

CHAPTER 100
STATE HEALTH PLAN

Authority

N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5 and 26:2H-8.

Source and Effective Date

R.1992 d.299, effective July 20, 1992.
See: 24 N.J.R. 1164(a), 24 N.J.R. 2561(a).

Executive Order No. 66(1978) Expiration Date

Chapter 100, State Health Plan, expires on July 20, 1997.

Chapter Historical Note

Attorney General Opinion 92-0094, issued July 15, 1992, addressed whether Assembly Bill 1144, concerning the nature of the State Health Plan, violated the constitutional principles of separation of powers and due process. See: 24 N.J.R. 2702(a).

Notice of Rule Invalidation: Validity of N.J.A.C. 8:100 affected by decision in *In the Matter of the Adoption of Regulations Governing the State Health Plan*, N.J.A.C. 8:100, et seq., 262 N.J. Super. 469 (App.Div.1993). See: 25 N.J.R. 3772(a).

Notice of Rule Invalidation: Validity of N.J.A.C. 8:100 affected by decision in *In the Matter of the Adoption of Regulations Governing the State Health Plan*, N.J.A.C. 8:100, et seq., 135 N.J. 24, Dkt. No. A-29-93 (February 28, 1994). See: 26 N.J.R. 1828(b).

Law Review and Journal Commentaries

Health Law. Steven P. Bann, 133 N.J.L.J. No. 11, 52 (1993).

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SUBCHAPTER 1. INTRODUCTION

8:100-1.1 Purpose

(a) The purpose of this chapter is to establish a plan that will satisfy the mandate of P.L. 1991, c.187 and support the public policy of the State in promoting health and high quality health care at a reasonable cost for all the citizens of the State. The State Health Planning Board, established by Section 33 of P.L. 1991, c.187 as the planning advisory board within the Department of Health is required to "prepare and revise annually, a State Health Plan. The State Health Plan shall identify unmet health needs in an area by service and location and it shall serve as the basis upon which all certificate of need applications shall be approved. The plan shall be effective beginning January 1, 1992. (P.L. 1991, c.1987 s.34). Specifically, the purpose of this chapter is to:

1. Identify unmet health care needs by service and location;
2. Establish a process for evaluating health care needs and services in six regional health planning areas;
3. Establish guidelines for making health planning decisions;
4. Contain the costs of providing health care;
5. Promote quality health care services;
6. Increase appropriate access for the residents of the State to preventive, primary, acute and sub-acute health care services;
7. Provide a comprehensive, population-based planning guide to health care; and

8. Establish policies for the rational use of health care resources in the State of New Jersey. One of the goals of these policies will be to reach the health targets established in *Healthy New Jersey 2000: A Public Health Agenda for the 1990's*, as well as other supporting health objectives identified below.

(b) The following goals and objectives will serve to guide subsequent policies and rules of the Department of Health (targets are set for attainment by the year 2000 unless otherwise specified).

1. Increase access to preventive and primary care:

i. Reduce the proportion of the population under age 65 with no health insurance coverage from 11.7 percent of the total population, 16.0 percent of African Americans and 25.0 percent of persons of Hispanic origin to 3.0 percent for all groups (1989 baseline);

ii. Reduce from 7.7 percent to 2.0 percent the proportion of the population without health insurance coverage who are under age 65 and employed or a spouse or dependent of an employed person (1989 baseline);

iii. Increase the percentage of residents who have a source of primary care from 84.4 percent of the total population and 84.2 percent of the African American population to 98.0 percent (1986 baseline);

iv. Decrease years of potential life lost per 100,000 population under 65 years of age from 5,778.7 years to 5,200.0 years (1988 baseline);

v. Increase life expectancy for white babies at birth from 75.9 years to 77.9 years (1988 baseline);

vi. Increase life expectancy for minority babies at birth from 71.8 years to 75.0 years (1988 baseline); and

vii. Reduce by 20.0 percent (26,000 admissions) the number of hospital admissions for ambulatory care sensitive diagnoses, such as pediatric otitis media, pneumonia, bronchitis and asthma, respiratory infections, gastroenteritis, cellulitis, and diabetes (1989 baseline).

2. Improve infant, child health, and maternal outcomes:

i. Reduce total infant mortality from 9.8 to 7.0 infant deaths per 1,000 live at births (1988 baseline);

ii. Reduce African American infant mortality from 19.5 to 11.0 infant deaths per 1,000 live births (1988 baseline);

iii. Reduce the percentage of infants weighing less than 2500 grams at birth from 6.8 percent to 5.0 percent of all births and from 13.6 percent to 9.0 percent of African American births (1988 baseline);

- (1) By 1995, increase the number of high-risk pregnant women in appropriate prenatal management, including referral and transport to tertiary centers where indicated (baseline not available);
- (2) By 1995, insure that hospitals provide care to mothers and infants based on their approved capabilities (baseline not available);
- (3) Increase the percentage of all women receiving prenatal care in the first trimester from 73.1 percent for all births and 57.1 percent of African American births to 90.0 percent of all births (1988 baseline);
- (4) By 1995, implement universal access to prenatal care, including comprehensive risk assessment;
- (5) By 1995, insure appropriate referral and followup for all pregnant women seen in emergency rooms without a primary care provider (baseline not available); and
- (6) Increase the proportion of eligible pregnant women served by Women, Infants, and Children (WIC) from 45.7 percent to 100.0 percent (1991 baseline);
- iv. By 1995, increase by 33 $\frac{1}{3}$ percent or 36,630, the number of women served by the publicly funded family planning agencies who are at risk of unintended pregnancy and in need of free or subsidized family planning services (1990 baseline 110,000);
- v. Reduce maternal deaths from 24.5 per 100,000 of all live births and 76.2 in the African American population to 5.0 per 100,000 live births (1986-1989 baseline);
- vi. Increase abstinence during pregnancy from as follows:
- (1) Alcohol to 95 percent (no baseline);
 - (2) Tobacco from 86.6 percent (1989 baseline) to 90 percent; and
 - (3) Cocaine, heroin, marijuana or methamphetamines by 20 percent (no baseline);
- vii. Reduce the annual incidence of measles (rubeola) from 405 cases to zero (1988 baseline);
- (1) Measles (rubeola) immunization levels in two-year-old children will be 90 percent (baseline not available);
 - viii. Immunization levels for H. influenzae type b started at two months will be 80 percent (baseline not available);
 - ix. Reduce the prevalence of blood-lead levels exceeding 15 mcg/dl in children aged nine months through five years to 14,000 (baseline not available) and those exceeding 25 mcg/dl from 1,500 to zero (1988 baseline);
 - (1) By 1995, 100.0 percent of children at high risk and 75.0 percent of all children will be screened for lead poisoning and receive appropriate environmental and medical management (baseline not available);
 - x. Reduce by 20.0 percent (26,000 admissions) the number of hospital admissions for children aged zero to four due to ambulatory care sensitive diagnoses, such as pediatric otitis media, pneumonia, bronchitis and asthma, respiratory infections, gastroenteritis, cellulitis, and diabetes (1989 baseline);
 - (1) 75.0 percent of families will have a community-based pediatric primary care provider (baseline not available);
 - (2) By 1995, all children seen in emergency rooms without a primary care provider will be referred and followed up for primary care (baseline not available); and
 - (3) 100.0 percent of maternity hospitals and prenatal care clinics will provide active programs of education and support for women to breastfeed (baseline not available);
 - xi. Reduce the proportion of children six through 18 with dental caries to 35 percent or less (baseline not available);
 - (1) Increase the proportion of people served by community water systems providing optimal levels of fluoride from 19 percent to 62 percent (1990 baseline, estimated; excludes population whose water source is well water and water systems serving fewer than 6,000).
 - xii. Reduce the incidence of iron deficiency among children one through two to under 10 percent and to five percent among children three to four (no baseline); and
 - xiii. Control the increase in the incidence of AIDS per 100,000 population in children zero to nine years of age so that it only doubles from 4.4 to 8.8 (1988 baseline);
3. Reduce the incidence of adolescent pregnancy and improve adolescent health:
- i. Decrease the prevalence of cigarette smoking among high school students from 41.2 percent to 20.0 percent (1989 baseline);
 - ii. Reduce the number of births per 1,000 females aged 15 to 19 years of age:
 - (1) To all women from a rate of 37.5 to 25.7 (1988 baseline); and
 - (2) To minority women from a rate of 78.9 to 55.8 per 1,000 (1988 baseline);
 - iii. Reduce the number of births per 1,000 females aged 10 to 14 years of age:

(1) To all women from a rate of 1.0 to 0.7 per 1,000 (1988 baseline); and

(2) To minority women aged 10 to 14 from 2.8 to 2.0 per 1,000 (1988 baseline);

iv. Ninety percent of sexually active high school students shall use contraception during intercourse and 60 percent will use barrier methods (baseline not available);

v. The proportion of adolescent females receiving family planning services will increase from 35.7 percent to 50 percent of adolescent females in need of such services (1987 baseline); and

vi. Adolescents who have engaged in sexual intercourse shall be no greater than 15 percent for tenth grade girls and boys, and 40 percent for 12th grade girls and boys (baseline not available);

4. Prevent and control injuries:

i. Reduce the rate per 100,000 population of deaths caused by motor vehicle crashes from 12.7 deaths to 11.4 in the total population (age-adjusted rates), from 25.8 to 23.0 for youth aged 15 to 24 and from 24.6 to 20.0 for people aged 70 and over (1988 baseline);

ii. Increase the use of seat belts by persons 18 and over "always" or "nearly always" when driving or riding in a car to 75.0 percent (baseline not available);

iii. Decrease the rate per 100,000 population of deaths due to falls and fall-related injuries from 13.0 to 12.0 for people age 65 to 84 years and from 117.7 to 105.0 for people age 85 years and over (1988 baseline);

iv. Decrease homicide deaths for minority males aged 15 to 44 from 48.9 to 39.0 per 100,000 population and from 9.2 to 7.0 per 100,000 population for minority females aged 15 to 44 (1988 baseline);

v. Reduce suicides per 100,000 population from 9.3 to 7.5 for youth aged 15 to 24 and reduce suicides for white men aged 65 and over to 39.2 per 100,000 (1988 baseline for youth, not available for white men aged 65 and over); and

vi. Decrease hospitalizations for nonfatal head and spinal cord injuries per 100,000 population by 15.0 percent (baseline not available);

5. Prevent and reduce the incidence of vaccine-preventable and other infectious diseases:

i. Reduce the annual incidence of measles (rubeola) from 405 cases to zero (1988 baseline);

ii. Reduce the annual incidence per 100,000 population of active TB from 10.3 to 4.4 in the total population and from 32.7 to 13.5 in the minority population (1988 baseline);

iii. Reduce the annual incidence of lyme disease (with rash) from 550 total cases to 275 cases (1988 baseline);

iv. Increase information levels for measles (rubeola) in children by age two to 90.0 percent (baseline not available);

v. Increase H. influenzae type b immunization levels started at two months to 80.0 percent (baseline not available);

vi. Increase hepatitis B immunization levels in pregnant women and infants to 100.0 percent (baseline not available);

vii. Increase hepatitis B immunization levels among intravenous drug users served in publicly-funded clinics from zero to 90.0 percent (1988 baseline);

viii. Increase hepatitis B immunization levels among gay men served in publicly-funded clinics from zero to 90.0 percent (1988 baseline);

ix. Increase the number of publicly-funded addiction treatment centers which screen HIV-positive clients for tuberculosis to 95.0 percent (baseline not available); and

x. Increase the number of all other publicly-funded clinics which screen HIV-positive clients for tuberculosis from zero to 75.0 percent (1988 baseline);

6. Prevent and reduce the incidence of STDs:

i. Reduce the incidence per 100,000 of primary and secondary syphilis from 14.2 to 10.0 for the total population and from 68.5 to 65.0 for the minority population (1988 baseline);

ii. Reduce the cases per 100,000 live births of congenital syphilis from 64.3 to 30.0 in the total population and from 259.2 to 100.0 in the minority population (1990 baseline);

iii. Reduce the incidence per 100,000 total population of gonorrhea from 212.7 to 175.0 (1988 baseline);

iv. Reduce the incidence of chlamydia trachomatis infections to 170.0 per 100,000 population (baseline not available);

v. Increase the number of publicly-funded clinics which offer provider referral service to patients with bacterial STD from 25.0 percent to 50.0 percent (1988 baseline); and

vi. Increase the number of publicly-funded clinics providing STD services to 100.0 percent of all prisons/detention centers (baseline not available) and from zero to 50.0 percent of all other publicly-funded clinics (1988 baseline);

7. Prevent and control AIDS and HIV infection:

- i. Reduce the transmission rate of HIV/AIDS so that the incidence rate per 100,000 population is not greater than:
 - (1) 8.8 for the pediatric population zero to nine years of age;
 - (2) 79.2 for white males 25 to 44 years of age;
 - (3) 868.2 for minority males 25 to 44 years of age; and
 - (4) 150.0 for minority females 15 to 44 years of age;
 - ii. Reduce deaths due to HIV/AIDS in the total population from 15.1 to 12.1 per 100,000 population (age-adjusted rates) and for 25 to 44 year olds from 37.6 to 30.1 per 100,000 population (1988 baseline);
 - iii. 60 percent of sexually active high school students will use barrier contraception at their most recent intercourse (baseline not available);
 - iv. 75 percent of primary care and mental health care providers shall provide age-appropriate counseling on the prevention of HIV infection (baseline not available); and
 - v. Publicly-funded clinics that provide counseling and testing services to HIV-infected individuals shall be increased:
 - (1) From zero to 40 percent of alcohol treatment centers (1991 baseline); and
 - (2) From a range of 16 to 95 percent to 100 percent of all other publicly-funded clinics (1991 baseline);
8. Reduce the rates of morbidity and mortality due to addictions:
- i. Reduce the prevalence of cigarette smoking among individuals age 20 and over from 24.5 percent to 15.0 percent and among high school students from 41.2 percent to 20.0 percent (1989 baseline);
 - ii. Increase the proportion of women who abstain from tobacco use during pregnancy from 86.6 percent to 90.0 percent (1989 baseline);
 - iii. Increase the proportion of women who abstain from alcohol use during pregnancy to 95.0 percent (baseline not available);
 - iv. Increase by 20.0 percent the proportion of women who abstain during pregnancy from use of cocaine, heroin, marijuana or methamphetamines (baseline not available);
 - v. Decrease the percentage of high school sophomores, juniors and seniors who have used the following substances in the past 30 days: alcohol from 49.6 percent to 37.0 percent, marijuana from 11.8 percent to 9.0 percent and cocaine from 2.2 percent to 1.6 percent (1989 baseline);
 - vi. Decrease by 10.0 percent the proportion of persons 18 years of age and older who consumed five or more alcoholic drinks per occasion, one or more times during the past month (baseline not available);
 - vii. Decrease deaths per 100,000 due to alcohol-related motor vehicle crashes for the total population from 4.0 to 3.5, and for youth aged 15-24 from 5.9 to 5.0 (1988 baseline);
 - viii. Decrease deaths per 100,000 population from cirrhosis for the total population from 10.3 to 6.8 (age-adjusted rates) and for minority males from 20.8 to 12.3 (age-adjusted rates, 1988 baseline);
 - ix. Decrease drug-related deaths per 100,000 population from 8.3 to 6.6 (age-adjusted rates, 1988 baseline);
 - x. Of clients in treatment, decrease the average time between first use and treatment by 20.0 percent for alcohol treatment (baseline not available) and from 9.3 years to 7.5 years for other drug treatment (1988 baseline);
 - xi. Increase the percentage of publicly-funded clinics providing addiction screening services from a range among types of clinics of zero to 27 percent to 100 percent of all types of publicly-funded clinics (1988 baseline);
 - xii. Increase the proportion of persons addicted to alcohol and/or drugs who are treated in residential or outpatient programs annually from 9.0 percent to 20.0 percent (1990 baseline); and
 - xiii. Reduce the prevalence of obesity from 24 percent in men and 27 percent in women aged 20 through 74 to no more than 20 percent, and from 15 percent to 10 percent in adolescents aged 12 through 19 (1976-80 baseline);
9. Increase efforts to prevent, detect and control cardiovascular and other vascular diseases:
- i. Reduce deaths per 100,000 population due to coronary heart disease:
 - (1) From 142.9 to 107.2 for the total population (age-adjusted rates, 1988 baseline);
 - (2) From 133.1 to 99.8 for the minority population (age-adjusted rates, 1988 baseline);
 - (3) From 206.2 to 154.7 for the total population aged 45-64 (1988 baseline); and
 - (4) From 214.8 to 161.1 for the minority population aged 45-64 (1988 baseline);
 - ii. Decrease deaths per 100,000 population due to cerebrovascular diseases:

- (1) From 27.0 to 20.8 for the total population (age-adjusted rates, 1988 baseline);
 - (2) From 39.5 to 32.0 for the minority population (age-adjusted rates, 1988 baseline);
 - (3) From 32.6 to 22.8 for the total population aged 45-64 (1988 baseline);
 - (4) From 64.2 to 44.9 for the minority population aged 45-64 (1988 baseline); and
 - (5) From 354.7 to 283.8 for the total population aged 65 and over (1988 baseline);
- iii. Reduce the rate of end-stage renal disease as a complication of diabetes from 1.9 to 1.8 per 1,000 diabetics (1988 baseline) and decrease end-stage renal disease as a complication of diabetes for African Americans by 10.0 percent (baseline not available);
 - iv. Increase by 10 percent the proportion of persons 18 and over who participate in physical activity for at least 30 minutes three or more times per week (baseline not available);
 - v. Increase to 90 percent the proportion of people aged 18 and over who have had their blood pressure checked by a health professional within the past two years and can state whether their blood pressure was normal or high (baseline not available); and
 - vi. Increase by 15 percent the proportion of people 18 and over who have had their blood cholesterol checked by a health professional within the past five years (baseline not available);
10. Increase efforts to prevent, detect and control cancer:
 - i. Decrease breast cancer deaths per 100,000 women:
 - (1) From 25.2 to 22.7 for all women (age-adjusted rates, 1988 baseline);
 - (2) From 80.6 to 72.5 for women aged 50-64 (1988 baseline); and
 - (3) From 144.7 to 130.2 for women aged 65 and over (1988 baseline);
 - ii. Increase to 60.0 percent the number of women aged 40 and over who received an annual clinical breast examination and a mammogram (baseline not available);
 - iii. Reduce the rate of deaths due to lung cancer per 100,000 population to a rate of no more than:
 - (1) 41.3 for the total population (age-adjusted rates, 1988 baseline); and
 - (2) 64.8 for minority males (age-adjusted rates, 1988 baseline);
 - iv. Reduce the prevalence of cigarette smoking among individuals:
 - (1) Age 20 and over from 24.5 percent to 15 percent (1989 baseline); and
 - (2) Among high school students from 41.2 percent to 20.0 percent (1989 baseline);
 - v. Reduce colorectal cancer deaths per 100,000 population from 16.9 to 15.5 (age-adjusted, 1988 baseline);
 - vi. Increase to five the average daily servings of fruits and vegetables (including legumes) consumed by people aged 18 and over (baseline not available);
 - vii. Decrease death rates per 100,000 women from cervical cancer:
 - (1) From 2.7 to 1.3 for all women (age-adjusted rates, 1988 baseline);
 - (2) From 5.3 to 2.6 for minority women (age-adjusted rates, 1988 baseline); and
 - (3) From 6.3 to 3.2 for women aged 65 and over (1988 baseline); and
 - viii. Increase the number of women (with uterine cervix) who have had a Pap smear in the past two years to 85.0 percent for all women, 80.0 percent for minority women and 70.0 percent for women aged 65 and over (baseline not available);
 11. Reduce morbidity and mortality related to occupational and environmental hazards:
 - i. Reduce work-related injury deaths per 100,000 for full-time, male construction workers from 15.0 to 10.0 (1983-1989 baseline);
 - ii. Reduce the number of workers with occupational exposure causing blood lead concentrations >25 mcg/dl of whole blood from 1,248 to zero (1988 baseline);
 - iii. Reduce the number of workers with exposures leading to hospitalizations for acute occupational lung diseases from 164 to 82 (1988 baseline);
 - iv. Increase the number of sites evaluated for potential human exposure pathways to hazardous waste from 100 to 350 (1988 baseline);
 - v. Reduce the prevalence of blood-lead levels exceeding 15 mcg/dl in children aged nine months through five years to 14,000 (baseline not available) and those exceeding 25 mcg/dl from 1,500 to 0 (1988 baseline);
 - vi. Increase from 76.0 percent to 100.0 percent the amount of asbestos either properly maintained or removed in school buildings with asbestos management plans submitted and approved by the Department of Health (1988 baseline); and

vii. Increase the proportion of people served by community water systems providing optimal levels of fluoride from 19 percent to 62 percent (1990 baseline, estimated; excludes population whose water source is well water and water systems serving fewer than 6,000); and

12. Improve the health status and quality of life for race/ethnic minority populations:

i. Improve the availability of, and accessibility to, culturally and linguistically sensitive comprehensive medical, dental and mental health care services for race/ethnic minority populations. (Baseline data not available; targets will be set pursuant to the completion of the Final Report on Minority Health by the end of 1992.)

ii. Improve financing for health care services to low income minority populations, that is, affordable services, available insurance coverage and reasonable reimbursement to providers. (Baseline data not available; targets will be set pursuant to the completion of the Final Report on Minority Health by the end of 1992.)

iii. Improve needs assessment, recruitment, retention and training strategies to increase the number of minority physicians and health care providers serving the minority community. (Baseline data not available; targets will be set pursuant to the completion of the Final Report on Minority Health by the end of 1992.)

iv. Organize and develop a Statewide minority health network by improving communications, cooperation, and collaboration with minority community based organizations and other health and human service providers. (Targets will be set pursuant to the completion of the Final Report on Minority Health by the end of 1992.)

13. Improve the health and quality of life for people with chronic functional impairments:

i. Increase the span of healthy, independent life for all New Jerseyans (no baseline available);

ii. Minimize the limiting effects of chronic conditions and help individuals to maintain their highest level of functioning (no baseline available);

iii. Support and encourage the endeavors of the predominant providers of long-term care: family (no baseline available);

iv. Provide access to an array of affordable long-term care options so that individuals can receive care in the least restrictive setting appropriate to their needs and preferences;

v. Improve access to care for special long-term care patient populations; and

vi. Increase the options available to persons who are eligible for nursing home care so that the number of people accessing these options increases from five percent to 23 percent of the eligible population (1990 baseline).

Case Notes

Agency exemption from APA rulemaking procedures. Matter of Adoption of Regulations Governing State Health Plan, N.J.A.C. 8:100 et seq., 262 N.J.Super. 469, 621 A.2d 484 (A.D.1993), certification granted 133 N.J. 442, 627 A.2d 1147, affirmed 135 N.J. 24, 637 A.2d 1246.

Requirements in certificate of need consistent with separation of powers. Matter of Adoption of Regulations Governing State Health Plan, N.J.A.C. 8:100 et seq., 262 N.J.Super. 469, 621 A.2d 484 (A.D. 1993), certification granted 133 N.J. 442, 627 A.2d 1147, affirmed 135 N.J. 24, 637 A.2d 1246.

Health Care Facilities Planning Act satisfies due process. Matter of Adoption of Regulations Governing State Health Plan, N.J.A.C. 8:100 et seq., 262 N.J.Super. 469, 621 A.2d 484 (A.D.1993), certification granted 133 N.J. 442, 627 A.2d 1147, affirmed 135 N.J. 24, 637 A.2d 1246.

State health plan is an advisory document in certificate of need process. Matter of Adoption of Regulations Governing State Health Plan, N.J.A.C. 8:100 et seq., 262 N.J.Super. 469, 621 A.2d 484 (A.D. 1993), certification granted 133 N.J. 442, 627 A.2d 1147, affirmed 135 N.J. 24, 637 A.2d 1246.

Regulations in conflict with laws are invalid. Matter of Adoption of Regulations Governing State Health Plan, N.J.A.C. 8:100 et seq., 262 N.J.Super. 469, 621 A.2d 484 (A.D.1993), certification granted 133 N.J. 442, 627 A.2d 1147, affirmed 135 N.J. 24, 637 A.2d 1246.

8:100-1.2 Scope

(a) This chapter establishes comprehensive goals and objectives for future certificate of need, licensure, reimbursement and public health rules to be promulgated by the Department of Health governing health care facilities as defined by the Health Care Facility Planning Act (P.L. 1971, c.136) and health care services. It also provides policies and guidelines for future grant making by the Department of Health and directs the Department to work with sister agencies including, but not limited to, the Departments of Human Services, Education, Insurance, and Community Affairs to address issues of mutual concern.

(b) The State Health Plan is a dynamic document that should change with the health needs of the people in the State. To that end, it is the role of each LAB:

1. To evaluate each new subchapter as it relates to the specific health care needs and resources of the region, and recommend to the State Health Planning Board revisions it deems necessary to respond to local health needs. The recommendations will be completed by January 20, 1993; and

2. To provide recommendations at least annually for changes to the plan in response to local health needs.

8:100-1.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless context clearly indicates otherwise.

“ACS” means ambulatory care sensitive conditions, which are hospital admissions that usually could have been avoided with appropriate primary care.

“Acute care hospital” means all short-term general hospitals governed by the Chapter 83 rate setting system.

“ALOS” means the average length of stay in a hospital.

“Alternate family care” means a contractual arrangement between a patient, alternate caregiving family, and a sponsoring agency whereby no more than two individuals in need of long-term care receive room, board, and care in the private residence of a nonrelated family that has been trained to provide the necessary caregiving.

“ASAM” means American Society of Addiction Medicine.

“Commissioner” means the Commissioner, New Jersey Department of Health.

“Community Care Program for the Elderly and Disabled” or “CCPED” means a Medicaid-funded, Federally waived program offering case managed home and community-based care to persons who meet specific eligibility criteria.

“Continuing care retirement community” means the provision of lodging and nursing, medical, or other related services at the same or another location to an individual pursuant to an agreement effective for the life of the individual or for a period greater than one year, including mutually terminable contracts, and in consideration of the payment of an entrance fee with or without other periodic charges. A fee which is less than the sum of the regular periodic charges for one year of residency is not considered an entrance fee.

“CN” means certificate of need.

“CT” means computerized tomography.

“CVD” means cardiovascular disease which is diseases of the heart and blood vessels, including coronary heart disease and cerebrovascular disease (stroke).

“Department” means Department of Health.

“ESWBL” means extra corporeal shock wave biliary lithotripsy.

“ESWL” means extra corporeal shock wave lithotripsy.

“ICU/CCU” means intensive care and critical care hospital units.

“LAB” means local advisory board, a regional health planning agency established by P.L. 1991, c.187 sec. 35 and designated by the Commissioner of Health.

“LDRP” means labor, delivery, recovery and postpartum obstetric units.

“Long-term care” means a wide range of personal care, psycho-social, nursing, and other supportive services for people with functional limitations due to chronic—and frequently degenerative—physical or cognitive disorders. Long-term care services range from in-home assistance provided by family members or a home care agency to nursing home care.

“Long-term care placement” means a unit of service provided to an individual who is nursing home-eligible. The unit of service may be a bed, for example, a nursing home bed, or a slot, for example, a Community Care Program for the Elderly and Disabled slot.

“M/S” means medical/surgical hospital units.

“Maternal and Child Health Region” means the perinatal and pediatric service delivery area defined by the concept of cooperative network formation. Contained within each region is at least one Regional Perinatal Center, one Regional Pediatric Center, and the balance, Community Perinatal and Pediatric Centers.

“Maternal and Child Health Consortia” means the perinatal and pediatric providers of the maternal and child health region which agree to associate and establish a nonprofit corporation consistent with the Internal Revenue Code under Title 26 of the United States Code Service, Section 501(c)(3).

“MRI” means magnetic resonance imaging.

“NIRA” means Nursing Incentive Reimbursement Awards.

“Nursing home” means a facility that is licensed by the Department of Health for long-term care beds.

“OB/GYN” means obstetric/gynecological hospital units.

“PET” means positron emission tomography.

“PICU” means Pediatric Intensive Care Unit.

“Provider” means an institution or individual actively delivering health care services, including, but not limited to, hospitals, physicians, nurses, clinics, local health departments and community health centers.

9. Provide for cost-effective, population-wide models that motivate persons and communities to permanently adopt behavior which promotes community and individual cardiovascular health;

10. Collaborate with organizations, and especially with the American Heart Association, to provide cardiovascular health education to health professionals throughout the State, enabling them to counsel and advise their clients and communities on lifestyle changes which support cardiovascular health;

11. Provide for population-wide cardiovascular health promotion media campaigns that stress healthy decisions and behavior regarding cardiovascular risk factors, healthy eating, and physical activity;

12. Provide for scientifically-based information about cardiovascular health for health professionals, communities and consumers;

13. Promote and support policies that ensure the availability of healthy food choices to all citizens, and promote policies and incentives to encourage food industry attention to nutrition in product development and promotion; and

14. Establish incentives for the development of innovative programs that encourage cardiovascular fitness.

(b) Mechanisms or evaluative techniques shall be continually developed and modified by the Department of Health to evaluate existing health promotion/prevention activities conducted in New Jersey, such as the New Jersey State Healthy Heart Programs.

(c) Outpatient nutrition counseling services should be provided through designated referral sources in all acute-care hospitals, in order to maximize the opportunity for cost-effective primary and secondary CVD prevention and intervention strategies. A sliding fee scale for underserved minority and elderly populations should also be provided.

8:100-9.3 Acute Care Cardiac Services and Resource Allocation Policy

(a) Statewide mechanisms shall be developed to review the quality and appropriateness of the cardiac procedures now performed in New Jersey. Implementation of pre-procedure, patient-risk stratification mechanisms shall be completed and perhaps extended to other aspects of cardiac intervention by the Commissioner's Cardiac Services Committee. The outcomes from these evaluative measures shall be linked to future expansion or contraction of the State's cardiac resources.

(b) Future certificates of need to expand cardiac services shall be contingent on the development of a regionalized plan by the local advisory boards to include, but not be limited to, organized referral patterns, a network of community-based secondary and tertiary, acute care providers, educational programs, and cost containment considerations.

Preference should be given to existing programs that have demonstrated quality care through utilization of its cardiac services. Pediatric cardiac services, to be provided by the State's children's hospitals are established in the acute care subchapter (N.J.A.C. 8:100-14).

(c) Increased Department of Health resources should be devoted to the Myocardial Infarction Data Acquisition System (MIDAS), in order to facilitate long-term policy and resource-allocation decisionmaking. The Department of Health should expand its support for MIDAS to evaluate variations in treatment of hospitalized myocardial infarction patients.

SUBCHAPTER 10. CANCER (RESERVED)

SUBCHAPTER 11. DIABETES (RESERVED)

SUBCHAPTER 12. MENTAL HEALTH (RESERVED)

SUBCHAPTER 13. OCCUPATIONAL AND ENVIRONMENTAL HEALTH (RESERVED)

SUBCHAPTER 14. HOSPITAL INPATIENT SERVICES

8:100-14.1 General recommendations

(a) The Department of Health shall:

1. Assure the appropriate distribution and supply of acute care hospital beds throughout New Jersey to meet the identified health care needs of consumers, assure access to care, and promote quality of care and cost effectiveness;

2. Promote the use of appropriate levels of care, such as primary care and preventive care, and care to special populations, including children, the frail elderly, and persons with AIDS;

3. Set priorities for approval of needed projects in order to allocate new hospital capital expenditures within the Statewide capital cap;

4. Encourage the development of a strong regionalized health care system through coordination and consolidation of institutional and community resources; and

5. Actively address quality of care by:

- i. Developing uniform quality indicators that are outcome measures;
- ii. Strengthen and make uniform Utilization Review that is quality driven;
- iii. Engage in research to determine appropriateness of care; and
- iv. Develop quality sensitive payment mechanisms.

8:100-14.2 Hospital efficiency targets and objectives

(a) The target occupancy rate by 1995 for medical-surgical units of hospitals shall be 85 percent.

(b) Within one year of approval of the Maternal and Child Health Consortia regional designation plan, the target annual OB/GYN occupancy rates, based on licensed beds, shall be determined as follows:

1. Units with less than 20 licensed beds;
 - i. LDRP: 55 percent
 - ii. Postpartum: 65 percent
2. Units with 20 or more licensed beds:
 - i. LDRP: 65 percent
 - ii. Postpartum: 75 percent

(c) The target occupancy rate by 1995 for all other inpatient services shall be 75 percent occupancy, except where otherwise identified in this rule.

(d) The Statewide objective for occupancy within the inpatient acute care hospital system is to achieve an occupancy of between 80 and 85 percent.

(e) Target rates for units located in geographically isolated areas or having unique service area responsibilities shall be developed by the LAB in conjunction with the Department.

(f) The Department and LABs will study the average length of stay for acute care services and promote appropriate utilization of facilities.

(g) The Department in conjunction with the LABs will investigate the high rates of hospital admissions for certain ambulatory care sensitive conditions in the State, and promote actions to reduce rates in areas significantly above the Statewide average.

8:100-14.3 Statewide bed need

(a) Using the methodologies adopted by the State Health Planning Board which are based upon hospital admissions, patient days and length of stay trends, the Department finds the State will have:

1. An excess of 2,175 licensed acute care beds in 1995;
2. An excess of 1,700 licensed M/S beds in 1995;
3. An excess of 100 licensed obstetric beds in 1995;
4. An excess of 300 licensed pediatric beds in 1994;¹
5. An excess of 375 licensed beds for other services in 1995; and
6. A need for 300 additional licensed ICU/CCU beds in 1995.

(b) All certificate of need projects submitted by a hospital shall be reviewed under the provisions of this chapter and also under the requirements of N.J.A.C. 8:43I, the Hospital Policy Manual, or under other planning rules, where applicable. In the event of a conflict in the meaning, this chapter shall supersede all other rules promulgated by the Commissioner of Health.

¹ So in original.

8:100-14.4 Removal of unused beds from a hospital license

(a) Pursuant to the Health Care Cost Reduction Act, N.J.S.A. 26:2H-38(d), the Commissioner may amend a facility's license to reduce that facility's licensed bed capacity to reflect actual utilization at the facility. This authority may be exercised if the Commissioner determines that 10 or more licensed beds in the health care facility have not been used for at least the last two succeeding years. For purposes of this rule, review of the hospital's utilization may go back as far as January 1, 1990.

(b) Notice of the Commissioner's intent to remove unused beds from a hospital license will be issued to an affected hospital with a statement of the reasons for the proposed action. The hospital may request an informal hearing with the Department within 30 days of receipt of the notice of intent.

(c) If the Commissioner issues a final decision to remove beds from a hospital license, a request for fair hearing submitted within 30 days of receipt of the decision will be granted and conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.