the elderly whether they live in nursing homes, assisted-living facilities, or other residential settings.

Harold and I would like to make one final recommendation before concluding. There should be an open forum developed which would be held on a quarterly basis. It should include representation from patients, caregivers, providers, State agencies, and members of this commission. This would give us an arena in which to work together to provide synergistic results that will improve the quality of life for all the elderly in New Jersey.

And thank you so much for allowing us to speak.

ASSEMBLYWOMAN MURPHY: Thank you for taking care of your car so you could get here. Thank you very much.

MS. BRICKMAN: Thank you.

ASSEMBLYWOMAN MURPHY: Linda Schwartz or Peggy Klauder?

MARGARET KLAUDER: Good morning.

I am Margaret Klauder, and I work at the Cumberland County Adult Medical Day Care here in the county. I am speaking for the Association since they could not be in this area today. We do thank you for the opportunity to testify on current and future health needs of older Americans and their caretakers.

The Association, which is the New Jersey Adult Day Services Association, is composed of adult day service providers and individuals who support day care as a key component to community-based, long-term care. Representing 90 members throughout the state, the Association sees daily the needs of both the older adults and their caregivers.

We are all familiar with the statistics about this fast-growing segment of the population that are the most frequent users of health-care services. We are also aware that the elderly are the most influential political block in the United States.

Older adults and/or their caretakers expect the best care possible. However, fiscal constraints may limit the available resources. Adult Day Services provide a broad range of services which can contain costs and provide medical care through case management and direct care to optimize effectiveness.

Some of the comprehensive services provided are therapeutic activities provided by a certified professional to provide physical and mental stimulation. Constant monitoring and teaching by professional nurses reduces medical crises from developing by increasing medical compliance and identifying emerging health problems early. Social Service assistance is provided to maintain independence as long as possible. Nutritional needs are met through food provision and dietary oversight. Adult Day Services provides consistency and reliability which may be missing from other home care providers. It does not rely on the availability of specific individuals. Also, Adult Day Services obviates the isolation inherent in home care. Social interactions lessen feelings of depression and make individuals feel connected to a peer group. Quality of life does not have a financial value, but its intrinsic value is immeasurable, as documented by geriatric professionals.

Participation in Adult Day Services has found to be helpful to older adults and their caregivers. The Association, in conjunction with UMDNJ, conducted a “Medical Complaints Among Adult Day Care Participants” in 1997. These results suggest that Adult Day Services participants present a wide range of medical complaints, the bulk of which are handled by day care program staff. The collaborative study on “Stress Reduction for Family Caregivers: Effects of Adult Day Care Use,” done by Penn State, Kent State University, and the New Jersey Department of Health and Senior Services, demonstrated that use of Adult Day Services by caregivers of dementia patients resulted in lower levels of caregiving-related stress and better psychological well-being when compared to that of controls. The results of these two studies indicate that Adult Day Services alleviate caretaker

burnout and also help the older adult use the most appropriate health-care resources.

Personally, in dealing with Adult Day Care, I would like to address the committee (*sic*) regarding the lack of Older Americans Act funds to address the services gap for those older Americans with limited resources. We have been funded since 1975 with Social Service Block Grants, which come through the Older Americans Act. We started out, at that time, with 25 slots for day care. That slot number has decreased greatly. We are now split. There have been no increases in funding. In fact, now they're talking cutbacks.

These people do not have resources to pay private-pay rates. Medicaid is reimbursing us \$56 a day for day care. People who are just over the limits, who do not qualify for Medicaid, don't have that kind of money-- There are four adult day cares in this county, but only two of us currently service those who are not Medicaid eligible. The numbers are getting more and more in need where we can take less for a fewer number of days.

There are also home care cuts being enforced. The home care is major for some of these people. The hospitals are discharging them now. They are sicker and more frail. They cannot survive at home without some kind of service, and an hour or a half hour a day does not do the job.

Thank you.

ASSEMBLYWOMAN MURPHY: Thank you very much for coming to testify today, Peggy. We appreciate it.

Do you have written testimony? (affirmative response)

Wallace Corneu, spouse of a client in senior care.

Then I am going to go back and ask Frank Byrne, who was not here when we called him before but has arrived, to testify after we hear from Wallace.

Good morning, Wallace.

WALLACE CORNEU: Madam Chairwoman, I am a caregiver. My wife has Alzheimer's disease. I have now placed her in a day care center where she is doing very well.

I would like to thank -- something I have been able to do -- first of all, I've been going to the Princeton Biomedical Association for research. I've had her in there, approximately, two years. Every three months she gets a complete evaluation, and I do also, which has helped me considerably in what to do and what not to do. And I have found it's a combination of common sense and certain things that you should know.

However, the life of a caregiver is not easy. You never know what is coming next. I have found, through experimentation, that I can reduce myself a lot of that problem through TLC. There is times where she gets dementia attacks, and she acts just like she is a baby. The same way you treat a baby who wakes up in a bad dream-- It helps, believe me.

I would like to say again my thanks to Princeton Biomedical Association. They give me invaluable help and also, the people where I now have her, the day care center in Vineland.

I thank you very much for your time.

ASSEMBLYWOMAN MURPHY: Thank you very much for being here, Mr. Corneu.

Frank Byrne.

FRANK BYRNE: I am sorry I was late.

Good morning, Assemblywoman Murphy and members of the Council. My name is Frank Byrne, and I am the Director of Public Policy for the New Jersey Association of Non-Profit Homes for the Aging. On behalf of the Association and its members, I would, first of all, like to take this opportunity to publicly thank Governor Whitman for establishing the Council and to commend each of you for making the commitment to take on such a critical assignment.

Although many of you are very familiar with the Association, it is important to now hear that NJANPHA represents over 140 not-for-profit facilities across the state that span the entire long-term care continuum. These include nursing homes, assisted-living residencies and programs, continuing care retirement communities, residential health-care facilities, board and care homes, and independent senior housing facilities. In addition to basic, subacute, nursing, rehabilitation, assisted-living, and personal-care services, many of our members also independently sponsor an array of programs including medical and social day care, meals-on-wheels, congregate housing services, and intergenerational child care. As not-for-profits, approximately two-thirds of our membership maintain some type of religious, philanthropic, government, or fraternal sponsorship. Because a majority of our members maintain a mission to serve low-income populations, over 75 percent of the facilities we represent participate in the Medicaid Program. In addition to being the oldest association of its kind in the nation, established in 1931, many of NJANPHA's members have been in existence for over 100 years

providing high-quality health care and social services to New Jersey's elderly residents.

Since my time is limited here today, I will focus my attention on the concerns of NJANPHA's four main membership groups: nursing, assisted living, CCRS, and independent housing. I also thought that since we are in the middle of the holiday season, I would present the Council with what could be considered the Association's wish list.

As you all are well aware, access to long-term care services has been a major concern for seniors and will become more important as our aging population increases. Coupled with rising costs and limited funding, the situation for nursing home providers has become almost critical. In its deliberations over the next few months, NJANPHA strongly encourages the Council to take a serious look at how reimbursement for long-term care services, Medicare, Medicaid, managed care, private insurance are managed in New Jersey and recommend that a comprehensive strategy be developed to streamline the system. We are confident that by utilizing and expanding upon the findings contained in existing documents, like the two major long-term care studies conducted in New Jersey last year, the Council can help guide the State into a directed course of action regarding this issue.

In the area of assisted living, the New Jersey Department of Health and Senior Services has done a tremendous job, over the past five years, developing and promoting alternative long-term care options like assisted living. In fact, at this coming Thursday's Health Care Advisory Board meeting, the Department will be proposing some changes to the regulations governing assisted living that will strengthen the program. While it seems like assisted

living is flourishing in New Jersey, with 69 facilities already licensed and 45 under construction statewide, making it affordable to seniors with moderate or low incomes has been problematic. Perhaps the Council can take a closer look at this very serious issue and support modifications to certain programs like the 1115 Medicaid Waiver Program in order to make it more user-friendly and increase funding so that all seniors can access this highly desirable alternative.

With regard to CCRCs, NJANPHA's request is twofold. First, we would strongly encourage this Council to recommend that the Governor reappoint the CCRC Advisory Council that was established pursuant the CCRC Regulation and Financial Disclosure Act of 1986. New Jersey Association of Non-Profit Homes for the Aging and the CCRCs it represents made this request in October of 1997, and for no apparent reason it has still not been reappointed. The CCRC Advisory Council is the only forum where residents, providers, and the Department of Community Affairs can exchange information and ideas about this very important segment of the continuum.

Secondly, your active support for the passage of Senate Bill No. 1273, return to home legislation, would lend tremendous assistance to correcting a very serious problem residents face when they experience an acute care episode, require hospitalization, and would like to return to their facility for subsequent nursing or rehabilitative services. Currently, a resident who is a member of an HMO may be diverted to a different facility simply because the HMO to which they subscribe does not have a contract with the facility where they reside. Coincidentally, a member of this Council, Senator Robert Singer, is the prime sponsor of this bill. I am sure that he and his staff can give

you more information on the measure and how important it is for New Jersey's CCRC and nursing home residents.

Last but not least is the independent senior housing facilities NJANPHA represents throughout the state. Many of NJANPHA's housing members provide congregate housing services to the frail elderly living in their facilities. These services allow individuals to remain independent and age with dignity in their own homes, thus, meeting one of the Department's main goals and fostering aging in place practices. You can imagine how disturbing it was for our members when they were told earlier this year that their grants from the State would be cut back to 1997 levels. The Council's assistance in opening up a dialogue with the State to work cooperatively in the development of creative solutions to these and other problems would greatly enhance the lives of many seniors residing in our housing facilities.

Once again, I appreciate your time and consideration. If NJANPHA can be any assistance to the Council over the next six months, please don't hesitate to contact us.

ASSEMBLYWOMAN MURPHY: Thank you very much, Mr. Byrne.

MR. BYRNE: Thank you.

ASSEMBLYWOMAN MURPHY: Did you leave a copy of that written testimony?

MR. BYRNE: Yes I did.

ASSEMBLYWOMAN MURPHY: We appreciate your being here.

Dolores Spotafore, client of the Department of Health and Senior Services.

D O L O R E S S P O T A F O R E: I guess we're using this, right?
(referring to PA microphone)

ASSEMBLYWOMAN MURPHY: Yes, thank you.

MS. SPOTAFORE: I just want to say that, as a former nurse, I know-- In one split second I became disabled and was never able to work again. I wasn't eligible, really, for anything from the government until I moved to New Jersey, and then I still wasn't eligible until Elise from VNA came. She got a hold of Cindy Chapman from CCPED, and Yvonne from Senior Care came and got the ball rolling because I wasn't eligible for anything.

Up until then, I was 24 hours a day, seven days a week alone. I never got out, I didn't have anyone to talk to, I became more depressed, I was suicidal, and I felt that I had no purpose in life whatsoever. What was the sense of me living?

While I did get to go to Senior Care, in Vineland, which has been a lifesaver for me-- It's like at night, when I count my blessings, I count that place twice. They could use more help, but they are wonderful.

Do you know what it is to go week after week without hearing another human voice, feeling a touch, a hug? I get a hug every day I go there. I would lay there and wouldn't eat. It didn't matter whether it was day or night, I didn't know, I didn't care. I eat every day.

You have to keep these places going because I don't know what a lot of us would do, especially the ones that are alone, without places like Senior Care -- especially for the people who work there because they do care. You named it well, Senior Care. I love it and I look forward to it. They are like my family.

So you have to keep these places going. You have to get these places going.

That is all I have to say.

Thank you.

ASSEMBLYWOMAN MURPHY: I think that is an awful lot to say. Thank you.

Alicia Gedhetti.

Good afternoon, Alicia.

A L I C I A G E D H E T T I: Good afternoon.

My name is Alicia Gedhetti, and I am here addressing you from the point of view of a caregiver.

I am a full-time employee of the State of New Jersey. I work in five counties of the state. This is one of my counties. I also work in Monmouth County and Ocean County and Salem County and Mercer County. And when my mother came to stay with me, which happened to be the last year of her life -- she spent six months with me -- I became a full-time caregiver while I had a full-time job also.

It goes without saying that it was extremely difficult. I couldn't afford to leave my job. I took as much sick days as I could take to be able to do that. And I am fortunate enough that this was my employer and they allowed sick days to take care of somebody that -- of the loved one that lives with you. Despite that, I couldn't take all the time that was needed to take care of her.

I speak loud but-- (referring to PA microphone)

So, essentially, I just want to make some points about some of the situations that both my mother and I went through and what kind of things, I think, can be done to address them more effectively. The first one -- there is definitely a need because hospital institutionalization is the last choice of most elderly people or people that are in need of sustained nursing care. Even at that point, they still would prefer to stay at home, still prefer to be cared for in their normal environment by people they trust and know and have been around all their lives. I recognized that with my mother, and she was clear. She didn't want to go to the nursing home. Up until the very end, when she saw how it was, she really did not want to go to a nursing home. I think one of the reasons she didn't want to go to a nursing home was because she had been hospitalized many times. There were times -- and we recognize that there is inadequate staffing in terms of nursing staff in hospitals. There were times, when she was in the hospital, she was neglected. I remember going every morning, at seven in the morning, to see my mother before I went to work and spending with her an hour and coming right after work to spend the rest of the evening with her. During the day, things would happen that would leave me enraged and baffled, and I felt this need that I should be there all the time.

So there is some need for programs that would have volunteer advocates, or if they exist, they should be expanded to be in hospitals, to deal with the needs of those patients that don't have relatives or people that are advocating for them regularly. Because they need to be there during the day.

There is also a need for programs to provide home health care and respite care programs at an affordable cost to the middle income. My mother wasn't eligible for anything. She wasn't eligible for the Waiver Program

because she only lived with me six months of the year in this state. She would never be able to get to that point.

In sufficient quantities -- to meet the existing needs in the community because there are programs, but they are totally inadequate in terms of the ability to deal with the needs of everybody in the community who needs them -- that are equally accessible throughout the state. Because I work in other counties, I can see the difference between counties that have availability of a wide choice of programs in sufficient quantities. It's never sufficient. But they are based on population formulas, etc., and we need to ensure that there is more equity in terms of the allocation of funding for programs for the elderly. They are all over the state, not just in the Camdens and Atlantics and southern Jersey for example.

We also need programs to educate, and that is because it is a personal need that I felt, and I am beginning to feel it with my mother-in-law, to educate caregivers on how to help the dying die with dignity and fully in control of their choices and decisions whenever that is possible. I felt-- I am in the human services system. I am surrounded by social workers a lot of the time, and I got some assistance and ideas and support from them, and still I feel unsure at times on how to deal with somebody that--

Is that my five minutes? Okay.

--that hasn't been told that she's dying and apparently asks the questions tentatively, but nobody addresses the issue.

So I think we, as caregivers, need that type of education.

ASSEMBLYWOMAN MURPHY: On a personal note, have you spoken to Hospice at all?

MS. GEDHETTI: Well, actually, Hospice had told us that they would be able to provide assistance. We needed to make sure that it couldn't be longer than six months. Emotionally, I wasn't able to make a decision about that because I couldn't recognize that my mother had less than that time to live.

So I am trying to expand the PAAD Program and raise income eligibility requirements, again because my mother was not eligible. So I am sure -- and we were not rich or anything near that.

Thank you.

ASSEMBLYWOMAN MURPHY: Thanks very much for coming here. We appreciate your experience bringing -- being brought to the table.

Luke Fannon had signed up for the morning and was not here.

Luke.

LUKE FANNON: I want to thank Assemblywoman Murphy and the other distinguished members of the panel for accepting our testimony. My name is Luke Fannon, and I am from Senior Care Centers of America.

Senior Care is the largest provider of adult day health services in New Jersey. We operate six centers here in South Jersey, one which was eloquently describe by our client, Mrs. Spotafore, Senior Care in Vineland. I know that it caused tears of joy to flow from our administrator's eyes. It was really a moving testimony, and I want to thank her for that.

The adult day care -- Adult Day Health Services industry-- Our job is to keep the elderly in their homes, either with their loved ones or in their own homes, for as long as possible. And the way we are able to accomplish that is by doing a couple of things. One, ensuring that elderly individuals

access the health-care continuum. We have very fine registered nurses and social workers in our Adult Day Health Services Centers that evaluate the needs of our clients, work with the primary care physician, and then ensure that they get access to the specialty care services and other health-care services that are designed to improve their quality of life and improve their health status and ultimately prevent or stave off the disability that can be associated with chronic and acute illness. I can attest to the fact, being part of the organization, our staff does an excellent job of that.

The other thing we do is improve the quality of life of our clients by providing them with a caring, loving environment that our clients are able to participate in on a regular basis. That stimulating and caring environment gives them a reason to live, gives them the type of feeling, personally, that enables them to continue on in their living situation. So we are just proud as punch to do that.

I would like to introduce two folks that came down from Camden County with me. Mrs. Williamson is a caregiver of a husband who is in one of our centers and Ms. Betty Lee, who doesn't want to speak today because she is shy. But Ms. Betty Lee is an extraordinary woman. She is the neighbor of one of our clients in Camden County and takes on the responsibility for this individual even though she is not related to her. It is a wonderful testament to her as a human being. It is the type of people that we deal with day in and day out-- I want to say thanks to Ms. Lee for that, and I am going to let Mrs. Williamson continue on.

ASSEMBLYWOMAN MURPHY: Good afternoon, Mrs. Williamson.

S H A N T E L W I L L I A M S O N: Yes. My name is Shantel Williamson, and all the testimonies today sound familiar. They just hit home.

I am an immigrant. I came here 15 years ago and married a wonderful man who was my boss. And a few years later, he became very sick. Through dialysis -- kidney failure -- he was still able to function as a husband and a father, and we do have a 12-year-old to take care of. One day he went into cardiac arrest, complication from dialysis, and he lost his short-term memory. It seems like everything vanished. Here was my American dream vanishing. He was home -- he would stay home from the hospital -- he was in a hospital for four months and in rehabilitation for two. When he came home, going to dialysis three days a week -- there was three more days left where he would be taken care of by my mother who does not speak English.

Alex went into depression. The confusion -- mental confusion-- I took a few days off just to be on the phone and getting more information of what is out there or available for him where he could go every day. I called different facilities -- different organizations until somebody referred me to Senior Care. It seems like somebody was sitting on the other line waiting for my call.

The help was tremendous. Through filling out applications and help and everything with my application -- getting qualified for the Alzheimer's Grant, and he has been going to day care three days a week. It has made a difference in my mother's life; in my life, being a full-time mother, a full-time wife. I take care of my mother who is 73 years old, and she is in excellent health, and she is very helpful to me.

Thank you for Senior Care and the day care program.

ASSEMBLYWOMAN MURPHY: Thank you very much for coming this morning, Mrs. Williamson.

And, Ms. Lee, thank you.

The next testifier today is Jack Kennedy. Jack Kennedy. (no response)

Lloyd Kellner.

Good afternoon, Mr. Kellner.

LLOYD KELLNER: Good afternoon.

I was asked to come here by the Alzheimer's Association to give you, I guess, a real-life scenario.

Hello, my name is Lloyd Kellner, and I reside in Cherry Hill, New Jersey. Thank you for providing me the opportunity to tell you about my personal experience as a caregiver of my 81-year-old, widowed mother. My mother's medical problems include multi-infarct dementia, hypothyroidism, noninsulin dependent diabetes, and a history of glaucoma. Despite these problems, she has been able to live on her own up until eight weeks ago when I, an only child, and my wife realized that finally my mom could no longer care for herself. Since she is ambulatory and still fairly with it, just confused, thank God, she is not yet ready for nursing home care. Rather, everyone agrees she's an excellent client for an assisted-living facility.

In the middle of this past October, hence, my search began. Besides the normal expectations of a safe, clean, and caring facility, the two major issues that rise to most important are finances and location. My mother has assets and Social Security that would only cover six to nine months in an average facility before Medicaid funding would be applied for. So my greatest

challenge became locating an assisted-living facility close to us that was a Medicaid-enrolled provider. I understand that it's been over two years since assisted living can be licensed as such.

Sounds pretty simple, but I'm here today to tell you that in eight weeks, my mother has been a resident of two different facilities and is now on a waiting list for a third. Besides the obvious traumas of moving to a person my mother's age, I feel that I've been lied to and misled by the two facilities she has lived in whose names and contacts I can provide to you later.

The first facility's intake people told my wife and I that Medicaid approval status would be coming any day when, in reality, the facility is still not even a licensed assisted-living residence. In addition, they misrepresented fees to me, and after we experienced poor care levels and care never given that was paid for and a \$500 nonrefundable appropriation fee, we moved her to a licensed assisted-living facility, also very close to us, after just two weeks.

This second facility, which opened last May, moved my mom in on November 1. The facility director told my wife and I on November 1 that they were about to make Medicaid Waiver application, and they expected to be a provider by May 1, 1999. Sounded great. I then received a call from this same director two weeks ago, on November 30. He advised me that he was notified by his parent company's corporate office that they had made a final corporate decision that they would not now become a Medicaid provider at all. Wonderful, isn't it? Let's move mom a third time.

Since currently there is no assisted-living facility that is also a Medicaid provider in all of Camden County, she's been forced to go on a waiting list for a facility in another county many miles away.

Although we haven't the time to go into many, many particulars that I have also experienced, I'm continuing to work through this living nightmare.

I've spoken to caregivers, attorneys, and numerous State Department of Health offices which give me sympathy but very little support for what I've experienced.

In summary, the Medicaid stigma is alive and well regarding assisted-living facilities. These private-pay residences tell me that the reduced funding they receive from Medicaid clients do not allow them to survive financially.

In conclusion, what needs to be done is that Medicaid funding should be increased to remove the stigma. Also, this Council needs to make sure that residences do not take in private pays, while posing as a Medicaid provider. I ask this Council to help me in any way possible to address these two facilities.

Thank you for your time, and I only ask what each of you would do if your mother or father was in the same situation.

Thank you.

SENATOR SINGER: Thank you very much.

Yvonne Crouch, who is from the Hospice Care of South Jersey.
Yvonne. (no response)

Mario Simone, Cumberland County Outreach Coordinator.

MARIO SIMONE: I want to thank the panel for having the opportunity to be here this afternoon.

My name is Mario Simone, a Program Coordinator for the Senior Citizen Information and Assistance Outreach Program of Cumberland County. As a supervisor for this Program for over 22 years, I feel I have gained some knowledge, not all knowledge, about the problems and concerns of senior citizens, especially since my department alone usually deals with over 7000 seniors each year and refers them to over 10,000 services, benefits, or programs, you name it. If it concerns a senior citizen, they call us. Our job is to refer them. In addition, I am also Editor of the newsletter which goes out to over 10,000 households. So that is our effort to make sure that information is disseminated.

I would like to testify on the following areas of concern. One of the areas deals with the very real frustration that Outreach workers who are on the front line, who actually experience some of the needs by the clients directly-- They feel such frustration, along with the client, when they're informed that the clients have to be placed on the following waiting lists. They can include home care services, respite care, rental assistance, home-delivered meals, dental health assistance, and home repairs just to name a few. Our job is to keep on referring them to find the help that they need. With this, I would like to state this point, that it will definitely be beneficial that the county -- Cumberland County -- will be officially designated as a New Jersey EASE County, as a matter of fact, starting today. This afternoon, we welcome everyone to be here for that celebration. However, I must warn you that we must realize that this State initiative will not, by itself, solve the problem of a waiting list. Making it easier, which is one of the primary goals of New Jersey

EASE, to be referred to programs does not automatically mean that seniors will get the services when sufficient funds for those services are not there.

I sincerely hope that the State Legislature will agree that eventually an increase in funds will be necessary in order to meet the needs of the growing number of senior citizens in New Jersey.

Another area of concern continues to be in providing health care -- basic health care, especially for those persons between 55 years old and 65 years old who don't even have Medicare. A number of years ago, there was a program -- there still is a program, Health Access Program, but apparently, it's been closed. Only so many people were allowed in. I would recommend an expansion of that because I know many people will be willing to pay \$100 even \$200 just so they can get some health insurance, especially those between 55 years old and 65 years old.

Another critical concern is the inability and hardships for seniors to continue to pay property taxes. I know there are efforts underway for that -- the Tax Reimbursement Program, which will start, and the Homestead Rebate, but further efforts need to be done along that line.

Finally, the other main concern, as I see it, is not having sufficient funds for home- and community-based care services such as home health and chore services, home-delivered meals, and respite care.

In conclusion, because of these concerns, I would like to recommend just a few other actions, and I hope you all consider them. In order to meet some of these needs that are already existing in New Jersey, I hope that the State will restore the \$12 million of SSBG funds that were recently eliminated by the Federal government. And perhaps they could use

part of the New Jersey \$70 million surplus to help restore the Social Services Block Grant.

SENATOR SINGER: Excuse me, it's \$700 million.

MR. SIMONE: Oh, it's 700, excuse me.

The other is to definitely expand the income limits for the PAAD Program and perhaps allow a greater copayment for those persons who would normally be over the regular income guidelines. By that I mean this.

Is it almost time?

SENATOR SINGER: Just finish up. You can finish up.

MR. SIMONE: By that I mean this: Just the other day, at the Senior Center, a gentleman whose wife is very sick said, "How come the income limits for one person, or will be starting in January, will be about \$18,151 and then for two it will only be about \$4000 more? It doesn't make sense." There is, I know, a certain amount of sense in it. But he says that when you consider his income, his Social Security, her Social Security, and maybe a pension, guess what, it puts them over. So something along the line of a greater copay for those that are over the normal limits would be appreciated by them.

And definitely, I urge, to increase funds for respite care. We refer many people for that program, and that is really a life-saving benefit for family members to assist their loved ones.

And finally this, to explore the use of providing additional funds such as Social Services Block Grants or matching Older Americans Act Funds to offices on aging directly, to be used to provide more home- and community-

based care services, especially for the frail elderly and not just those who have a current medical condition.

Thank you.

SENATOR SINGER: Thank you very much.

ASSEMBLYWOMAN MURPHY: Misono Miller.

MISONO I. MILLER: Hello to the members of the public present, Chairperson Murphy, and the members of the Elder Care Advisory Council. We're so very glad you're in Cumberland County to conduct this hearing, and we thank you for your activities on behalf of the elderly.

I am commenting on one aspect of caregiving, and that is the availability of services to assist the elderly and caregivers in their basic needs. I think Nina Bobkovf said "concrete needs" for home care, meals, and adult day care for the elderly or disabled person at home. Of course, this also includes the Respite Program.

A common thread of testimony at your November 13 hearing and one that you will hear today is that the service network available to the client is existent. However, there are basic gaps in that service network that prevent access by the client to those services. There are two major problems. Number one, not enough money in programs that exist, therefore, resulting in waiting lists for service and virtual nonaccessibility to those in immediate need. Number two, inability of the client to qualify for existing assistance available because of restrictive asset and income criteria as well as criteria that imply that home care needs arise only out of medical concerns, not custodial.

I have a phrase that I interject as often as I can in a situation such as this. Elderly need community-based care not primarily because they are sick

or medically in need, but primarily because they are frail or disabled. And if they are sick, it is the extent of their frailty that, really, one must look at to determine if they need home- and community-based care. We all know that Medicare only covers home care if there is a need for a home health nurse or therapist and if the patient is homebound. Patient is a good word to point out here. Most persons who need home care are not patients. If I may ask the panel, when was the last time you were sick at home, and when were you sick to the extent that you needed a nurse or therapist at home? This is Medicare's criteria for providing home care.

There are resolvable actions that can be taken within the next 25 years to address these barriers, and I am going to list them. I have seven.

1. Review by area the funding now being spent on home- and community-based care from three major funding sources. That is Medicare, Medicaid, and Federal and State grant allocations. You will find that, in the present situation, funds for community-based care are primarily in the areas of Medicare and Medicaid and hardly supported by grant funds.

2. Recognize that the Medicare Program's medical bias is valid, and depend on Medicare for medically necessary or affiliated home care. Recognize that this is a very limited aspect of the home care needs of the elderly and should be considered so. Since medically associated care is more expensive, recognize that custodial care and care needed on the basis of physical frailty and disability of clients should be addressed by other funding sources.

3. Recognize that there is a planning, funding, and service delivery network in New Jersey under the area agencies on aging. Grant funds received for local services can be received, monitored, and coordinated through this

local service delivery network administered by the Offices on Aging in New Jersey. And we've had this network for a long, long time, beginning back in 1965 -- 1965.

4. Recognize that there is no excuse for having waiting lists for meals-on-wheels, a service that, in Cumberland County, all costs included, is approximately \$5.27 per day. That's for meals, for gasoline, for cars, and for staff -- everything. By the way, we also employ senior citizens in that meals program so that program is very cost effective. There are minimal Federal and State grant funds for the meals-on-wheels effort. Incorporate funding for home-delivered meals in New Jersey in the Medicaid-based State CCPED and Personal Care Programs and allocate additional funds for the support of this essential program.

Could I have two more minutes?

ASSEMBLYWOMAN MURPHY: I'll give you one. Let's start with one.

MS. MILLER: Okay, number five-- I'm going to cut this short.

Recognize that the grantfunded sources of community-based care are the most flexible and least restrictive in terms of income criteria and ability to let clients into the program.

6. Recognize that grant-funded sources of community-based care are highly lacking in funding and comprise a very small percent of service dollars for community-based care.

7. -- this is the last thing -- work toward turning this picture around in the next quarter century. Revise the Medicaid Program to be more

flexible in New Jersey in terms of the method of providing care in New Jersey so that the \$18,000 cost per person in the CCPED Program or the Personal Care Assistance Program can serve more people. Advocate on a national level -- it isn't all State, but we get a lot of our funding from the Federal government. Advocate on a national level for policy makers to realize that more persons could be served and would have access to services if the funding stream were more evenly distributed through grant sources, such as the Older Americans Act and Social Services Block Grant, rather than through medically biased and income-restrictive entitlement programs of Medicare and Medicaid as the primary means to fund home- and community-based care.

I only have five minutes, but I have a lot more suggestions if you want to hear them.

SENATOR SINGER: Madam Chairwoman.

ASSEMBLYWOMAN MURPHY: Yes, Senator.

SENATOR SINGER: In Ocean County, we do not have a waiting list for meals-on-wheels, and we are probably one of the largest senior counties in the State of New Jersey. Let me just tell you what we do. We ask all the municipalities in the state to make direct donations to the municipalities in the county to make sure that no one is left out. I would suggest that if Cumberland County is not doing that, they turn around and do that.

MS. MILLER: We have done that.

SENATOR SINGER: It is a shame that any senior is on a waiting list for meals-on-wheels, and that should be stopped.

MS. MILLER: I agree with you there. And we are getting help from Vineland, Millville, Bridgetown, and they increased their allocation about two years ago. There is only so much the local government can do.

ASSEMBLYWOMAN MURPHY: Thanks, Misono.

Nancy Ivey. Nancy Ivey. (no response)

Patty Small.

P A T T Y S M A L L: This is Patty Small.

ASSEMBLYWOMAN MURPHY: Hi Patty Small, how are you? Nice to have you here.

MS. SMALL: Thanks to the sponsors today for my being here. I am grateful for the opportunity to be here today. I am a living witness as to what I am going to talk about today. I am going to be brief.

I have been diagnosed as having severe arthritis, diabetes, heart problems, glaucoma, and such. A year ago I fell in my home, and after some therapy and surgery, I went home after the therapy. My insurance stopped. I contacted a few agencies which helped for a couple of weeks. Two hours down to one hour down to nothing, hearing conversations like -- while I was receiving those hours of service like, "We don't have the money." "There is someone over there who needs the care more than you do." And I thought I was on my way to full recovery while receiving these services. But after hearing this news every day, I began to get frustrated and began to wonder what I was going to do from here after the help stopped.

Then I was left alone except for a daughter who is a single parent taking time out from her lunch hour job -- her job's lunch hours to do little errands on my behalf. Otherwise, I would probably be in a nursing home

because I could not -- did not have access to information or other facilities that would come over and help me.

This is a personal thing that I wanted to talk about today because, as it is now today, I still don't have the help that I need. So I do the best I can for myself with what I am able to do. But the threat is always there. "We don't have the money, or we can't help you." So rather than hear the frustrations about money and complaints and "We don't have the time and somebody needs the help over there better than you," I said, "Well, when they left, I was probably better off because that was making me sicker than I really was from the start." So I wanted to say a little something about that today.

I am hearing today that there are a lot of services out there, but do you realize that a lot of people do not know about your services. I speak for myself today, and I know hundreds of people that I live around or live around me who have this same problem. There is no help. Where is the help? We can't get no help. And so I am not speaking on my behalf, I speak on the behalf of so many others that I know.

So I came today to voice this. If whoever is providing the service-- Why make it so difficult to provide the money? Information about services are not always available. Then the PAAD is, aside from the other problems that you have to live with day by day -- not being able to get out and do little things that you automatically have to do not having any help-- The PAAD is eating up your Social Security check by having to run to the drugstore so often with limited amounts of medication. That means you have to spend X amount of dollars when you take a lot of medications. If you are on just one medication

that is one thing, but if you're taking more than one medication, it takes a lot of money from your income to have to run to the drugstore so often.

I am thankful for Cumberland County, and I am thankful that I live in Cumberland County because they do provide good services. The thing about it is you have to try to make it a little bit more available to the people who are left behind.

I thank you.

ASSEMBLYWOMAN MURPHY: Thank you very much.

Yvonne Crouch.

YVONNE CROUCH: Hi, I am Yvonne Crouch, Executive Director of Hospice Care of South Jersey. It is an independent hospice program affiliated with the South Jersey Health System. I am here today to share our hospice's view on the needs of the elderly and their caregivers today and into the future.

We care for almost 500 terminally ill persons and their families each year. The largest group of our patients are 75 years of age or older. Just in the past year, we have seen a 9 percent increase in this age-group. This means that the patients are not only elderly, but if they are fortunate enough to have a spouse that is living, that caregiver is also elderly and frail. Many of our patients have children that serve as caregivers; although, they usually live in separate households and need to work. We are also seeing a growing number of elderly people living alone, having difficulty caring for themselves and their homes, but fiercely resistant to entering a nursing home. They usually need assistance with personal care, preparing and taking their medications, and in maintaining their households. They often are unable or

unwilling to pay for needed services and are ineligible for any programs that are available.

What I see this particular population needing now and in the future is in-home custodial care for those that are chronically ill. Over and over we see that as a need.

The people that are falling through the gaps between skilled care and if they are not terminally ill, where do they get care;

companion services while the caregiver is working;

increased State Respite Program hours to relieve the caregivers.

That is a wonderful Program and a lot more is needed;

increased home health aide services. And I see a need to increase the home health aide scope of practice so that medications can be prepared, administered as needed, certainly with special training and supervision, as is allowed in other states;

medication preparation -- I mentioned that -- and monitoring for the chronically ill, filling the pill boxes. With a home health agency they can only do that if there is a skilled need.

increased access to transportation for the elderly at various hours where they don't have to wait a long time if they are frail and need to get back from their doctor's visit;

education of consumers to make informed decision about care is extremely important;

and information referral services such as the New Jersey EASE Program that is being introduced. They need to know, as we heard this woman saying -- they need to know what they do have available to them. And I see a

need for expanded eligibility requirements for pharmaceutical and other services because people spend a lot of money on their medications, and sometimes they fall just under the amount that is allowed and end up spending most of their monthly income on medications.

And coordination and case management of services for the elderly is so important. The services are so fragmented that there are pieces everywhere.

Hospice services have proven to be more cost effective for Medicare than traditional care during the final stages of any disease. I believe that the investment of in-home services for chronically ill persons will also prove to be more cost effective than nursing home placement for many of our elderly.

During the next 25 years, our population, including caregivers, will continue to age. Medical breakthroughs will allow us to live longer, and we will have more chronic illness to manage. This is a daunting challenge for our society, caregivers, and for you, our policy and legislative decision makers.

I thank you for accepting this challenge, and I wish you a good holiday.

ASSEMBLYWOMAN MURPHY: Thank you very much.

Nancy Ivey is here now.

NANCY IVEY: My name is Nancy Ivey, and I am a nursing supervisor with the city of Vineland, Department of Health.

I have had 22 years of experience working with the elderly through our home care agency and our public health programs for seniors. I would like to thank you for the opportunity to speak to you today.

Twenty years ago, the expectation was that when an older person became ill and unable to care for himself, Medicare, his health insurance, would provide the needed services both skilled and unskilled. Patients received visits from the nurse and/or a therapist and a home health aide, and Medicare covered the entire cost. Many patients received up to 20 hours per week of home health aide service. Many had family members close by who could participate in providing the needed care. Those who required more care than could be managed at home were placed in a nursing home.

Today the story is quite different. Health insurance has dramatically reduced the amount of service provided. Skilled services are provided for shorter periods of time after an episode of acute illness. Patients are sicker when they return home from the hospital. They are weaker and less able to care for themselves. The need for home health aide services has increased while insurance carriers have decreased them to an average of six hours per week. Custodial services such as meal preparation, laundry, grocery shopping, and housecleaning are not covered by insurance. HMOs are asking home care agencies to find community resources to pay for home health aide services.

Now that our senior citizens are living longer, the need for support services has increased significantly. Chronic illness, disabilities due to advancing age, and changes in family structure all indicate that communities need to help their older citizens.

Common problems senior citizens have include the inability to perform routine activities of daily living. This includes dressing, bathing, and hair washing. For many, the need or help with ADLs is a long-standing

problem, possibly for the rest of their lives. Other problems include basics to maintain a safe living environment. Help is needed with housework, meal preparation, laundry, purchasing groceries, errands to perform, banking, picking up prescriptions. Another issue is the forgetful client who no longer is able to remember reliably to take needed medication or to pay bills or to manage their money well.

The question is, who will be providing these services? It has been shown that the most desired scenario is for the elderly to remain at home. This is where they want to live. The home care industry has shown that care at home is cost effective. Clients recuperate faster at home. However, most need the assistance of a caretaker. Who is that caretaker going to be, and where do we find them?

It was always assumed that other family members would provide care as needed. They would live nearby and provide meals, help keep up the home, and check on their elderly relative every day. Today, this is frequently not possible. Children and siblings often live far away in other parts of the country or the world. Many families are not in touch with other relatives. Family members have many other commitments. Being a caregiver can be a 24-hour a day job. Spouses frequently are physically or mentally unable to care for their mate. There are many senior citizens living alone with no surviving family. They rely on friends and neighbors for help. These people are frequently elderly, too.

Many of the problems the elderly have at home could be controlled or prevented if a reliable caregiver was available. For example, a poorly kept home, unclean as well as in disrepair. With some regular cleaning

and routine repair, a safe environment could be maintained. Poor nutrition results in poor health. Someone to purchase food and cook it may be needed. Refusal to seek medical care or other help happens too often. These seniors are afraid they will be forced out of their homes and lose control of their lives. Many realize they are ill but refuse to get the help they need.

A very common problem is in affording and taking medications properly. Many seniors do not take their medication correctly because they forget. Some refuse to pay the very high cost of prescriptions, and they do not recover. Often, a home care nurse can work with the physician to order a less expensive medication. Often, the nurse will fill medication boxes every one or two weeks to help clients take their medication properly.

There are many senior citizens that have caregivers available to them. In some instances, these are family members, friends, or hired help. All of the above problems can be well monitored by a good caregiver. The senior citizen can be well cared for at home. Many times, we forget that the caregiver has limits as well. They may need some relief if 24-hour care is needed. Many have other jobs, family issues such as young children, or health limits of their own. Some resources to help the caregiver are needed.

Every situation is different and needs to be evaluated individually. I will give you some examples that we come up against every day.

An elderly couple in their 90s have been caring for each other and now they can no longer do so. What can we do to help them?

A mildly confused, single senior with no children gets anyone to help write checks or manage banking, oftentimes, people she does not know well.

ASSEMBLYWOMAN MURPHY: Mrs. Ivey, the five minutes is up.

MS. IVEY: Oh, okay.

ASSEMBLYWOMAN MURPHY: Can you kind of wind up?

MS. IVEY: Yes I can.

ASSEMBLYWOMAN MURPHY: Thank you.

MS. IVEY: I think that the issue here is that we need to find some way to help people get the care to keep them at home where they are happy and where it's more cost effective, and to provide some assistance and supportive care for the caretakers. This means we need to take some of our current programs and give them more funding and have higher limits for assistance.

ASSEMBLYWOMAN MURPHY: Thank you very much. You have that testimony submitted?

MS. IVEY: No, but I can do that.

ASSEMBLYWOMAN MURPHY: If you could leave it in that box there, we can make copies for everyone to have.

MS. IVEY: Okay fine. Thank you.

ASSEMBLYWOMAN MURPHY: We have 22 people left who would like to speak to us today. At five minutes each, even if you all raced up here and were promptly speaking, that's 110 minutes. We have just about 60 minutes or 70 minutes left, so obviously, we don't have time to hear all of the people who wish to be heard.

I am going to recite some names. If you hear your name, please raise your hand so that I will know you're here.

Theresa White. (no response)

Dolores Meulstee and Cindy Powers. (no response) We're moving right along, aren't we?

Theodore Moore. (no response)

Lucille Dick. (no response)

Dana Sexton. (no response) We might get everyone in who is here.

Adeline Eagan. (affirmative response) Adeline is here. Just hold on Adeline.

Anthony Scarpine. (no response)

Stacy Carr. (no response)

Susan Atkinson. (no response)

Dolores Calican. (no response)

Anna Stewart. (no response)

Gloria Hluszak. (affirmative response) Okay that's two.

Mr. and Mrs. Rolling. (affirmative response) Okay, I think we're going to be able to accommodate the people who are here. This is good. This is good.

Who was that person that was here?

You're Adel Eagan?

A D E L I N E E A G A N: Adeline. (indicates pronunciation)

ASSEMBLYWOMAN MURPHY: Adeline, I apologize. Would you like to come up and speak to us, Adeline?

Boy, I tell you, this may just work out. Wouldn't that be nice?

Adeline, thank you very much for being here.

MS. EAGAN: Oh, you're welcome. I really didn't come prepared to talk.

ASSEMBLYWOMAN MURPHY: Well, just tell us what your interest is, and that will be fine.

MS. EAGAN: Well, first of all, I am Adeline Eagan, and I am from Brigantine, New Jersey.

ASSEMBLYWOMAN MURPHY: Right.

MS. EAGAN: After 52 years of marriage, and my husband spent 41 of them as a Chief in the Navy -- Senior Chief in the Navy and retired as a Command Senior Chief in the Navy-- At this point in his life, he is not ready to take orders from anybody.

ASSEMBLYWOMAN MURPHY: Sounds as though he never was.

MS. EAGAN: No, he never was.

Suddenly I have a terrible two in my house. After all of these years, I've got one back.

My only problem is-- My husband's retirement and my small Social Security takes us a little bit over the top. So thanks to the Holy Redeemer in Atlantic County, they put us together and we made the line. So I now, finally, have respite care for four hours a week. And it means I can at least get out and run somewhere. The first time I got out, I forgot to get everything I went to get. I was so excited.

I find I am the only one to take care of him. We're both-- He'll be 80 in June, and I am going to follow along right behind him in July. But other than that I am only here to say thank you so very, very much. Not only

to you people, but to the Holy Redeemer, the Nursing Association, and to Atlantic County. They found us. We didn't fall through the cracks.

ASSEMBLYWOMAN MURPHY: That's very nice to hear, Adeline.

MS. EAGAN: Well, thank you.

ASSEMBLYWOMAN MURPHY: I think so often some of our human service agencies and our county agencies don't get thanked for things often. It's quite often that the people are not as happy.

MS. EAGAN: But they didn't tell me I was going to talk today.

ASSEMBLYWOMAN MURPHY: Well, I am delighted you did. It's nice to hear good things about our counties and our county government and our human service agencies.

MS. EAGAN: Well, it is nice to know that we've got them. My husband has got his own personal respite caretaker, and there is a love affair going on in my own house.

ASSEMBLYWOMAN MURPHY: Is he giving orders?

MS. EAGAN: No, because she is bigger than he is and she is also Irish.

ASSEMBLYWOMAN MURPHY: There you go. I have to say that does it every time. That's why I married one.

Thanks, Adeline.

MS. EAGAN: Thank you very much.

ASSEMBLYWOMAN MURPHY: Dolores Hluszak -- no. Gloria Hluszak. I'm sorry.

I am reading half of one name and half of another, Gloria. I'm sorry.

GLORIA HLUSZAK: I hold this? (referring to PA microphone)

My name is Gloria (indiscernible) Hluszak. I live in Trenton, New Jersey, Mercer County. There's not too many of us here today.

For the last 15 years, I took care of my mom. The last 13 of those years I had assistance, and I was working at the time. My older brother was helping me. My mom lives with me for the last three years because of my brother's health. He died in January of this year. I have been a caregiver to my mom completely. I am the only one. I have no other family.

About my mom. My mom is 93 years old. She has osteoporosis, she has an ulcer, she has-- This year she's been in the hospital twice. She had a knee fracture, blood clot. She is almost deaf, thus, my voice because I have to really strain my voice to talk to her. But the hardest part is handling her dementia. Sixty percent to seventy percent of the time she is in that state. Eighty percent of the time she does not know who I am.

I am 60 years old now. When I was 57 years old, I had to have 24-hour care for my mom. It was too expensive for me to hire somebody at between \$400 and \$600 a week to stay with my mom. The circumstances with where I worked-- I worked for the same place for 37 years. I retired early at 57 years old. Up to now, I have been at home with my mom.

I chose to take care of my mom. I elected to have my mom be with me and not be institutionalized. The reason-- My mom came to this country in the late 1940s. We were born in Eastern Europe. She went through the Second World War. She was born in Ukraine. And Ukraine

being occupied by many countries-- It was a hard life. I see it now by the flashbacks that she has. When she is in this dementia state, she goes back to her younger years, and they were terrible years. So I thought, perhaps, being with me at home, seeing the flowers in the garden that she loves so much-- I do think her quality of life is better, and I hope to continue to keep her home.

The last three years, financially, have been straining on me. All my mom has is the Social Security. Prior to-- My dad died 15 years ago, and he was quite ill, so the financial -- their financial money went for his care. So in April of this year, I started looking into agencies that could help me out. I now have the pharmaceutical -- the \$5.00 per prescription.

ASSEMBLYWOMAN MURPHY: Right, the PAAD.

MS. HLUSZAK: Yes. I also applied, in April of this year, for respite, and July 31 I was approved. The two young ladies that are here, Myra Pressman and Maryann Ferdetta, are just great. I am allowed 10 hours per week for me to go to the movies, going shopping, just being away from home. But that is really not enough -- 10 hours a week. When I elected to take care of my mom, I didn't realize what a caregiver has to give up of their own life. I used to work. I was very active socially. I belonged to three or four different clubs, I did volunteer work, and all of that is cut now. My life, now, is with my mom. There are sleepless nights. Sometimes I have to have someone stay with my mom so I can just catch up on my sleep because she does get aggressive very often.

What I would like to see done-- I would like more help than the 10 hours because I average between 15 hours and 25 hours that I pay, personally, so I can go to the movies, I can go shopping, I can go to see my

friends, and I still belong to one club. Once a week we still meet. I ask that, for instance, more funding be given to respite because they have been super. I have now applied for Medicaid because I understand that if I have Medicaid, from that standpoint, I can receive home aide. Also, for instance, small things like diapers -- Depends Diapers, taking my mother to the doctor by ambulance -- all of that has to be covered by insurance. It has to be covered by my mom and me.

Yesterday, when I was ready to come here-- I like to work on a computer because I used to work in an office. I put just a-- I'm really saving the State a lot of money by staying home with my mom. On the average -- okay-- On the average-- To put her in a nursing home, on the average, it would be \$4500. I average between -- about \$2000 a month, sometimes more sometimes less depending. If she is in the hospital, then my care is less.

It would be great if my expenses could decrease. And I just want one-- My mom's income is \$10,096 a year this year. I averaged December because December is not over yet. Total expenses my mom had were \$14,700. That means we're in the red \$4600. This is not the first year. I was in the red last year and the year before that. I have to cover that. Please understand I don't work. I am not eligible for Social Security until I am 62 years old. So it is pretty tough. I would like more assistance with my mom at home.

Thank you.

ASSEMBLYWOMAN MURPHY: Thank you very much and thank you for coming. If you have anything written that you would like to leave for us--

MS. HLUSZAK: Yes.

ASSEMBLYWOMAN MURPHY: Dr. Cicchini. Cicch-- I am not saying that right. Dr. C-I-C-C-H-I-N-I. (no response)

The Rollings--

Mr. and Mrs. Rolling, I am sorry. I did see your hand, and I apologize. Thank you for being here.

LOUISE ROLLING: Why we need home health aides and respite care.

My name is Louise Rolling. I live at 62 Dunham Street. I will tell you some of the things I do for one of our neighbors, Mrs. Robinson, who lives alone at 78 Dunham Street. She is now with her second stroke. After having her first stroke, I did take care of her for quite a while. Then some of her church friends did take care of her for about six months. And then-- That gave me some relief. Then Mrs. Robinson wanted to come home. She asked me if I would help her. I told her that I would help her as much as I could. I found she needed someone to help her with her bathing and helping her get dressed and getting her breakfast and helping her to take the right medicine at the right time and keeping her floor clean. Sometimes-- I had to clean her floor often. Sometimes I go shopping for her. And sometimes she gets very depressed and nervous, and she'll call me and I'll go up and try to calm her down.

She falls quite often. I call my husband, and together we pick her up. And also we have to take her to the doctor. And there are several other things we have to do for her. We try to make her comfortable.

She does have home aides to come in, but even with that I still have to help Mrs. Robinson. She's 92 years old, and there is not very much

she can do for herself. I really appreciate the health aides that come in to help us.

Thank you.

JAMES ROLLING: I would like to say a few words. I am like the lady that preceded. I didn't anticipate having to talk today, but Mrs. Robinson-- She has no one, no relatives, no one in the city of Trenton or the State of New Jersey. So she doesn't hesitate to call us 3:00 in the morning or whatever time. When she gets depressed, she will get off of the bed and call my wife and say she fell off the bed. But when you get there, she has gotten from the bed to the telephone to call my wife. So this is what we've been going through for about two years. On top of that, my wife's uncle had his second stroke. She delegated that patient to me. So now, in the morning when she fixes breakfast, I am going out the back door, and she is going out the front door, and the same thing in the afternoon. For two years we couldn't take a vacation. This year my wife got in touch with someone that had this--

MS. ROLLING: The Respite Program has been wonderful.

MR. ROLLING: So we did get 15 days this year.

I guess I have a question. When senior citizens -- when people begin to get their Social Security, is there any way that a package can be included, at that time, explaining what is available? I am 74 years old now. I don't think I need any of these programs yet, but it would be good to know what is out there for us.

So with that I thank you, and you have a good day.

ASSEMBLYWOMAN MURPHY: Thank you, Mr. and Mrs. Rolling. If everybody had neighbors like you all, the world would, probably,

be a lot different, and we wouldn't have any agencies at all because the neighbors would be doing it. But we're very grateful to you for coming and talking to us. Sometimes we forget how wonderful a good neighbor is.

Thank you for being good neighbors.

We're still looking for Doctor--

Go ahead, Nick.

ASSEMBLYMAN ASSELTA: Cicchini. (indicates pronunciation)

ASSEMBLYWOMAN MURPHY: Cicchini. (indicates pronunciation)

Joyce Camm. (no response)

Ilana Crowther, who was on the first page, has now arrived. Okay.

Hello, Ilana, how are you?

I L A N A C R O W T H E R: Hi, my name is Ilana Crowther. I work for Holy Redeemer Visiting Nurses. I have been a nurse for 35 years. I've been working-- At the agency, I am responsible for home health aide services and all the community outreach programs that we do. So I have been involved in Statewide Respite since 1991.

Last night I viewed a tape that one of our clients provided to us. He wanted to use his experience in caring for his wife with Alzheimer's to help educate us and the public about what it's like on a daily basis to provide care to a client with Alzheimer's. The love that you saw in his eyes and the look of love on the client's face as she looked at him and as he provided the most intimate personal care that needed to be done was just lovely and brought you to tears. I am an old, hard-hearted nurse of many years. To see the love that was there -- knowing that if he doesn't get some relief, he is not going to be

able to do this much longer, and it is his desire and his wife's desire to be at home.

I see many other clients, that we provide service to, don't know where to start to look for help. They find us, and luckily we're able to do something or pull something together with the programs that the State has provided in order to meet their needs. Often they ask for very little. But once you get in there and you start providing services, they realize how overburdened they are. We're very happy when we can get in there early before they're burned out completely. I feel, in my position-- My own life experiences have been such that I cared for my father at home for 12 years while working full-time and having three children. So when a daughter or son calls me and tells me they are at the end of their rope, I understand where they are, and I can help them not to feel guilty about feeling at the end of their rope and that they can't take it anymore and that they should look for help and they should get help.

As one of the other couples said, they're saving the State a lot of money. But they're doing what they want to do. They're doing something that they feel is important. I think all of us need to support them in whatever way possible.

Thank you.

ASSEMBLYWOMAN MURPHY: Thank you very much for taking the time to come.

We have five people left, and we have time to hear the five people, so I think things are going to work out well.

Carol Deugenia. (phonetic spelling); (no response)

Booker Johnson. (no response)

Mildred Oversbee. (phonetic spelling);(no response)

Well, we just eliminated three of the five.

ASSEMBLYMAN ROMANO: Oh, I thought this was on top of the five.

ASSEMBLYWOMAN MURPHY: Gussie Little.

And Joan Crow is with you?

G U S S I E L I T T L E: Yes.

ASSEMBLYWOMAN MURPHY: Okay.

MS. LITTLE: She's been sitting a long time--

ASSEMBLYWOMAN MURPHY: Yes she has.

MS. LITTLE: --and this is a little difficult for her.

ASSEMBLYWOMAN MURPHY: Take your time.

Good afternoon.

MS. LITTLE: Good afternoon.

I would like to say good afternoon to the committee (*sic*) and the Chairwoman. My name is Gussie Little. I am a caregiver for Sterling Choice, it's an alternative program. What we do-- We take care of patients that are not able to take care of themselves in their homes, or many times they have families and their family cannot take care of them. Our agency takes them in and-- First, I would like to let you know that we are -- we have to go to school and we get trained for it. We have to also be fingerprinted. Everything has to happen according to the State, so it's not that your putting your loved ones into some stranger's hands because they have already checked us out.

I heard one of the panel members say, earlier, that all of us are coming to that stage, and we don't know how or what is going to happen down the end of the road. We don't know that. But how Joan Crow-- This is my friend, and she is also living in my home. We began to love each other. It didn't make any difference because she was Caucasian and I was black. We still love each other. We are God's children.

Joan Crow came from-- Do you want to tell her?

JOAN CROW: King David Nursing Care Facility.

MS. LITTLE: And she came to me. I've had her now for about two years. My family has become her family. We have learned to actually get along with each other. We have our problems, but that's all right.

At this time, I am just going to say this to the panel. There are many things that we need -- need to be improved in this program. One of them is that taking care of Joan Crow, whom I love, is not a great deal of money. Don't think that we're getting \$4000 or \$2000 a month. We're not getting that. We get \$28.50 per day. That's for night and day. So you can tell from this that it's not the money, but it's love. So we thank God for that.

At this time we also have Jack DeBoris, who is a part of Sterling Choice, here with us. He is a fine young man, and we love him.

At this time, I am going to let Joan tell you-- I'll tell you something about what happened really-- How she came to live with me was that my husband had just passed, I had gone through some of the same things that I have heard so many people talk about here -- taking care of your husband who was terminally ill. I was alone in the house after he died. It was like nobody was there. I would get up in the morning, and it was just me. I

would go out, and it was just me coming back. When I heard of this program, I said, "Lord, it's something I could do with my home." You know, in my home I had three bedrooms and a nice little home. I said, "I don't need to be here alone." So when I heard about Joan, I got happy. And we thank God that she is here with us. She'll tell you some of the things about herself and how she likes being in the home with us.

MS. CROW: I had to go to a nursing home because I had a stroke, and I had open-heart surgery. So the doctor sent me there because I couldn't take care of myself at home. I had rheumatic fever when I was a little girl, so I had a very early stage when I was very little. I got my disability from my father. My stroke-- (remainder of comment indiscernible) So I am very happy here, though I didn't have a very unhappy home. I was happy here with Ms. Little because she just provides the things I had when I was home.

ASSEMBLYWOMAN MURPHY: Thank you very much.

MS. LITTLE: Thank you for hearing us.

ASSEMBLYWOMAN MURPHY: We appreciate you coming today. Thank you.

If there is no one else who wishes to be heard today.

UNIDENTIFIED SPEAKER FROM AUDIENCE: (indiscernible)

ASSEMBLYWOMAN MURPHY: You are.

UNIDENTIFIED SPEAKER FROM AUDIENCE: (indiscernible)

ASSEMBLYWOMAN MURPHY: And I think that will be the last person of the day.

ASSEMBLYMAN ROMANO: I think you have somebody else.

ASSEMBLYWOMAN MURPHY: Do we? (no response)

Thank you all.

And you are--

JANICE PIZZUTO: My name is Janice Pizzuto. I am with Virtual Health System, which is a West Jersey Health System. I want to thank you for giving me the opportunity to speak, and I will be very brief.

I just want to say that you have an immense task in front of you today, and I wish you all the luck because there is a lot of work to do.

I would just like to briefly speak about the frail elderly and the socially isolated people. Many-- Also the MS patients that I deal with on a regular basis, people with diabetes, heart problems -- their problems are very numerous. One program that our health system offers, that was not spoken of today, is a personal emergency response system. You've probably heard of it. "Help, I've fallen and I can't get up." People laugh about that, but really, the service is a wonderful service.

Just to bring you home to a situation, we had a couple in their eighties. The man fell when he went into the bathroom. His wife, who is of the same age, went in to help him up and fell on top of him. They laid there for several hours when the daughter came in to check on them. Through the use of a personal emergency response system, these kinds of incidents can be prevented because, through the simple push of a button, they can get help within a very short period of time. This has been a proven tool to help with health-care dollars and the prevention of early institutionalization.

I have written letters to some of the Senators and Assembly people, and one blockage that we come across is that it is not covered through Medicare or Medicaid. The only way to do that is actually revamp the

Medicaid Waiver, which falls under 2176. The Medicaid Waiver would have to be looked at and possibly changed, which I don't know if that is at all possible, but that would be one of my requests. And also for the State of New Jersey to also, possibly, do a pilot study on a personal emergency response system. This has never been done. Although PERS are offered in 25 other states, all surrounding the State of New Jersey-- Pennsylvania offers it. Maryland, Delaware, and all of that also.

ASSEMBLYWOMAN MURPHY: Janice, this Council is empowered to look at how people will live in terms of housing and caregiving, not really so much those kind of services. So if we don't take you up on the offer to really look at it, you will understand that is really not our charge from the Governor.

MS. PIZZUTO: Okay.

ASSEMBLYWOMAN MURPHY: But you certainly may testify.

MS. PIZZUTO: It really does-- The whole focus here, which is for caregiving -- it is also to prevent early institutionalization, which I know is one of the focuses of the State. This is one tool that can actually do that.

So if there is another forum that this can be brought up into, we would be happy to bring that information.

ASSEMBLYWOMAN MURPHY: And your testimony will be on the record. Thank you.

MS. PIZZUTO: Thank you.

ASSEMBLYWOMAN MURPHY: And there was one other woman who wished to say something in--

And you are?

NANCY F. MALISZIEWSKI - CURLETT: My name is longer than a blackboard. My name is Nancy F. Maliszewski-Curlett, and I am from Cumberland County. I am grateful that you allowed me to be the last speaker.

A couple of things that haven't been mentioned today, one on Alzheimer's-- The Alzheimer's Association does something called the ABC Program. That is how my husband and I were brought into the Alzheimer's Association. It was four different sessions with authorities on different programs that needed to be addressed such as nursing home care, etc. They were done through the community colleges. The one we attended was here in Cumberland. I understand that one was just held in Atlantic County, and you were looking for educating people on different situations within Alzheimer's. I think that is excellent.

We are family members of an extended-- We have just buried the third Alzheimer's patient in our family, and we still have two more to go. They are all in the generation above us. If Alzheimer's comes by heredity, then my two step-daughters are going to get it from both sides of the family. That's not fun to think about.

Frail elderly have been mentioned-- Please remember that a lot of women have osteoporosis; that's not been mentioned or seemed to be addressed. The one that is my pet, probably because I have it, is something called post-polio syndrome. With Salk and Sabin vaccines, we no longer have polio in this country. But those of us who have had polio are living longer, and things need to be addressed for that situation also.

I thank you very much.

ASSEMBLYWOMAN MURPHY: Thank you very much for that.
Ladies and gentlemen, thank you for being here.

And to the members of the Council, you are absolutely wonderful people.

ASSEMBLYMAN ROMANO: You say that to me all the time.

ASSEMBLYWOMAN MURPHY: Well, it's because I happen to think you are, Lou.

ASSEMBLYMAN ROMANO: When are we meeting again?

ASSEMBLYWOMAN MURPHY: You will be receiving a draft of the progress report that we will be sending to the Governor, for your approval, is being--

ASSEMBLYMAN ROMANO: When?

ASSEMBLYWOMAN MURPHY: By the end-- I'm telling you this-- Probably just after Christmas. We need to give this progress report to the Governor for the 1st of January. Then we will be meeting toward the end of January in a hearing at the State House. I will send you a couple of days to pick from that. The end of January--

ASSEMBLYMAN ROMANO: I mean we're not going to be meeting in between the Christmas and January holiday.

ASSEMBLYWOMAN MURPHY: No, we will not.

ASSEMBLYMAN ROMANO: Okay.

ASSEMBLYWOMAN MURPHY: I am going to have a 66th birthday, Lou.

ASSEMBLYMAN ROMANO: I know. It's Christmas Eve.

ASSEMBLYWOMAN MURPHY: I am going to do it no matter what you say.

ASSEMBLYMAN ROMANO: Christmas Eve.

ASSEMBLYWOMAN MURPHY: Thank you all for being here.

And, Assemblyman Asselta, thank you for welcoming us.

(HEARING CONCLUDED)