

**DEPARTMENT OF
HUMAN SERVICES**



NEW JERSEY

STATE STRATEGIC PLAN ON AGING

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Executive Summary

New Jersey has a growing and diverse older adult population who wish to maintain their independence and live in the community for as long as possible. This State Plan empowers older adults in New Jersey by enabling and supporting them to make lifestyle changes to reduce their risk of disease, disability and injury and to manage their own care and make choices that will allow them to avoid or delay the need for long-term care services. It also provides options and supports when individuals need them.

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

New Jersey's State Unit on Aging has been placed in several departments since its inception. During Governor Chris Christie's state fiscal year 2013 budget address, he announced the restructuring of state government to better serve its citizens. Part of his change included the decision to move senior services from the Department of Health and Senior Services to the Department of Human Services (DHS). The improvement of health outcomes, appropriate care in the appropriate setting, coordination of wrap-around services, and the ability to create opportunities for aging adults to remain at home guided this move.

Effective July 1, 2012, all senior supports and services from the Department of Health were transferred to DHS through statute. The legislation created the Division of Aging Services (DoAS), a realignment of the former Divisions of Senior Benefits and Utilization Management and Aging and Community Services. This structure has established a single point of access for older adults, people with disabilities and their caregivers regardless of Medicaid eligibility.

Given the restructuring of aging services in DHS and the changing demographics of New Jersey's growing and diverse older adult population, DHS will assume responsibility as the State Unit on Aging under the Older Americans Act. DoAS will serve as the administrative agency.

DoAS administers federal and state-funded services and supports and makes it easier for older adults to live in the community as long as possible with independence, dignity and choice. The division receives Older Americans Act funding and serves as the focal point for planning services for the aging, developing comprehensive information about New Jersey's older adult population and its needs, and maintaining information about services available to older adults throughout the state. Due to the consolidation of the two divisions, DoAS is now responsible for the operation of two prescription drug assistance programs, the Pharmaceutical Assistance to the Aged and Disabled and the Senior Gold Prescription Discount Program, as well as the Lifeline Utility Assistance program and the Hearing Aid Assistance to the Aged and Disabled program. The division maintains a staff of approximately 320 full-time employees based in Trenton and three regional field offices (see Appendix A).

DoAS is also the State Administering Agency for the Medicaid 1115 Demonstration Waiver Global Options for Long-Term Care (GO) program. In January 2014, DHS plans to move home and community-based services under its new Comprehensive Medicaid Waiver into Managed Long Term Services and Supports (MLTSS). In July 2014, the nursing homes are scheduled to move into a managed care model under MLTSS. While the administration for MLTSS will be run under DHS' Office of Managed Health Care, Division of Medical Assistance and Health Services, DoAS will retain an important role in the MLTSS program.

DHS is required to develop and submit a State Strategic Plan on Aging to the U.S. Administration on Aging under the Older Americans Act of 1965, as amended. This plan, covering the years 2013-2017, outlines the direction in which New Jersey's long-term care reform efforts are moving and identifies strategies to address the needs of the fast growing new generation of older residents and their caregivers who want to remain in their homes and communities with the assistance of long term services and supports as and when needed.

This plan outlines five goals and accompanying strategies to address New Jersey's vision for improving the delivery of aging services. Each strategy also has performance measures against which DoAS can be evaluated in meeting its goals over the life of the plan. The plan is not a static document and is flexible to meet changing priorities on the state and federal levels. Here is an overview of what is detailed in the New Jersey's State Plan:

Context

New Jersey has adopted this State Strategic Plan on Aging to formalize its goals, objectives and strategies for addressing current and future needs of the state's older adults and their caregivers. The State's goals align with those established by the U.S. Administration on Aging in its most recent Strategic Action Plan, with one notable exception. In the wake of both Hurricane Irene (August 2011) and Superstorm Sandy (October 2012), New Jersey selected a goal to strengthen the aging network's ability to prepare for and respond to emergencies. Our goals are:

- **Goal 1:** Empower older adults to be active, healthy and engaged in their communities.
- **Goal 2:** ADRC Partnership serves as the no wrong door/single entry point to home and community-based and long term services and supports for older adults, persons with disabilities and their caregivers, regardless of their income.
- **Goal 3:** Older adults and their caregivers have access to the full array of public and private home and community-based services (HCBS), regardless of income.
- **Goal 4:** Ensure the rights of older people and prevent their abuse, neglect and exploitation.
- **Goal 5:** Ensure older adults and the network that serves them are better ready for the next emergency.

To solicit input into the development this plan, the Division of Aging Services (DoAS) held a stakeholders' meeting and three public hearings between February, April and May 2013. A summary of those meetings can be found in Appendix B.

Aging in New Jersey: New Jersey's older adult population is growing and diverse (see Appendix C). 2010 Census data ranked the state 11th in the nation in overall population and 10th in the number of individuals (1,666,535) age 60 and older. From 2000 to 2010, the percentage of New Jersey residents age 60 and older rose 15 percent. The largest population growth was among the youngest cohort, age 60-64 years, at 45.3 percent, and the oldest, age 85 and over, at 32.1 percent. This change reflects the aging of the baby boomers (those born between 1946 and 1964) and their parents. The population over age 60 years is projected to grow substantially in the near future. By 2030, the population in this age group in New Jersey is projected to number 2.5 million. People aged 60 and over represented 19 percent of the state population in 2010: by 2030, this figure is expected to rise to 25.6 percent.

New Jersey is one of the most diverse states in the nation across all generations. Among state residents aged 60 years and over, 42.6 percent are from racial or ethnic minority groups compared to 37.7 percent nationally. According to the 2010 Census, 9.8 percent were non-Hispanic black, 8.5 percent were Hispanic and 5.3 percent were Asian and Pacific Islanders. Within each of these groups, there is a tremendous diversity among ethnicities and primary languages spoken in the home. Census survey data shows that 22.1 percent of residents age 60 and older spoke a language other than English at home and 13.7 percent reported they spoke English less than "very well."

In the 60 and older age group, 55.9 percent are married and 24.7 percent are widowed. In addition, 40.8 percent are living alone. There is also a significant gender gap among New Jersey older adults. Women account for 56.8 percent of the population age 60 and older, and 68.6 percent of the population age 85 and older.

For income data, this plan looked to two main sources: the 2010 Census and the Elder Economic Security Standard Index, a resource measuring how much income older adults need to adequately meet basic needs without public or private assistance. The New Jersey Foundation for Aging developed the Index in partnership with Wider Opportunities for Women (WOW) and the Gerontology Institute at the University of Massachusetts Boston. Their 2012 release found that in order to reach economic security, a single senior needed an annual income ranging from \$25,320 (for homeowners without a mortgage) to \$37,320 (homeowners with a mortgage). For couples, the standards ranged from \$36,204 to \$48,204. The standard for renters was roughly \$2,500 higher than for homeowners without mortgages. With more than 25 percent of seniors relying solely on their Social Security benefit, it is clear that many cannot adequately meet their basic living expenses. Census data reveals that between 2006-2010, 7.5 percent of New Jersey residents age 60 years and over had incomes below the poverty level, which is lower than the proportion for the population as a whole. The poverty rates were higher for minority seniors.

Approximately 20 percent of the statewide non-institutionalized population age 65-74 claimed a disability in 2010. The prevalence increased substantially with age. In the 75+ age group, 48.8 percent of men and 48.9 percent of women had a disability.

Service utilization of home and community-based services continues to rise. On January 1, 2012, more than 11,700 seniors and adults with disabilities were enrolled in the state's Medicaid 1915 (c) waiver, Global Options for Long-Term Care. Close to 1,400 more were enrolled in the state-funded Jersey Assistance for Community Caregiving. Through efforts to rebalance the state's long-term care system, the percent of government funding now dedicated to home and community based services has risen to a record 30 percent.

In 2012, over 400,000 individuals received services through their Area Agencies on Aging. For detailed information on programs and services at the Division of Aging Services, including utilization data, see Appendix D. When planning to help older adults, it must be taken into account that despite society's hectic pace, caregivers continue to provide the majority of long-term services and supports in our state and across our country. It is estimated that 980,000 New Jersey residents are currently providing some degree of help to an elderly relative or friend.

To meet the changing demographics, diversity, needs and demands of its consumers, the aging network in New Jersey is changing the way it does business. The following activities and accomplishments are keys to our success moving forward:

Aging Services Restructuring: Governor Chris Christie announced the restructuring of state government to better serve its citizens in his state fiscal year 2013 budget address. Part of his change included the decision to move senior services from the Department of Health and Senior Services to the Department of Human Services (DHS). The improvement of health outcomes, appropriate care in the appropriate setting, coordination of wrap-around services, and the ability to create opportunities for aging adults to remain at home guided this move.

Legislation was enacted effective July 1, 2012 and all senior supports and services from the Department of Health were transferred to DHS. The legislation created the Division of Aging Services (DoAS), a realignment of the former Divisions of Senior Benefits and Utilization

Management and Aging and Community Services. This structuring has established a single point of access for older adults, people with disabilities and their caregivers regardless of Medicaid eligibility.

Given the restructuring of aging services in DHS and the changing demographics of New Jersey's growing and diverse older adult population, DHS will assume responsibility as the State Unit on Aging under the Older Americans Act. The Division of Aging Services will serve as the administrative agency. This organization mirrors the way in which the Department is the single state agency for Medicaid recognized by the U.S. Department of Health and Human Services and the Division of Medical Assistance and Health Services is the administrative agency.

Aging and Disability Resource Connection (ADRC): In 2003, New Jersey was one of 12 states awarded an ADRC grant by the U.S. Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) to improve access to information and services, and to streamline the Medicaid eligibility process. The ADRC initiative was the first joint venture between the Department of Health and Senior Services (now Health) and the Department of Human Services (DHS) to create a “no wrong door” coordinated single entry system for older adults, younger persons with physical disabilities and long-term chronic illnesses and their caregivers. The state introduced the concept beginning with Atlantic and Warren Counties as pilot programs in 2005. In May 2012, New Jersey achieved a major milestone in which all 21 Area Agencies on Aging (AAAs) now serve as the lead agencies for the ADRC model. This achievement creates a single point of access in every county for aging residents and individuals with disabilities to get information or referrals, submit applications and access services, regardless of income. This type of one-stop resource and convenience is invaluable, especially for people with mobility and transportation challenges.

The ADRC is a key component of New Jersey's plan to transform its overall long-term care system to one that encourages community-based services and consumer-direction and gives consumers greater choice and more control over how, when and where needed services are provided. The model is built on an algorithm created to identify a standardized client pathway and decision-making process for accessing information and determining clinical and financial eligibility for State and federal programs. The algorithm consists of these six steps: (1) building organizational capacity; (2) initiating contact with consumers; (3) identifying consumers' needs; (4) counseling consumers on home and community-based services and long-term care options; (5) coordinating consumer directed care plans, and (6) integrating a continuous quality management framework into the ADRC model.

ADRC Website: The ADRC website was launched in May 2012 and contains information on thousands of state and national resources for older adults, individuals with disabilities and their caregivers. At launch, its *Services & Providers* section contained information on the approximately 400 organizations providing services under an Area Agency on Aging (AAA) Area Plan Contract. Since then, DoAS converted AAA service directories into website-compatible formats and uploaded information on an additional 3,000 providers. The *Learn About* section was also modified to add New Jersey resources to those national resources posted and maintained by the site's host. The website – www.adrcnj.org – offers several new search

options and other consumer-friendly tools including Google translation and mapping features. The site is Section 508 compliant for improved access to individuals with vision impairments.

DHS applied for and is receiving federal funding through September 30, 2015 from the Balancing Incentive Program (BIP). The federal initiative offers an additional 2% in Federal Medical Assistance Percentages (FMAP) funding for New Jersey in exchange for expanding home and community based services and decreasing reliance on institutionalization. Under the BIP, the website will be expanded to serve as the online resource directory for the Divisions of Disability Services, Developmental Disabilities and the Mental Health and Addiction Services.

ADRC Five-Year Strategic Plan: With strong collaborative partnerships comprised of aging and disability entities at the state and county levels, New Jersey has the authority to ensure the Area Agencies on Aging (AAAs) become fully-functioning ADRCs and the state has the flexibility to manage home and community-based services (HCBS) and long-term services and supports (LTSS) more efficiently. A primary focus will be one of continuous quality improvement to the infrastructure, process and delivery of LTSS to older adults and persons with disabilities across the department and programs.

Building upon the achievements of the past 10 years, DoAS adopted a new ADRC five-year plan to ensure that DHS and the county-based ADRC partnerships, will continue to be enhanced throughout New Jersey (see Appendix E). These goals are:

- **Access:** The Aging and Disability Resource Connection serves as NJ’s “no wrong door” for older adults, people with disabilities and caregivers to learn about and access the full range of home and community-based services (HCBS) and long term services and supports (LTSS).
- **Assessment and Options Counseling:** Through the identification of care needs ADRC assessors will educate consumers on their care needs, counsel them on appropriate service options, and various funding sources, including public, private and personal resources.
- **Money Follows the Person (MFP):** Through comprehensive assessment and provision of coordinated LTSS, nursing home residents will be able to transition to appropriate community-based settings that promote their independence, dignity and choice.
- **Transition Care Models:** Establish partnerships and connections between ADRCs and hospital and/or community transitional care programs. ADRCs will provide supportive services and case management in order to decrease number of re-admissions.
- **Information Technology Support:** Improve client access to LTSS through the use of integrated IT systems and use the systems to monitor quality services rendered.
- **Financing Opportunities for HCBS:** Support NJ’s leadership to rebalance long-term supports through cost-effective strategies.
- **Quality Management:** Through the HCBS framework, DoAS will continuously improve all services, activities and organizational efforts to promote independence, dignity and choice for older adults, persons with disabilities and their caregivers.

Impact of ADRCs on County’s Rebalancing Efforts: In 2006 the ADRC was included in the legislation known as the “Independence, Dignity and Choice in Long Term Care Act.” The Act charged the state with expanding public expenditures for long term services and supports by offering a larger array of home and community-based services (HCBS). The Act fostered greater consumer choice to facilitate maximum flexibility between HCBS and nursing facility care.

Thus, one of the goals of the ADRCs has been to effect LTSS rebalancing through an integrated approach that strengthens communications between acute and HCBS settings, focuses on early identification and response to health care risks, and ensures continuity of care across providers and settings. As shown below, ADRC activities have positively impacted the reduction in nursing facility costs in those counties where ADRCs are functioning in SFY 2011.

Member Months in Nursing Facility by County by SFY:

County Type	SFY 2008	SFY 2009	SFY 2010	SFY 2011	2008 to 2011 Change
ADRC Counties	50%	48%	45%	43%	-7%
Non-ADRC Counties	44%	43%	41%	39%	-5%

1115 (a) Research and Demonstration Waiver: New Jersey is significantly reforming its long-term care system with the transformation of the state Medicaid program through the federal government’s approval of a five-year Medicaid Section 1115 (a) research and demonstration waiver known as the New Jersey Comprehensive Medicaid Waiver (CMW). In October 2012, the Centers for Medicare and Medicaid Services (CMS) approved the CMW – which included the state’s plan to implement managed long term services and supports (MLTSS) and serve more individuals with the home and community-based services (HCBS). The waiver approval authorized:

- Streamlining of the Medicaid/NJ FamilyCare program by consolidating two 1915(b) waivers, four 1915(c) waivers and two existing 1115 waivers.
- Integrating primary, acute, long term and behavioral health care through contracts with Administrative Service Organizations.
- Establishing a federally-funded supports program, previously a state-only funded family supports initiative that provided in-home services to individuals with intellectual or developmental disabilities.
- Advancing Managed Long Term Services and Supports (MLTSS), which increases utilization of HCBS for seniors and individuals with disabilities, instead of nursing facility or developmental center care.
- Making changes to the hospital delivery system of care by transitioning funding from the Hospital Relief Subsidy Fund to an incentive payment model.
- Increasing community-based services for children who are dually diagnosed with developmental disabilities and mental illness by providing case management, individual supports and respite for caregivers.

It is within the context of enhancing the current managed care environment through the CMW – with its integrated primary, acute, behavioral health and long-term services – that New Jersey reiterates its commitment to making structural reforms and ensuring consumers and their caregivers have access to a no wrong door/single entry point (NWD/SEP) to HCBS, a core standardized assessment, and conflict-free care/case management. It is the ADRC model that will serve as the NWD/SEP for individuals and their caregivers seeking to information and access to the full range of public (federal/state/county) including MLTSS. With its ADRC fully operational statewide, New Jersey has a pathway by which individuals seeking LTSS have access to programs and services through a statewide toll-free number, a website, and county-based locations.

As a provision under the CMW, New Jersey requested approval to secure Medicaid Federal Financial Participation (FFP) for the ADRC to support the necessary administrative functions associated with Medicaid eligibility. The ADRC functions identified for FFP are: 1) Level 1 screen for MLTSS; 2) Outreach to the target populations about the CMW; 3) Level 2 functional assessment for long term services and supports; 4) Options Counseling on the full range of LTSS options; and 5) MLTSS Navigator/Service Coordination.

Currently DoAS works with DHS' Central Budget Office and the Division of Medical Assistance and Health Services, to develop the methodology for claiming FFP and ensuring compliance with federal regulations under the Medicaid program.

Balancing Incentive Payment Program: New Jersey was awarded a Balancing Incentive Payment (BIP) program grant, effective April 1, 2013 through September 30, 2015, which will enable the state to receive a two percent enhanced match rate for non-institutional long term services and supports. The award is projected to be \$108.5 million.

One of the state's greatest strength in advancing the structural changes required under the BIP grant is the approval of the Comprehensive Medicaid Waiver (CMW). The CMW is designed to advance the state's balancing efforts away from institutionally-based expenditures to less costly HCBS. The BIP will further support this goal. New Jersey is committed to the goals of the BIP and its requirements of a NWD/SEP system, conflict-free case management services and core standardized assessment instruments. A number of elements are already in place, starting with the statewide ADRC model and its county-based partnerships.



Traditionally, services for older adults have been administered separately from those for persons with disabilities although these groups share many of the same needs and face many similar barriers to care. A challenge for our ADRC will be to expand its knowledge and customer base to assist the populations served by the Divisions of Disability Services (DDS), Developmental Disabilities (DDD), and Mental Health and Addiction Services (DMHAS). Under the CMW, the ADRC partnership, as the NWD/SEP, will be expanded to include additional community agencies who serve the new target populations seeking managed LTSS including county welfare agencies (CWAs), county offices on disability services, Centers for Independent Living (CILs) and other nonprofit agencies in the aging and disability service networks.

While consumers will continue to enter through the service delivery systems associated with the divisions of DDS, DDD and DMHAS, currently there are no standardized responses as to how the ADRCs should respond to inquiries for the expanded target populations. To address this issue DoAS will: (1) expand the ADRC client pathway to include the additional entry points; (2) modify the ADRC Level 1 Screen for Community Services to include functional questions appropriate for the new target populations; (3) expand the ADRC website to include national, state and local community agencies; and (4) cross-train current and new ADRC partners to use the new tools and client pathway to ensure individuals and their caregivers seeking MLTSS can be screened and referred to the appropriate community-based program.

Goals, Objectives and Strategies

Goal 1: Empower older adults to be active, healthy and engaged in their communities.

Objective 1.1: Promote nutrition education in programs.

Objective 1.2: Promote behavior changes that lead to better self-management of chronic diseases, increased activity and improved physical fitness of older adults.

Objective 1.3: Expand and support the role of the Area Agencies on Aging (AAAs) in evidence-based disease prevention.

Objective 1.4: Strengthen state-level partnerships to support healthy aging.

Objective 1.5: Promote the use of prevention benefits under Medicare.

Objective 1.6: Improve access to transportation services.

Goal 2: ADRC Partnership serves as the no wrong door/single entry point to home and community-based and long term services and supports for older adults, persons with disabilities and their caregivers, regardless of their income.

Objective 2.1: Implement an enhanced training curriculum for Area Agency on Aging (AAA) staff members to help them understand the effects managed care will have on business processes (eligibility and enrollment) and the service options available to the designated target populations including individuals with physical, developmental and mental illness and addictions.

Objective 2.2: Establish a financial infrastructure in which federal matching funds are received for performing ADRC functions that are Medicaid-related activities.

Objective 2.3: The Area Agencies on Aging (AAAs), serving as the lead agencies in the ADRC network, continue to establish local partnerships with providers representing persons with disabilities, mental health and addictions.

Objective 2.4: Expand the state's current options counseling curriculum to focus on all publicly- and privately-funded programs inclusive of the disability, veterans, dual eligible and mental health populations as well as those individuals enrolled in managed care or PACE.

Goal 3: Older adults and their caregivers have access to the full array of public and private home and community-based services (HCBS), regardless of income.

Objective 3.1: Consolidate five of the nine state-funded Community Based Senior Programs (Home Care Expansion, Alzheimer's Adult Day Services, Jersey Assistance to Community Caregiving, Supplemental Home Delivered Meals, Statewide Respite Care Program for the Elderly, and Safe Housing and Transportation) to provide older adults at risk of nursing home placement and spend down to Medicaid with a consumer-directed home and community-based service alternative to institutionalization.

Objective 3.2: Modernize OAA contracting policies to support consumer-directed cash management plans.

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

Objective 4.1: Increase appropriate reporting of neglect and abuse and decrease the incidence of abuse through the work of the Ombudsman for the Institutionalized Elderly.

Objective 4.2: Strengthen the Long-Term Care Ombudsman Program's capacity to provide information to older consumers and the public at large on elder rights and consumer protection issues.

Objective 4.3: Continue to promote advance care planning to ensure that the care and treatment an individual receives is consistent with their wishes and their goals of care.

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

Objective 4.5: Address and train others to identify abuse, neglect and exploitation among vulnerable adults.

Objective 4.6: Identify special needs among **the vulnerable elderly** population and advocate for provision of individualized services.

Objective 4.7: Work toward greater autonomy and self-determination for adults under protective arrangements by advocating for supported decision-making models and enhanced community support services.

Objective 4.8: Provide technical assistance where appropriate regarding the needs of at-risk adults with respect to access to long-term care services and supports systems.

Objective 4.9: Enhance legal services advocacy, and the education of seniors, gatekeepers and aging network professionals.

Goal 5: Ensure older adults and the network that serves them are better ready for the next emergency.

Objective 5.1: Area Agencies on Aging (AAAs) have coordinated, updated and practiced emergency plans.

Objective 5.2: The New Jersey Division of Aging Services (DoAS) provides leadership and guidance for AAA disaster planning efforts.

Objective 5.3: Bring together representatives from the Offices of Emergency Management, Department of Human Services, DoAS and AAAs to evaluate and recommend changes to current preparedness and emergency response plans.

Objective 5.4: Increase the ability of senior centers and other entities to serve as shelters.

GOALS

Goal 1: Empower older people to be active, healthy and engaged in their communities.

Objective 1.1: Promote nutrition education in programs.

Progress Update 2009-2013: For many older adults, the first tangible service they receive from the aging network is a hot meal served in a senior center or delivered to their homes. In FY 2012, 33,818 older adults received congregate meals and 29,724 received home delivered meals (HDMs). Since their inception in 1974, congregate and HDMs are cornerstones of New Jersey's home and community-based service system and a gateway to more intensive services as needed.

Between 2009 and 2013, the demand for HDMs remained high, while participation in congregate meals declined. In 2009, 215 nutrition sites served 34,644 consumers and in 2013, the totals were 204 and 33,818, respectively. This equates to a 5% decline in the number of meal sites and a 7% decline in participants. Reasons cited by eligible adults for non-participation in congregate meals included: not recognizing that they have a need for services, inadequate transportation, social discomfort with attending or applying for assistance, dissatisfaction with foods served and activities provided, and lack of awareness that the program exists. To address this trend, nutrition directors throughout New Jersey are working on a unified marketing plan as well as exploring ways to accommodate "younger" seniors with different service needs.

The demand for HDM outpaces availability. On March 31, 2013, the waiting list for HDMs stood at 1,247 statewide. In 2009, New Jersey was the recipient of \$2.7 million for nutrition programming through the American Recovery and Reinvestment Act (ARRA). Together with a 15% required county match, this short-term infusion of funds allowed the state to open 29 new nutrition sites, expand 35 and keep 18 others from closing while delivering almost 562,000 meals to 24,500 seniors at home or at nutrition sites. While ARRA funds were available, five counties eliminated and eight counties reduced their waiting lists for nutritional services.

Under administrative changes imposed since 2009, all 21 Area Agencies on Aging (AAAs) now prepare a line item budget showing detailed annual costs for nutrition. Comparisons of cost are required to be submitted with requests for direct service waivers to the Division of Aging Services (DoAS) for approval. Currently, 10 AAAs provide all nutrition services directly, three provide only congregate nutrition directly and eight contract all nutrition services. The division's nutritionist also completes annual on-site programmatic reviews of all AAA nutrition programs.

Strategies

- Contract with the Medicaid Managed Care Organizations (MCOs) to provide HDMs to eligible individuals receiving care management services.
- Develop and implement a statewide marketing plan to increase awareness and use of nutritional services.
- Identify and enlist new partners to promote nutritional services to their constituents.

- Post the interest survey on DoAS' website and distribute copies to places and organizations frequented by older adults.
- Analyze survey results to determine preferred activities, educational opportunities and meal delivery options (i.e., time, place, cuisine and type of menu).
- Utilize data entered by nutrition programs into the Social Assistance Management Systems (SAMS) as a new tool for monitoring effective and efficient service delivery.

Performance Measures

- AAAs service utilization data is used to make appropriate inter-Title budget line transfers to address changes in demand between congregate and home delivered meals.
- Participation in the congregate meal program is maintained through effective marketing, partnering and program revisions based, in part, on the results of the interest survey.
- Nutrition directors receive up-to-date information on national, state and local trends through an annual meeting and other methods as appropriate.
- Data on nutrition services in SAMS reflects statewide activity and trends.

Objective 1.2: Promote behavior changes that lead to better self-management of chronic diseases, increased activity and improved physical fitness of older adults.

Progress Update 2009-2013: DoAS fortified and expanded its statewide infrastructure for the delivery of Take Control of Your Health, New Jersey's name for the Chronic Disease Self-Management Program (CDSMP). It did so by providing funding through federal grants for network expansion and workshop delivery, supporting and monitoring a statewide network of local workshop providers, and strengthening state-level partnerships. Between 2009 and 2013, DoAS received two competitive grants from the U.S. Administration on Aging (AoA) to support its efforts: the two-year American Recovery and Reinvestment Act (ARRA) and a three-year Empowering through CDSMP grants. Prior to receipt of an AoA grant in 2006, there was no capacity for delivery of CDSMP, as there was only one known CDSMP master trainer in-state.



Today, the program has 60 active master trainers and 200 active peer leaders delivering workshops statewide, and more than 5,000 individuals have participated in a CDSMP workshop. As part of its sustainability plan, DoAS purchased a single statewide license from the program's developer, Stanford University. It also produced, distributed and placed on its website tools for master trainers and peer leaders. DoAS has also begun to build capacity for three other

Stanford evidence-based disease prevention programs: Tomando Control de su Salud, the Spanish language version of CDSMP; the Diabetes Self-Management Program (DSMP), in both English and Spanish; and Better Choices, Better Health, an on-line version of the original program.

The division's ongoing partnership with the Office of Minority and Multicultural Health in the Department of Health enables the program to partner with faith-based and other community-minded organizations to target minority populations, including training individuals to deliver CDSMP in Spanish, Chinese, Mandarin and Korean.

DoAS has a number of initiatives that directly or indirectly address the risk of unintentional injury through falls. AoA grant funds helped introduce A Matter of Balance, an eight-session program designed to reduce falls and the fear of falling. The program now has master trainers and lay leader coaches in 21 agencies across 15 counties. The division is currently working with eight counties on Move Today, a non-aerobic exercise class designed to improve flexibility, balance and stamina. Project Healthy Bones, DoAS' 24-week exercise and education program for older adults with or at-risk of osteoporosis, continues to flourish. Each year, more than 1,500 people take part in the program statewide as lead coordinators, peer leaders or program participants. DoAS and the Fall Prevention workgroup of the Interagency Council on Osteoporosis, encouraged agencies to host events during the Fall Prevention Awareness Week, held annually the first week of fall in September. DoAS developed, printed and distributed more than 20,000 copies of a restaurant promotional placemat to senior nutrition programs statewide. The placemat, brochures, home safety checklists and other help resources were then posted on its website. DoAS also added a fall prevention module to its now seven-session, turn-key health education curriculum known as HealthEASE.

Strategies

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

Performance Measures

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

Objective 1.3: Expand and support the role of the Area Agencies on Aging (AAAs) in evidence-based disease prevention.

Progress Update 2009-2013: Starting with the Area Plan Contract (APC) in 2010, New Jersey's policy for administering Older Americans Act Title III D funds was revised to require those dollars be spent on outcomes-driven programs and activities. Training was provided for AAA staff members to help them understand the definition and components of evidence-based practice, the role of AAAs in supporting evidence-based disease prevention, and the various

models that have been established in New Jersey to support local programs. DoAS wellness staff members now review all AAA submissions as part of the APC approval process.

Strategies

- Review APC submissions to ensure Title III D funds are used to supports outcomes-driven programs and activities.
- Provide additional training and support to AAA staff members as appropriate.

Performance Measures

- Title III D-funded service plans submitted for approval meet established policy.

Objective 1.4: Strengthen state-level partnerships to support healthy aging.

Progress Update 2009-2013: DoAS made a number of presentations over the past four years to increase awareness of and engagement in evidence-based disease prevention programs to such groups as the NJ Foundation for Aging, Robert Wood Johnson Foundation NJ Health Initiatives grantees, Office of Local Public Health, Office of Emergency Medical Services, NJ Hospital Association and American Physical Therapy Association of New Jersey. It also focused on establishing working relationships with groups/partners to support healthy aging, often as a follow up to previous presentations. Groups that would fall within the working relationship/collaboration category include the NJ Prevention Network, AAAs, Division of Disability Services, UMDNJ School of Nursing, NJ State Nurses Association, NJ Primary Care Association, and NJ HQSI.

The division established strong inter-departmental relationships with the Office of Chronic Disease Prevention and Control Services, the Office of Local Public Health Infrastructure and the Office of Minority and Multicultural Health with the Department of Health (DOH). Priorities within each of these offices align closely with those of DoAS. The division will continue to foster these relationships to maximize resources (funding and staff) and expand access to community-based programs. This interdepartmental partnership fostered the integration of CDSMP into local health



departments and state-funded chronic disease programs. From the initial steps of establishing the Chronic Disease Self-Management Program (CDSMP), staff with Chronic Disease Prevention and Control Services Office has been engaged as master trainers and peer leaders. The office has worked to integrate CDSMP into its diabetes, cardiovascular and stroke prevention health programs and worksite wellness initiative. The Office of Public Health Infrastructure, which oversees the state's 115 local health departments, has supported CDSMP by promoting the program to local health departments, particularly in response to the priorities in the networks' recently completed needs assessment process.

Strategies

- Integrate CDSMP into the Office of Chronic Disease Prevention and Control Services' diabetes, cardiovascular and stroke prevention programs and worksite wellness initiative.

- Raise awareness among the Office of Minority and Multicultural Health’s provider networks, including faith-based organizations, of the proven benefits of evidence-based health programs that can help to address health disparities.
- Provide leadership to state groups striving to advance the health and wellness of older adults, including the leadership of the Health Promotion Advisory Committee, the Interagency Council on Osteoporosis and its Falls Prevention Workgroup, New Jersey Partners: Aging, Mental Health and Substance Abuse, and the New Jersey Health Literacy Coalition.

Performance Measures

- Increased number of evidence-based disease prevention programs supported through local health departments from 20 to 25.
- Partner agencies (approximately 125 as of July 1, 2013) remain actively engaged in promoting or supporting evidence-based disease prevention programs, and 25 new partners are brought into the process

Objective 1.5: Promote the use of the prevention benefits under Medicare.

Progress Update 2009-2013: The Division of Aging Services (DoAS) received two federal grants following the passage of the Medicare Improvements for Patients and Providers Act (MIPPA) to encouraging low-income Medicare beneficiaries to enroll in two under-utilized federal programs that can help reduce their out-of-pocket health and prescription drug costs. The second round included activities to urge all beneficiaries – regardless of income – to use the free and reduced-cost preventive services covered by Medicare Part B including a new annual wellness visit with their doctors. DoAS and subgrantee partner agencies produced and distributed posters and brochures, and ran radio and newspaper ads, promoting these new or reduced-cost services. The division recently applied for a third MIPPA funding opportunity that will run for one year beginning in the fall of 2013.

Strategies

- Utilize all tools/resources provided by the Centers for Medicare & Medicaid Services and those produced within the division to promote awareness and utilization of Medicare’s prevention benefits.
- Include a discussion on the prevention benefits and strategies for encouraging utilization at the SHIP counselor update training sessions held three times annually in all 21 counties.
- Update and highlight the Medicare prevention benefits in the division’s on-line resource directory, *A Guide to Community-Based Long Term Care in New Jersey*.
- Promote prevention benefits by integrating them into all activities undertaken as part of NJ’s activities under the MIPPA for Beneficiary Outreach and Assistance grant.

Performance Measures

- SHIP counselors receive training on prevention benefits and methods for encouraging utilization among individuals they counsel.
- Track number of people educated on prevention benefits through the MIPPA grant.
- Long-term care guide is updated and posted on-line.

Objective 1.6: Improve access to transportation services.

Progress Update 2009–2013: Transportation is one of most requested services by New Jersey’s older adults and individuals with disabilities and is often a deciding factor as to whether a person can remain independent at home or in the community. In 2012, the Division of Aging Services (DoAS) provided 506,857 units of transportation services to 11,562 clients at a cost of \$5.8 million, and provided 100,972 units of assisted transportation to 3,647 clients at a cost of just over \$1 million. Due in large part to rising gas and insurance prices over the past four years, the number of trips and riders served has dropped while expenses have risen. Primary funding for transportation services comes from the Older Americans Act and New Jersey’s Casino Revenue Fund, a source hit hard by the recession and rising casino competition in neighboring states. Counties also receive significant paratransit funding directly from NJ Transit.

DoAS, as well as its county partners, has explored opportunities for additional transportation resources, coordination and innovation. As part of the United We Ride effort, DoAS staff members served on workgroup exploring access and mobility issues. The division also participated in the annual Federal Transit Administration (FTA) Section 5310 State Applications Review Committee where information on resources, grants and innovative programs from the National Center on Senior Transportation and Project Action, the Beverly Foundation and other sources are disseminated. All 21 Area Agencies on Aging (AAAs) serve on their county transportation stakeholder coordinating groups and provide input into transportation plan updates and revisions. Several AAAs received grants to implement innovative programs to teach transportation access strategies to older adults and individuals with disabilities previously incapable of using these services on their own.

Strategies

- Collaborate with state and county-level partners in the aging and disability services network to advocate for enhancements to public and private transportations systems statewide.
- Promote older adult safe driving and pedestrian education and initiatives.
- Support efforts to train older adults and their caregivers how to access transportation services in their area to maintain independence, including peer-to-peer models.
- Identify strategies to address local transportation route limits that preclude trips outside the funding organizations’ municipality or county.

Performance Measures

- Increased awareness of transportation services among older adults and caregivers.
- Training programs held throughout the state to support and encourage system usage.
- Strategies to enhance access to inter-municipal and inter-county transportation are developed and shared with policymakers.
- Ridership is maintained at its current level.

Goal 2: ADRC Partnership serves as the no wrong door/single entry point to home and community-based and long term services and supports for older adults, persons with disabilities and their caregivers, regardless of their income.

Progress Update 2009-2013: Three major milestones were achieved during the past four years: (1) the ADRC model and client pathway was implemented statewide, effective May 2012; (2) the ADRC website was launched at the same time; and (3) based on the State Fiscal Year 2011 Independence, Dignity, and Choice in Long Term Care Annual Report, counties that were operating under the ADRC model in 2011 had shown a 1% reduction in nursing facility costs and a 1% increase in home and community-based services.

From January 1, 2010 to December 31, 2012, 396,498 calls were made to the AAA/ADRCs. The top five reasons individuals contacted the ADRC were to seek information on public benefits, social services, health benefits, financial assistance and transportation. Of the total number of callers since statewide implementation of the ADRC model, approximately eight percent have been screened for community services using a computerized assessment tool.

The newly designed ADRC website – www.adrcnj.org – was launched in May 2012. The consumer-friendly site offers a number of unique features for consumers and service providers such as access to thousands of national, state and local resources, several search options, Google translation and mapping features. The site is Section 508 compliant for improved access to individuals with vision impairments. Information is refreshed on a schedule set by the Division of Aging Services (DoAS) and has the ability to electronically request content updates and verification from providers.



A future main challenge for New Jersey’s AAA/ADRCs will be to expand its knowledge and consumer base to assist the populations served by the Divisions of Developmental Disabilities (DDD) and Mental Health and Addiction Services (DMHAS). Under the Comprehensive Medicaid Waiver (CMW) and the move to managed long term services and supports (MLTSS), New Jersey plans to use the ADRC partnerships (inclusive of all divisions access points) as the no wrong door/single entry point (NWD/SEP) for consumers to access MLTSS.

Objective 2.1: Implement an enhanced training curriculum for Area Agency on Aging (AAA) staff members to help them understand the effects managed care will have on business processes (eligibility and enrollment) and the service options available to the designated target populations including individuals with physical, developmental and mental illness and addictions.

Strategies

- Train the staff members responsible for providing Information and Assistance, conducting the Screen for Community Services and Options Counseling.

- Establish written protocols for MLTSS eligibility, referrals and enrollment.
- Develop ongoing educational training modules through On-Demand and Go-to-Training; and educate network, contractors and partners on tools available through the ADRC website.
- Monitor consumer records on the types of information shared with consumers, referral types and options counseling provided.

Performance Measures

- Approximately 225 AAA staff members will be initially trained.
- Eighty to eighty five percent of staff members will be compliant with written protocols.
- Eighty percent of AAA staff members will access the learning modules for continual updates.
- Eighty to eighty five percent of referrals will be appropriate referrals based on established policies and protocols.

Objective 2.2: Establish a financial infrastructure in which federal matching funds are received for performing ADRC functions that are Medicaid-related activities.

Strategies

- State Medicaid office and Division of Aging Services (DoAS) staff members define ADRC functions that are directly related to Medicaid activity.
- Collaborate with fiscal office of the Department of Human Services to develop a Cost Allocation Plan to claim federal financial participation (FFP), as well as to establish a documentation methodology for identified ADRC functions.
- Obtain CMS approval for FFP match.
- Provide instructions to AAAs on how to complete the Cost Allocation Plan required to receive FFP.

Performance Measures

- AAAs have built an infrastructure that complies with federal documentation requirements.
- AAAs are using the SAMS database system to track and separate Medicaid related activities eligible for FFP.
- Development and usage of reports at the state level for oversight and consistency of claimable activities by user and county; and periodic site reviews to establish accuracy.

Objective 2.3: The Area Agency on Aging (AAAs), serving as the lead agencies in the ADRC network, continues to establish local partnerships with providers representing persons with disabilities, mental health and addictions.

Strategies

- ADRCs expand partnerships and Planning & Quality Management to be inclusive of the following target populations: Centers for Independent Living (CILS), hospitals, senior centers, nursing facilities, the county welfare agencies, offices of disability services, mental health program analysts, and local offices of developmental disabilities.
- Identify and develop additional screening criteria to be added to the ADRC Level 1 screening tool for the new target populations.
- Identify key access points where the new target populations can be educated and informed in gaining access to long term services and support options (LTSS); have access to Level 1

screenings in order to target support to individuals at high risk and be counseled on options to facilitate informed decision making about LTSS.

- Establish formal linkages and written protocols/procedures that are integrated or closely coordinated so that the process is seamless for consumers.
- Identify knowledge gaps and provide cross-training for all staff members to ensure they have a basic knowledge and understanding of the target populations.
- Broaden the existing ADRC website to include information on services and programs for Divisions of Disability Services, Developmental Disabilities, Mental Health and Addiction Services and include local entities.
- The Division of Disability Services will assume responsibility at DHS for managing the community LTSS 1-800 number to provide the widest access to the no wrong door/single entry point (NWD/SEP) system.

Performance Measures

- Approximately 500 professionals from AAAs and the Divisions of Developmental Disabilities and Mental Health will be trained.
- All resource materials, including brochures, will be put on the ADRC website. Website hits will increase by 50%.
- Eighty to eighty-five percent of consumers report satisfaction with the information received via the website.
- Eighty to eighty-five percent of consumer satisfaction surveys indicate consumers can access the single toll-free number and are routed to the appropriate entry point.

Objective 2.4: Expand the state's current options counseling curriculum to focus on all publicly- and privately-funded programs inclusive of the disability, veterans, dual eligible and mental health populations as well as those individuals enrolled in managed care or PACE.

Strategies

- Develop a curriculum focused on person-centered planning, decision making and knowledge about service delivery systems for target populations.
- Align NJ Options Counseling training and standards with that of the U.S. Administration for Community Living.
- Conduct Options Counseling training and certification for ADRC partners, managed care organizations (MCOs), Program of All-Inclusive Care for the Elderly (PACE) organizations, the Office of Community Choice Options (OCCO), and other partner agencies.
- Establish a yearly recertification process for ADRC partners, MCOs, PACE, OCCO and other partner agencies.

Performance Measures

- Approximately 1500 staff members from the AAA, managed care organizations and PACE will be trained and certified in options counseling.
- Within first year eighty percent of the options counselors will integrate the person-centered options counseling model into practice; 100% expected by 2017.
- Eighty five percent of consumers express satisfaction with type of options counseling provided.
- One hundred percent of the options counselors will be recertified yearly.

Goal 3: Older adults and their caregivers have access to the full array of public and private home and community-based services (HCBS), regardless of income.

Progress Update 2009–2013: The passage of the Independence, Dignity and Choice in Long-Term Care Act in 2006 provided the legislative mandate and the operating framework to redesign New Jersey’s Medicaid long term services and supports (LTSS) delivery system. The Act charged the state to transform LTSS from an institutionally-based system to one that is person-centered; offers a continuum of care for eligible consumers; and provides options that promote dignity and choice in the most integrated community setting based on an individual’s care needs. Through the Money Follows the Person program, 281 participants transitioned from facilities to the community and in 2013 (through May 30) 101 were transitioned.

The Act requires the state to create a new budgetary process for expanding HCBS within the existing budget allocation by diverting persons from nursing homes to allow maximum



flexibility between nursing homes and community options. Yet, the act does not address the growing number of individuals who are at risk of nursing home placement, but just above the Medicaid financial eligibility guidelines.

As the state began its efforts to rebalance the Medicaid LTSS system, the Division of Aging Services (DoAS) was presented with new opportunities to promote HCBS for non-Medicaid older adults. In 2007, New Jersey was awarded a three-year Nursing Home Diversion and Modernization grant funded by AoA and in SFY’ 10 the Office of

Management and Budget consolidated 13 budget line items into the Community-Based Senior Program.

The AoA grant, with its focus on adults who are not eligible for Medicaid and at risk of nursing home placement and Medicaid spend-down, promotes consumer-direction through a cash and counseling option that offers flexible service dollars and allows consumers to purchase services and goods to meet their care needs. It is this model that DoAS is using as the foundation to build the infrastructure to transform the consolidated Community-Based Senior Programs and ultimately Older Americans Act (OAA) programs from provider-based contracts to a consumer-directed model. This goal provides DHS with a unique opportunity to develop the funding and eligibility infrastructure to support older adults at risk of nursing home placement, but above Medicaid financial eligibility with a consumer-directed option.

DHS is in the process of soliciting a Request for Proposal to engage one statewide contractor to provide fiscal management and counseling services for program participants in numerous participant-directed programs of care offered through DHS, including Personal Preference

Program, Veterans-Directed Home and Community Based Services and the Jersey Assistance for Community Caregiving, a state-funded program for older adults at risk of nursing home placement. The fiscal management and counseling will counsel individuals and families enrolled in participant-directed service programs to understand their responsibilities as an employer, process payroll checks for their employees, process tax filings, and ensure participants' cash management plans are within their approved budgets.

Objective 3.1: Consolidate five of the nine state-funded Community Based Senior Programs (Home Care Expansion, Alzheimer's Adult Day Services, Jersey Assistance to Community Caregiving, Supplemental Home Delivered Meals, Statewide Respite Care Program for the Elderly, and Safe Housing and Transportation) to provide older adults at risk of nursing home placement and spend down to Medicaid with a consumer-directed home and community-based service alternative to institutionalization.

Strategies

- Initiate a comprehensive planning and implementation process with stakeholder participation beginning in fall 2014.
- With stakeholder input, standardize service package, clinical and financial criteria and sliding scale fees.
- During the planning and implementation phases, all programs consolidated into the CBSP budget line item will continue to operate as currently mandated.
- CBSP scope of services will be included in the Financial Management Service (FMS) Request for Proposal, which will be issued shortly.
- The CBSP will be integrated into the ADRC model.
- The ADRCs will be trained to conduct screenings, assessments, options counseling and based on the outcomes of the counseling, establish individualized cash management plans.

Performance Measures

- Stakeholder input is obtained and consensus is reached on service package, clinical and financial criteria, and sliding scale fee structure.
- Program regulations are introduced and approved for CBSP.
- Funding infrastructure is established and administrative support is in place.
- ADRCs are trained to assume operational responsibilities for the CBSP initiative.

Objective 3.2: Modernize OAA contracting policies to support consumer-directed cash management plans.

Strategies

- In partnership with the NJ Association of Area Agencies on Aging, develop program criteria and guidelines to establish a consumer-directed option under Title III-B in-home services and Title III-E caregiver funds.
- Build upon the Veterans Directed HCBS (100 served to date) and Community-Living Program models (79 served to date), to develop and test eligibility criteria, service package and allowable goods. Pilot cash & counseling option in two or three AAAs.

- Train AAA staff members (i.e. care managers, fiscal, and planners) on CBSP standards, requirements and policies and procedures.
- Evaluate the CBSP pilot and based on data make programmatic changes.
- Implement OAA Cash & Counseling option statewide.

Performance Measures

- AAA network assists in the development of the consumer directed option.
- Funding infrastructure is established and administrative support is in place.
- Area Plan Contracts are modified to include a consumer directed option.
- The four counties serving Veterans increase numbers served by 10%.

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

Objective 4.1: Increase appropriate reporting of neglect and abuse and decrease the incidence of abuse through the work of the Ombudsman for the Institutionalized Elderly.

Progress Update 2009–2013: Care concerns -- including failure to follow care plans, pressure sores and injuries of unknown origin -- remain the most frequent type of complaint received by the New Jersey Office of the Ombudsman for the Institutionalized Elderly (OOIE). While financial exploitation remains a major concern, the number of financial exploitation cases has remained stable while the number of investigations regarding potentially inappropriate discharges has increased over the four-year period overall. The office is working with county prosecutors and, in some cases, the state’s Attorney General Medicaid Fraud Unit to prosecute these cases whenever possible.



In order to broaden its reach into nursing homes, the OOIE dramatically increased the number of active volunteer advocates assigned to nursing homes during 2011 and 2012 and has set a goal of having 80 percent of all NJ nursing homes assigned a volunteer by the end of calendar year 2013.

The Ombudsman has sent guidance to all long-term care facilities clarifying mandatory reporting requirements and has reinforced this message at dozens of provider conferences.

Strategies

- Provide effective monitoring of programs and services in long-term care facilities to continue reduction of incidence of abuse in long-term care facilities.
- Provide effective training in mandatory reporting requirements to long-term care facilities and other interested parties including Managed Care Organizations (MCOs) operating under the Managed Long Term Care Services and Supports program (MLTSS). The purpose is to ensure that reportable incidents are being communicated to OOIE appropriately.

- Work with the State’s Attorney General Medicaid Fraud unit, local law enforcement and individual county prosecutors to identify and prosecute incidents of significant abuse and exploitation of the elderly in long term care facilities.
- Provide information to families, residents, health care and social services professionals, and the community about the importance of reporting incidents of neglect and abuse.
- Continue to increase the number of trained volunteer advocates placed in nursing homes.

Performance Measures

- Track the number of complaints investigated by OOIE staff or handled by OOIE volunteers, the number of outreach events with an elder abuse focus and the number of new volunteers recruited to the program. Track reports received from MCOs. Also, collect data regarding financial exploitation recoveries that result from OOIE and law enforcement intervention.

Objective 4.2: Strengthen the Long-Term Care Ombudsman Program’s capacity to provide information to older consumers and the public at large on elder rights and consumer protection issues.

Progress Update 2009-2013: The OOIE has dramatically increased its outreach to a wide variety of stakeholders, with an emphasis on consumers, over the last four years. The OOIE has increased its public profile with key stakeholders including: residents, families, providers, and other advocates. As a result, the number of complaints from residents has increased by 83 percent and from family members by 17 percent. In 2010, the OOIE and the then Public Advocate, Office of Elder Advocacy, drew national attention for a broad-based investigation of the discharge practices of a major national assisted living company, Assisted Living Concepts. Public attention to the company’s discharge practices led to the creation of an Assisted Living Disclosure form and greater public scrutiny and consumer awareness of the importance of contract transparency in assisted living environments. All of the OOIE’s residents’ rights materials were upgraded and distributed broadly throughout the state – at facilities and at other public and provider events. Calls to the intake line are slightly down (from 7,779 in FY 2009 to 6,857 FFY 2012) as the OOIE implemented an telephone auto attendant system that routed other program information calls directly to those program areas or to support staff, allowing intake staff to focus on complaint calls or consultations only.

Strategies

- Provide all residents of nursing homes and assisted living homes and their family a copy of a pamphlet that will describe the Ombudsman Program and how a resident can access a long-term care ombudsman.
- Expand outreach activities to Adult Medical Day Care and Class C Boarding homes.
- Continue meeting with long-term care residents on a regular basis.
- Continue to host Resident’s Rights Bingo events. Resident’s Rights Bingo was developed by The Legal Center for People with Disabilities and Older People and provides an opportunity for advocates to empower nursing homes residents and train staff about resident’s rights.
- Provide resident rights information to all long term care facilities and encourage staff to prominently display them.
- Provide ombudsman posters to long-term care facilities and encourage staff to prominently display them.

- Work with the media to inform the general public about long-term care resident rights and the Ombudsman Program.
- Continue to provide in-service trainings to long-term care provider staff.
- Continue to recruit, train and assign volunteer Ombudsman to all nursing homes and assisted living facilities.

Performance Measures

- Track the sources and nature of complaints received, the number of new volunteers, and the effectiveness of public relations efforts. Specifically, track any increases in complaints from Adult Medical Day Care and Class C Boarding Homes. Also increase the number of public outreach events and in-service trainings.

Objective 4.3: Continue to promote advance care planning to ensure that the care and treatment an individual receives is consistent with their wishes and their goals of care.

Progress Update 2009-2013: The OOIE continues to work to revitalize the Regional Ethics Committees (RECs). After a lull in recruitment in 2010, a renewed effort has been made to attract and train new members. The current number of active RECs stands at 11. In the last two years, more than 1,000 people have received end-of-life and medical ethics training at eight separate OOIE-sponsored events. The REC Consortium Meetings were re-established in 2011 and enjoy robust attendance today. OOIE has partnered with the RECs to promote National Health Care Decisions Day in April and has heavily publicized these events. In the last year, OOIE has partnered with the Department of Health, the NJ Hospital Association and others to help educate the public, lawyers and the healthcare community about advance care planning and specifically the new Practitioner Orders for Life Sustaining Treatment (POLST).

Strategies

- Continue to revitalize the 14 existing RECs.
- Continue to strengthen the existing relationships with the REC and the ethical committees of hospitals throughout the state.
- Train nursing home on the value of RECs.
- Identify opportunities to partner with aging advocacy groups and other interested parties to further public awareness of this important topic.
- Create a separate page on the OOIE website, titled Your Care Your Choice, to provide information on advance care planning options and provide links to resources.
- Prepare materials that will be useful to individuals and families who are planning or facing End-of-Life issues.
- Make advance care planning booklets and planning documents available.
- Collaborate with other stakeholders on statewide roll-out of POLST (Practitioner Orders for Life Sustaining Treatment) This program will focus on educating long-term care providers, residents and their families and other stakeholders on the benefits of the POLST form and how to use it.
- Work with long-term care facilities in the development of a comprehensive advance care planning train-the-trainer program.
- Work to create a collaborative multi-organization coalition to successfully implement POLST in a specific geographic area.

Performance Measures

- Track the number of active RECS and active REC participants, REC activities (case consultations or public education), and attendance at Consortium meetings. Track visits to the Your Care, Your Choice website and educational/training programs conducted either in facilities or within the confines of a geographic-specific, multi-organization coalition.

Objective 4.4: Increase Consumer Knowledge and Self-Direction in Long Term Care Choices and Management

Progress Update 2009-2013: The OOIE has dramatically increased its outreach activities during the last four years. Information about how to select a long-term care community is readily available on the OOIE website as are links to other consumer-choice websites. OOIE has focused heavily on providing information to attorneys and health care professionals about the importance of consumer choice when it comes to advance care planning. OOIE staff is continually educating nursing home staff about such issues. OOIE has partnered with the Department of Human Services (DHS) to increase consumer awareness and utilization of Money Follows the Person/I Choose Home NJ program.



Strategies

- Continue to expand consumer and family education of long-term care choices, including providing access to consumer guides for choosing assisted living and residential care facilities and making that information available on the OOIE website.
- Conduct training for older citizens and their families, attorneys and social service providers, and Area Agencies on Aging about long term care options, resident rights and remedies.
- Continue to host Residents' Rights Bingo events at facilities.
- Provide assistance to residents and their families around any issues on the state's move to Medicaid Managed Long Term Care Services and Supports (MLTSS).
- Train lawyers, social service workers, and consumers to know and enforce the rights of those residing in facilities, including the benefits and limitations of the durable power of attorney, health care proxy, or guardianship.
- Continue to partner with DHS' Money Follows the Person/I Choose Home NJ program to educate residents, their families and facility staff about the availability of consumer-directed Home and Community Based Services for eligible nursing home residents.

Performance Measures

- Track the number of outreach programs and attendees, the number of calls to the MFP/I Choose Home NJ 800 number, the number of complaints/concerns processed that relate to MLTSS.

Objective 4.5: Address and train others to identify abuse, neglect and exploitation among vulnerable adults.

Progress Update 2009-2013: Mandatory Reporting Legislation enacted in 2010 resulted in increased referrals to Adult Protective Services (APS) without additional funding. In light of the additional responsibilities that come with mandatory reporting, and in order to ensure the

integrity of the state's network of qualified local providers, the office advocated for an increase in APS funding, and is cautiously optimistic.

In addition to handling an increased caseload, the office has responded to a heightened number of requests for information and referrals, including from new mandatory reporters of abuse and neglect. Informational trainings have been conducted with state and county bar associations, county constitutional officers, acute and long-term care facilities, members of the judiciary, health care industry associations, community advocacy groups and regional ethics committees. A training module on recognizing and addressing elder economic exploitation was offered for government staff in related agencies.

The office conducted dialogues with state and national guardianship advocacy groups regarding best practices for addressing fiduciary abuse and neglect with an eye toward enhancing the state's guardianship system. An internal tracking system was implemented to gather data on reasons behind petitions for state guardianship.

Other highlights included providing assistance to elderly victims of Superstorm Sandy, assisting law enforcement with successful prosecution of significant cases of exploitation of elderly adults, and participating in events marking World Elder Abuse Awareness Day.

Strategies

- Enhance the ability of county APS offices to support the increasing number and complexity of individuals served.
- Work toward best practices to encourage uniformity among providers of protective services.
- Cooperate with law enforcement to pursue perpetrators of elder abuse and exploitation.
- Provide assistance to judiciary with respect to issues that arise from new guardianship monitoring program.
- Pursue increased civil remedies in instances of elder economic exploitation where feasible.

Performance Measures

- Track data regarding rationale for referrals for abuse investigation and guardianship.
- Adopt standardized statewide protective services rules and practices.
- Enhance contacts with law enforcement for investigations of elder economic exploitation.
- Increase number of cases resulting in pursuit of civil remedies for economic exploitation.

Objective 4.6: Identify special needs among the vulnerable and elderly population and advocate for provision of individualized services.

Progress Update 2009-2013: Adult Protective Services conducted a limited demonstration project to show that with proper resources and services, an incapacitated, institutionalized geriatric consumer with a poor prognosis could be successfully maintained in the community despite limited personal resources. Employing intensive inter-disciplinary support, the office collaborated with community mental health providers, law enforcement and others to ensure that specialized services were provided and highly individualized supports were rendered to support consumer remaining at home against the odds.

In addition, APS forged working relationships with state programs that provide services to consumers with developmental disabilities and providers of mental health services aimed at reducing psychiatric hospitalizations for patients in nursing homes.

Program staff received training in working with individuals with mental illness, including obsessive compulsive disorder and related hoarding behaviors, traumatic brain injuries, the LGBT senior population, deaf and hard-of-hearing seniors, Megan's Law offenders, and individuals suffering from addiction.

Protective services workers received training from law enforcement officers on novel approaches to de-escalating behaviors resulting from psychiatric disabilities.

Strategies

- Adhere to program mission of providing outstanding individualized guardianship services by treating each client as an individual with distinctive behaviors and values.
- Conduct staff training on aging issues that affect individuals with chronic disabilities.
- Continue to pursue creative solutions and enhanced advocacy for individuals with addictions and promote restoration of legal rights where feasible.

Performance Measures

- Track reasons for referral of cases for abuse investigation and guardianship in order to allocate resources for specialized services effectively.
- Expand demonstration project showing adherence to principles of self-determination can be incorporated into lives of incapacitated older adults with special needs and disabilities.
- Engage in regular participation in government and stakeholder forums on disability policy to represent interests of incapacitated seniors and vulnerable adults.

Objective 4.7: Work toward greater autonomy and self-determination for adults under protective arrangements by advocating for supported decision-making models and enhanced community support services.

Progress Update 2009-2013: Adult Protective Services has been called upon to carry out



complex, protective arrangements emphasizing broad retention of rights. Even where not judicially mandated, program workers have collaborated with incapacitated clients to support their wishes to travel to other countries, make health and behavioral decisions/choices with appropriate protections, continue to reside with family members who have unsuccessfully provided care in the past (with professional support and oversight), and be maintained in less than optimal circumstances with

enhanced supports where it is their genuine wish to do so. For individuals for whom expressing clear wishes is difficult, program policy will continue to require that information be regularly solicited from involved family members and friends and weighted accordingly. In addition, the office has provided information on alternatives to guardianship and the wisdom and mechanics of advance care planning where appropriate.

Strategies

- Where possible, re-locate individuals in long-term care to less restrictive settings.
- Return to court to advocate for restoration of legal rights for incapacitated older individuals who are capable of making independent or supported decisions or who no longer require judicial protective arrangements.
- Advocate for supportive services for individuals who may be otherwise eligible for less restrictive arrangements.
- Educate providers and the community regarding scope and limitations of protective services and arrangements and retained rights of legally incapacitated individuals.
- Participate in dialogue with other professionals and programs regarding selective use of guardianship only where no other less-restrictive solutions are supports are viable.

Performance Measures

- Increase by 5%, the number of program participants moving from institutional settings to community placements for long-term care.
- Increase access to services that enable supported client decision-making.
- Work with legal and guardianship groups to advocate for limitations in scope and frequency of guardianship arrangements.
- Provide increased education to providers and interested parties regarding the rights of individuals with guardians.

Objective 4.8: Provide technical assistance where appropriate regarding the needs of at-risk adults with respect to access to long-term care services and supports systems.

Progress Update 2009-2013: Adult Protective Services (APS) has provided, and continues to provide, instruction and outreach to ensure that pertinent staff of the managed care organizations (MCOs) contracted with the state to deliver long term care services are appropriately trained to understand their obligations under the mandatory reporting laws of APS. It has also served as a resource for professionals and the public to understand issues affecting at-risk elderly.

Strategies

- Track referrals to ensure that MCOs promptly refer at-risk adults if protective services are needed.
- Continue to make program staff available to answer questions and provide input into optimal structure of long-term care systems and community integration issues.
- Undertake additional outreach to providers where requested to discuss parameters of state guardianship and protective services programs.
- Identify issues during the implementation of Managed Long Term Services and Supports (MLTSS) affecting special targeted populations.

Performance Measures

- Track referral data from MCOs and follow-up on any concerns about lack of referral activity.
- Compile anecdotal and other data regarding unforeseen needs of incapacitated seniors and vulnerable adults entering managed care.
- Increase understanding, through ongoing education and outreach, of the special needs of the vulnerable elderly in the long term care system.

- Be a resource for the public to understand the move to MLTSS as it impacts at-risk adults.

Objective 4.9: Enhance legal services advocacy, and the education of seniors, gatekeepers and aging network professionals.

Progress Update 2009-2013: Over the past four years, legal services for the elderly has continued to be a valuable asset for New Jersey’s older adults. Legal services staff members advocate on behalf of seniors to resolve disputes with landlords, bill collectors, insurance companies and others. They assist grandparents raising grandchildren and provide legal advice



to caregivers. Legal Service providers are an integral part of the network of aging services. Most recently, legal services in the areas hardest hit by Superstorm Sandy helped older adults navigate complicated issues such as insurance claims, bills and housing, a task made more difficult for those who lost documents and had their homes damaged or destroyed in the storm. Based on the post-event experiences of other states that faced similar disasters such as

Hurricane Katrina, DoAS is taking steps to address the expected rise in elder abuse and financial exploitation cases and an increase in mental health issues requiring intervention. DoAS developed an Action Plan for Sandy Recovery that includes specific strategies to foster recognition, education and training and provide legal representation for older adults.

Strategies

- Identify and advocate on behalf of seniors impacted by Superstorm Sandy to resolve claims with both FEMA and private insurance companies.
- Provide education to gatekeepers such as delivery persons, banks and local entities on potential fraud, exploitation and abuse of the elderly population.
- Create and deliver an interdisciplinary issue identification and response training curriculum for the aging network, prosecutors, legal and law enforcement professionals and others.

Performance Measures

- Number of older adults assisted to resolve claims (anticipate 85% of applicants).
- Increase in referrals from the education of gatekeepers.
- Number of trainings and increase in identification of perpetrators and prosecution.

Goal 5: Ensure older adults and the network that serves them are better ready for the next emergency.

Objective 5.1: Area Agencies on Aging (AAAs) have coordinated, updated and practiced emergency plans.

Progress Update 2009-2013: This is a first-time goal in the State Plan made necessary by flooding and damage wrought by Hurricane Irene in August 2011, and Superstorm Sandy (Sandy) – the largest and most destructive Atlantic hurricane on record – in October, 2012. Both storms resulted in massive evacuations, destroyed property and lost lives. According to the

Office of the State Medical Examiner, 70 New Jersey deaths are attributed to Sandy, including 53 who were age 60 and older.

Area Agencies on Aging (AAAs) worked with their County Offices of Emergency Management, FEMA, the American Red Cross, Salvation Army and other non-profit social services agencies deployed before and after the storms. In response to Sandy, AAA staff members printed out client contact lists from the SAMS client tracking computer system and contacted those in evacuation zones and/or their emergency contacts in order to secure inland shelters for safe relocation. For those who sheltered at home, a supply of shelf-stable meals was provided.

When Sandy hit, AAAs and their provider networks were among those impacted. One coastal AAA temporarily moved to another location but continued to operate. Senior centers and other public buildings were used as shelters and, as the temperature dropped, warming centers. Many in the state were without power for several weeks. The Division of Aging Services' (DoAS) response included deploying nursing and professional staff members who conducted assessments and assisted with placement when the needs of some older adults exceeded the shelters' capability to provide care.

Sandy focused attention on the importance of ensuring emergency planners statewide consider the special needs of frail older adults and individuals with disabilities when establishing and implementing disaster response plans. In the days prior to the storm, registrations on Register Ready (New Jersey's Special Needs Registry for Disasters website) rose steadily to 14,000 individuals. AAA participation in plan development and practice helped ensure the safety of many older adults impacted by the storm.

Strategies

- Develop or update business continuity plans for DoAS and the AAAs to include several ways to communicate with staff members and create an inventory of potential alternate work sites to continue service delivery to older adults.
- Explore ways to ensure the ADRC hotline remains fully operational as the single entry, no wrong door portal for older adults and their caregivers in an emergency, including providing staff members with up-to-the-minute disaster updates and activated resources, and redirecting calls to mobile phones.
- Develop and maintain staff member skills inventories and ensure their participation in disaster drills and shelter simulation exercises.
- Update emergency preparedness and response plans addressing the needs of older adults in coordination with state and county OEM offices.
- Create and maintain partnership agreements at the state, county and local levels to ensure resources are available in an emergency.
- Explore the feasibility of State OEM credentialing of aging network staff members.

Performance Measures

- DoAS and AAAs remain open or re-open quickly following a disaster to provide services for older adults both in response to the emergency and for regular business matters.
- Appropriate DoAS and AAA staff members are activated as part of the larger, interagency preparedness and response teams.

- AAAs utilize their client contact information, as well as data from www.registerready.nj.gov, to ensure the safety of older adults before, during and after disaster strikes.
- State and county emergency plans fully address access and functional needs of the frail elderly and of individuals with disabilities.

Objective 5.2: The New Jersey Division of Aging Services (DoAS) provides leadership and guidance for AAA disaster planning efforts.

Progress Update 2009-2013: DoAS has one staff member assigned the role of disaster response coordinator. This individual receives and disseminates severe weather and other warnings with aging network contacts. In response to emergencies, DoAS gathers situational and response updates from the Area Agencies on Aging (AAAs) for federal and state agencies seeking this information. DoAS includes emergency preparedness requirements in its Area Plan Contract policy, but will create a new, separate policy going forward.



Strategies

- Provide emergency preparedness training for AAA staff members and their local partners.
- Revise policy memoranda to require AAA Requests For Proposals (RFPs), provider contracts, inter-agency and intra-agency agreements to require disaster service continuity plans beginning with the 2014 Area Plan Contracts (APCs). Monitor compliance during annual on-site assessments.

Performance Measures

- Emergency Response policy is updated and issued.
- Training opportunities are created or identified for AAA staff member participation.

Objective 5.3: Bring together representatives from the Offices of Emergency Management, Department of Human Services, DoAS and AAAs to evaluate and recommend changes to current preparedness and emergency response plans.

Progress Update 2009-2013: The Division of Aging Services (DoAS) was located within the Department of Health and Senior Services until July 2012. As requested, DoAS provided input into various sections of the state’s emergency response plans to ensure the needs of seniors and their caregivers were properly addressed. DoAS leadership also participated in drills for various types of emergency situations. Most AAAs had similar experiences at the county level.

Strategies

- Through the New Jersey Group for Access and Integration Needs in Emergency and Disasters (NJGAINED), create a workgroup focusing on older adults to assess utilization and effectiveness of systems and services, with particular attention to four areas: 1) communications, 2) sheltering, 3) maintaining services such as home delivered meals, and 4) immediate and long-term after-storm needs.

- Ensure information sharing across departments and divisions.
- Analyze data from Monmouth and Ocean County long term recovery groups and Ocean County Unmet Needs Assessment interviews.
- Participate in FEMA think tank with state, local, tribal, public sector, private sector, disability community and volunteer community to explore best practices.
- Build emergency preparedness questions/script into the options counseling software.

Performance Measures

- NJGAINED workgroup on older adults meets and makes recommendations based in part on the experiences of the aging network before, during and after Superstorm Sandy.
- Best practices are identified and shared with those in the aging network.
- Emergency preparedness participant-level data is collected in the options counseling software system for use in future emergencies.

Objective 5.4: Increase the ability of senior centers and other entities to serve as shelters.

Progress Update 2009-2013: New Jersey has over 200 senior centers and nutrition sites, as well as many community centers – both public and private – and an expansive network of licensed facilities to meet the care needs of older adults. During both Hurricane Irene and Superstorm Sandy many of these facilities became safe havens for older adults seeking short-term shelter from the elements that for some turned into a stay of several weeks. Some came fully prepared while others arrived without food, a change of clothing or essential medications or durable medical equipment.

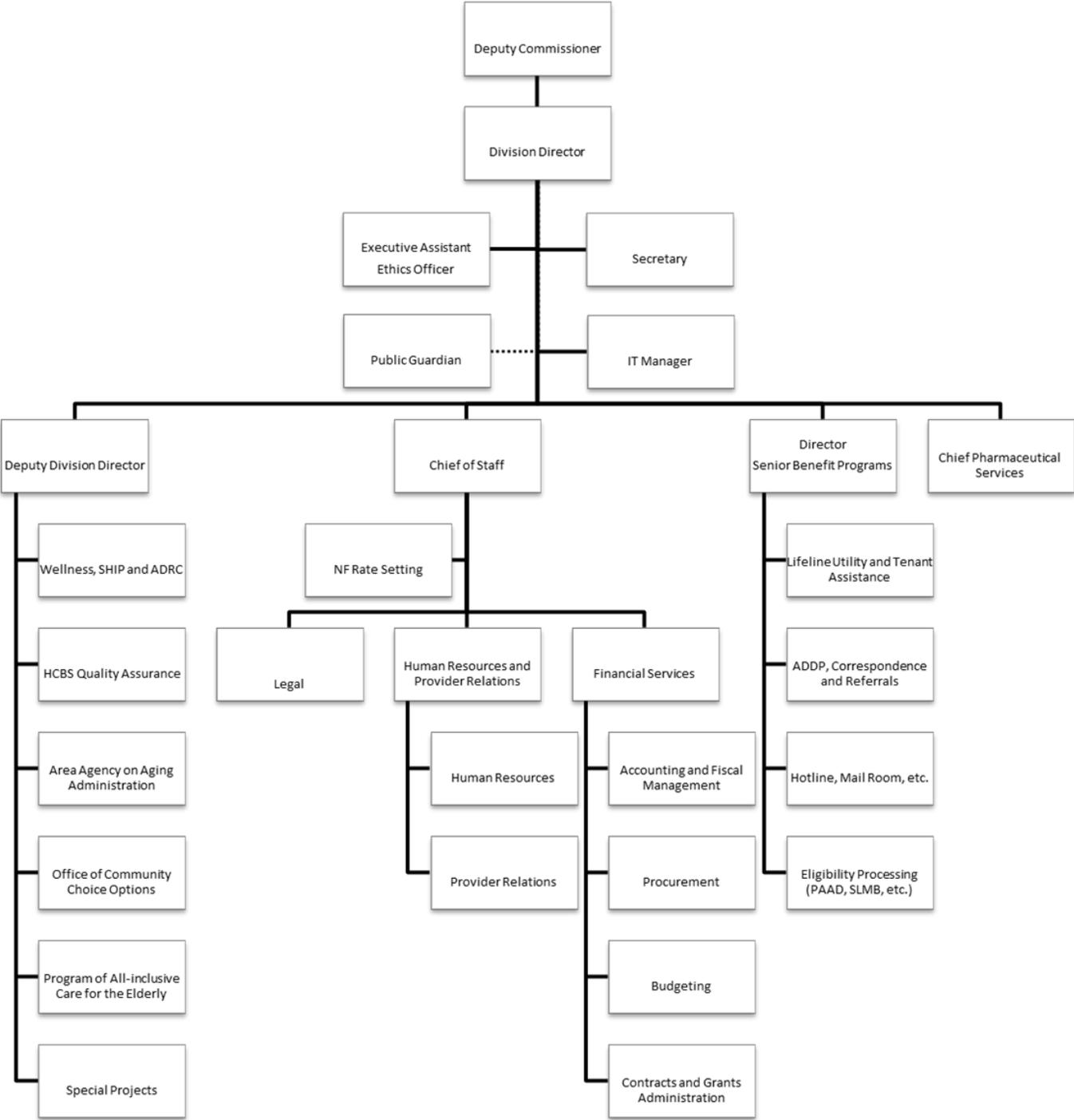
Strategies

- Explore and advocate for senior centers to be designated as SAFE Centers, a model in which the centers are stocked with food, medicine, equipment, generators, batteries, etc. in preparation for an emergency.
- Build emergency preparedness resources on the Aging & Disability Resource Connection (ADRC) website, with links to shelter lists and updated information on conditions.
- Have care managers work with program participants on personalized emergency plans kept by both that identify where to go in an emergency and what to bring.

Performance Measures

- Senior centers and other places of senior care and services are prepared for sheltering.
- Website uniformity and current information available with remote update capacity.
- Most older adults are prepared and have all necessary information and supplied in the event of emergency.

Department of Human Services
 Division of Aging Services
 Table of Organization (Functional)



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

To solicit input into the development of its proposed 2014-2017 Strategic Plan for Aging, the Division of Aging Services (DoAS) held a meeting of approximately 90 key stakeholder's on February 27, 2013. Attendees identified and prioritized needs and developed strategies. Three public hearings were then held on April 18, April 26 and May 3, 2013 – one each in the northern, central and southern regions of the state. An estimated 130 older adults and service providers attended, with 39 providing testimony.

Top Priorities Identified at the Stakeholder Forum

Access to Services: Easier access needed to information, services, benefits and entitlements, as well as transportation to get to services providers, medical appointments and shopping. Information needs to be presented in multiple formats and different languages, and recognize cultural and literacy differences.

Marketing of Services: Statewide marketing efforts are needed to ensure older adults and their caregivers, well as their points of contact in religious, social, financial and medical fields, are made aware of services available through the AAAs and the aging network. Promotion of the Aging & Disability Resource Connections (ADRCs) as the single entry/no wrong door access points for those seeking long-term services and supports essential to improving visibility and building trust.

Supporting Caregivers: The aging network must expand resources and develop new models of service delivery for caregivers. Also must partner with employers to education today's caregivers and the next generation and services recipients about service availability and options.

Coordinate and Update Practiced Emergency Planning, Response and Recovery: In the wake of Superstorm Sandy, aging services leadership needs to work with emergency management officials at all levels to increase coordination and decrease fragmentation and share lessons learned. Focus of these discussions should be on service needs, communication, housing, transportation and disaster recovery.

Funding: Need to secure funding from traditional, new, and previously untapped sources to support and expand services for older adults and caregivers. This includes Older American Act, state and Casino Revenue funds, grants, and Medicaid dollars.

Public Hearings

Many of the issues raised at the stakeholder meeting were also identified at the three public hearings. Main concerns raised centered around transportation, home delivered meals, affordable housing, home health aides, caregivers, emergency preparedness, and Medicaid and Medicare.

Summary of specific, essential services and concerns most mentioned:

South Jersey:

- Medicare and Medicaid eligibility
- Funding and monitoring of services
- The potential effect of Medicaid managed care on home health agencies and aides
- Discharge plan coordination between hospitals and nursing homes
- Providing medical services in the home as opposed to hospitals

Central Jersey:

- Care needed when closing state and county run facilities to ensure appropriate levels of care are maintained for individuals with dementia.

- Medicaid managed care's potential impact on the home health industry
- Home delivered meals
- Affordable housing and special needs housing
- Housing for older adults should be mandated to have operational generators to run elevators, lights and provide heat in periods of power outage, short or long.
- The Olmstead lawsuit requires people with mental illness be given the opportunity to live in the community. Adequate support in the community is needed to ensure they succeed.
- Senior centers should provide new and interesting activities
- Home repair programs
- Mail fraud
- Advance directives
- Need for creative partnerships to provide services less expensively
- Use of new technology to get the word out concerning services to caregivers and to provide services to seniors who have no supports.
- Need certification and oversight of individuals providing home care services
- Personal needs allowance levels

North Jersey:

- Increase transportation options to allow trips across county lines, outings without multiple days' advance notice, and trips to banks and other non-medical destinations
- Transportation should use an automated calling system if services are not running.
- Ensure buses are accessible
- Must be able to take to someone live when calling an office
- Once Medicaid eligibility is established, it should follow the person no matter where he or she lives (i.e., home, institution, new county or state)
- Comprehensive waiver and eligibility for services.

Basic Demographics

- New Jersey's population was 8,791,894 in 2010. 1,666,535 (19%) of those were age 60 and over.¹
- There is a significant gender gap among NJ seniors. Women account for 56.8% of the population aged 60 years and older and 68.6% of the population 85 and older.²
- 75.8% of New Jerseyans age 60 and over are white alone, not Hispanic or Latino. 10.1% are black or African American and 5.2% are Asian.³
- In 2010, people aged 60 years and over exceeded 27% of the population of Ocean County and 29% of the population of Cape May.⁴
- Six counties accounted for just over half of New Jersey's population age 60 and older in 2010: Bergen (190,092), Ocean (157,064), Middlesex (140,202), Essex (129,272), Monmouth (123,809) and Morris (96,659).⁵

Diversity

- Using one measure of racial/ethnic diversity,⁶ expressing the chance of randomly selected residents (age 60 or older) being of different races/ethnicities, Hudson (73.2%), Essex (64.5%), Passaic (57.8%) and Union (57.2%) are the most diverse counties, while Cape May (9.8%), Sussex (11.4%), Ocean (11.7%) Hunterdon (11.9%) and Warren (11.9%) are the least diverse. The overall figure for NJ is 42.6%. The score for the US is 37.7%.⁷
- 75.8% of NJ's population age 60 and over is white, non-Hispanic. In five NJ counties, this proportion exceeds 90%: Cape May (95.3%), Sussex (94.6%), Ocean (94.3%), Hunterdon (93.9%) and Warren (93.8%). Essex (49.7%) and Hudson (42%) have the lowest proportions of white, non-Hispanics. in the state.⁸
- Blacks or African Americans make up 10.1% of NJ's population age 60 or older. Essex (35.5%), Union (18.3%), Mercer (15.8%) and Camden (14.2%) counties have the highest proportions of this demographic.⁹
- Asians make up 5.2% of NJ's population age 60 and older. Middlesex (12.3%) has the highest proportion of Asians, followed by Hudson (9.5%), Bergen (9%), and Somerset (8.9%).¹⁰
- Hispanics or Latinos or any race make up 8.3% of NJ's population age 60 and older. Hudson (37.2%), Passaic (19.6%), Union (14%), Cumberland (11%) and Essex have the highest proportions of this category.¹¹

English Proficiency

- Among people aged 60 and over, 13.4% spoke English less than "very well". Cape May (2.2%), Salem (2.2%), and Gloucester (2.7%) counties had the lowest proportion in this category, while Hudson (41.6%), Passaic (26.4%) and Union (21.5%) had the highest figures.¹²

Marital Status

¹ US Census Bureau, 2010 Census, Summary File 1, Tables P12, P13 and PCT12

² US Census Bureau, 2010 Census, Summary File 1, Tables P12, P13 and PCT12

³ US Census Bureau, 2007-2011 American Community Survey, Table S0102

⁴ US Census Bureau, 2010 Census, Summary File 1, Tables P12, P13 and PCT12

⁵ US Census Bureau, 2010 Census, Summary File 1, Tables P12, P13 and PCT12

⁶ Meyer, P., & Overburg, P. (2001). Updating the USA Today Diversity Index. <http://www.unc.edu/~pmeyer/carstat/tools.html>

⁷ US Census Bureau, 2007-2011 American Community Survey, Table S0102

⁸ US Census Bureau, 2007-2011 American Community Survey, Table S0102

⁹ US Census Bureau, 2007-2011 American Community Survey, Table S0102

¹⁰ US Census Bureau, 2007-2011 American Community Survey, Table S0102

¹¹ US Census Bureau, 2007-2011 American Community Survey, Table S0102

¹² US Census Bureau, 2007-2011 American Community Survey, Table S0102

- 55.9% of New Jerseyans age 60 and older are married and 24.7% are widowed. Essex (45.7%) and Hudson (48%) counties had the lowest proportion of married adults age 60 and older, while Hunterdon (64.2%), Cape May (64.1%) and Sussex had the highest figures.¹³

Isolation

- 40.8 of NJ households were made up of a single householder age 60 or older living alone. Sussex County (35%) had the smallest proportion of older, householders living alone, while Essex (45.3%), Cumberland (45.3%) and Hudson (45.1%) had the largest proportions.¹⁴

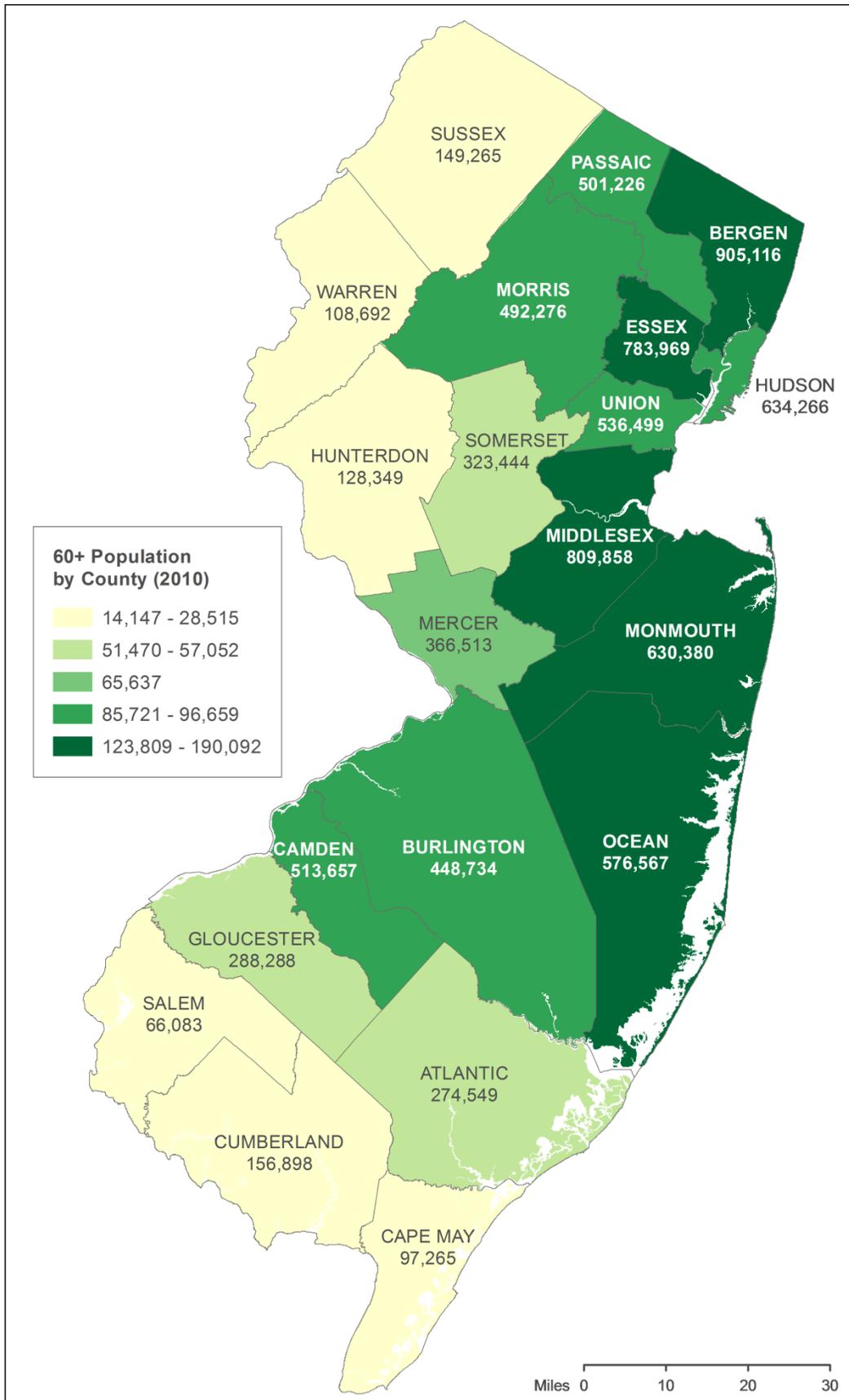
Poverty

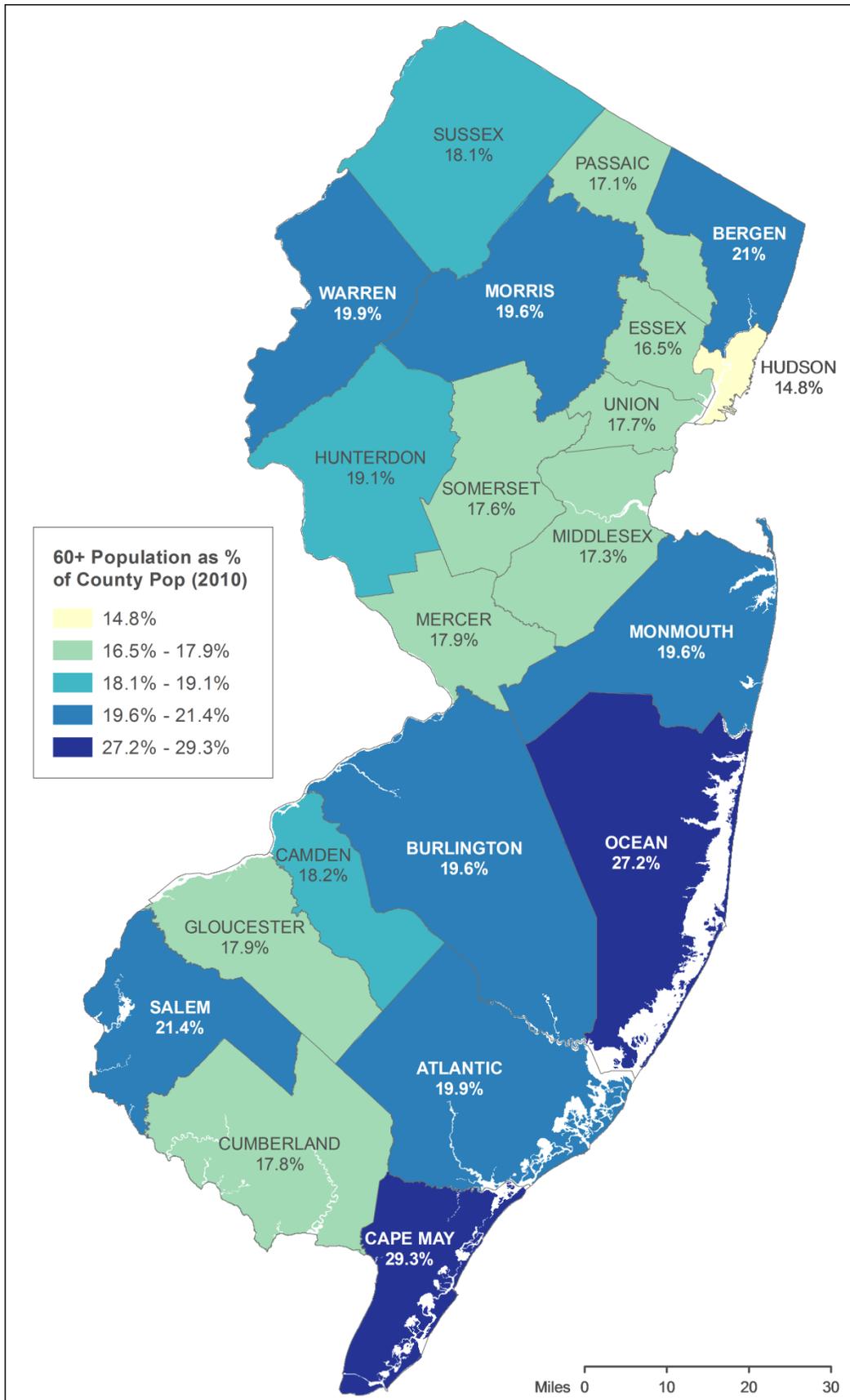
- 85.3% of New Jerseyans age 60 and older had incomes at or above 150% of poverty level. Hudson County (74%) had the lowest proportion above poverty, while Hunterdon (91.5%), Morris (91.3%), Somerset (90.3%) and Burlington (90.1%) had the highest proportions¹⁵.

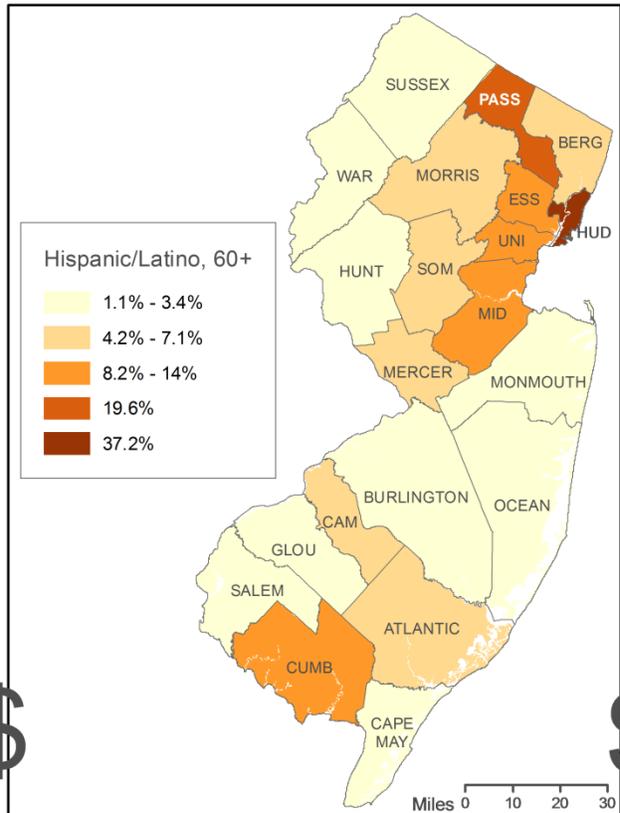
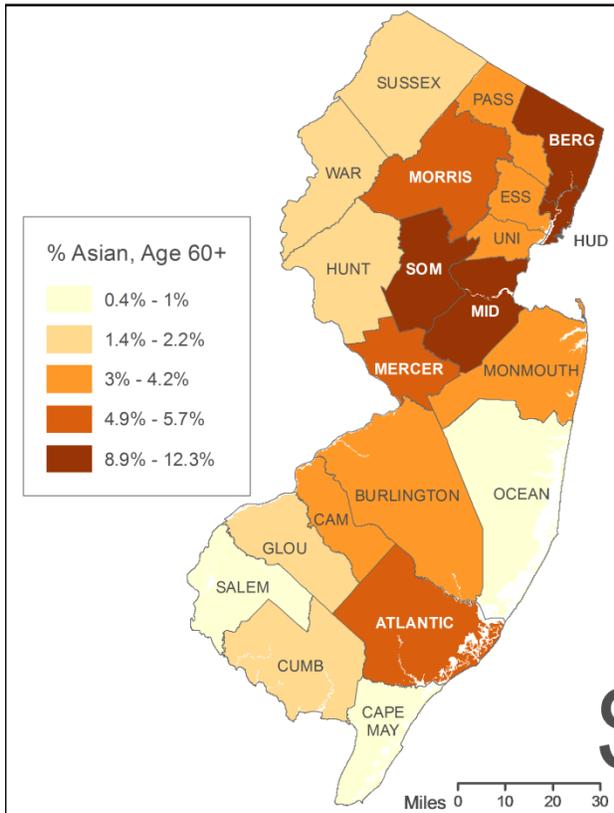
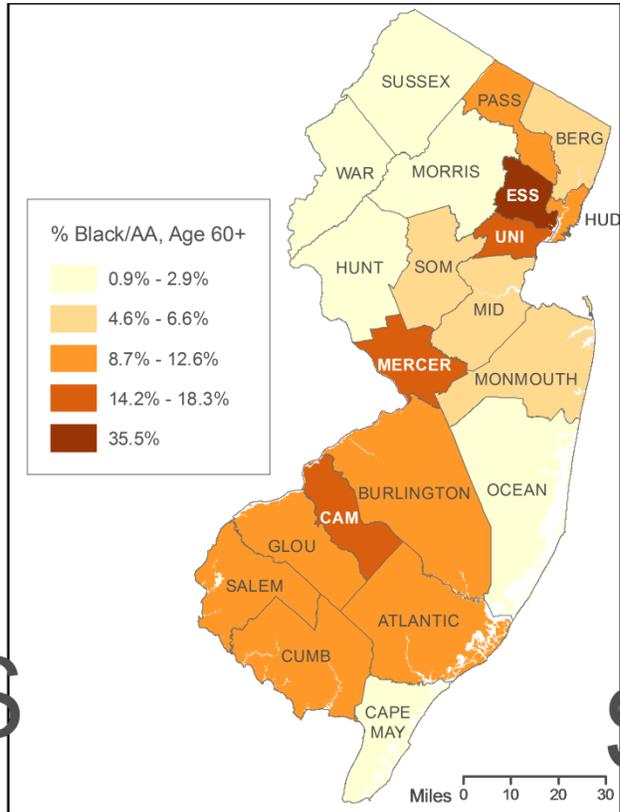
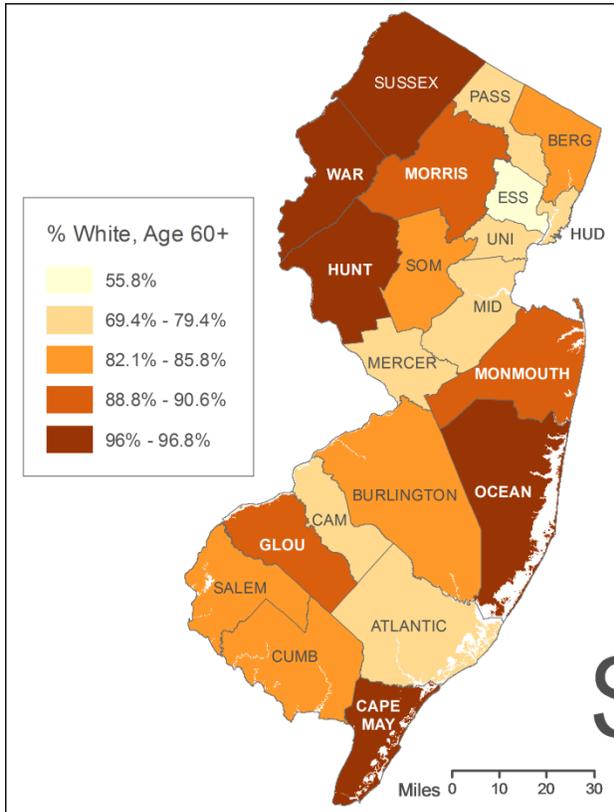
¹³ US Census Bureau, 2007-2011 American Community Survey, Table S0102

¹⁴ US Census Bureau, 2007-2011 American Community Survey, Table S0102

¹⁵ US Census Bureau, 2007-2011 American Community Survey, Table S0102







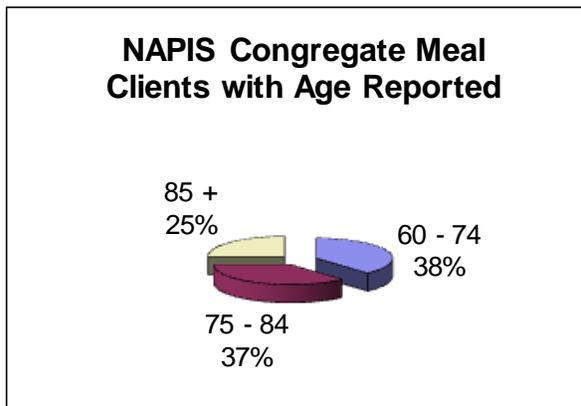
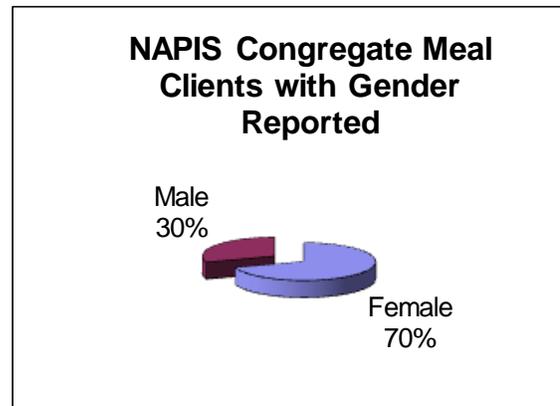
<u>New Jersey Division of Aging Services</u>	<u>Area Plan Contract Services Provided in Calendar Year 2012</u>		
<u>Service</u>	<u>Units</u>	<u>Clients</u>	<u>Expenditures</u>
Information & Assistance	284,523	103,517	6,652,095
Benefits Screening	30,156	8,786	1,011,610
Extended Assessment	7,001	1,948	312,419
Outreach	48,218	15,701	1,275,758
Care Management	69,468	4,468	3,550,013
Transportation	506,857	11,562	5,837,821
Assisted Transportation	101,887	3,660	1,052,724
Language Translation / Interpretation	5,958	1,221	94,664
Public Awareness / Information	705	35,130	56,918
Friendly Visiting	21,541	548	252,024
Telephone Reassurance	227,268	3,460	403,471
Residential Maintenance	27,946	4,096	1,272,070
Housekeeping	55,298	1,565	1,134,656
Certified Home Health Aide	248,609	1,817	5,031,718
Visiting Nurse	7,655	1,049	452,844
Respite Care	76,560	613	1,209,035
Hospice Care	7,522	307	253,673
Emergency	10,181	2,035	541,394
Homesharing/Matching	1,904	440	48,800
Housing Assistance	1,705	832	78,679
Caregiver Support Group	2,509	582	124,389
Adult Day Services - Social	508,657	1,532	3,553,957
Adult Day Services - Medical	67,619	372	936,883
Personal Care	6,316	153	128,978
Adult Protective Services	159,151	4,842	5,256,697
Legal Assistance	25,182	6,118	1,696,550
Physical Health	21,448	6,569	828,149
Oral Health	4,974	785	499,158
Mental Health	7,625	915	428,739
Counseling	10,452	718	243,102
Physical Activity	149,025	5,575	658,939
Education	98,722	20,469	964,888
Socialization/Recreation	295,579	9,407	1,394,240
Money Management	1,164	45	23,536
Congregate Meals	1,649,616	34,616	18,925,892
Home Delivered Meals	3,256,027	26,439	22,181,348
State Weekend Home Delivered Meals	268,326	5,680	2,047,039
Nutrition Education	80,391	24,349	227,158
Nutrition Counseling	1,862	1,798	66,259
Caregiver Mental Health Counseling	3,583	608	386,062
Professional In-Home Education	1,338	307	127,154
Trained Volunteer Assistance	2,136	328	48,313
Wander Safety System	689	57	22,176
Total of All Services	8,363,353	355,019	\$ 91,291,992

Appendix D2

Units	Clients	Expenditures	Service
65,890	678	\$1,364,804	Respite Care
2,211	259	\$794,248	Certified Home Health Aide
4,742	34	\$1,079,809	Adult Day Services – Social
4,428	137	\$395,756	Adult Day Services – Medical
8,552	1,580	\$1,042,900	Care Management
4,131	5,882	\$988,217	Information & Assistance
4,533	1,537	\$150,824	Outreach
4,431	84	\$39,139	Friendly Visiting
3,707	144	\$47,404	Trained Volunteer Assistance
2,649	319	\$89,641	Physical Health

Profile of Congregate Meal Recipients

	<u>Total Clients</u>	<u>% of Total</u>
Total Congregate Clients	33,818	
Female	21,480	69.80%
Male	<u>9,293</u>	30.20%
Total with Gender Reported	30,773	
In Poverty	9,997	29.56%
Poverty Missing	3,689	10.91%
Live-Alone	10,478	30.98%
Live-Alone Missing	4,406	13.03%
Age Groups:		
60 - 74	11,942	38.33%
75 - 84	11,417	36.65%
85 +	7,796	25.02%
Total with Age Reported	31,155	

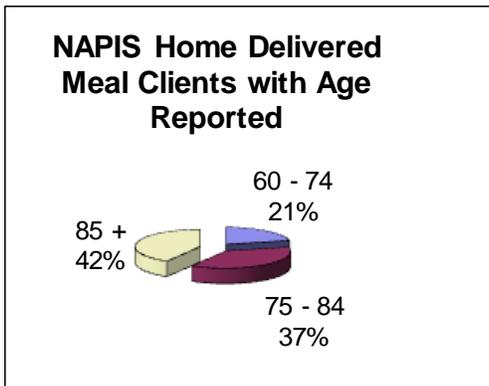
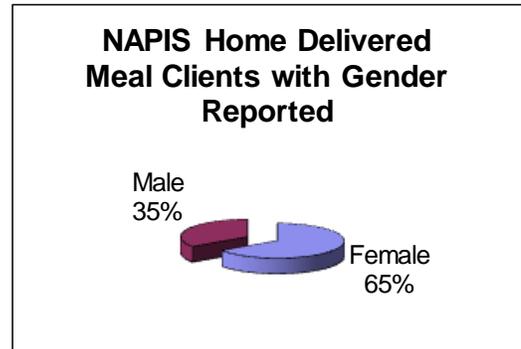


Total Congregate Clients	33,818
Number of Meals Served	1,722,429
Total Cost	\$19,145,102
Cost per Meal	\$11.12
Cost per Client	\$566.12

** NAPIS is the National Aging Program Information System*

Profile of Home Delivered Meal Recipients

	<u>Total Clients</u>	<u>% of Total</u>
Total Home Delivered Meal Clients	29,724	
Female	19,358	65.38%
Male	10,249	34.62%
Total with Gender Reported	29,607	
In Poverty	9,729	32.73%
Poverty Missing	950	3.20%
Live-Alone	15,831	53.26%
Live-Alone Missing	393	1.32%
<i>Age Groups:</i>		
60 - 74	6,338	21.33%
75 - 84	11,056	37.21%
85 +	12,316	41.45%
Total with Age Reported	29,710	



Total HDM Clients	29,724
Number of Meals Served	3,574,420
Total Cost	\$23,932,698
Cost per Meal	\$6.70
Cost per Client	\$805.16

* *NAPIS is the National Aging Program Information System*

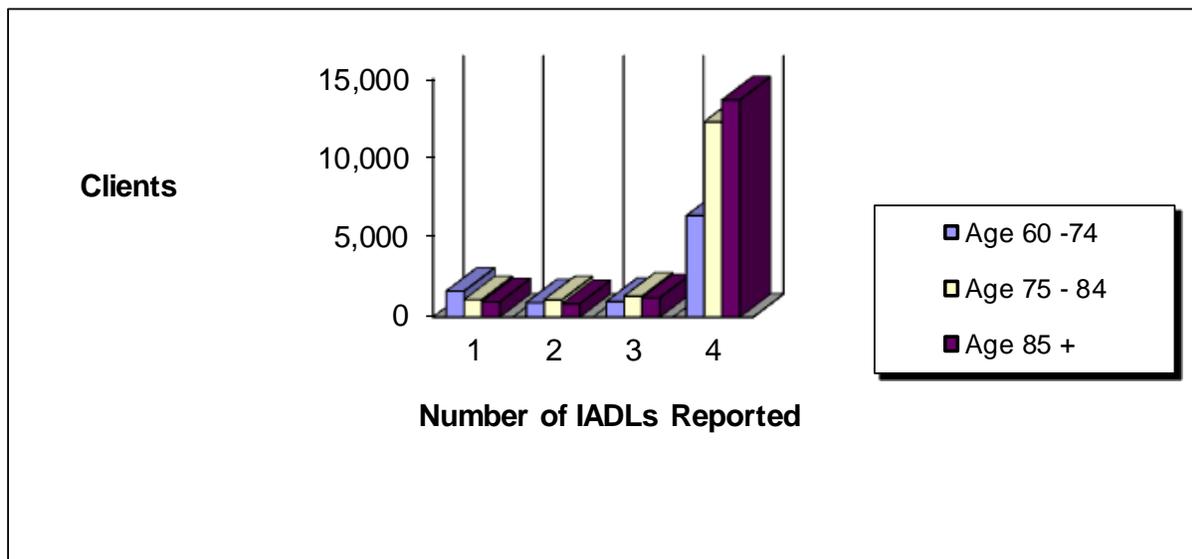
New Jersey NAPIS* data as reported to the Administration on Aging for FFY 2012

NAPIS* Services to Seniors

Total Cluster 1 Clients with Age and Impairment in Instrumental Activities of Daily Living (IADL) Status Reported**

IADL Status

Age Groups	Total	0 IADL	1 IADL	2 IADL	3+ IADL
60 - 74	9,943	1,647	916	987	6,393
75 - 84	15,831	1,111	1,103	1,323	12,294
85 +	16,713	969	844	1,226	13,674
Total with Age Reported	42,487	3,727	2,863	3,536	32,361



*** NAPIS is the National Aging Program Information System**

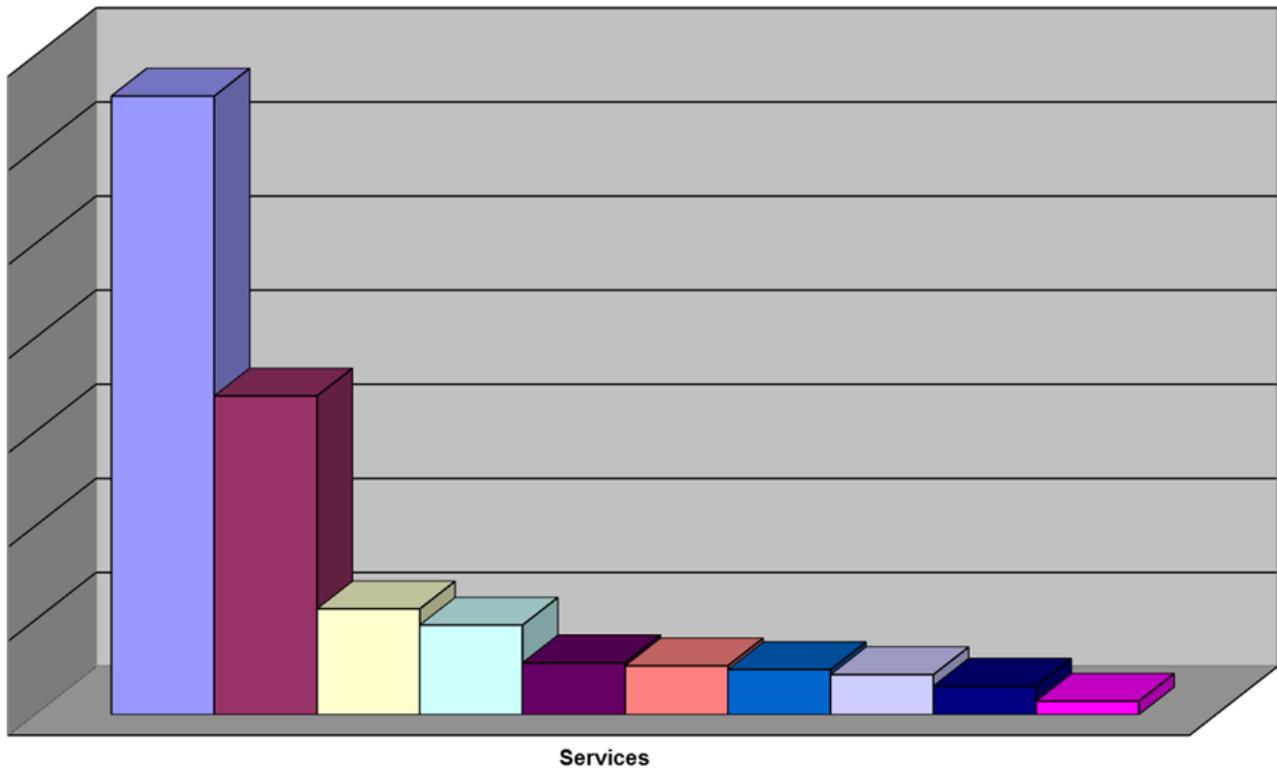
**** Cluster 1 includes the following services: Personal Care, Homemaker, Chore, Home Delivered Meals, Adult Day Care/Health and Case Management**

**New Jersey Department of Human Services
Division of Aging Services
Area Plan Contract Services Provided to Seniors
Calendar Year 2011**

Top Ten Area Plan Contract Services to Seniors Based on Units Served in 2011			
Service	Units	Clients	Expenditures
Home Delivered Meals	3,286,782	24,698	\$21,691,687
Congregate Meals	1,693,174	38,298	\$18,677,301
Transportation	561,540	13,698	\$5,756,584
Adult Day Services - Social	475,365	1,825	\$2,425,491
State Weekend Home Delivered Meals	275,418	5,601	\$1,888,834
Information & Assistance	259,579	109,982	\$5,471,021
Telephone Reassurance	238,980	2,595	\$382,728
Certified Home Health Aide	212,297	1,542	\$4,280,602
Adult Protective Services	152,028	4,261	\$5,087,551
Assisted Transportation	71,361	2,589	\$992,897

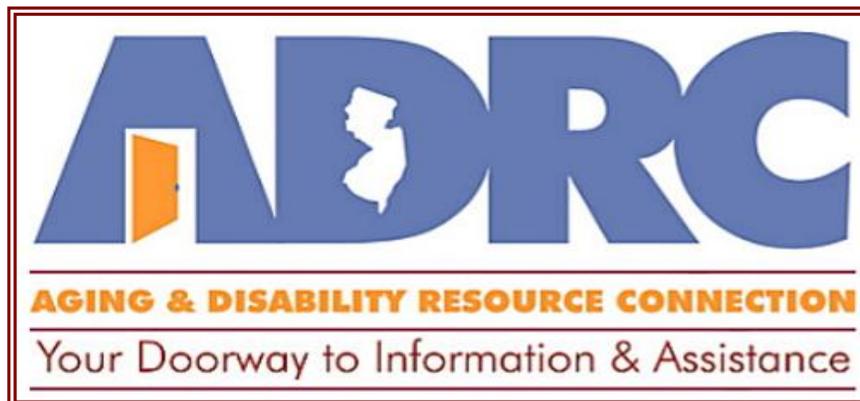
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Adult Protective Services	152,028	4,261	\$5,087,551
Assisted Transportation	71,361	2,589	\$992,897
Nutrition Education	70,977	28,048	\$307,014
Adult Day Services - Medical	58,488	315	\$827,453
Housekeeping	58,391	1,690	\$1,302,691
Care Management	56,328	3,574	\$2,161,077
Outreach	49,490	21,134	\$1,273,196
Socialization/Recreation	36,870	11,011	\$1,380,464
Benefits Screening	35,309	10,132	\$868,205
Physical Health	28,550	9,917	\$932,205
Residential Maintenance	26,903	3,853	\$1,189,392
Legal Assistance	25,032	6,201	\$1,659,065
Physical Activity	23,462	5,260	\$633,687
Education	19,864	19,739	\$899,236
Friendly Visiting	16,676	510	\$173,299
Emergency	13,317	2,027	\$513,565
Counseling	8,421	223	\$142,010
Visiting Nurse	7,971	1,086	\$435,619
Hospice Care	7,219	314	\$247,077
Mental Health	6,971	1,064	\$452,856
Extended Assessment	6,314	1,852	\$267,307
Personal Care	6,113	124	\$125,623
Language Translation/Interpr (732/832)	5,415	1,225	\$97,573
Oral Health	4,227	763	\$473,924
Homesharing/Matching	2,729	648	\$48,800
Nutrition Counseling	2,283	2,090	\$158,693
Housing Assistance	1,926	819	\$79,768
Money Management	1,623	58	\$35,132
Public Awareness/Information (502)	213	30,060	\$50,999
Ombudsman	150	33	\$38,474
	7,807,756	368,859	\$83,429,100

New Jersey Top Ten Area Plan Contract Services to Seniors Based on Units Served in 2011



■ 3,286,782 Weekday Home Delivered Meals	■ 1,693,174 Congregate Meals	□ 561,540 one-way Transportation trips
□ 475,365 hours of Social Adult Day Services	■ 275,418 Weekend Home Delivered Meals	■ 259,579 Information and Assistance contacts
■ 238,980 Telephone Reassurance calls	□ 212,297 Certified Home Health Aide hours	■ 152,028 Adult Protective Services contacts
■ 71,361 one-way Assisted Transportation trips		

New Jersey's
AGING AND DISABILITY RESOURCE CONNECTION
(ADRC)
FIVE YEAR PLAN
2011-2016



DEPARTMENT OF HEALTH AND SENIOR SERVICES ♦ DIVISION OF AGING AND COMMUNITY SERVICES

Introduction

ADRC Initiative

In 2003, New Jersey was one of 12 states awarded an Aging and Disability Resource Center (ADRC) grant by the federal Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) to improve access to information and services, and to streamline the Medicaid eligibility process. In New Jersey, the grant was renamed the Aging and Disability Resource Connection (ADRC) initiative. The ADRC initiative was the first joint venture between the Department of Health and Senior Services (DHSS) and the Department of Human Services (DHS) to create a “no wrong door” coordinated single entry system for older adults, younger persons with physical disabilities and long-term chronic illnesses and their caregivers. ADRC serves all income levels with special outreach efforts to the private pay population. The State introduced the concept beginning with Atlantic and Warren Counties as pilot programs in 2005. With the ADRC model tested and partnerships now in place, New Jersey is scheduled to complete the statewide implementation process December 31, 2011.

An algorithm for the ADRC model was created to identify a new client pathway and decision-making process for accessing information and determining clinical and financial eligibility for State and federal programs. The algorithm development consists of these six steps: (1) building organizational capacity; (2) initiating contact with consumers; (3) identifying consumers’ needs; (4) counseling consumers on home and community-based services (HCBS) and long-term care (LTC) options; (5) coordinating consumer directed care plans, and (6) integrating a continuous quality management framework into the ADRC model.

A New Clinical Assessment Tool

The Division of Aging and Community Services (DACS) researched, evaluated, and tested the Michigan assessment tool that was based on the InterRAI MDS-HC assessment, a nationally and internationally validated tool. The Michigan tool was modified to align with NJ's nursing facility level of care regulations. The assessment suite, known as NJ Choice includes: (1) minimum data elements for Information and Assistance (I&A) intake; (2) a “Screen for Community Services” (a set of 20 clinical and 10 financial questions) that I&A specialists ask consumers over the phone to assess their potential need for long-term care support services; and (3) the comprehensive care needs assessment tool. Both the screening and comprehensive care needs tools identify five levels of care needs, which are Information and Assistance (I&A), homemaker, intermittent personal care, home care, and nursing home level of care.

Based upon the outcome of the screening, consumers may be referred to the ADRC assessors who are responsible for conducting home visits and the comprehensive assessments to identify their physical/health care needs. The ADRC assessors review the assessment outcomes; counsel consumers and their caregivers on appropriate HCBS and LTC options; and connect them to their locally-based care management agencies or other appropriate agencies.

Between 2006 and 2010, five fully functional ADRC counties (Atlantic, Bergen, Gloucester, Hunterdon, Warren) processed over 242,610 contacts. Ninety-two percent were consumer (self) contacts and three percent were family members/caregivers. Thirty-six percent of the callers asked for financial assistance information, seventeen percent asked for information on health benefits and fifteen percent asked for information on in-home services. In terms of caller profile, 101,990 callers provided age information of which 83 percent were 60 years and older. Of the 83 percent, 48 percent were 80 years old and older. Seventeen percent were callers under 60 years. Three percent of the total contacts were persons with disabilities.

As mentioned above, the 2006-2010 data reveals 242,610 ADRC contacts in five counties. Out of the 242,610 contacts, a total of 6,283 screenings for community services were completed during this period. Sixteen percent of the contacts scored in need of information and assistance, 19 percent scored in need of homemaker services, 25 percent scored for intermittent personal care, 31 percent scored for home care, and 9 percent scored in need of nursing home care.

As documented by the outcomes of the comprehensive clinical assessment, the ADRC screening tool has proven to be an effective indicator of a consumer's need for HCBS. When assessed, 94 percent of those individuals who scored at level three or above on the screening tool were clinically determined appropriate for support services. Not only is the tool effective in targeting the appropriate individuals for home visits and assessments, the tool is an important management tool to help allocate State and county resources more efficiently and cost-effectively.

Medicaid Financial Fast Track Eligibility Determination

The ADRC developed an expedited financial eligibility determination process that allows consumers, who appear to have a high probability of being eligible for Medicaid, to be authorized to receive HCBS for up to 90 days while they complete the full Medicaid application and determination process. Because Federal Financial Participation is not available for services delivered to applicants determined ineligible for Medicaid, the State assumes the cost of services should the applicant be determined ineligible.

Under the NJ-Choice assessment tool previously described, the Screen for Community Services triggers the Fast Track Eligibility process: the names of consumers whose screening indicates a high probability of being eligible for Medicaid long-term care benefits are forwarded to the ADRC assessor for an in-depth clinical assessment. Once the assessment is scored, the results are uploaded to a central database, whereby the DHSS reviews the assessment and approves or denies nursing facility level of care (NFLOC). Names of individuals who meet clinical eligibility are forwarded to the DHSS, Division of Senior Benefits and Utilization Management (SBUM) to check income and resources against the Medicare Part D Low Income Subsidy (LIS) database. Within two business days, SBUM forwards the financial information to the ADRC to review and approve or deny Medicaid benefits under the Fast Track process. If the person is approved for Fast Track, a temporary Medicaid number is assigned and State Plan services and care management are authorized for up to 90 days. Within 30 days the person must schedule an appointment with the county welfare agency to complete the full Medicaid application process or risk being terminated from the Fast Track program.

To date a total of 2,333 consumers have been processed for Fast Track eligibility resulting in 424 consumers gaining immediate access all Medicaid State Plan services, for up to 90 days, while their financial eligibility was determined.

The DACS and the DHS, Division of Medical Assistance and Health Services (DMAHS) have closely monitored the progress and met with the county welfare agency (CWA) directors and eligibility supervisors to identify and address their issues and concerns. Based on feedback, it was realized that the Medicare Part D - Low Income Database being used for Fast Track limited the pool of individuals potentially eligible for the program. Therefore the Pharmaceutical Assistance to the Aged and Disabled (PAAD) database was added because it contains a greater number of individuals potentially eligible and provides additional financial information. However, CWA feedback still indicates that a major contributor to the low number of participants being approved is because the database must show that the federal financial requirements are met. Fast Track can't proceed without proof that the person's current income/assets fall within the financial guidelines at the time of application.

ADRC Implementation Process

To implement the ADRC model, the State established a team to work one-on-one with each county to formalize local partnerships and integrate the ADRC client-pathway and model into their business processes. The first step that each county must undertake is to organize a local ADRC implementation team to oversee the development of a county-based single entry system. The AAA serves as the lead and is responsible for establishing the ADRC partnership. The partners must minimally include the following: county government officials and social service department heads, County Welfare Agencies (CWAs), offices on disability services, Centers for Independent Living, SHIP coordinators, State and county veteran service offices, hospital systems, senior centers/nutrition sites, home care agencies and other access points.

Working with the county ADRC team, the State guides the partners to identify which agencies will assume responsibilities for intake, screening, assessment/reassessment, options counseling, care management, and quality assurance. The State ADRC team provides intensive training for each of these core functions identified above, and continues to mentor the agency staff throughout the implementation phase.

Comprehensive Client-Tracking System

A central focus of the ADRC is the implementation of a comprehensive data system to track long-term care expenditures and services, and consumer profiles and preferences. It is the Social Assistance Management System (SAMS) that once fully operational, will provide the information and technology (IT) infrastructure to the 700 HCBS agencies and 2000 end users.

In August 2008, the State's Office of Information and Technology (OIT) approved DACS to enter into a three-year (2008-2011), \$3.8 million waiver of advertisement with Harmony Information Systems Inc. to purchase the SAMS application. As a web-based,

client-tracking system, SAMS has the capacity to support multiple departments, divisions and programs. The SAMS integrated database includes intake, consumer profiles, screening for home and community-based services, clinical assessment, case management, service planning and authorization, service utilization, and the federal reports required by New Jersey under the Older Americans Act.

The approved waiver with Harmony Information Systems, Inc. included the following: (1) licenses and subscriptions to Harmony's hosting service, AgingNetwork.com for 2,000 end users; (2) support to complete the statewide deployment of the SAMS federal reporting system to the remaining 21 Area Agencies on Aging (AAAs); (3) project management to deploy SAMS to over 700 aging, disability, and veteran agencies that administer the federal Older Americans Act, Medicaid HCBS Waiver services and State-funded programs; (4) technical assistance to support the business processes of the ADRC model; (5) an interface between the DACS' MDS-HC clinical database and SAMS; and (6) the provision of technical assistance to create forms to capture additional data elements needed to implement DACS' quality assurances management strategy.

Through the 2009 ADRC grant, NJ purchased additional modules from Harmony Information Systems that included an online resource center, document storage, agency reporting tool and consulting hours to support the ADRC business process.

As of June 30, 2011, 1,032 associate users of the 21 AAAs and their contracted agencies were trained and nearly 200,000 client records were entered into the SAMS' database. The completion of the project's first step represents the implementation plan's most expansive phase. By the end of 2011, it is anticipated that SAMS will be able to serve as the single database for Older Americans Act funded programs to collect, analyze and transfer federally required data elements to the Administration on Aging (AoA).

Rebalancing Long-Term Care to Promote Home and Community Based-Services

On June 21, 2006, the governor signed the Independence, Dignity and Choice in Long-Term Care Act (Act) to create a process to reallocate Medicaid long-term care expenditures and develop a more appropriate funding balance between nursing home care and other home and community-based care services (HCBS). The State is now charged in rebalancing its Medicaid long-term care system to include more community care and greater consumer choice, and ensure that "money follows the person," allowing maximum flexibility between nursing homes and home and community-based settings.

The Act specifically requires the commissioners of the DHSS and DHS, together with the State Treasurer, to create budgetary processes for expanding home and community-based services (HCBS) within the existing budget allocation. According to the Act, for the State fiscal years 2008 through 2013, funds equal to the amount of the reduction in the projected growth of Medicaid expenditures for nursing home care (State dollars only), plus the percentage anticipated for programs and persons that would be eligible to receive federal matching dollars, shall be reallocated to HCBS.

The DHSS engaged Mercer Government Human Resources Consulting (Mercer), a part of Mercer Health & Benefits LLC, to create a budget rebalancing model to track DACS

and Division of Disability Services (DDS) waivers, Adult Day Health Services (MD), Personal Care Assistance (PCA) and nursing facility (NF) expenditures, as well as project future LTC expenditures.

The purpose of the model is two-fold:

1. To estimate the State and federal budgets for waivers and direct care costs that fall under the responsibility of DACS and DDS, and
2. To quantify the impact of the Act by estimating the cost savings of the rebalancing efforts made by the State by redirecting Medicaid clients from NFs to HCBS.

Based on the tenets of the Act, the first and most important graph in the model illustrates the reduction in the projected growth of Medicaid expenditures from moving or diverting clients from a nursing home (NF) into home and community based services (HCBS). For the purposes of the model, July 1, 2007 (State Fiscal Year 2008) is the date cited in the Act that the State must begin measuring cost savings.

Rebalancing the State's long-term care budget can also be estimated by determining what would have been spent if the Act had not been passed. The budget projection model calculates historical and projected savings as a result of rebalancing efforts. In the chart below, the Act Induced lines represent the total cost of nursing facility and HCBS services respectively after the passage of the Act. The non-Legislative lines represent what might have happened had the Act not been passed.

The nursing facility (NF) savings are derived by calculating the difference between the NF costs had the Act not passed (non-legislative) and the nursing home costs due to the Act. The difference between the Act Induced HCBS costs and non-legislative HCBS costs are then subtracted from the nursing facility savings to arrive at projected net savings due to rebalancing.

As a result, the reduction in the projected growth of Medicaid expenditures (state and federal dollars) for the State due to its rebalancing efforts can be seen in the graph below:

Based on the Global Budget Projection model, the impact of the Independence, Dignity and Choice in Long-Term Care Act (Act) has been positive on the State's fiscal situation if one considers the potential costs of long-term care without any rebalancing activities. Looking at historical and projected savings resulting from rebalancing activities, in federal and state dollars combined, New Jersey saved a total of \$99,003,741 in 2010; in 2011 \$68,728,929 is the projected savings and for 2013 the projected savings is \$111,011,789. At this point in time the State's public HCBS expenditures are increasing minimally as a percentage of the total long-term care Medicaid expenditures. The Global Budget Projection model shows definite cost containment of \$442,721,077 (combined federal and state funds) over five years (2010-2014).

**Act
Passed**

**GO
Launched**

The State of New Jersey now has a new budgetary process for tracking its long-term care system expenditures and projecting future expenditures. It is designed to increase home and community-based care within the existing budget allocation by diverting persons from nursing home placement, allowing maximum flexibility between nursing facilities and HCBS.

Another way to measure the effectiveness of the State’s rebalancing efforts to date is to calculate the percentage of total spending among the different long term care services. If rebalancing efforts are working, then the percentage of nursing home spending should decrease over time with a corresponding increase in HCBS spending, including waiver, Adult Day Health Services (MD) and Personal Care Attendant Services (PCA). Again based on the Act, data from SFY2007 was used as the baseline, while data from SFY2009 was used to measure change. As additional counties migrate to the ADRC model, the rebalancing projections will change as well.

Addressing the imbalance in New Jersey’s long-term care budget – which currently favors nursing home care – remains a large part of the solution in the context of the State’s long-term care reform agenda. Although cost containment will be compounded by the aging of the baby boom generation, New Jersey is moving steadily and purposefully in the right direction.

Table I shows the count of people, by county, served through the GO Waiver in each calendar year since 2007. It is clear that the GO Waiver is expanding throughout the State. By providing less-costly HCBS to its members, the GO Waiver helps to keep the cost of the State’s overall long-term care program down. The growth in this program is one of the major drivers of the State’s recent success in rebalancing the long-term care program.

*Decrease due to an Adult Foster Care provider agency withdrawing from Medicaid. All GO participants were relocated to assisted living facilities adjacent to Cumberland County.

Table I
GO Waiver recipients by county, 2007 – 2010

County	2007	2008	2009	2010	Change in recipients – 2007 to 2010	Percentage change – 2007 to 2010
Atlantic	625	648	656	769	144	19%
Bergen	641	690	686	797	156	20%
Burlington	471	536	531	688	217	32%
Camden	918	973	940	1,112	194	17%
Cape May	283	297	300	357	74	21%
Cumberland	452	444	423	442	(10)*	-2%
Essex	561	567	551	604	43	7%
Gloucester	467	485	473	600	133	22%
Hudson	826	823	846	1,094	268	24%
Hunterdon	68	89	85	116	48	41%
Mercer	458	468	432	498	40	8%
Middlesex	657	685	701	816	159	19%
Monmouth	1,140	1,141	1,106	1,255	115	9%
Morris	366	401	414	555	189	34%
Ocean	995	1,077	1,033	1,273	278	22%
Passaic	539	585	564	691	152	22%

County	2007	2008	2009	2010	Change in recipients – 2007 to 2010	Percentage change – 2007 to 2010
Salem	134	133	125	170	36	21%
Somerset	311	334	348	419	108	26%
Sussex	105	104	117	150	45	30%
Union	612	620	636	766	154	20%
Warren	160	224	290	401	241	60%
Total	10,789	11,324	11,257	13,573	2,784	21%

In SFY 2007, 45% of member months for clients receiving long-term care services were classified as nursing facility based on the model’s algorithm, while 13% were classified as long-term care waiver. In SFY 2009, however, the percentage of members classified as nursing facility had decreased to 43%, while the percentage of members classified as waiver had increased to 14%. This continued into SFY 2010, as the percentage of members classified as nursing facility had decreased even further to 41%, while the percentage of members classified as waiver had continued to increase to 15%.

This trend is indicative of more clients being directed to and opting for home- and community-based settings for their care. As discussed earlier, the nursing facility, MD and PCA populations are determined based on claim activity. As a result, the SFY 2010 numbers may change as more claims come in. This data includes claims paid through January 2011.

There has been a strong effort on the part of the State to provide waiver services to the new long-term care members. While all HCBS services have seen growth (as exhibited in Table I), the waiver programs have shown continued and substantial growth since their inception. From SFY 2009 to SFY 2010, the waiver membership grew by over 15%. As the data in Table II below indicates, there was a lower but still significant growth of 6.7% when all HCBS related member months are combined.

Table II

Long-term care classification by SFY

Service	SFY 2007	SFY 2009	SFY 2010
Nursing Facility	369,213	363,966	355,877
Medical Day Care	121,080	131,316	133,732
Personal Care Assistant	220,595	232,756	245,145
Waiver Services	104,448	114,567	132,069
Total	815,336	842,605	866,823

One way to measure the effectiveness of the State’s rebalancing efforts to date is to evaluate the percentage of total spend among the different long-term care services. If rebalancing efforts are working, then the percentage of nursing facility spending should decrease over time with a corresponding increase in HCBS spending (including waiver, PCA and MD). Based on the date of implementation of the Act, data from SFY 2007 was used as the baseline while data from SFY 2009 and SFY 2010 was used to measure change.

In SFY 2007, nursing facility expenditures represented 73% of Medicaid long-term care spending, while waiver expenditures, including DACS and DDS, represented only 7% of spending. In SFY 2009, nursing facility expenditures decreased to 72% of Medicaid long-term care spending, while waiver expenditures increased to 8% of spending, indicating a slight statewide shift. This shift continued into SFY 2010, as we see nursing facility expenditures fall to 70% while waiver expenditures continued to grow to 10% of Medicaid long-term care spending.

One item that may have influenced the slow (or negative) growth of nursing facilities is that there was no rebasing done for the nursing facility rates in SFY 2009 or SFY 2010. Additionally, in SFY 2010 inflation was not applied to the nursing facility rates. While these factors directly impact the overall costs, utilization of nursing facilities also fell. The change in utilization is the main driver of the cost decrease.

Table III

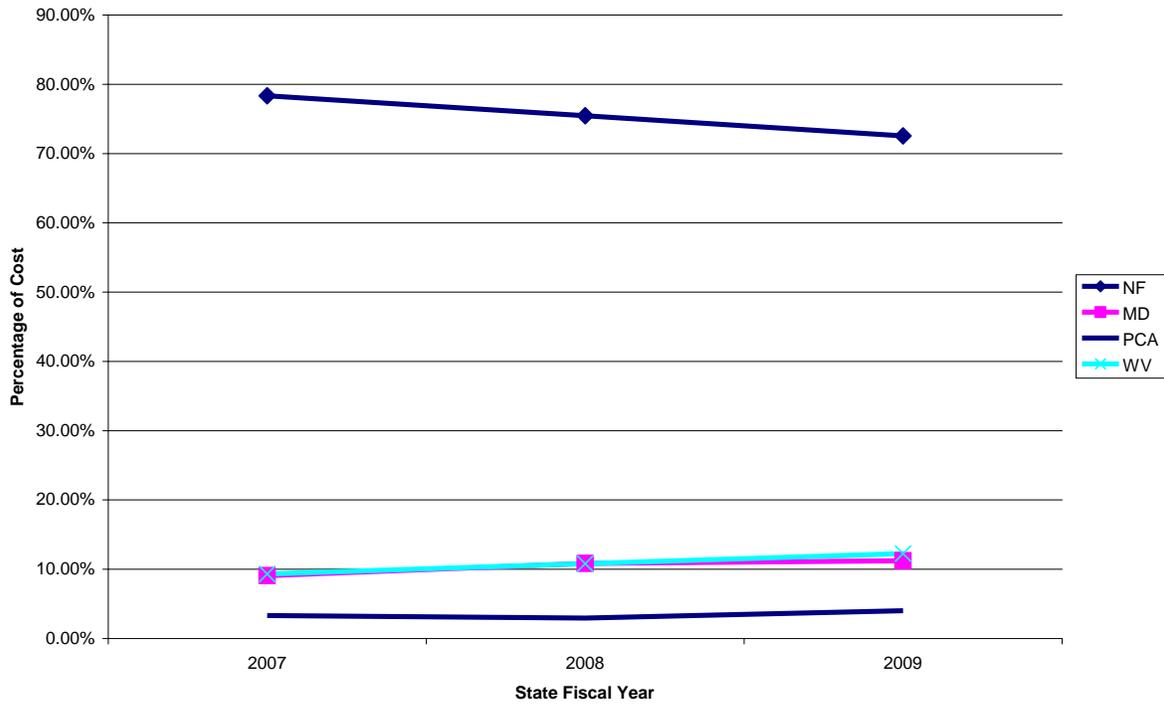
Long-term care spending by member classification and SFY (in millions)

Service	SFY 2007	SFY 2009*	SFY 2010*
Nursing Facility	\$1,733	\$1,872	\$1,805
Medical Day Care	\$209	\$255	\$253
Personal Care Assistant	\$256	\$268	\$279
Waiver Services	\$162	\$205	\$257
Total	\$2,360	\$2,600	\$2,594

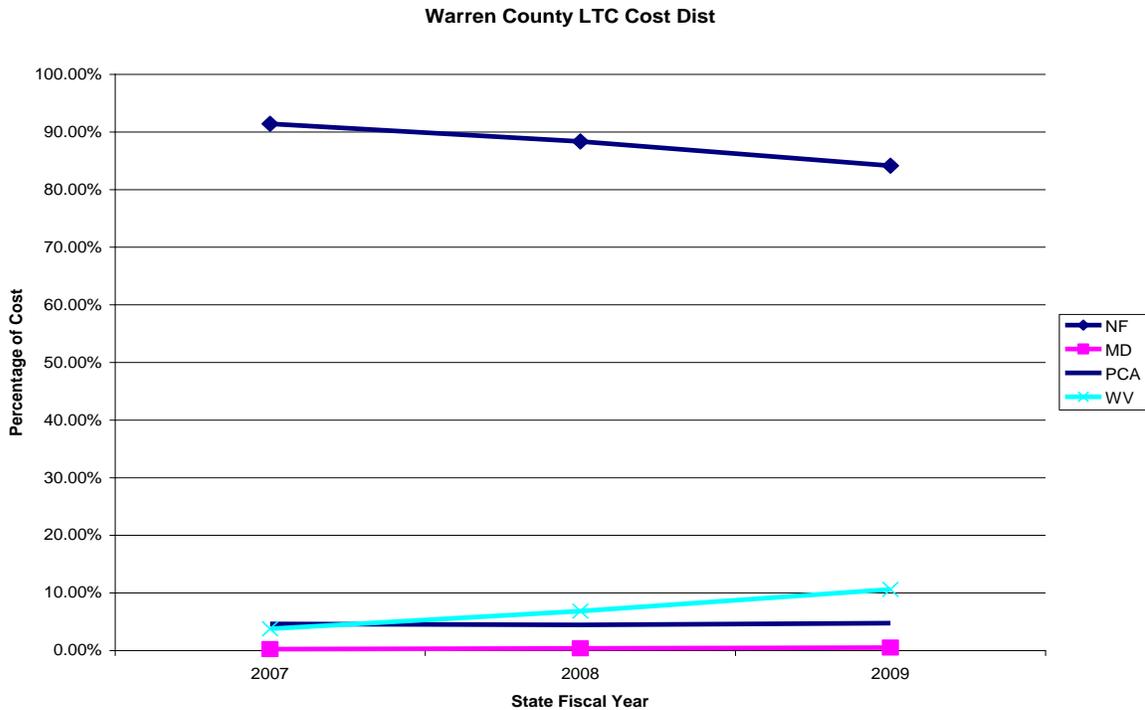
**Note that there was no rebasing of the nursing facility rates in SFY 2009 or SFY 2010*

At this time, the most complete data available to support the budget projection model is for the two original ADRC pilot counties, Atlantic and Warren. These two counties have showed marked improvement in HCBS penetration. In Atlantic County, nursing home (NF) costs decreased from 79 to 73 percent, while HCBS waiver costs increased from 9 to 13 percent as seen in the following graph.

Atlantic County LTC Cost Dist



Warren County, the change was even more pronounced, as nursing home (NF) costs decreased from 91 to 83 percent. In addition, Waiver costs, including the Global Options (GO) waiver, increased from 4 to 11 percent.



The Global Options (GO) Medicaid waiver budget has thus far supported the increase in waiver members and the model is currently constructed to take recent enrollment changes into account without regard for factors such as enrollment caps. As the State moves forward with a comprehensive 1115 Medicaid Reform waiver, the basis for these projections may undergo significant change.

Thus, the ADRC initiative has become the primary catalyst for rebalancing the long-term care budget. The goal of securing a LTC global budget impacts other major state agencies and requires increased community capacity (resources) to support the ADRC initiative at county, regional and state levels.

NEW JERSEY ADRC 5 YEAR PLAN FOR 2011 - 2016

Since 2003, New Jersey has been building a model that focuses on a system-wide change and integration process, making it easier for older adults and persons with physical disabilities to access the full array of public and private HCBS. Now the State is embarking on a new five year plan to enhance the operational framework, while still maintaining its focus on consumer-directed services and supports and rebalancing LTC expenditures to promote cost-effective HCBS.

The ADRC/Systems Transformation State Management Team (SMT) comprised of the leadership from DHSS/DHS and consumers will continue to serve as the executive authority for ADRC 5 Year Plan. The State Management Team, established under the original ADRC grant in 2004, is comprised of the leadership from the Division of Aging and Community Services, Division of Medical Assistance (Medicaid), Division of Developmental Disabilities and the Division of Disability Services.

With strong collaborative partnerships comprised of aging and disability entities at the State and county levels, NJ has the authority to ensure AAAs become fully functioning ADRCs and the State has the flexibility to manage HCBS and LTC services and supports more efficiently. A primary focus of the SMT will be one of continuous quality management to the infrastructure, process and delivery of long term services and supports to older adults and persons with disabilities across the departments and programs.

Division of Aging and Community Services Mission Statement

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

ADRC Guiding Principles

- Customer Service Excellence - is creating and maintaining a positive environment that promotes committed service to customers by a trained, knowledgeable, courteous, and culturally congruent professional staff.
- Cultural and Linguistic Competence - the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.
- Consumer choice/direction - consumers are given a choice in a range of service options to meet their diverse needs. Consumer choice may include opportunities to decide when and where services will be provided, and how and by whom tasks will be performed.

The NJ ADRC project's 7 impact goals focus on development and implementation of a state model with system-wide focus. Using the ADRC algorithm as a conceptual base and the ADRC client pathway as an operating framework for DACS services, DACS continues its emphasis on achieving sustainability through institutionalization at both the state and county level. The ADRC initiative now serves as the catalyst for continued infrastructure, process

and delivery of long-term care services and supports for older adults and younger persons with physical disabilities.

Goals

Building upon the achievements of the past 8 years the new ADRC 5 year plan will ensure that DHSS, in partnership with DHS and the county-based ADRC partnerships, will continue to be enhanced throughout New Jersey. The 7 goals are:

1. **Access:** The Aging and Disability Resource Connection serves as NJ’s “no wrong door” for older adults, people with disabilities and caregivers to learn about and access the full range of Home and Community Based Services and Long Term Care services and supports.
2. **Assessment and Options Counseling:** Through the Identification of care needs ADRC assessors will educate consumers on their care needs, counsel them on appropriate service options, and various funding sources, including public, private and personal resources.
3. **Money Follows the Person (MFP):** Through comprehensive assessment and provision of coordinated LTC services and supports, nursing home residents will be able to transition to appropriate community-based settings that promote their independence, dignity and choice.
4. **Transition Care Models:** Establish partnerships and connections between ADRCs and Hospital and/or Community Transitional Care programs. ADRCs will provide supportive services and Case Management in order to decrease number of re-admissions.
5. **IT Support:** Improve Client Access to LTC Services through the use of Integrated IT Systems. Use Integrated Systems to monitor quality services rendered.
6. **Financing Opportunities for HCBS:** Support NJ’s leadership to rebalance long-term supports through cost-effective strategies.
7. **Quality Management:** Through the HCBS framework DACS will continuously improve all services, activities and organizational efforts to promote independence, dignity and choice for older adults, persons with disabilities and their caregivers.

ADRC 5 YEAR PLAN ~ GOALS INTEGRATED

GOAL #1: ACCESS			
The Aging and Disability Resource Connection serves as NJ's "no wrong door" for older adults, people with disabilities and caregivers to learn about and access the full range of Home and Community Based Services and Long Term Care services and supports.			
OBJECTIVE	KEY TASKS	TIME FRAME	MEASURES OF SUCCESS
Fully functioning ADRCs (as defined by AoA) established in each of NJ's 21 counties.	ADRC staff trained on I&A, Screen for Community Services and Options Counseling.	December 2011	Staff in all 21 counties trained on I&A, Screen for Community Services and Options Counseling.
	State and local officials and key partners hold statewide event to announce ADRC capacity throughout NJ.	January 2012	Awareness of ADRC increased as assessed through media coverage and number of inquiries to DACS and local ADRCs.
	Marketing campaign to raise awareness of ADRC among private pay consumers designed and implemented.	2012	Materials developed and disseminated. Contacts by private pay population (baseline and continuing) tracked via SAMS.
Expand the ADRC model to include: a. persons with disabilities b. access to evidence-based disease prevention programs and Medicare assistance c. Online access to information and services	Using results from a Readiness Assessment Tool, work collaboratively with the Centers for Independent Living and the Offices of Disability Services (ODS) into the ADRC. Train I&A staff in each of the 21 ADRCs on evidence-based programs and Medicare assistance (including SHIP and financial assistance). Integrate information on these programs/services in ADRC resource materials.	June 2012 2011-2016	Information and access to Disability Services incorporated into the ADRC business plan. Contacts tracked via SAMS. Track the number of referrals to evidence-based disease prevention programs and SHIP via SAMS.

	Fully functional website inclusive of a resource database (searchable by needs or organization), the Department’s Guide to Community-Based Long Term Care in New Jersey, and links to other resources and self-help tools created.	2011 initial launch and ongoing	Assess utilization of various sections of the website through “hits”.
Maintain high quality service and consumer satisfaction in the ADRC in regard to access to the full array of HCBS/LTC services and supports.	<p>Ensure high quality service among I&A specialists and screeners through a certification process that includes training (initial and ongoing) and performance standards. Training shall include resources and tools available through the ADRC website.</p> <p>Fully integrate cultural and linguistic competency as a guiding principle of the ADRC through initial and ongoing training of ADRC staff/partners.</p>	<p>2012</p> <p>Between 2012-2015, train 7 counties per year.</p>	<p>I&A specialists and screeners trained and certified in each county. (see Goal 7, Objective 1).</p> <p>Staff/partners trained in all counties. Information/access at state and local levels is responsive to languages spoken in service delivery area. (see Goal 7, Objective 1).</p>

GOAL #2: IDENTIFICATION/DETERMINATION OF CONSUMERS' NEEDS, SERVICES AND FUNDING:

- i. Provide consumers with information and linkages to services available within their communities based on stated and/or assessed need.
- ii. Identify consumers “at risk” of NF placement. Assess consumer needs, strengths, and preferences and develop person-centered service planning in the least restrictive environment.
- iii. Provide temporary state plan services to certain clinically eligible individuals during the financial eligibility process.

OBJECTIVE	KEY TASKS	TIME FRAME	MEASURES OF SUCCESS
<i>Screen for Community Services (SCS):</i> Consistent administration of SCS throughout NJ in accordance with the ADRC business process.	Strategy to assure effective and accurate administration of the SCS (inclusive of training, technical assistance and monitoring of performance standards) developed and implemented.	June 2012 and ongoing	NJ Choice assessment results validate 90% of the SCS scores. ADRC staff demonstrate proficiency in administering SCS via the Agency Audit (see Goal 7, Objective 1).
<i>Care Needs Assessment:</i> Establish model for conducting NJ Choice client assessments.	Quality assurance protocol established inclusive of performance standards, client satisfaction measures, and agency audits.	2012-2013	Agency audits demonstrate staff competencies, high consumer satisfaction, and compliance with ADRC business process (see Goal 7, Objective 1).
Options Counseling on all publicly and privately funded programs including State, Waiver, Private Pay.	Enhance current options counseling curriculum to ensure full comprehension of all service options, including both private pay and publicly funded by assessor/options counseling staff. The Resource Directory from the ADRC website will be included in the training as a tool for assessors.	Fall 2012 align NJ Options Counseling standards with AoA standards. Winter 2013 revise current Options Counseling curriculum to address revised standards. Spring 2013 implement training statewide.	As demonstrated through the annual QA Audits (see Goal 7, Objective 1) assessors/OC integrate standardized OC processes into practice, ensuring the consumer is well informed of potential service options to meet needs while allowing for consumer self-direction and determination.

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OBJECTIVE	KEY TASKS	TIME FRAME	MEASURES OF SUCCESS
Care Planning	Assessor will assist the consumer to develop an interim plan of care and identify publicly and private funded community programs and resources to meet their needs/preferences.	Ongoing	Consumer is supported in the decision-making process for determining what type of services they will seek related to their assessed needs and preferences.
Fast Track Eligibility	Expand the provision of state plan services on a temporary basis while financial eligibility is being determined.	Ongoing	Clinically eligible consumers are identified for the program and receive basic services in a timely manner thus reducing the risk of out of home placement.
	Promote and streamline the Fast Track process.	Ongoing	

GOAL #3: MONEY FOLLOWS THE PERSON (MFP)/NURSING FACILITY TRANSITIONS

Through comprehensive assessment and provision of coordinated LTC services and supports, nursing home residents will be able to transition to appropriate community-based settings that promote their independence, dignity and choice.

OBJECTIVE	KEY TASKS	TIME FRAME	MEASURES OF SUCCESS
Identify and counsel NF residents on alternative HCBS.	<p>Develop and implement integrated training modules on MFP for ADRC and Community Choice Options (OCCO) staff completing I&A and Screen for Community Services (SCS).</p> <p>Within each of the 3 regional OCCO recruit MFP Support Specialist Team leader (RN) to meet regularly with ADRC staff.</p> <p>Expand the MFP partnerships with other grant-funded programs such as the Medicaid Infrastructure Grant - Workability (DHS, Division of Disability Services) to offer employment alternatives for the MFP and ADRC participants.</p>	<p>March 2012 initiate training for ADRC staff.</p> <p>Ongoing training and support for ADRC</p> <p>Ongoing</p> <p>June 2013</p>	<p>Increased knowledge of HCBS offered through the ADRCs to support and maintain consumers in the community.</p> <p>Counties are continuously trained and knowledgeable about MFP.</p> <p>I&A Consumer Survey includes questions about MFP.</p> <p>OCCO RN makes monthly contacts to ADRC to increase collaboration between the MFP and ADRC staff.</p> <p>Track number of referrals from ADRCs to OCCO.</p> <p>Increased quality of life options for MFP participants includes employment and volunteer opportunities.</p> <p>Track number of MFP participants employed or volunteering.</p>
Enhance and refine the Interdisciplinary Team (IDT) approach to ensure appropriate and safe discharges to the community.	Update and implement IDT training curriculum for MFP key team members including ADRC, OCCO, NF discharge planners,	October 2011 initiate training and provide ongoing support	Training curriculum is implemented. Training satisfaction survey is completed by all participants and

	<p>community care managers, and other health related professionals.</p> <p>Develop strategies to support consumers and their caregivers to direct their transitional planning process.</p> <p>Create a standardized MFP packet to Includes MFP fact sheet and brochure, participant handbook, and information on HCBS options.</p> <p>OCCO will arrange Interdisciplinary Team meetings with ADRCs to coordinate HCBS for MFP participants.</p>	<p>October 2011 initiate and ongoing</p> <p>October 2011</p> <p>October 2011 initiate and ongoing</p>	<p>outcomes are used to improve curriculum.</p> <p>Consumer satisfaction surveys indicate that MFP participants felt that they directed their transitional planning process and their personal goals and preferences were respected and were reflected in their plan of care.</p> <p>MFP Fact Sheet has been developed and the brochure is in development.</p> <p>Increased referrals to ADRC at IDT for services such as Meals on Wheels, transportation, legal services, health and wellness programs, etc. to ensure care needs are supported in the community.</p>
<p>Provide consumers and professionals access to appropriate and accessible housing options</p>	<p>Hire a Statewide Housing Coordinator and DACS Housing Specialist for MFP related activities.</p> <p>Develop and implement training curriculum to educate OCCO and ADRC partners on affordable and accessible housing options.</p>	<p>August 2012 for Statewide Housing Director October 2012 for DACS Housing Specialist</p> <p>January 2012 initiate Launch training – spring 2012.</p>	<p>State has designated staff to establish strong working partnership with housing associations.</p> <p>MPF internal and external partners are trained and knowledgeable about affordable and accessible housing options.</p> <p>Strengthened lines of communication between OCCO MFP Support Specialist and ADRC to identify available housing resources.</p>

	Develop within ADRC webpage a housing directory for consumers to learn about and locate affordable and accessible housing options	Fall 2012 initiate Complete by June 2013.	Increased available solutions for current housing issues. Track number of MFP participants who have accessed housing options through MFP staff.
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GOAL #4: TRANSITIONAL CARE

Establish partnerships and connections between ADRCs and Hospital and/or Community Transitional Care programs. ADRCs will provide supportive services and Case Management in order to decrease number of re-admissions.

OBJECTIVE	KEY TASKS	TIME FRAME	MEASURES OF SUCCESS
Develop partnerships between Hospital/Community Transition Care Programs and AAAs.	<p>In collaboration with Healthcare Quality Systems, Inc. (NJ’s Peer Review Organization) identify Hospital and/or Community Transitional Care Programs and foster partnerships with local ADRCs.</p> <p>Identification of JACC clients who can participate in Transitional Care Programs</p> <p>Educate Hospital and/or Community Transitional Care programs on ADRC resources and DACS Programs such as CDSMP</p>	<p>December 2011(initial)</p> <p>Spring 2012 develop criteria and outreach strategy</p> <p>Fall 2012 – begin working with hospitals who will be implementing a TCM.</p>	<p>Partnerships between ADRCs and Transitional Care Programs in place in at least 2 counties</p> <p>JACC client’ s with multiple readmissions will be enrolled in Transitional Care Programs</p> <p>Hospital and Transition Care Program staff will be fully trained on community resources available through the ADRC and DACS, will make referrals for services, ensuring consumer receives needed support in the community.</p>
Develop IDT Protocols between Hospital TCM and ADRCs	<p>ADRC Care Managers to attend Hospital IDT meeting prior to discharge to establish relationship with client and Transitional Care Manager</p> <p>Educate hospital Transitional Care staff on the role and responsibilities of ADRCs community resources.</p> <p>Identify process for notifying ADRC and Transitional Care Manager when client is re-admitted to hospital.</p>	<p>Fall 2012</p> <p>Winter 2012</p> <p>Fall 2012</p>	<p>Care Managers will begin attending Hospital IDT</p> <p>Clients who participate in programs will be able to demonstrate knowledge of follow-up care, and the ability to manage their illness, decreasing hospital readmissions.</p> <p>A process will be put in place so when client is readmitted, the Care Manager and the Transitional Care Manager will be notified of client admission.</p>

GOAL #5: Information Technology (IT) SUPPORT

Improve Client Access to LTC Services through the use of Integrated IT Systems. Use Integrated Systems to monitor quality services rendered.

OBJECTIVE	KEY TASKS	TIME FRAME	MEASURES OF SUCCESS
<p>Complete and expand the implementation and integration of IT systems.</p>	<p>Complete the implementation of IT systems in all of the ADRCs.</p> <p>Integrate and expand the use of these systems to the Veteran and Disability communities, incorporating DDS and DMAHS.</p>	<p>June 2012</p>	<p>IT systems implemented in all ADRCs.</p> <p>Ability to use IT systems in all ADRCs to run required reports on I&A, Assessments, and Care Management services.</p> <p>Complete and implement Care Management policies and procedures using IT systems.</p> <p>Completion of on-line Resource Directory as part of ADRC webpage.</p>
<p>Use IT Systems to Monitor Quality Services Rendered</p>	<p>Integrate Quality Assurance Standards into IT systems.</p> <p>Develop Reports to measure quality and quantity of services.</p>	<p>January 2013</p>	<p>State, County, and Private Partner Agencies will have the capability to use standardized reports for tracking of services rendered.</p>

GOAL #6: FINANCING OPPORTUNITIES for HCBS

Support NJ's leadership to rebalance long-term supports through cost-effective strategies.

OBJECTIVE	KEY TASKS	TIME FRAME	MEASURES OF SUCCESS
<p><i>Comprehensive Waiver</i> Submit a five year Medicaid and Children's Health Insurance Program (CHIP) Section 1115 research and demonstration waiver that encompasses all services and eligible populations served under a single authority which provides broad flexibility to manage these programs more efficiently.</p>	<p>The State of New Jersey, Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), in cooperation with the Departments of Health and Senior Services (DHSS) and the Department of Children and Families (DCF) will develop innovative strategies that will allow the State the flexibility to define who is eligible for services, the benefits they receive and the most cost-effective service delivery and purchasing strategies.</p>	<p>September 2011</p>	<p>CMS approves the 1115 research and demonstration waiver</p>
<p>Redesign the delivery system for long-term care to promote home and community-based services.</p>	<p>The Aged, Blind and Disabled will be enrolled into managed care for acute/medical care and additional services (pharmacy, personal care, medical day care, home health, and physical, occupational and speech therapies.)</p>	<p>July 1, 2011</p>	<p>ABDs will begin receiving health plan benefits from one of the 4 Managed Care Organizations (MCO).</p>
<p>Develop strategies to coordinate Medicaid and Medicare LTC services and supports for dually eligible.</p>	<p>Individuals who are dually eligible and/or waiver participants will be enrolled in managed care membership for acute/medical care including Medicare/Medicaid.</p> <p>Medicare Special Needs plans will be offered by Medicaid MCOs to integrate Medicare and Medicaid/Family Care services.</p>	<p>October 1, 2011</p> <p>January 1, 2012</p>	<p>Individuals who are dually eligible and/or waiver participants will begin receiving health plan benefits from one of the 4 Managed Care Organizations (MCO).</p> <p>Medicare and Medicaid services will be coordinated for Individuals who are dually eligible.</p>

<p>Provision of LTC services and supports will be delivered through the contracted MCOs including home and community based and nursing facility services</p>	<p>Those at risk of LTC or meet the LOC criteria established by the State will have integrated HCBS (including alternative residential services), Behavioral Health services, primary care and acute care services through MCOs.</p>	<p>July 1, 2012</p>	<p>Individuals who are clinically and financially eligible will receive coordinated acute & waiver services through a single MCO.</p>
<p>Implement the ADRC streamlined eligibility process for Medicaid LTC supports.</p>	<p>Simultaneous processing of clinical and financial eligibility for the elderly and physically disabled and using national databases to initiate fast-track eligibility for individuals who appear to meet financial eligibility.</p>	<p>July 1, 2012</p>	<p>Individuals who appear to be financially eligible and are clinically approved for LTC will receive services and support prior to full eligibility determination.</p>
<p>Designate ADRC assessment agencies to conduct the clinical eligibility determination for LTC for population whose income is above 100% FPL.</p>	<p>ADRC assessors will be trained and certified to conduct the comprehensive clinical eligibility assessment for NJ's Comprehensive Waiver program.</p>	<p>September 2012 Initiate training</p>	<p>Individuals will be assessed and based upon their care needs counseled on the full array of HCBS.</p>
<p>Under the Comprehensive Waiver secure Medicaid Federal Financial Participation (FFP) for ADRC functions.</p>	<p>Develop a detailed plan identifying specific functions and costs the ADRCs will perform qualifications of those performing the function and the data to be collected to document the functions.</p>	<p>July 1, 2012 – January 2013</p>	<p>ADRCs will receive FFP for functions related to outreach, screening, assessment, options counseling, service coordination and planning, and quality improvement for individuals seeking Medicaid LTC services and supports.</p>
<p>Modernize OAA contracting policies to support consumer directed cash management plans</p>	<p>In partnership with the NJ Association of Area Agencies on Aging (NJ4A), develop a pilot to test the viability of a consumer-directed option under Title III-B in-home services and Title III-E caregiver funds that may be</p>	<p>Initiate planning and development of protocols winter of 2012</p>	<p>Older adults at risk of nursing home placement will have flexible, individualized budgets to purchase services and goods and to hire workers to meet their care needs.</p>

	<p>allocated for consumer-directed, cash and counseling option.</p> <p>Building upon the VD-HCBS model, develop and test eligibility criteria, range of services and goods allowable, administrative and care management costs and financial management and counseling to be provided through NJ's Financial Management Services vendor to include OAA services.</p> <p>Identify 2-3 AAAs to pilot cash & counseling option & sponsor training sessions for AAA staffs (i.e. care managers, fiscal, and planners) on the cash and counseling option.</p> <p>Pilot and evaluated OAA cash & counseling option.</p> <p>Implement OAA Cash & Counseling option statewide</p>	<p>January through June 2012.</p> <p>Fall 2012</p> <p>January – June 2013</p> <p>January 2014</p>	<p>ADRCs will be responsible for screenings, assessments, reassessments, options counseling and based on the outcomes of the assessment, establish individualized cash management plans.</p> <p>Through a limited number of AAAs the State will be able to work closely with the staffs and provide technical assistance to resolve issues as they occur.</p> <p>Based upon the experience of the AAAs and consumer outcomes, the State and the AAA network will have data to analyze, make changes to policies and procedures prior to statewide deployment.</p> <p>Older adults, regardless of income will have an opportunity to enroll in a cash and counseling program.</p>
<p>Consolidate 5 State funded HCBS into a consumer-directed model for individuals at risk of NF placement and spend down to Medicaid LTC.</p>	<p>Develop strategies to integrate the consolidated program into the ADRC process.</p> <p>Sponsor stakeholder meetings to provide input into CBSP policies,</p>	<p>Initiate planning and development of protocols Fall 2012</p> <p>Fall 2012- March 2013.</p>	<p>Older adults at risk of nursing home placement will have flexible, individualized budgets to purchase services and goods and to hire workers to meet their care needs.</p>

	<p>eligibility criteria, cost share sliding scale fees, and service budgets.</p> <p>Propose changes to State statutes and regulations to consolidate programs</p> <p>Implement consolidated state funded program.</p>	<p>March-September 2013</p> <p>January 2014</p>	<p>ADRCs will be responsible for screenings, assessments, reassessments, options counseling and based on the outcomes of the assessment, establish individualized cash management plans.</p>
Private Pay Population and Cost Share	<p>In partnership with the NJ AAA, develop and implement new policies and procedures for private pay individuals and contracting with for-profit organizations including managed care organizations.</p>	<p>Initiate planning and development of protocols Fall 2012</p> <p>Implement January 2013.</p>	<p>Older adults and their caregivers will be able to use their personal resources and avoid spend down to Medicaid to purchase care management and HCBS through the AAA network.</p>
Expand the Veterans-Directed Home and Community-Based Services (VD-HCBS) to other counties.	<p>NJ was one of the first states to pilot the VD-HCBS, which began in two counties in July 2009 and is operational in a third county. The program will be expanded to the remaining counties by December 2014.</p>	<p>Ongoing continue through December 2014</p>	<p>Veterans of all ages at risk of nursing home placement will have flexible, individualized budgets to purchase services and goods and to hire workers to meet their care needs.</p>
Expand the Global Budget Projection Model to incorporate impact of expanded non-Medicaid HCBS options and ADRC interventions	<p>Conduct research and information gathering in order to assure proposed performance metrics are consistent with needs of populations and programs.</p> <p>Identify data sources for inclusion in the model.</p> <p>Create a consumer-facing community resource center website</p>	<p>Initiate January 2012 and complete by December 2013</p>	<p>An integrated Budget Projection Process for assessing the impact of ADRCs on LTC costs.</p>

GOAL #7: Through the Home and Community-Based Services framework, DACS will continuously improve all services, activities and organizational efforts to promote independence, dignity and choice for older adults, persons with disabilities and their caregivers.

OBJECTIVE	KEY TASKS	TIME FRAME	MEASURES OF SUCCESS
<p>Re-design DACS organizational structure to establish a Quality Management Strategy encompassing the six goals including in this 5-year plan.</p>	<p>Develop a comprehensive ADRC audit to be conducted annually for each county ADRC to assess and improve functions in each of the primary ADRC components: outreach, inform, screen, assess and counsel. The audit will include:</p> <ul style="list-style-type: none"> • On-site review of documents • Assessment of staff competencies in meeting performance standards • Customer Satisfaction survey review • Analysis of IT data reports <p>Audit findings will be reported to ADRC and county administration, and will guide training and IT development.</p>	<p>2012, development 2013, implementation</p>	<p>Audits reveal that:</p> <p>Consumers: Have access to information and home and community-based services and supports in their communities and satisfied with their services and achieve desired outcomes.</p> <p>Services and supports: Are planned and effectively implemented in accordance with each consumer’s unique needs, expressed preferences and decisions.</p> <p>Systems: Support participants efficiently and effectively and constantly strive to improve quality.</p>

ADRC Five Year Plan Approval



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DEPARTMENT OF HEALTH AND SENIOR SERVICES ♦ DIVISION OF AGING AND COMMUNITY SERVICES

Intrastate Funding Formula

The New Jersey State Unit on Aging (SUA) is submitting for approval, a new funding formula set to begin January 1, 2014. The formula was developed in collaboration with the Area Agencies on Aging (AAAs). It puts greater weight on 60+ minority and poverty factors, and adds a new factor for the number of older adults age 75 and above.

Background: New Jersey's existing funding formula for the distribution of Title III funds of the Older Americans Act was developed in 1992 by a joint task force comprised of representatives of the AAAs and the SUA, and took effect in subsequent State Plans on Aging. The formula was based on three weighted factors: the number of individuals aged 60 and older (65% weight); number of minority individuals aged 60+ (15%); and the number of low-income individuals aged 60+ (20%) in each of the Planning and Service Areas (PSA). A minimum funding level was also established to ensure that each PSA had a functioning AAA.

The funding formula is used for Title III B (Supportive Services), Title III C1 (Congregate Meals), Title III C2 (Home Delivered Meals), Title III D (Preventive Health), Title III E (Caregiver Services), as well as State Weekend Home Delivered Meals (SWHDM), Safe Housing and Transportation Program (SHTP), Adult Protective Services (APS), Medicaid Match, Cost of Living Adjustment (COLA) and State Area Plan Matching Funds.

It was noted that older adults with higher incomes were migrating out of the urban counties in the north and into rural and suburban counties in other parts of the state. This left the northern urban counties with a high population of low income and minority older adults. As a result, the formula did not support the counties with the highest percentage of the target population of poverty and minority older adults.

In 2013, with 2010 Census data readily available and a new State Plan set to take effect on October 1, 2013, the State and AAAs once again convened and reviewed the weights and factors in the formula. DoAS reached out to AoA, other states to gather and review demographics and formulas used across the nation. Based on input from the AAA network, the DoAS ran a total of 16 different funding formula scenarios using various factors and weights, and consensus was reached. The formula is hereby submitted for approval with the 2013-2017 State Strategic Plan on Aging.

Formula: The minimum funding percentage established as part of the 2009–2013 State Plan will remain in effect for this plan. This allows the minimum-funded counties to share in any increases in future years. The minimum funding percentage will continue to be based on the 2009 mid-year funding amounts for Title III B, C1, C2 and E.

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

The funding formula has a base funding amount of 50% of the prior year's allocation. After the base is applied, the balance of funding is distributed to those AAAs that are not in minimum-funded counties using the formula below:

Z = New Jersey's 2014 allocation minus the sum of minimum-funded counties.

Q = The AAA funding index S+T+M+P (defined below)

S = The percent of those 60+ in each PSA multiplied by the weight factor A (30%).

T = The percent of those 75+ in each PSA multiplied by the weight factor B (25%).

M = The percent of those 60+ in each PSA minority multiplied by the weight factor C (20%).

P = The percent of those 60+ in each PSA at the poverty level multiplied by the weight factor D (25%).

Weight Factors: The formula above includes four weighted factors related to the number of individuals aged 60+, number of individuals aged 75+, the number of minority individuals aged 60+ and the number of low-income individuals aged 60+ in each of the PSA as defined below:

A = 30% (60+)

B = 25% (75+)

C = 20% (60+ minority)

D = 25% (60+ low-income)

Based on these weighted factors, Q is calculated as $((S \times .30) + (T \times .25) + (M \times .20) + (P \times .25))$.

The most recent Census data is applied to the weight factors every two years in order to accurately reflect each PSA's population breakdown. The American Community Survey will be used for years that the decennial Census is not available.

Allocation Percentage: 100.00%

Attachment A-1

COUNTY	02				03				04			
	Title III B				Title III C1				Title III C2			
	100% Allocation	Allowed C/O	Authorized Funds	Approved Title III Funds	100% Allocation	Allowed C/O	Authorized Funds	Approved Title III Funds	100% Allocation	Allowed C/O	Authorized Funds	Approved Title III Funds
Atlantic	333,382	41,937	375,319	375,319	353,023	37,787	390,810	390,810	199,868	937	200,805	200,805
Bergen	1,095,619	152,875	1,248,494	1,248,494	1,160,168	94,265	1,254,433	1,254,433	655,454	47,895	703,349	703,349
Burlington	434,214	0	434,214	434,214	459,796	0	459,796	459,796	259,805	8,181	267,986	267,986
Camden	571,550	0	571,550	571,550	605,223	0	605,223	605,223	342,421	12,147	354,568	354,568
Cape May	159,527	14,263	173,790	173,790	168,926	21,655	190,581	190,581	95,273	14,807	110,080	110,080
Cumberland	194,492	0	194,492	194,492	205,950	0	205,950	205,950	116,645	0	116,645	116,645
Essex	1,122,432	21,424	1,143,856	1,143,856	1,188,561	2,869	1,191,430	1,191,430	675,318	2,391	677,709	677,709
Gloucester	247,366	0	247,366	247,366	261,939	0	261,939	261,939	147,939	0	147,939	147,939
Hudson	893,813	0	893,813	893,813	946,472	0	946,472	946,472	537,917	0	537,917	537,917
Hunterdon	156,381	5,943	162,324	162,324	133,131	460	133,591	133,591	54,172	0	54,172	54,172
Mercer	406,348	15,532	421,880	421,880	430,288	810	431,098	431,098	243,563	23,480	267,043	267,043
Middlesex	782,311	41,346	823,657	823,657	828,401	42,026	870,427	870,427	468,406	9,838	478,244	478,244
Monmouth	642,925	49,919	692,844	692,844	680,803	8,053	688,856	688,856	384,577	4,750	389,327	389,327
Morris	436,497	8,098	444,595	444,595	462,214	30,000	492,214	492,214	260,802	33,000	293,802	293,802
Ocean	790,144	3,009	793,153	793,153	836,696	6,976	843,672	843,672	471,601	78	471,679	471,679
Passaic	577,869	0	577,869	577,869	611,914	0	611,914	611,914	346,648	0	346,648	346,648
Salem	156,623	432	157,055	157,055	133,131	10,800	143,931	143,931	46,624	2,369	48,993	48,993
Somerset	265,589	0	265,589	265,589	281,236	0	281,236	281,236	158,784	287	159,071	159,071
Sussex	156,454	620	157,074	157,074	133,131	0	133,131	133,131	61,003	0	61,003	61,003
Union	682,723	34,091	716,814	716,814	722,947	26,484	749,431	749,431	409,609	35,642	445,251	445,251
Warren	156,713	7,771	164,484	164,484	133,131	0	133,131	133,131	59,723	0	59,723	59,723
TOTALS	10,262,972	397,260	10,660,232	10,660,232	10,737,081	282,185	11,019,266	11,019,266	5,996,152	195,802	6,191,954	6,191,954

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

10				08					
Title III D				Title III E					
100% Allocation	Allowed C/O	Authorized Funds	Approved Title III Funds	100% Allocation	Allowed C/O	Authorized Funds	Approved Title III Funds	Authorized Federal Totals	APPROVED Federal Totals
25,973	84	26,057	26,057	138,207	4,441	142,648	142,648	1,135,639	1,135,639
43,125	9,624	52,749	52,749	453,240	23,330	476,570	476,570	3,735,595	3,735,595
16,249	138	16,387	16,387	179,652	845	180,497	180,497	1,358,880	1,358,880
28,088	0	28,088	28,088	236,781	0	236,781	236,781	1,796,210	1,796,210
27,004	115	27,119	27,119	65,880	259	66,139	66,139	567,709	567,709
21,230	0	21,230	21,230	80,659	14,346	95,005	95,005	633,322	633,322
56,107	0	56,107	56,107	466,976	7,494	474,470	474,470	3,543,572	3,543,572
18,843	0	18,843	18,843	102,298	0	102,298	102,298	778,385	778,385
56,751	0	56,751	56,751	371,964	0	371,964	371,964	2,806,917	2,806,917
13,534	35	13,569	13,569	37,459	0	37,459	37,459	401,115	401,115
23,147	230	23,377	23,377	168,421	10,603	179,024	179,024	1,322,422	1,322,422
30,022	5,345	35,367	35,367	323,898	16	323,914	323,914	2,531,609	2,531,609
36,299	3,015	39,314	39,314	265,932	69,635	335,567	335,567	2,145,908	2,145,908
20,040	25	20,065	20,065	180,342	823	181,165	181,165	1,431,841	1,431,841
40,262	2,188	42,450	42,450	326,107	2,141	328,248	328,248	2,479,202	2,479,202
37,270	0	37,270	37,270	239,704	0	239,704	239,704	1,813,405	1,813,405
26,169	335	26,504	26,504	32,241	828	33,069	33,069	409,552	409,552
21,440	5,673	27,113	27,113	109,797	25	109,822	109,822	842,831	842,831
20,153	6,671	26,824	26,824	42,183	0	42,183	42,183	420,215	420,215
41,069	173	41,242	41,242	283,242	7,315	290,557	290,557	2,243,295	2,243,295
15,759	0	15,759	15,759	41,298	231	41,529	41,529	414,626	414,626
618,534	33,651	652,185	652,185	4,146,281	142,332	4,288,613	4,288,613	32,812,250	32,812,250

										06	11	14	20
STATE MATCH													
State Match B-D	State Match E	Total State Match ALLOCATION	Allowed C/O-B-D	Allowed C/O-E	TOTAL C/O	Authorized B-D	Authorized E	Total Authorized	Total Funds	SWHDM	SHTP	APS	SSBG
50,260	41,462	91,722	0	1,479	1,479	50,260	42,941	93,201	93,201	31,758	37,683	161,091	378,200
162,805	135,972	298,777	0	0	0	162,805	135,972	298,777	298,777	104,367	123,598	421,481	830,683
64,480	53,896	118,376	0	0	0	64,480	53,896	118,376	118,376	41,363	48,992	156,226	180,603
85,262	71,034	156,296	31,572	257	31,829	116,834	71,291	188,125	188,125	54,446	64,563	272,814	804,164
24,813	19,764	44,577	3,023	1	3,024	27,836	19,765	47,601	47,601	15,197	17,967	79,056	131,808
29,651	24,198	53,849	0	9,511	9,511	29,651	33,709	63,360	63,360	18,527	21,991	108,012	493,257
167,660	140,092	307,752	139	0	139	167,799	140,092	307,891	307,891	106,923	127,298	566,614	1,473,166
37,248	30,689	67,937	0	0	0	37,248	30,689	67,937	67,937	23,564	27,897	111,026	162,008
134,172	111,588	245,760	27,721	28,328	56,049	161,893	139,916	301,809	301,809	85,144	101,393	481,001	1,659,255
19,565	11,238	30,803	0	0	0	19,565	11,238	30,803	30,803	13,000	10,217	71,541	77,027
60,794	50,526	111,320	1,317	1,761	3,078	62,111	52,287	114,398	114,398	38,709	45,922	182,695	573,727
116,232	97,169	213,401	97	0	97	116,329	97,169	213,498	213,498	74,523	88,323	324,830	525,309
96,127	79,780	175,907	6,102	5,124	11,226	102,229	84,904	187,133	187,133	61,245	72,519	279,832	736,618
64,997	54,103	119,100	31	0	31	65,028	54,103	119,131	119,131	41,581	49,183	165,557	97,672
117,844	97,832	215,676	4	1,622	1,626	117,848	99,454	217,302	217,302	75,269	88,940	324,213	232,635
86,710	71,911	158,621	0	0	0	86,710	71,911	158,621	158,621	55,048	65,355	286,340	557,253
19,817	9,672	29,489	0	0	0	19,817	9,672	29,489	29,489	13,000	9,222	71,782	235,226
40,053	32,939	72,992	444	0	444	40,497	32,939	73,436	73,436	25,300	29,943	110,165	223,422
20,328	12,655	32,983	374	0	374	20,702	12,655	33,357	33,357	13,000	11,505	73,632	13,192
102,288	84,973	187,261	7,040	0	7,040	109,328	84,973	194,301	194,301	65,036	77,226	286,606	469,725
20,031	12,389	32,420	0	0	0	20,031	12,389	32,420	32,420	13,000	11,263	74,486	106,050
1,521,137	1,243,882	2,765,019	77,864	48,083	125,947	1,599,001	1,291,965	2,890,966	2,890,966	970,000	1,131,000	4,609,000	9,961,000

19	17	23	45	35										
STATE HDM	Care Coordination (CMQA)	Special Programs	Sandy Disaster Meals-AoA	Medicaid Match	Carry Over	Authorized Medicaid Match	Allowed NSIP	C/O NSIP	Authorized NSIP	State COLA	State/Other Fund Allocations	State/Other Fund Authorized	Grand Total Allocated Funds	Grand Total Authorized Funds
0	23,810	120,000	609	14,437	0	14,437	190,036	0	190,036	173,943	1,131,567	1,131,567	2,273,742	2,360,407
0	23,810	0	4,230	47,344	0	47,344	450,917	376	451,293	570,487	2,576,917	2,577,293	6,283,300	6,611,665
0	23,810	0	416	18,766	0	18,766	100,358	0	100,358	226,128	796,662	796,662	2,264,754	2,273,918
46,605	23,810	0	0	24,734	0	24,734	146,366	11,567	157,933	298,015	1,735,517	1,747,084	3,675,876	3,731,419
7,287	23,810	8,455	3,246	6,882	4	6,886	103,775	0	103,775	82,926	480,409	480,413	1,041,596	1,095,723
1,087	23,810	0	1,682	8,425	0	8,425	76,175	0	76,175	101,512	854,478	854,478	1,527,303	1,551,160
146,871	23,810	0	2,350	48,778	0	48,778	158,300	0	158,300	587,655	3,241,765	3,241,765	7,058,911	7,093,228
20,044	23,810	0	1,645	10,686	0	10,686	122,471	0	122,471	128,761	631,912	631,912	1,478,234	1,478,234
75,063	23,810	0	12,863	38,854	2,748	41,602	403,182	0	403,182	468,078	3,348,643	3,351,391	6,401,320	6,460,117
20,097	23,810	0	0	3,913	0	3,913	39,245	352	39,597	47,155	306,005	306,357	731,485	738,275
0	23,810	0	2,248	17,593	608	18,201	139,296	7,332	146,628	211,973	1,235,973	1,243,913	2,619,060	2,680,733
25,402	23,810	0	4,885	33,834	0	33,834	249,479	20,005	269,484	407,675	1,758,070	1,778,075	4,404,509	4,523,182
0	23,810	0	2,638	27,779	0	27,779	272,010	1,070	273,080	334,723	1,811,174	1,812,244	3,997,617	4,145,285
11,566	23,810	0	18,199	18,838	0	18,838	353,056	0	353,056	227,005	1,006,467	1,006,467	2,485,462	2,557,439
0	23,810	7,500	5,197	34,064	0	34,064	199,445	0	199,445	410,495	1,401,568	1,401,568	4,082,054	4,098,072
166,360	23,810	0	1,022	25,039	0	25,039	181,941	0	181,941	301,680	1,663,848	1,663,848	3,635,874	3,635,874
15,373	23,810	0	540	3,368	0	3,368	25,086	0	25,086	43,024	440,431	440,431	864,708	879,472
15,851	23,810	0	9,107	11,469	0	11,469	97,072	0	97,072	138,205	684,344	684,344	1,594,182	1,600,611
19,486	23,810	0	816	4,406	0	4,406	27,453	0	27,453	53,100	240,400	240,400	686,307	693,972
16,598	23,810	0	639	29,587	0	29,587	271,021	0	271,021	356,476	1,596,724	1,596,724	3,923,575	4,034,320
37,310	23,810	0	2,668	4,314	0	4,314	46,560	0	46,560	51,984	371,445	371,445	810,489	818,491
625,000	500,010	135,955	75,000	433,110	3,360	436,470	3,653,244	40,702	3,693,946	5,221,000	27,314,319	27,358,381	61,840,358	63,061,597

MINIMUM PERCENTAGE OF TITLE III-B FUNDS TOWARD PRIORITY SERVICES

The 2006 Amendments to the Older Americans Act specify that each State Unit on Aging set a minimum percentage of funds to be used by each Area Agency on Aging in the service categories of access, in-home, and legal. The following are New Jersey's Minimums:

Access – 10%

In Home – 10%

Legal – 5%

Services to the Elderly		
SERVICE CODE	SERVICE	SERVICE CATEGORY
101	Information and Assistance – contact	ACCESS
102	Benefits Screening – 1/2 hour	
103	Extended Assessment – 1/2 hour	
104	Outreach – contact	
105	Care Management – 1/2 hour	
106	Transportation – 1 one-way trip (location to location)	
107	Assisted Transportation – 1 one-way trip (location to location)	
109	Language Translation & Interpretation – contact	
110	Public Awareness / Information – activity	
209	Friendly Visiting – visit	
210	Telephone Reassurance – call	
211	Residential Maintenance – hour	
212	Housekeeping – hour	
213	Certified Home Health Aide – hour	
214	Visiting Nurse – visit	
216	Hospice Care – hour	
217	Emergency – contact	
218	Homesharing/Matching – contact	
219	Housing Assistance – contact	
321	Adult Day Services – Social – hour	COMMUNITY SUPPORT
322	Adult Day Services – Medical – hour	
323	Personal Care – hour	
324	Adult Protective Services – contact	
325	Legal Assistance – hour	
326	Physical Health – contact	
327	Oral Health – contact	
328	Mental Health – hour	
329	Counseling – hour	
330	Physical Activity – 1 session per participant	
331	Education – 1 session per participant	
333	Socialization/Recreation – 1 session per participant	
340	Money Management – hour	
435	Congregate Nutrition – meal	NUTRITION
436	Home Delivered Nutrition – meal	

437	State Weekend Home Delivered Meals – meal	SUPPORT
438	Nutrition Education – 1 session per participant	
439	Nutrition Counseling – 1 session per participant	

National Family Caregiver Support Program Caregivers Serving Elderly Individuals		NFCSP
SERVICE CODE	SERVICE	SERVICE CATEGORY
502	NFCSP Public Awareness / Information – activity	06 Information Services
701	NFCSP Information and Assistance – contact	05 Access Assistance
702	NFCSP Benefits Screening – 1/2 hour	05 Access Assistance
703	NFCSP Extended Assessment – 1/2 hour	05 Access Assistance
704	NFCSP Outreach – contact	05 Access Assistance
705	NFCSP Care Management – 1/2 hour	05 Access Assistance
706	NFCSP Transportation – 1 one-way trip (location to location)	05 Access Assistance
707	NFCSP Assisted Transportation – 1 one-way trip (location to location)	05 Access Assistance
711	NFCSP Residential Maintenance – hour	03 Supplemental Services
712	NFCSP Housekeeping – hour	03 Supplemental Services
713	NFCSP Certified Home Health Aide – hour	02 Respite Care
714	NFCSP Visiting Nurse – visit	02 Respite Care
715	NFCSP Respite Care – hour	02 Respite Care
716	NFCSP Hospice Care – hour	02 Respite Care
717	NFCSP Emergency – contact	03 Supplemental Services
719	NFCSP Housing Assistance – contact	05 Access Assistance
720	NFCSP Support Group – session per participant	01 Counseling/Support Groups/Caregiver Training
721	NFCSP Adult Day Services – Social – hour	02 Respite Care
722	NFCSP Adult Day Services – Medical – hour	02 Respite Care
725	NFCSP Legal Assistance – hour	03 Supplemental Services
726	NFCSP Physical Health – contact	03 Supplemental Services
731	NFCSP Group Education – 1 session per participant	01 Counseling/Support Groups/Caregiver Training
732	NFCSP Language Translation & Interpretation – contact	05 Access Assistance
733	NFCSP Socialization/Recreation – 1 session per participant	03 Supplemental Services
740	NFCSP Caregiver Mental Health Counseling – 1 session per participant	01 Counseling/Support Groups/Caregiver Training
741	NFCSP Professional In-Home Education and Support – 1 session per participant	01 Counseling/Support Groups/Caregiver Training
742	NFCSP Trained Volunteer Assistance – visit	02 Respite Care
743	NFCSP Wander Safety System – contact	03 Supplemental Services

National Family Caregiver Support Program Grandparents and Other Elderly Caregivers Serving Children		GP NFCSP
SERVICE CODE	SERVICE	SERVICE CATEGORY
502	GP NFCSP Public Awareness / Information – activity	06 Information Services
801	GP NFCSP Information and Assistance – contact	05 Access Assistance
802	GP NFCSP Benefits Screening – 1/2 hour	05 Access Assistance
803	GP NFCSP Extended Assessment – 1/2 hour	05 Access Assistance
804	GP NFCSP Outreach – contact	05 Access Assistance
805	GP NFCSP Care Management – 1/2 hour	05 Access Assistance
806	GP NFCSP Transportation – 1 one-way trip (location to location)	05 Access Assistance
807	GP NFCSP Assisted Transportation – 1 one-way trip (location to location)	05 Access Assistance
811	GP NFCSP Residential Maintenance – hour	03 Supplemental Services
812	GP NFCSP Housekeeping – hour	03 Supplemental Services
813	GP NFCSP Certified Home Health Aide – hour	02 Respite Care
814	GP NFCSP Visiting Nurse – visit	02 Respite Care
815	GP NFCSP Respite Care – hour	02 Respite Care
816	GP NFCSP Hospice Care – hour	02 Respite Care
817	GP NFCSP Emergency – contact	03 Supplemental Services
819	GP NFCSP Housing Assistance – contact	05 Access Assistance
820	GP NFCSP Support Group – session per participant	01 Counseling/Support Groups/Caregiver Training
825	GP NFCSP Legal Assistance – hour	03 Supplemental Services
826	GP NFCSP Physical Health – contact	03 Supplemental Services
831	GP NFCSP Group Education – 1 session per participant	01 Counseling/Support Groups/Caregiver Training
832	GP NFCSP Language Translation & Interpretation – contact	05 Access Assistance
833	GP NFCSP Socialization/Recreation – 1 session per participant	03 Supplemental Services
840	GP NFCSP Caregiver Mental Health Counseling – 1 session per participant	01 Counseling/Support Groups/Caregiver Training

**New Jersey Department of Human Services
DIVISION OF AGING SERVICES (DoAS)**

PROGRAM DESCRIPTIONS

July 2013



DIVISION OF AGING SERVICES

Effective July 1, 2012, all senior supports and services from the Department of Health were transferred to DHS through statute. The legislation created the Division of Aging Services (DoAS), a realignment of the former Divisions of Senior Benefits and Utilization Management and Aging and Community Services. This structure has established a single point of access for older adults, people with disabilities and their caregivers regardless of Medicaid eligibility.

Given the restructuring of aging services in the DHS and the changing demographics of New Jersey's growing and diverse older adult population, the DHS will assume responsibility as the State Unit on Aging under the Older Americans Act. The Division of Aging Services will serve as the administrative agency.

DoAS administers federal and state-funded services and supports and makes it easier for older adults to live in the community as long as possible with independence, dignity and choice. The division receives Older Americans Act funding and serves as the focal point for planning services for the aging, developing comprehensive information about New Jersey's older adult population and its needs, and maintaining information about services available to older adults throughout the state. Due to the consolidation of the two divisions, DoAS is become responsible for the operation of two prescription drug assistance programs, the Pharmaceutical Assistance to the Aged and Disabled and the Senior Gold Prescription Discount Program, as well as the Lifeline Utility Assistance program and the Hearing Aid Assistance to the Aged and Disabled program. The division maintains a staff of approximately 320 full-time employees based in Trenton and three regional field offices.

DoAS is also the State Administering Agency for the Medicaid 1115 (a) Demonstration Waiver Global Options for Long-Term Care (GO) program. In January 2014, the DHS plans to move home and community-based services under its new Comprehensive Medicaid Waiver into Managed Long Term Services and Supports (MLTSS). In July 2014, the nursing homes are scheduled to move into a managed care model under MLTSS. While the administration for MLTSS will be run under the DHS' Office of Managed Health Care, Division of Medical Assistance and Health Services, DoAS will retain an important role in the MLTSS program.

DoAS is comprised of the following offices: Deputy Director; Administration and Finance; Area Agency on Aging Administration; Support Services; Quality Management; Community Resources, Education, and Wellness; Community Choice Options; and Public Guardian and Elder Rights.

OFFICE OF THE DEPUTY DIRECTOR

Office Description: This Office is responsible for programs designed to help individuals in need of long-term supports and services (LTSS) to receive them in the community. Units within the office include the Aging and Disability Resource Connection (ADRC) Unit and the Quality Assurance Unit [which has administrative and fiscal responsibilities for Global Options for Long-Term Care (GO) and the state-funded Jersey Assistance for Community Caregiving (JACC)].

Aging and Disability Resource Connection (ADRC)

Program Description: The Aging and Disability Resource Connection is a partnership between the Department of Human Services (DHS) as the single state Medicaid agency and the State Unit on Aging, the county-based Area Agencies on Aging, the county welfare agencies (CWAs), the county offices on disability services, Centers for Independent Living and other agencies in the aging and disability services networks. The ADRC provides consumers with improved access to community programs such as meals-on wheels, personal care, housekeeping, specialized transportation, assisted living and nursing home care. It also connects seniors and adults with disabilities with work and volunteer opportunities, insurance programs, health promotion programs, housing and other home and community-based programs.

The ADRC serves as the single point of access in all 21 counties for older adults and persons 18 and older with a physical disability. A future main challenge for New Jersey's AAA/ADRCs will be to expand its knowledge and consumer base to assist the populations served by the Divisions of Developmental Disabilities (DDD) and Mental Health and Addiction Services (DMHAS). Under the Comprehensive Medicaid Waiver (CMW), and the move to managed LTSS, New Jersey plans to use the ADRC partnerships (inclusive of all Divisions' access points) as the NWD/SEP for consumers to access managed LTSS.

of Beneficiaries Served: *From January 1, 2010 to December 31, 2012, 396,498 calls made to the AAA/ADRCs. The top 5 reasons individuals contacted the ADRC was to seek information on public benefits, social services, health benefits, financial assistance and transportation.*

The Social Assistance Management Systems is the present client tracking system used by the ADRC sites. SAMS presently collects data on consumer data information and tracks the types of services received by consumers. SAMS also maintains a comprehensive resource database available to professionals and consumers to learn about and link to home and community based services.

ADRC Website and On-Line Resource Center

Program Description: The ADRC website – www.adrcnj.org – was launched in May 2012. The consumer-friendly site offers a number of unique features for consumers and service providers such as access to thousands of national, state and local resources, several search

options, and other consumer-friendly tools including Google translation and mapping features. The site is Section 508 compliant for improved access to individuals with vision impairments. Information is refreshed on a schedule set by the Division of Aging Services and has the ability to electronically request content updates and verification from providers. **# of Beneficiaries Served Annually:** *In 2012, the website had 8,550 unique visitors, including 2,062 who made multiple visits.*

Global Options Medicaid Waiver Program (GO)

The Division is the State Operating Agency for an 1115 (a) Medicaid Demonstration Waiver Global Options for Long-Term Care (GO) program.

Program Description: GO participants must be: 65 years old or older, or between the ages of 21-64 and determined physically disabled by the Social Security Administration or by the Disability Review Section of the Division of Medical Assistance and Health Services; Meet specific Medicaid financial eligibility criteria in NJ; Meet Nursing Facility Level of Care after a clinical eligibility determination; and Reside in an approved community living arrangement. GO participants have access to New Jersey Title XIX Medicaid State Plan Services, and must need and receive at least two GO Waiver services monthly, one of which is the service of care management.

GO participants work with a Care Manager to create a personalized Plan of Care based on the participant's assessed care needs. All GO services, such as Home-Based Supportive Care, Assisted Living, Chore, Personal Emergency Response System, and Respite to name a few, are subject to limitations and program requirements. Generally services can be rendered by traditional Medicaid providers, qualified Non-traditional entities, or potentially by qualified Participant-Employed Providers (individuals hired by the participant).

of Beneficiaries Served Annually: *FFY 2011 9,602 individuals*

Jersey Assistance for Community Caregiving (JACC)

Program Description: JACC provides 13 in-home services and supports that enable an individual at risk of placement in a nursing facility to remain in his/her community home. By providing a uniquely designed package of supports for the individual, JACC is intended to supplement and strengthen the capacity of caregivers, as well as to delay/prevent placement in a nursing home. JACC services individuals who are not eligible for Medicaid or Medicaid waiver services. This program is supported totally with state funds. Participants in JACC may share in the cost of their care on a sliding scale based on income. Participants must also meet Nursing Facility Level of Care.

of Beneficiaries Served Annually: *FFY 2011 1,519 individuals*

Community Living Program (CLP)

Program Description: In 2007 and 2008, New Jersey was awarded federal Nursing Home Diversion and Modernization grants (now known as the Community Living Program) to develop and implement a cash-and-counseling model for individuals at risk of nursing home placement and spend down to Medicaid. An infrastructure has been developed to support

consumer direction and flexible service dollars and to enable participants to purchase services that meet their care needs. Additionally, the grants are providing the State with an opportunity to introduce a cost-share sliding scale for home and community-based services. The 2007 Community Living Program was piloted in Camden County and the 2008 Community Living Program is being piloted in Somerset (December 2012) and Ocean Counties (January 2013). The pilot will end on September 30, 2013.

Veterans-Directed Home and Community Based-Services (VD-HCBS)

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

According to DMAVA, the biggest obstacle confronting elderly veterans is that they “make too much money” to be eligible for Veteran Administration (VA) healthcare. To address the growing long-term care needs of veterans and their caregivers, the Departments of Health and Senior Services and Military and Veterans Affairs, with U.S. Veterans Administration New Jersey Healthcare System (Lyons VA Healthcare System), formed a partnership that resulted in the awarding of federal funding under a Veterans-Directed Home and Community-based Services (VD-HCBS) grant. Lyons VA Healthcare System is a part of the Veterans Integrated Services Network 1 (VISN 1) that covers northern/central New Jersey. The VD-HCBS program is providing services to veterans in Bergen, Morris, Warren and Somerset counties.

Transitional Care Model (TCM)

Program Description: Through funding made available by the Affordable Care Act through the Partnership for Patients in June 22, 2011, the U.S Department of Health and Human Services announced that it would be providing \$500 million dollars in funding to hospitals and their partners to improve care transitions.

The Transitional Care Program focuses on reducing hospital re-admissions for consumers with chronic medical conditions. This initiative is designed to improve continuity of care for consumers transitioning from acute care settings to various care settings. This is accomplished through collaboration between hospitals, ADRC/AAA, and other community partners. By providing comprehensive discharge follow up, which includes enlisting caregiver/client involvement, providing education on illnesses, promoting self-management, and collaborating and coordinating services, positive consumer outcomes are obtained. New Jersey has several hospitals that formed partnerships with Community Based Organizations and applied and received transitional care grants.

Fast Track Eligibility Determination (Fast Track)

Program Description: Fast Track is the process through which consumers who are clinically eligible for nursing home care and meet the Medicaid financial criteria receive State Plan services for up to 90 days while they complete the full Medicaid application and

eligibility determination process. The Fast Track Eligibility process is operational in all 21 counties and the screening criteria have been broadened to increase program participation. **# of Beneficiaries Served:** *The State has had contact with over 2,323 individuals who were potentially eligible for Medicaid and received counseling on long-term care options. Of this number, 424 individuals were eligible to access immediate state plan services, for up to 90 days, while their Medicaid financial eligibility was determined.*

OFFICE OF ADMINISTRATION AND FINANCE

Office Description:

Oversee and provide administrative and fiscal support to the operational units of DoAS, which resulted from the 2012 consolidation of the two divisions in Senior Services responsible for all home and community based services.

AREA AGENCY ON AGING (AAA) ADMINISTRATION

Office Description: The Office of AAA Administration is responsible for the oversight of the statewide network of comprehensive community based services provided by the county Area Agencies on Aging (AAAs) through Area Plan Contracts. These services include: information and assistance; access services; transportation; legal assistance; in-home services; care management; health and wellness programs; congregate and home-delivered nutrition services; and adult protective services. The programs under the Area Plan Contract are targeted to those who are 60+ and their caregivers. The office also oversees the home and community based programs funded solely through State dollars for individuals above the Medicaid income eligibility requirements. The office works closely with the Grants Management and Fiscal staff to ensure quality and accountability. Together they provide policy guidance, support, technical assistance and training to the Aging Services network. The office is responsible to meet federal NAPIS, state and federal reporting requirements under the Older Americans Act.

of Beneficiaries Served Annually: *Over 400,000 individuals*

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

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

of Beneficiaries Served Annually: *900 individuals in FY 2012*

Congregate Housing Services Program (CHSP)

The Congregate Housing Services Program (CHSP) provides supportive services to low-income elderly persons or adults with disabilities who reside in selected affordable housing sites. These services may include daily meals provided in a group setting, housekeeping,

personal assistance, laundry, shopping, and service coordination. Service subsidies are available on a sliding scale (based on disposable income) to assist tenants in meeting the full cost of the program. There are 36 providers serving 66 buildings in 17 counties.

of Beneficiaries Served Annually: 2,538 participants in 2012

Lifespan Respite Care Program

Program Description: In 2011, the Department of Human Services, Division of Developmental Disabilities was awarded the Lifespan Respite Care grant from the U.S. Administration on Aging. The Division of Aging Services is a partner along with the Lifespan Respite Coalition of NJ. With \$200,000 in funding over a three-year period, New Jersey will work to increase access to and strengthen the quality of respite services. The initiative targets caregivers across the lifespan. Activities in the second year of the project include the analysis of the respite provider survey and development a survey on caregiver's experiences with respite services. A University of Medicine and Dentistry of New Jersey medical student will work on the surveys as well as attend several Lifespan Respite focus groups which will be held with New Jersey's various regional caregiver coalitions.

Senior Nutrition Program

Program Description: Through more than 200 nutrition centers, New Jersey adults age 60 and older receive at least one nutritious meal, five or more days per week in a group or congregate setting. Title III home delivered meals (HDMs) are available to homebound persons who are eligible for service based on need due to frailty, disability, illness, and isolation. Each meal meets the nutritional standard of one-third of the Dietary Reference Intakes (DRIs), and complies with the Dietary Guidelines for Americans - 2010. The HDM program has been expanded through State funds to meet the growing number of homebound elderly. In 1987 Casino Revenue Funds were allocated to provide weekend and holiday HDMs. Since 2000, State General funds have been allocated to provide supplemental funds to reduce the HDM waiting list of eligible older adults.

of Beneficiaries Served Annually: 1.7 million meals served to 37,000 individuals in a congregate setting; 3.6 million home-delivered meals to 30,360 individuals (CY2011)

Statewide Respite Care Program

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

of Beneficiaries Served Annually: 3,418 care recipients and caregivers in CY 2012

OFFICE OF SUPPORT SERVICES

Office Description: The Office of Support Services houses several benefit programs for the aged and disabled populations in New Jersey, including the Pharmaceutical Assistance to the Aged and Disabled Program, Senior Gold, Lifeline, and the Hearing Aid Assistance for the Aged and Disabled Program. The office determines eligibility for other programs like the Aids Drug Distribution Program and the Specified Low-Income Medicare Beneficiary Program. In addition, the office screens or acts to link the aged and disabled to other assistance programs in the State such as the following:

- Medicare Part D – Low Income Subsidy
- Universal Service Fund – Utility Assistance
- Low Income Home Energy Assistance Program Property tax freeze
- Reduced motor vehicle fees
- Communications Lifeline and LinkUp America
- Supplemental Nutrition Assistance Program (SNAP – known as Food Stamps)

Pharmaceutical Assistance to the Aged and Disabled

Program Description: This state funded program helps income eligible New Jersey seniors and disabled persons with the cost of prescribed medication, including insulin, insulin needles, and needles for injectable medicines used for the treatment of multiple sclerosis. It began in 1975, as the first program of its kind. It is the payer of last resort and as such coordinates with Medicare Part D and other prescription drug plans providing creditable coverage. Beneficiaries pay a \$5 co-payment for generic drugs and a \$7 co-payment for brand name drugs. The eligibility income limit for PAAD is \$25,743 if single or \$31,563 if married.

of Beneficiaries Served Annually: *The average number of beneficiaries on PAAD on any given week is 130,000.*

Senior Gold

Program Description: The Senior Gold Program was established in 2001. It expands pharmaceutical assistance to senior citizens and disabled persons with income of up to \$35,743 for singles and \$41,563 for married couples. Senior Gold cardholders pay a \$15 co-payment plus 50% of the remaining drug cost. Once members incur annual out-of-pocket expenses of \$2000 (singles) or \$3000 (married couples), they pay only a \$15 co-payment.

of Beneficiaries Served Annually: *The average number of beneficiaries on PAAD on any given week is 21,000.*

Lifeline

Program Description: The Lifeline program was established in 1979. It provides a \$225 benefit to offset utility costs for the aged and disabled population with income levels at or below the limits set under the PAAD program. The program is funded by a surcharge on utility bills called the Universal Service Fund, which is collected by the Board of Public Utilities.

of Beneficiaries Served Annually: *Approximately 300,000*

Hearing Aid Assistance to the Aged and Disabled

Program Description: The Hearing Aid Assistance to the Aged and Disabled program provides a \$100 benefit to seniors and the disabled who are in need of hearing aids. The beneficiary must meet the PAAD income eligibility requirements.

of Beneficiaries Served Annually: *Approximately 400*

Specified Low-Income Medicare Beneficiary

The Office of Support Services determines eligibility for the Specified Low-Income Medicare Beneficiary Program (SLMB) and the Specified Low-Income Medicare Beneficiary-Qualified Individual Program (SLMB-QI). These federal programs assist low-income seniors with Medicare Part B premiums.

of Beneficiaries Served Annually: *SLMB, 20,000; SLMB-QI, 6,000*

Aids Drug Distribution Program

The Office of Support Services determines eligibility for this program which provides pharmaceutical assistance to those with HIV and AIDS. The program is funded through state and federal funds through the Department of Health

of Beneficiaries Served Annually: *7,000*

OFFICE OF NURSING FACILITY RATESETTING

Office Description: This program is responsible for determining reimbursement to long term care facilities with Medicaid provider agreements. There are 325 nursing facilities, 33 special care nursing facilities, for a total of 358 providers. The program reviews and establishes prospective rates of Medicaid reimbursement and handles appeals associated with the established rates. Facilities receive reimbursement for their costs or the “rate limit,” whichever is lower.

of Beneficiaries Served Annually: *27,252 patients were served in 2012.*

OFFICE OF COMMUNITY RESOURCES, EDUCATION AND WELLNESS

Office Description: The Office of Community Resources, Education and Wellness provides older adults, people with disabilities and the people who work with them with access to information and support services to improve health and quality of life while promoting independence, dignity and choice. There are three program units: Older Adult Health and Wellness; Information and Assistance and Community Outreach; and State Health Insurance Assistance Program (SHIP).

Information, Assistance and Community Outreach

Program Description: The unit is responsible for providing information on, and promoting the use of, state and federal programs for senior citizens and caregivers via the department's website, toll-free telephone counseling, and through the development and distribution of promotional and educational materials.

of Beneficiaries Served Annually: *51,000 individuals served directly by the unit, plus 170,000 by the network, including an estimated 75,000 through the Aging & Disability Resource Connection (ADRC) toll-free service, in CY2012.*

Older Adult Health and Wellness

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

Health Promotion Advisory Committee

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

Interagency Council on Osteoporosis

In 1997, the Osteoporosis Prevention and Education Program Act established the NJ Interagency Council on Osteoporosis. Staff provides leadership to the Council and implement initiatives in the areas of public and professional education and outreach.

- **Falls Prevention** – An Osteoporosis Council workgroup leads the development and implementation of an annual Fall Prevention Week to promote awareness of the risk of falling and ways to prevent falls. Activities include county-based community events, educational materials and a yearly Governor's proclamation. Activities include the development of the falls free website providing educational materials and resources for local fall prevention efforts.

Take Control of Your Health

Program Expansion Description: Take Control of Your Health (known nationally as the Chronic Disease Self-Management Program, or CDSMP) is an evidence-based, six-week course designed by Stanford University that meets once a week for 2 ½ hours. It is designed to give people with chronic conditions (such as arthritis, heart disease, diabetes, emphysema, asthma, bronchitis, osteoporosis) and/or their caregivers the knowledge, skills

and confidence they need to take a more active part in their health care. The program is led by volunteer lay leaders who complete a four-day training program led by master trainers certified by Stanford University. Participants learn strategies for managing symptoms, working with health care professionals, setting weekly goals, problem-solving, relaxing, handling difficult emotions, eating well, and exercising safely and easily. Established outcomes include reduced hospital days, ER visits and physician visits; better self-reported health; and healthier behaviors.

In 2006, NJ was one of 16 states to receive a grant from the U.S. Administration on Aging to establish CDSMP. Subsequent grants from the National Council on Aging and Administration on Aging (including ARRA and Empowerment funds) were used to develop statewide infrastructure to expand and sustain the program. The statewide infrastructure includes partnerships with statewide service delivery systems and more than 100 local agencies. In addition, through a partnership with the Department of Health's Division of Family Health Services, CDSMP is being integrated into CDC-funded chronic disease programs such as asthma, diabetes, cancer and cardiovascular disease. A partnership with the Department of Health's Office of Minority and Multicultural Health is fostering CDSMP delivery to minority populations.

of Beneficiaries Served Annually: *To date, more than 4,000 individuals have participated in the program. As of January 2009, there are master trainers and/or peer leaders in every county.*

A Matter of Balance

In January, 2009, a master trainer program was held in New Jersey to introduce A Matter of Balance and then has been repeated. A Matter of Balance is a community-based program specifically designed to reduce fear of falling, stop the fear of falling cycle, and improve activity levels among older adults. The program includes eight classes, each lasting two hours, presented over a four-week period by trained coaches using a detailed training manual, two instructional videos and a visit from a guest health professional. The program focuses on practical coping strategies to reduce fear of falling and to diminish the risk of falling. The unit monitors the program statewide, collecting data and ensuring fidelity. The program is available in Spanish and Chinese.

of Beneficiaries Served Annually: *There are 23 master trainers who have trained 103 coaches to lead the program in local communities. Since 2009 through March 2013, 89 workshops have been held with 1,084 participants. Matter of Balance is a very popular program and continues to have waiting lists.*

Project Healthy Bones

Project Healthy Bones – A peer-led program for adults with or at-risk for osteoporosis that includes weight bearing exercise and related education on bone health. Developed in 1997, the Division is updating the program. Training is held yearly for Lead Coordinators, who in turn train Peer leaders, to implement the program. This train-the-trainer model has allowed us to reach older adults statewide.

of Beneficiaries Served Annually: *Nearly 2,000 people participate in the program annually throughout the state.*

Move Today

Move Today – A 30-45 minute non-aerobic exercise class designed to improve flexibility, balance and stamina. The program features a brief education component focusing on an exercise-related topic. Classes are led by trained peer leaders and meet weekly or bi-weekly for twelve-sessions. Inexpensive exercise bands are used to gain maximum effect from resistance exercises.

of Beneficiaries Served Annually: *Eight counties are currently implementing the program, 24 classes are being held, serving 257 people. The manual was recently translated into Russian.*

HealthEASE Health Education

HealthEASE Health Education – Includes seven one-hour sessions on health promotion and disease prevention/management. The sessions can be used as stand-alone sessions or as a series. The curriculum for each module includes a power-point presentation, a pre-post-test, an interactive educational activity, hand-outs and instructor resources. The curriculum was updated and refresher training was provided regionally in October 2011. The modules are: Keeping Up the Beat (heart health), Keeping Your Mind Sharp, Be Wise About Your Medications, Serving Up Good Nutrition, Move to Get F.I.T., Bone Up On Your Health (osteoporosis), and Standing Tall Against Falls.

of Beneficiaries Served Annually: *In 2011, 137 health educators were trained to deliver the health education modules. Through the end of 2012, 157 presentations were delivered, reaching 3,170 people. In 2013, an additional 136 people were trained to deliver the program.*

State Health Insurance Assistance Program (SHIP)

Program Description: Trains staff and volunteers in 21 counties to assist Medicare enrollees who have problems with or questions about their health insurance. Approximately 500 counselors provide assistance face-to-face and over the phone on issues related to Medicare enrollment, claims and coverage choices. Information provided on Medicare supplement policies, Part D Drug Plans, Medicare Advantage Health Plans, Long Term Care Insurance, Medicare coordination with employer health plans or Medicaid. Educational presentation also provided on Medicare topics for beneficiaries and service providers.

of Beneficiaries Served Annually: *CY2012—23,500 in-person contacts and 21,300 phone contacts. Additional 24,000 persons reached through educational events.*

Medicare Improvements for Patients and Providers Act (MIPPA)

Program Description: The division received two federal grants following the passage of the Medicare Improvements for Patients and Providers Act (MIPPA) to encouraging low-income Medicare beneficiaries to enroll in two under-utilized federal programs that can help reduce their out-of-pocket health and prescription drug costs and to urge all beneficiaries – regardless of income – to use the free and reduced-cost preventive services covered by

Medicare Part B including a new annual wellness visit with their doctors. In both grant periods, the division awarded sub-grants to local community-based organizations through a competitive process. The division recently applied for a third MIPPA funding opportunity that will run for one year beginning in the fall of 2013.

of Beneficiaries Served Annually: *Through SFY 2013, 10,000 MSP & LIS applications were generated and more than 200,000 were reached through presentations, health fairs, advertising and other methods.*

OFFICE OF COMMUNITY CHOICE OPTIONS

Office Description: The Office of Community Choice Options (OCCO) administers the Pre-Admission Screening (PAS) and the Pre-Admission Screening and Resident Review (PASRR) Screening programs through which currently/potentially-eligible Medicaid seniors and individuals with functional disabilities are evaluated to determine if they are clinically eligible for long-term care services in the community or nursing facility settings. This office also works with nursing home residents, their families and nursing home discharge planners to assist with resident transitions back to the community with necessary services in place to help support their independence. The focus is to ensure that current/potentially-eligible Medicaid beneficiaries in need of long-term care receive quality services and appropriate service delivery in the least restrictive care setting. The three OCCO Regional Field Offices serving the state are the Northern Regional Office/Newark, Central Regional Office/Edison and Southern Regional Office/Hammonton.

Pre-Admission Screening (PAS)

Program Description: The Pre-Admission Screening (PAS) program is a care needs assessment process available to persons applying for Medicaid reimbursed long-term care in nursing facilities and home and community-based waiver programs. The PAS program helps applicants and families choose between various long-term care programs and assists them in securing the selected service delivery placement.

of Beneficiaries Served Annually: *In CY2012, OCCO Community Choice Counselors completed approximately 33,000 assessments for nursing facility and waiver program placement.*

Hospital Enhanced At-Risk Criteria Pre-Admission Screening Program (EARC-PAS)

Program Description: In 2011, DHSS/OCCO launched the Hospital EARC-PAS Program statewide. DHSS/OCCO staff trained and certified hospital discharge planners who now can complete an EARC-PAS clinical assessment on currently/potentially Medicaid-eligible individuals. The EARC-PAS is then submitted to DHSS/OCCO reviewers who in turn evaluate the assessment for nursing facility level of care (NF LOC) criteria. The program has streamlined the preadmission screening process and reduced the State's response time for hospital referrals requiring Medicaid preadmission screening.

of Beneficiaries Served: *In CY2012, over 15,000 Hospital EARC-PAS assessments have been conducted statewide since the program began in April 2011.*

Community Choice Counseling/Global Options Nursing Home Transitions

Program Description: The statewide Community Choice Program identifies Medicaid nursing home residents who can be supported in the community. Community Choice Counselors counsel these individuals on community-based alternatives and facilitate discharge planning through an Inter-Disciplinary Team. This program encourages and assists those individuals capable of living in the community to do so. Community Choice staff also counsel interested individuals, who are not Medicaid eligible, on community alternatives to nursing facility placement. The Nursing Home Transition component encourages residents to direct and receive home based services in a community setting.

of Beneficiaries Served: *Since August 1998, over 6,500 individuals were served. In CY2012, 220 individuals were transitioned from nursing homes into home and community based services.*

Money Follows the Person (MFP)

Program Description: Money Follows the Person (MFP) Is a federal demonstration project that assist individuals with transitions from Institutions and helps states strengthen and improve community based systems of long term care for low income seniors and individuals with disabilities. New Jersey submitted an Operational Protocol on 2007 and started transitioning participants under MFP, in 2008.

MFP is an interdivisional project, where Division of Aging Services (DoAS) partners with Division of Developmental Disabilities (DDD) and Division of Developmental Services (DDS). DDD is the lead Agency for New Jersey. The Office of the Ombudsman for the Institutionalized elderly (OOIE) markets the program and assists in identifying residents of nursing homes who would like to transition to the community. In July 2011, DACS formed a team of seven nurses under the supervision of the Assistant Project Director to work exclusively in identifying and transitioning qualified individuals. The team is providing in-services on MFP, Global Options (GO) and Section Q to the nursing homes statewide.

of Beneficiaries served: *As of September 2011, the project has served 790 individuals: 287 DD, 307 elderly and 196 disabled.*

Program of All-Inclusive Care for the Elderly (PACE)

Program Description: Since April 2009, New Jersey has seen the introduction of PACE (Program of All-Inclusive Care for the Elderly). PACE is designed to serve individuals 55 and older who require nursing facility level of care but who can continue to reside safely in their communities. Enrollees can be dual eligible beneficiaries, be Medicare beneficiaries, be Medicaid beneficiaries or be private pay enrollees. PACE is required to integrate care along the entire spectrum from primary care to home and community based service to behavioral health, pharmaceutical care, acute and long term care with a PACE Center as the hub. PACE organizations receive capitated Medicare and Medicaid payments. They are full risk bearing organizations (i.e., insurers) for the total cost of care and all incentives are aligned to promote cost effectiveness and optimal outcomes. As both direct care providers and payers for care, PACE organizations deliver comprehensive, fully integrated care that addresses the needs of those who are medically complex, and functionally and/or cognitively impaired. There are currently four PACE sites operating as LIFE St. Francis in Trenton, LIFE at

Lourdes in Pennsauken, Lutheran Senior LIFE in Jersey City and South Jersey LIFE in Vineland.

of Beneficiaries served: *As of June 1, 2013, the PACE census was 700 participants.*

OFFICE OF THE PUBLIC GUARDIAN AND ELDER RIGHTS

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

Office of the Public Guardian (OPG)

Program Description: The Office of the Public Guardian for Elderly Adults (“OPG”) provides guardianship services to incapacitated adults, age 60 and older. It is administratively situated in the Division of Aging Services. The Public Guardian is appointed by the Superior Court of New Jersey when no family or friends are willing or appropriate to serve as guardian. Once appointed, OPG can oversee medical, social, financial, legal and all other aspects of the client’s life on a 24/7 basis.

of Beneficiaries Served Annually: *1074 clients in CY 2011, 2137 clients in CY 2012*

Adult Protective Services (APS)

Program Description: Adult Protective Services (APS) helps vulnerable adults who are being subjected to abuse, neglect or exploitation and lack sufficient understanding or capacity to make, communicate or carry out decisions concerning their well-being. APS serves adults who live in the community in their own homes, apartments, or with others and suffer from a physical or mental illness or disability.

of Beneficiaries Served Annually: *In 2012, APS received 6 706 referrals resulting in 4,191 investigations.*

AARP Foundation Money Management Program

Program Description: The Money Management Program helps clients with budgeting, bank reconciliation, bill payment and mail opening. Money Management is currently in 13 counties throughout the state, serving disabled clients 18 and over and elderly clients 60 and over. The program also provides education to the community and other professionals regarding financial exploitation.



DEPARTMENT OF HUMAN SERVICES ✕ DIVISION OF AGING SERVICES

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APPENDIX I – 1, LIST OF ASSURANCES

Listing of State Plan Assurances and Required Activities Older Americans Act, As Amended in 2006

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

ASSURANCES

Sec. 305(a) - (c), ORGANIZATION

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

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

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

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

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

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

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

Sec. 306(a), AREA PLANS

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

- (A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);
- (B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
- (C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—

- (aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need and older individuals at risk for institutional placement;
- (bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency and older individuals residing in rural areas; and
- (II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);
- (ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
 - (I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency and older individuals residing in rural areas in the area served by the provider;
 - (II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency and older individuals residing in rural areas in accordance with their need for such services; and
 - (III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency and older individuals residing in rural areas within the planning and service area; and (4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--
 - (I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
 - (II) describe the methods used to satisfy the service needs of such minority older individuals; and
 - (III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

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

(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(4)(C) Each area agency on aging shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

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

(6)(F) Each area agency will: in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

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

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

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

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

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

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

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

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

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

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

(15) provide assurances that funds received under this title will be used-

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund

accounting procedures will be adopted as may be necessary to assure proper disbursement of and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--

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

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

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

(11)(A) The plan shall provide assurances that Area Agencies on Aging will--

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

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

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished

with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

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

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

(A) public education to identify and prevent abuse of older individuals;

(B) receipt of reports of abuse of older individuals;

(C) active participation of older individuals participating in programs under this Act through outreach, conferences and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

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

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

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

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency and older individuals residing in rural areas);

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency and older individuals residing in rural areas);

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A) and the caretakers of such individuals, of the availability of such assistance.

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

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

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

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

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

(21) The plan shall

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

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

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

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

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment and family support programs.

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

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

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

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION and ADMINISTRATION OF STATE PLANS

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

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

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

(2) The State plan shall provide an assurance that New Jersey will hold public hearings and use other means, to obtain the views of older New Jerseyans, area agencies on aging, recipients of

grants under title VI and other interested persons and entities regarding programs carried out under this subtitle.

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

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

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

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

(A) in carrying out such programs the New Jersey Department of Human Services will conduct a program of services consistent with relevant State law and coordinated with existing New Jersey adult protective service activities for--

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older New Jerseyans participating in programs under this Act through outreach, conferences and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) New Jersey will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

REQUIRED ACTIVITIES

Sec. 307(a) STATE PLANS

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

(B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:

(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance and transportation services), nutrition services and multipurpose Senior Centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency and older individuals residing in rural areas). *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

(5) The State agency:

(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

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

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

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically and with comparable quality, by such State agency or area agency on aging.



Lowell Arye, Deputy Commissioner
Interim Director, Division of Aging Services
New Jersey Department of Human Services

7/29/13

Date



Verification of Intent

The State Plan on Aging is hereby submitted for the State of New Jersey for the period October 1, 2013 through September 30, 2017. It includes all the assurances and plans to be conducted by the New Jersey Department of Human Services under the provisions of the Older Americans Act, as amended, for the period identified. The State Agency named above has been given the authority to develop and administer the State Plan on Aging in accordance with all requirements of the Act, and is primarily responsible for the coordination of all State activities related to the purposes of the Act, i.e., the development of comprehensive and coordinated systems for the delivery of supportive services and to serve as the effective and visible advocate for the elderly in the State.

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

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

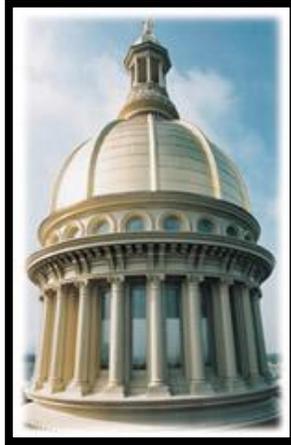
I hereby approve this State Plan on Aging and submit it to the Assistant Secretary for Aging for approval.

Lowell Arye
 Lowell Arye, Deputy Commissioner
 Interim Director, Division of Aging Services

7/2/13
 Date

Jennifer Velez
 Jennifer Velez, Commissioner
 New Jersey Dept. of Human Services
 Governor Designee

7/2/13
 Date



State of New Jersey
Department of Human Services
Division of Aging and Community Services
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State of New Jersey
Chris Christie
Governor

Department of Human Services
Jennifer Velez
Commissioner