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 ⅓ 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

Under Health Care Cost Reduction Act, authority to adopt nonconflicting regulations, and permission to consider State Health Plan constituted sufficient safeguards to satisfy due process, certificate of need applications. Matter of Adoption of Regulations Governing State Health Plan, N.J.A.C. 8:100, 135 N.J. 24, 637 A.2d 1246 (1994).

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.

Case Notes

Under Health Care Cost Reduction Act, authority to adopt nonconflicting regulations, and permission to consider State Health Plan constituted sufficient safeguards to satisfy due process, certificate of need applications. Matter of Adoption of Regulations Governing State Health Plan, N.J.A.C. 8:100, 135 N.J. 24, 637 A.2d 1246 (1994).

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 waivered 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.

"Regionalization" means the planning and coordination of services for the best use of financial and medical resources such as staffing, equipment, facilities, education, and expertise to support appropriate, quality health care to a specific population.

"Reproductive health services" means all of the health services related to issues of fertility which include, but are not limited to: preconceptual care, perinatal care, family planning services, sterilization, prevention and treatment of sexually transmitted diseases, abortion services, adoption options counseling, infertility counseling and education and information on all of the above.

SUBCHAPTER 2. PREVENTION, PRIMARY AND AMBULATORY CARE SERVICES (RESERVED)

SUBCHAPTER 3. HEALTH PERSONNEL SUPPLY (RESERVED)

SUBCHAPTER 4. MATERNAL AND CHILD HEALTH SERVICES

8:100–4.1 General recommendations

(a) The Department shall:

1. Develop a regionalized system of maternal and child health care that emphasizes community-based preventive and primary care, including reproductive, prenatal and pediatric services, with particular attention to the appropriate linkage of outpatient to regional inpatient providers.

2. Establish a comprehensive health care system which is accessible, affordable and acceptable to women of reproductive age, infants, children, and adolescents including those with special needs, between the ages of 1 and 18.

3. Develop a regionalized system of total quality improvement, using outcome-oriented objectives including peer review, and monitor and enforce programs through licensure standards, certificate of need rules, and grant requirements.

8:100–4.2 Regionalization

(a) The Department shall establish an Office of Regionalized Maternal and Child Health Services in the Department to:

1. Coordinate the regional system both locally and between State agencies;

2. Monitor the Maternal and Child Health Consortia;

3. Evaluate the Maternal and Child Health Consortia using performance criteria based on outcome objectives; and

4. Develop letters of agreement with each Maternal and Child Health Consortia for funding through the rates.

(b) The Department of Health shall revise perinatal planning rules, N.J.A.C. 8:33C, and initiate the development of pediatric rules. The Commissioner of Health shall convene a pediatric clinical advisory committee to make recommendations regarding the development of pediatric rules. This committee shall include, but not be limited to: representation from the private pediatric provider community for both hospital and community-based services (medical and nursing), the American Academy of Pediatrics (New Jersey Chapter), the New Jersey Pediatric Society, the Parental Child Health Advisory Committee to the Department of Health, the Pediatric Subcommittee of the New Jersey Emergency Medical Services Council, the March of Dimes, the Governor's Committee on Children's Services Planning, the Maternal and Child Health Consortia, the local advisory boards, local health departments, community health centers, the University of Medicine and Dentistry of New Jersey, the New Jersey State Nurses Association, the New Jersey Public Health Nurse Administrators Association, the Medical Society of New Jersey, the New Jersey Hospital Association, and consumers. This committee will be staffed by the Office of Regionalized Maternal and Child Health Services and consultants external to the State.

(c) The pediatric clinical advisory committee shall make recommendations for the development of pediatric planning rules for a system for pediatric primary and inpatient care with attention to quality of care issues and will also make recommendations for the development of adjunct licensing rules as appropriate.

8:100–4.3 Regional designation

(a) The Department of Health shall designate Maternal and Child Health Regions, Consortia, and regional perinatal centers based on the most recent year or the average of the last three consecutive years of data available and which is consistently applied in all applications within a region, and only for approved services in existence at the time of application for certificate of need in accordance with N.J.A.C. 8:33C. A maternal and child health service region shall have:

1. A minimum of 10,000 live births or 100 very low-birthweight neonates (in no case may the number of deliveries be below 8,000 women);

2. At least one facility meeting the qualifications of and functioning as a regional perinatal center and a

regional pediatric center (although regions may have more than one of each); and

3. A geographically rational and cohesive network of services with documentation of accessibility to patients and a three year documented history of referral and transport patterns.

(b) Regionalization shall link inpatient with outpatient services.

(c) For perinatal designation, a Certificate of Need application shall be filed in accordance with N.J.A.C. 8:33C–1.19 et seq. and N.J.A.C. 8:33.

1. Funding for the consortia will proceed once the certificate of need application has been filed and fulfills all components specified in N.J.A.C. 8:33C–1.19 et seq.

2. In order to provide perinatal services, facilities shall join and participate in a maternal and child health consortium and apply for the appropriate designation through their Maternal and Child Health Consortia in accordance with the certificate of need process specified above.

3. Changes in certificate of need regarding unit size or capital expenditures by facilities following initial designation shall be endorsed by the consortia and affected local advisory boards. Changes in certificate of need regarding designation status shall be submitted by the Maternal and Child Health Consortia.

(d) For pediatric designation, pediatric applications shall be filed in accordance with the pediatric planning rules to be developed by the Department as specified in N.J.A.C. 8:100–4.2, and the certificate of need process in N.J.A.C. 8:33. The designation process shall take place in the following sequence:

1. Certificates of need for renovation, construction, or downsizing of pediatric units shall be accepted and processed in accordance with the recommendations in N.J.A.C. 8:100–14 by local advisory boards with support from the consortia. Applications for designation shall not be accepted until pediatric planning rules are adopted.

2. A pediatric clinical advisory committee shall be convened by the Department as specified in N.J.A.C. 8:100–4.2.

3. Pediatric planning rules shall be proposed utilizing the recommendations of the pediatric clinical advisory committee.

4. In order to provide new or continuing pediatric services, facilities shall join and participate as members of a maternal and child health consortium. Pediatric applications shall be submitted through their Maternal and Child Health Consortia and all affected LABs and the Department.

5. Applications for certificate of need regarding unit size or capital expenditures by facilities following initial designation shall be endorsed by the consortia and affected local advisory boards. Changes in certificate of need regarding designation status shall be submitted by the Maternal and Child Health Consortia.

(e) Regionalized services shall take into account existing referral patterns, which may not be consistent with regional health planning boundaries. Maternal and Child Health Regions need not be in accordance with regional health planning boundaries; however, care at regional centers must be geographically accessible to patients living within the regions.

8:100–4.4 Maternal and Child Health Consortia

(a) Services in each Maternal and Child Health Region shall be coordinated by a Regional Maternal Child Health Consortium, a private, nonprofit agency organized under IRSC 501(C)(3). This consortium shall be a central service facility licensed by the Department of Health and funded through hospital reimbursement and available State funding. General membership in the Consortia shall include a balance of agencies with interests in pediatric, perinatal and reproductive health issues. Membership shall include all hospitals with maternity, newborn, and/or pediatric services, local health departments, local advisory boards, community health centers, Healthy Mothers/Healthy Babies Coalitions, WIC agencies, family planning agencies, all licensed ambulatory care facilities which provide prenatal or pediatric care, County Human Services Advisory Committees, and any other voluntary, professional or local/county governmental agencies concerned with maternal and child health services.

(b) The Board of Directors of each consortium shall be nominated from and voted upon by the general membership. The general membership shall also vote on the bylaws. The Board shall consist of a minimum of 18–21 members, one-third of which are hospital providers, one-third are nonhospital providers, and one-third are consumers. Each member agency or hospital is entitled to one vote in either the general membership or the Board. The Board shall also have one each licensed and currently practicing pediatrician and obstetrician, a licensed and currently practicing registered nurse with a certification in either maternal and child health nursing or in community health nursing and one health officer.

(c) The Maternal and Child Health Consortia shall be required to comply with patient confidentiality requirements as specified in Hospital Licensing Standards N.J.A.C. 8:43G–4.1(a)21.

8:100–4.5 Functions of Maternal and Child Health Consortia

(a) Maternal and Child Health Consortia shall:

1. Assess local needs (including service capacity, accessibility, and cultural sensitivity);

2. Develop regional perinatal and pediatric plans;

3. Develop family-centered primary care services as needed;

4. Develop patient tracking systems;

5. Collect and share data with regional providers;

6. Provide total quality improvement;

7. Offer professional education;

8. Coordinate maternal, neonatal and pediatric transport systems;

9. Resolve conflicts;

10. Submit Certificate of Need applications for facilities and the region;

11. Coordinate outreach and education programs; and

12. Make recommendations to the Department of Health for funding local services.

(b) In addition to (a) above, Maternal and Child Consortia will assess the need to consolidate or expand services provided in the currently funded categorical programs of local health departments, prenatal clinics, and family planning agencies. These agencies should be encouraged, through new funding sources, to expand their scope of care to provide community-based, accessible primary care to women and children where such services are indicated. For example, Maternal and Child Health block grant funds shall be removed from hospital-based services and replaced with funds from the rates. Maternal and Child Health Block grant funds should then be utilized to expand existing family planning clinics to provide child health and prenatal services, and/or to expand existing prenatal care clinics to provide child health and family planning where the need exists and in accordance with regional plans. Primary care availability should begin with evaluating the feasibility of expanding existing programs such as family planning agencies and local health departments. In all settings, there should be coordination of referrals and smooth transitions between and among services so that moving from family planning to prenatal to pediatric and to postpartum family planning can be easily achieved.

(c) One alternative for agencies with specific expertise would be to merge service provision in order to consolidate the availability and delivery of care. Satellite services should be available in housing projects and schools as needs are determined by the Maternal and Child Health Consortia in conjunction with the local advisory boards. These services should be linked or co-located with other services such as employment or job training. See also N.J.A.C. 8:100–2, Prevention, Primary and Ambulatory Care Services, for more detail on specific need areas.

(d) Prenatal care services shall not be funded without concurrent evaluation of the need for family planning and pediatric components or linkage with existing agencies providing these services. Maternal and Child Health Consortia shall make recommendations to the Department of Health regarding funding for local direct care providers. Local advisory boards should work in concert with Maternal and Child Health Consortia when planning for primary care services for women and children.

(e) Hospitals should follow-up all women and children without primary care providers who are seen in emergency rooms.

(f) Local advisory boards and Maternal and Child Health Consortia should jointly evaluate whether the acute care facilities slated for transition may become primary care facilities or residential and outpatient treatment facilities for pregnant addicted women and their children.

8:100–4.6 Perinatal system of care

(a) Hospital-based and community-based care must comply with licensed ambulatory care standards (N.J.A.C. 8:43A), HealthStart standards (N.J.A.C. 10:49–3), and Standards for Obstetrics and Gynecological Services, 6th ed., 1985, published by the American College of Obstetricians and Gynecologists, 600 Maryland Avenue, SW, Suite 300 East, Washington, DC, 20024–2588, incorporated herein by reference. Prenatal care clinics in a region shall accommodate, at a minimum, the number of Medicaid births in a region annually.

(b) Prenatal care shall include, but not be limited to: history, physical exam, laboratory, risk assessment and plan of care. Support services shall include the following:

1. Outreach and education;

2. Case management;

3. WIC, on-site Medicaid eligibility determination;

4. Public health nursing follow-up in the home which can include the utilization of community volunteers or outreach workers supervised by a public health nurse, including the evaluation by the Department of the use of Nursing Incentive Reimbursement Award (NIRA) funds;

5. Patient/family education which is culturally sensitive and includes nutrition (especially breastfeeding), dental health, contraception, parenting skills, growth and development, injury prevention, HIV risk, and addictions;

6. Family risk assessment for abuse and neglect, addictions, and HIV exposure;

7. Consultation routinely available from registered dieticians or nutritionists, geneticists, social workers, other physician and pediatric specialties; and

8. Co-management between regional perinatal facilities and the perinatal provider in the community-based setting.

(c) Access to routine and high-risk inpatient perinatal care shall be improved by designating a network of perinatal facilities linked with community providers. In accordance with requirements specified in perinatal planning rules, N.J.A.C. 8:33C, and based on their capability of caring for low-birthweight infants, facilities shall comply with Hospital Licensing Standards, N.J.A.C. 8:43G–22, and shall be designated as one of the following:

1. Community Perinatal Centers shall be licensed facilities providing prenatal care, intrapartum care including delivery of the patient, and postpartum care to women. Community Perinatal Centers should provide a range of high risk neonatal management based on regional needs, in-house staffing and task capability and in accordance with the letter of agreement with their Regional Perinatal Center. Community Perinatal Centers shall each be designated as one of the following:

i. Community Perinatal Center—Birthing Center (less than 500 deliveries per year, uncomplicated deliveries);

ii. Community Perinatal Center—Basic (less than 800 deliveries per year, anticipated deliveries of greater than 2499 grams and 36 weeks gestation);

iii. Community Perinatal Center—Intermediate (anticipated deliveries of greater than 1499 grams and 32 weeks gestation); or

iv. Community Perinatal Center—Intensive (anticipated deliveries of greater than 999 grams and 28 weeks gestation).

2. Regional Perinatal Centers are licensed facilities able to provide a full range of perinatal services to their patient population and support to their regional affiliates. The Regional Perinatal Center shall document that for the most recent year or the average of the last three consecutive years of data available, and which is consistently applied in all applications within a region more than 80 maternal referrals or transports were accepted and full neonatal management was provided to more than 40 very low birthweight infants (less than 1500 grams). The Regional Perinatal Center shall have a neonatal intensive care unit in-house and a pediatric intensive care unit available either in-house or linked regionally;

3. Letters of agreement between all facilities in a region shall be specific regarding the coordination of services, transports, and referrals. The Regional Perinatal Center shall be able to provide: total management of the high risk maternal patient referred by the Community Perinatal Center, co-management with the attending physician at the Community Perinatal Center or community based setting, and telephone consultation to the attending physician at the community perinatal center; and

4. All facilities shall provide to the consortia and the Department individual patient data for the purpose of a total quality improvement program.

(d) Family planning information, or referral to services, shall be routinely available at prenatal clinics and primary care facilities.

(e) Reproductive health care services shall be routinely available and accessible which should include information on the full array of reproductive health options. Adolescents should have information about methods of contraception readily available and, if sexually active, have access to family planning services. Mentoring programs should be initiated and evaluated for effectiveness. Renewed emphasis should be placed on male involvement and responsibility in reproductive health. Refer to N.J.A.C. 8:100–2, Prevention, Primary and Ambulatory Care Services, for more detail.

(f) Residential and outpatient services to pregnant addicted women shall include followup after delivery.

8:100–4.7 Pediatric system of care

(a) The pediatric system of care shall be evaluated and planning rules developed as specified in N.J.A.C. 8:100–4.2 and 4.3.

(b) The provision of comprehensive pediatric care shall be in compliance with standards established by the American Academy of Pediatrics, P.O. Box 1034, Evanston, Illinois 60204, the Advisory Committee on Immunizations Practices (Centers for Disease Control) and HealthStart N.J.A.C. 10:49–3.1 through 3.20 which are incorporated herein by reference, and include:

1. A strong network of cooperating pediatric providers; and

2. An infant-tracking system of all newborns in need of primary care. This shall be accomplished through public health nursing home visits done by public health nurses or community volunteers or outreach workers under the supervision of a public health nurse. All nurses making home visits should have received Nursing Child Assessment Training (NCAST). Funding allocation shall be explored by the Department of Health and should include the possibility of utilizing some Nursing Incentive Reimbursement Awards (NIRA) to reduce ambulatory care sensitive admissions, and improve immunization status.

(c) Accessible (operating some evenings and weekends), community-based comprehensive preventive and primary care services to all children and adolescents shall include, but are not limited to, well and 24–hour sick care, as well as:

1. Periodic physical examinations, which include dental assessments;

2. Immunizations;

3. Developmental and nutritional assessments with referral if indicated;

4. Screening tests such as lead levels, vision and hearing screening with referral if indicated;

5. Anticipatory guidance, including injury prevention and age-appropriate sex education;

6. Prompt treatment of all medical conditions not requiring immediate hospitalization or referral for secondary or tertiary care;

7. Case management;

8. Adolescent health services which includes assessment for sexual activity, substance abuse, and appropriate referral, teen male involvement in reproductive health issues, mentoring, and esteem building programs; and

9. Co-management of children with special needs by primary care providers and pediatric specialists.

(d) Refer to N.J.A.C. 8:100–2 and 6 on Prevention, Primary and Ambulatory Services and Infectious Diseases, respectively, for more information on strategies to improve primary immunization status in children.

(e) Local access to routine inpatient pediatric care shall be assured by a network of efficient and high-quality regional and community pediatric facilities linked with community providers. Facilities shall comply with Hospital Licensing Standards, N.J.A.C. 8:43G–22. Facility designation shall take place, with the development of pediatric planning rules and in accordance with specific hospital recommendations discussed in N.J.A.C. 8:100–14, Hospital Inpatient Services. The process for developing pediatric planning rules shall consider, but not be limited to, the following criteria for inclusion:

1. The requirement that all hospitals with and without licensed pediatric units, admitting pediatric patients must belong to a maternal and child health consortia and a structure for linkage where issues cross regional boundaries.

2. The configuration of Community Pediatric Centers, Regional Pediatric Centers, and Specialty Acute Care Children's Hospitals and requirements for each as follows:

i. Minimum staffing requirements for all facilities admitting pediatric patients;

ii. Minimum occupancy and average daily census for pediatric units based on facility designation;

iii. Emergency pediatric care including universal adoption of Emergency Department Approved for Pediatrics (EDAP) protocol by all facilities with emergency departments, pediatric training for emergency department staff, triage capabilities, and transport systems;

iv. Geographic accessibility;

v. A description of the relationship between hospitals and the primary care system and the provision of primary and preventive care outpatient services;

vi. Evaluation of the impact on existing residency programs;

vii. Evaluation of the impact on obstetric and newborn services designated to continue;

viii. Inpatient specialty and sub-specialty care by type of designated facility;

ix. Utilization of the National Association for Children's Hospitals and Related Institutions (NACHRI) criteria for determining requirements of Specialty Acute Care Children's Hospitals;

x. The structure of the relationship between all member facilities in a region via letters of agreement and their linkage to a designated Specialty Acute Care Children's Hospital for consultation;

xi. Evaluation of the need for requirements which provide or link to specialized ambulatory care programs which includes, but is not limited to: rehabilitation and communication evaluation and treatment, sickle cell/hemoglobinopathies treatment, hemophilia services, and cleft lip/palate craniofacial anomalies services; and

xii. Evaluation of adolescent health services.

(f) The Department of Health in conjunction with the Dental School (UMDNJ) should assess dental needs Statewide through the use of data gathering such as a study to determine the "decayed, missing, filled and treated" (DMFT) rate.

8:100–4.8 Policy changes/restructuring

(a) The Department of Health shall propose to the Public Health Council to amend Minimum Standards of Performance for Local Boards of Health (N.J.A.C. 8:52) as follows:

1. Special delivery shall reflect a prioritized system of care based on needs assessment, utilization, cost effectiveness, and a total quality improvement program;

2. Service delivery shall be commensurate with the community's needs such as:

i. Local health departments who have defined unmet pediatric primary care needs shall provide a comprehensive preventive health program for infants and preschool children. This shall include an appointment system where an initial appointment shall be no longer than 30 days and for children in areas of high immunization needs identified by the Department of Health shall be scheduled for the appropriate immunization within 14 days;

ii. Local health departments shall facilitate service delivery to women and children through linkages and referrals to primary care providers and WIC agencies;

iii. Local health departments who serve municipalities which exceed key indicators such as infant mortality, adolescent pregnancy, inadequate prenatal care, and poor immunization status shall provide home visits prenatally and postpartally in order to prevent poor birth outcomes and improve the poor parenting skills that can result in abuse and neglect. All nurses making home visits should receive Nursing Child Assessment Training (NCAST);

iv. Local health departments shall facilitate service delivery to high risk pregnant women such as pregnant addicted women, incarcerated women, etc.;

v. Local health departments shall provide for the prevention and control of lead poisoning in young children in accordance with Chapter 13 of the State Sanitary Code (N.J.A.C. 8:51); and

vi. Local health departments shall provide a strong program of health promotion and prevention linked to the primary care system; and

3. Local health departments shall participate as members of the Maternal and Child Health Consortia.

(b) The Department of Health shall ensure that proposed intermunicipal contracts for local health services are in accordance with the Local Health Services Act, N.J.S.A. 26:3A2–1–20. See N.J.A.C. 8:100–2, Prevention, Primary and Ambulatory Care Services, for further information on local health departments.

(c) The Department of Health shall require that WIC agencies, family planning agencies, community health centers, Healthy Mothers/Healthy Babies Coalitions and other community-based providers of prenatal or pediatric services participate on the Maternal and Child Health Consortia.

(d) The Department of Health shall work to eliminate system barriers:

1. Women, Infants and Children (WIC) shall develop a memorandum of agreement with Local Health Development Services to expedite follow-up of pregnant women and children with primary care needs;

2. HealthStart and Maternal and Child Health Services shall streamline the existing reporting requirements including the Maternity Services Summary Data Report (MSSD), which is overly comprehensive and demands much administrative time. To attract more providers, the recertification process should also be streamlined, with a concentration on the quality of care delivered. The requirement for home follow-up of high-risk patients should be enforced by a performance audit during recertification. The HealthStart rule should be evaluated regarding the issue of comprehensive care on the first prenatal visit. Provider staffing standards should be more flexible during the certification process in order to expand the provider base; and

3. The Department of Health should streamline State monitoring procedures to eliminate duplication.

(e) The Department should coordinate with the Department of Education the expansion of the role of school nurses and increase the utilization of mid-level practitioners as important resources of health care for children and adolescents in public schools linked with primary care providers. This can be done through:

1. School-based youth services clinics;

2. Immunization provision on-site;

3. Adolescent health care, including information about reproductive health which may require linkage with local family planning agencies; and

4. Comprehensive follow-up of children deficient in immunizations and Early Prevention, Screening, Detection and Treatment (EPSDT) referrals by linking with local health departments and/or primary care providers.

(f) The Department of Health, in conjunction with the Department of Human Services, should coordinate the administration of health programs at the State level through:

1. The administration of health programs and coordination with other departments to eliminate duplication of services and oversite and barriers to care; for example, by providing on-site Medicaid eligibility determination;

2. Coordination of services serving the same populations in need; for example, providing immunizations for indigent populations that are served by the Department of Human Services at Aid for Dependent Children (AFDC) and Food Stamp offices;

3. Coordination with the Department of Education to further develop educational programs for pregnant adolescents to encourage them to finish school or obtain occupational/vocational training; to encourage them to seek postpartum family planning services; to provide prevention curricula on HIV/AIDS, sexually transmitted diseases, family life education, substance abuse, and injury; and to assess for mental health needs or substance abuse problems; and

4. Coordination with the Department of Education to facilitate comprehensive plans to address educational, emotional, social, and health needs of children with specialized needs.

(g) The Department of Health shall propose a Statewide mass media campaign, including prime time television and radio, to change public perceptions of the importance of early and adequate prenatal care and pediatric well child care and to emphasize the importance of adolescent pregnancy prevention.

(h) The Department of Health shall seek changes in the Federal categorical funding process to promote comprehensive care in accordance with N.J.A.C. 8:100–4.5(b) and to provide services to women beyond reproductive health age.

8:100–4.9 Reimbursement and cost containment

(a) Reimbursement rules (N.J.A.C. 8:31B) shall be revised in order to:

1. Fund Regional Maternal and Child Health Consortia through an inclusion in hospital rates that is based on obstetrical, neonatal and pediatric admissions. The initial estimated total cost annually is $4.4 million. Funding shall be administered by the Department of Health through letters of agreement with each Maternal and Child Health Consortium. Each Consortium will be monitored, evaluated and held accountable to the Department of Health. Regional allocations shall be based on the number of deliveries and other criteria as determined by the Department of Health;

2. Encourage co-management of ambulatory and primary care services between specialists and primary care providers for children with specialized needs;

3. Reimburse inappropriate pediatric primary care delivered in emergency rooms at a reduced rate;

4. Allow for back transport of stabilized high risk neonates from facilities with intensive care capabilities to the community perinatal centers—basic or intermediate; and

5. Deny hospital inpatient reimbursement for perinatal and neonatal care delivered at hospitals not designated to provide that care excluding emergencies beyond stabilization.

(b) The Department of Health shall coordinate activities with the Department of Human Services to:

1. Revise the Medicaid reimbursement system to:

i. Increase the level of Medicaid (including HealthStart) reimbursement for pediatric primary care providers including pediatricians and family practitioners for both well and acute care to at least 80 percent of reasonable cost;

ii. Reimburse mid-level practitioners (nurse practitioners and physicians' assistants) at a rate commensurate with their practice;

iii. Expand cost-based payment for Medicaid and other payers to include free-standing licensed ambulatory care facilities, local health departments, and other free-standing facilities;

iv. Expand HealthStart to include increased reimbursement for acute care pediatric visits;

v. Develop a plan for reimbursing Special Child Health Services (SCHS) case management in order to best utilize Federal and State sources of funds, including Medicaid; and

vi. Expand reimbursement to cover the cost of the multidisciplinary approach and the intensity of primary care required by special needs children.

(c) The Departments of Health, Insurance and Human Services should jointly develop strategies to encourage health insurance companies and plans to cover comprehensive preventive services to women and children including prenatal care, family planning, immunizations, lead screening and preventive dental care and other services such as genetic testing, counseling, and multidisciplinary specialty care.

(d) The Department of Health should eliminate the provision of grant funds to expensive hospital-based primary care services and incorporate such costs into the rates.

(e) Regional perinatal centers should be encouraged to have open staffing arrangements for physicians from community perinatal centers to deliver their high risk patients whenever possible.

(f) The Department of Health should fund programs utilizing minimum performance standards for productivity levels per full-time equivalent (F.T.E.) which will be established for providers in publicly-funded clinics, in accordance with standards established by John Snow, Inc. for the Bureau of Health Care Delivery and Assistance, Department of Health and Human Services (DHHS) incorporated herein by reference. For example:

1. Obstetricians—150 to 225 women/year;

2. Certified nurse midwives—90 to 125 women/year;

3. Family practice physicians—75 to 90 prenatal patients per year; and

4. Pediatricians/family practice physicians—4,500 to 6,000 pediatric encounters per year.

(g) The Department of Health shall seek to enact legislative changes necessary to:

1. Designate a fund for revenue generated by local health departments in the provision of Medicaid services;

2. To amend the Public Health Priority Funding Act, N.J.S.A. 26:2F–6.2, to exempt local health departments from the provision of requiring increasing expenditures in order to qualify for the receipt of Public Priority Funds; and

3. Amend N.J.S.A. 40A:45.2 to exclude increases in local health budgets from the current municipal "cap" of 4.5 percent for priority health services.

(h) Local health departments shall obtain reimbursement from the Department of Education for school health ser-

vices provided in nonpublic schools, in accordance with P.L. 1991, c.226.

(i) The Department of Health shall recommend to the Hospital Rate Setting Commission the utilization of Nursing Incentive Reimbursement Awards (NIRA) to annually fund public health nursing home visiting activities.

(j) The Department of Health should work to initiate legislation requiring home testing for lead by house purchasers. Lead abatement should be funded in environments where children live, using Federal and State housing funds and employing specially trained neighborhood workers.

8:100–4.10 Manpower

(a) Loan-forgiveness programs for primary care physicians and mid-level practitioners should be expanded on condition of Medicaid participation.

(b) The practice of mid-level practitioners (for example, nurse practitioners and physicians' assistants), and the advanced practice of post-graduate trained nurses under the direction of a physician should be authorized through licensure.

(c) The Department of Health should recommend to the Hospital Rate Setting Commission that Nursing Incentive Reimbursement Awards (NIRA) be utilized to encourage nurses to seek expanded practice through nurse practitioner and certified nurse midwifery programs.

(d) Hospitals with primary care residencies should be reimbursed at a higher rate for primary care, and pro-rated based on the actual number of residents within each program.

(e) The Department of Health should collaborate with the Department of Insurance, the Trial Lawyers Association, and the Medical Society of New Jersey to resolve the issues of prohibitive costs of liability insurance and to seek tort reform.

(f) Hospitals should be encouraged to allow family practice physicians and certified nurse midwives to provide prenatal care and deliver their patients, where they have privileges and where the care is appropriate.

(g) Local health departments should be encouraged to seek providership as HealthStart Support Package providers for maternity services to augment private obstetricians who desire to become HealthStart providers.

(h) See also N.J.A.C. 8:100–3, Health Personnel Supply, for more specific recommendations.

8:100–4.11 Total Quality Improvement Program

(a) Consortia and facilities shall develop a total quality improvement program which assures that:

1. Local peer review shall include infant and fetal death review.

2. Facilities shall document that all obstetric providers utilize a comprehensive prenatal risk assessment on all pregnant women.

3. Local audit shall include immunization level analysis in conjunction with local health departments and schools.

4. Monitoring of ambulatory care sensitive admissions shall occur locally by the Maternal and Child Health Consortia and each facility.

SUBCHAPTER 5. INJURIES (RESERVED)

SUBCHAPTER 6. INFECTIOUS DISEASES (RESERVED)

SUBCHAPTER 7. AIDS AND HIV (RESERVED)

SUBCHAPTER 8. ADDICTIONS

8:100–8.1 Purposes

(a) The purposes of this subchapter are to decrease morbidity and mortality due to addictive illnesses by:

1. Preventing the onset of addiction;

2. Screening for addiction;

3. Treating addiction and co-dependence as early as possible in the least costly and least restrictive setting;

4. Providing aftercare and relapse prevention; and

5. Ensuring universal access to care, based on severity of illness.

8:100–8.2 Prevention

(a) The Department of Health shall establish effective prevention programs appropriate to each stage of the life cycle and each aspect of addictive illness using the biopsycho (host) social (environment and agent) model to:

1. Reinforce "light use" norms for alcohol, prescription and over the counter drugs, and gambling;

2. Promote norms of "no use" of tobacco, illicit drugs, and alcohol for persons under age 21 and pregnant women;

3. Support policies to control promotion, limit access and raise prices of alcohol and tobacco; and

4. Increase use of fruits, vegetables and complex carbohydrates, and decrease use of sugar, caffeine, refined carbohydrates, and fats, especially among addicted and co-dependent persons.

(b) The Department of Health in cooperation with the Prevention Committee of the Governor's Council on Alcoholism and Drug Abuse through the Statewide Prevention Affiliate Network shall:

1. Conduct a bi-lingual media campaign to promote education and awareness in the general population, especially targeting vulnerable groups, such as women, youth, minorities, the disabled, and the elderly;

2. Participation in the dissemination of Public Service Announcements prepared by the Partnership for a Drug Free America. Encourage the use of added messages regarding the addictive properties of alcohol and nicotine and discourage their use;

3. Promotion of media campaigns conducted by other groups to address addictive illnesses, for example, the Chamber of Commerce, March of Dimes, United Way, American Cancer Society, the Medical Society of New Jersey; the New Jersey Coalition on Disabilities, Alcoholism and Drug Abuse; the New Jersey State Nurses' Association;

4. Collaboration with the Governor's Council on Alcoholism and Drug Abuse to support media activities on the part of local Community Alliance planning groups, the Statewide Prevention Affiliate Network and in cooperation with County Alcoholism and Drug Abuse Authorities and Local Advisory Boards for Health Planning;

5. Cooperation with the Departments of Education, Human Services, and Labor to establish appropriate prevention initiatives for all addictions for use in schools, workplaces, child care agencies, Headstart, and local human service agencies;

6. Earmarking a percentage of tobacco and alcohol taxes to counter tobacco and alcohol advertising;

7. Targeting families and significant others of addicted persons for receipt of public information;

8. Providing addiction prevention materials, such as videos and brochures, to primary care providers for use in waiting areas, and for in-service training of staff; and

9. In cooperation with the Department of Human Services, expansion of school-based youth service programs, including special education and teen programs, currently dealing with adolescent drug, alcohol and mental health issues to include health education, intervention and care for gambling and food addiction; and

10. In cooperation with the Department of Human Services, engage in planning and program development for improving and expanding services for individuals with mental illness and alcohol and drug addiction.

(c) The Department of Health shall establish a reporting system for prevention activities and relate the conduct of prevention programs to measured changes of health status, opinion and behavior. The Department shall:

1. Convene a work group of individuals knowledgeable about information gathered in New Jersey on addiction prevention. This group should include, but not be limited to, the Department of Human Services Office of the Prevention of Mental Retardation and Developmental Disabilities; the prevention section of the Division of Alcoholism, Drug Abuse and Addiction Services within the Department of Health; the Commission on Smoking or Health; the American Heart Association; Rutgers Center of Alcohol Studies Clearinghouse; the alliance section of the Governor's Council on Alcoholism and Drug Abuse; the New Jersey Coalition on Disabilities, Alcoholism and Drug Abuse; and the Statewide association of the local Councils on Alcoholism and Drug Abuse;

2. Determine uniform taxonomy and identifying missing data elements;

3. Publish an annual report on all prevention activities;

4. Seek and obtain funding from government or private sources, such as the Office of Substance Abuse Prevention of the U.S. Public Health Service, to establish a survey agency to track changes in public opinion about addiction and changes in high risk behavior;

5. Prepare bi-annual reports to the Legislature and the cabinet on the relationship of prevention efforts to high risk behaviors and public opinions and attitudes on addiction;

6. Cooperate with the Governor's Council on Alcoholism and Drug Abuse to review findings and establish policy; and

7. Enhance the quality, consolidate the collection, and analyze the existing sources of patient data regarding drug, alcohol, and nicotine exposed births, drug and alcohol related deaths and emergency room contacts.

(d) The Department of Health shall seek to have enacted the legislative changes necessary to restrict advertising and activities promoting the use of alcohol and tobacco, especially those targeted at women, youth and minorities. The Department shall:

1. Support legislation to limit alcohol and tobacco advertising and promotions, especially in urban areas, on

college campuses, and in State buildings and facilities, including sporting events conducted on State property;

2. Promote advertising which ties sports and physical exercise to non-smoking, non-drinking behaviors;

3. Eliminate the advertising of alcohol and tobacco products on billboards, in transit vehicles and at points of purchase; and

4. Publicize and strengthen clean indoor air laws, and smoke-free workplaces.

(e) The Department of Health, Office of Health Policy and Research, shall assess the positive and negative impact of triplicate prescription statutes, in states such as New York, which have implemented the additional reporting requirement, for effectiveness in decreasing abuse.

(f) The Department of Health shall seek to have enacted the legislative and regulatory changes required to:

1. Revise the age of sale law for tobacco from 18 years to 19 years of age in order to stop sales to high school aged youth;

2. Ban automatic or vending machine sales of tobacco products, single cigarette sales, and self service;

3. Establish a means of local enforcement to ensure that all sales take place only from behind the counter rather than self service;

4. Increase penalties for underage sales. Establish primary enforcement through administrative procedures, such as escalating fines, license suspension, and revocation;

5. Discourage the sale of tobacco in retail pharmacies;

6. License retailers at the local level to sell tobacco products, and establish specific local roles and responsibilities to educate these retailers regarding these rules; and

7. Use licensing fees to fund this program at the local level.

(g) The Department of Health shall initiate and support initiatives which expand the number of sites which are smoke-free, such as:

1. Updating existing legislation providing for clean indoor air and smoke free workplaces and schools to reflect new knowledge of medical harm to persons exposed to smoke in their environment;

2. Amending hospital smoking ban policies to incorporate nicotine dependence treatment by:

i. Working with patients, staff and visitors to assure compliance with the smoking ban by establishing education and enforcement programs; and

ii. Mandating that treatment be available for patients and employees;

3. Providing education to businesses and schools about how to establish smoke free environments and why they are important;

4. Assisting the Department of Education in extending school building smoking bans to include school grounds, both when school is in session and when it is not;

5. Proposing a gubernatorial executive order to ban alcohol and tobacco advertising, promotion, sale and sponsorship on State property;

6. Amending licensing rules N.J.A.C. 8:39, 8:42, 8:42A, 8:42B, 8:43, 8:43A, 8:43F and 8:43H to establish smoke-free environments in all licensed health care facilities by July 20, 1995; and

7. Issuing advisories and providing training to all Department of Health contractors in preparation for becoming smoke-free by July 20, 1995.

(h) The Department of Health shall initiate and support activities directed to sensitizing high risk populations about food addiction, such as amending licensure rules (N.J.A.C. 8:42A, 8:42B, and 8:43A) to promote education about the addictive properties of sugar and caffeine, and to achieve sugar and caffeine free alternatives by July 20, 1994.

(i) The Department of Health shall publish alcohol and drug addiction, nicotine dependence, gambling and food addiction treatment directories in accessible format for disabled persons (that is, Braille, cassette tape). The Department shall:

1. Promote communication and referral among addiction providers through establishment of a newsletter, regional information exchanges, and development of interagency referral agreements;

2. Assist the New Jersey Alcoholism and Other Drugs of Abuse Counselor Certification Board in the development and certification of expertise in food, nicotine, and gambling addictions; and

3. Establish cross-training in addictions for counselors, planners, and managers of addictions programs, using new and established training networks.

8:100–8.3 Uniform addiction screening

(a) The Department of Health shall establish and implement utilization of uniform addiction screening by:

1. Amending the licensing standards at N.J.A.C. 8:42A, 8:42B, 8:43A, and 8:43G to require screening in all licensed health care facilities; and

2. Collaborating with the Departments of Human Services, Education, Labor, Law and Public Safety, Corrections and State agencies serving the disabled population to implement the use of screening in their service settings.

(b) Every appropriate medical contact for health care, illness or injury should result in an objective, non-judgmental screening and, if needed, referral for diagnosis and treatment. The Department of Health shall:

1. Convene a task force to select and field test a screening protocol and measures by January 20, 1993. The task force should include experts in nicotine, alcohol, drugs, gambling and food addiction, co-existing mental disorders, and disabilities;

2. Develop addiction screening curriculum, films, and training for health care professionals within six months of the adoption of the screening instrument;

3. Implement assessment and referral training for employees of all health care institutions and programs within two years of the completion of the training curriculum;

4. Incorporate this screening methodology into ongoing continuing education components at the University of Medicine and Dentistry of New Jersey, the New Jersey Hospital Association, the New Jersey Medical Society, the New Jersey Council on Alcoholism and Drug Abuse, and the Academy of Medicine;

5. Establish a reporting system for aggregate reporting of results of implementation of screening for addictions throughout the health care system;

6. Include an addiction screening as part of the 12–hour evaluation process in Intoxicated Driver Resource Centers. Treatment plans should include attention to other addiction problems;

7. In conjunction with the Division of Mental Health and Hospitals of the department of Human Services, provide training to clinicians in community mental health programs and psychiatric hospitals. Sessions should include information about addictions, as well as training in the use of the standardized addiction screening instrument, and when to refer to addiction evaluation professionals to determine the severity of addiction;

8. Cooperate with the Department of Human Services' Division of Mental Health and Hospitals, and the Governor's Council on Alcoholism and Drug Abuse in the development of a comprehensive assessment tool for determining mentally ill chemical abusers for use by both systems;

9. Train student assistance counselors in grades kindergarten through 12 to recognize the symptoms of all addictions and to intervene and refer for treatment students with addictions including special education students. Training should be supported by policy changes by the Department of Education encouraging the expansion of services to addicted students; and

10. In cooperation with the Department of Labor, Division of Vocational Rehabilitation and the Department of Human Services, Commission for the Blind and Visually Impaired and Division of the Deaf and Hard of Hearing, establish screening for addiction as part of vocational assessment, and establish vocational assessment as part of addiction treatment, as appropriate.

8:100–8.4 Diagnostic criteria and treatment placement

(a) The Department of Health shall establish a review committee to adapt the American Society of Addiction Medicine (ASAM) criteria for use in New Jersey to establish medical necessity for each level of care by January 20, 1993. The review committee shall:

1. Assess the severity level of people identified by screening to be at risk for addiction; this shall be known as the severity of addiction assessment;

2. Determine the appropriate nature and intensity of treatment, based on addiction severity, treatment history, environment, and other patient characteristics;

3. Promote the use of the least costly and least restrictive setting for treatment;

4. Determine the severity level of co-dependence using a standard for prescribing the level and duration of treatment; and

5. Ensure the appropriateness of the addition severity assessment to the needs of persons with disabilities, and persons with co-existing mental disorders.

(b) The Department of Health shall develop curriculum, films, and training on the use of the New Jersey adaptation of the ASAM criteria for patient placement in level of treatment within six months of adoption of the criteria.

(c) The Department of Health shall support the New Jersey Council on Alcohol and Drug Abuse and Rutgers Center on Alcohol Studies and other accredited providers in the implementation of training for credentialled addiction professionals by July 20, 1994.

(d) The Department of Health shall monitor and support the establishment of ongoing in-service training at the University of Medicine and Dentistry of New Jersey, the New Jersey Hospital Association, the Medical Society of New Jersey, Rutgers Center on Alcohol Studies, the New Jersey Council on Alcoholism and Drug Abuse, the Academy of Medicine, the New Jersey State Nurses Association, Trenton State College, and the New Jersey Alcoholism and Other Drugs of Abuse Certification Board.

(e) The Department of Health shall prepare a uniform client record to be used in health care settings for screening and placement at six month intervals for two years from point of assessment as described in the case management process contained in N.J.A.C. 8:100–8.6(a)3.

8:100–8.5 Establish appropriate levels of care

(a) The Department of Health shall designate a working group to review the ASAM levels of care and revise them to

establish a comprehensive system reflecting primary New Jersey addiction treatment modalities.

(b) The Department of Health shall revise licensure standards and reimbursement rules (N.J.A.C. 8:42A, 8:42B, 8:43A and 8:31C) to:

1. Classify licensed alcohol and drug treatment programs into a single continuum of care, to include unlicensed out-patient and halfway house addiction treatment programs;

2. Define a comprehensive addictions treatment system which has varying levels of intensity of care;

3. Promote the development of program components specific to the type and degree of addiction and co-dependence;

4. Recommend changes consistent with New Jersey patient placement criteria by January 20, 1993;

5. Set rates for residential drug treatment and alcohol halfway house treatment programs within one year of adoption of the patient placement criteria;

6. Set rates for outpatient treatment within two years of adoption of the patient placement criteria;

7. Monitor compliance of licensed facilities with the Americans with Disabilities Act of 1990 (P.L. 101–336, 42 U.S.C. 794), Section 504 of the Rehabilitation Act of 1973 (P.L. 93–112, 29 U.S.C. 794) and its amendments, and Title X:5–1, N.J.S.A. 10:2–1 et seq.; and

8. Review unlicensed treatment programs to determine whether a licensing or certification process is appropriate to establish a standard of care.

(c) The Department of Health shall authorize the issuance of certificates of need for addiction services as described in the addictions chapter of the State Health Plan in accordance with N.J.A.C. 8:33. New certificate of need applications will be accepted for treatment programs targeted at adolescents, and pregnant women.

(d) The Department of Health shall revise licensure standards (N.J.A.C. 8:43G) to require that hospital based addiction services be staffed by a physician who is certified in Addiction Medicine by the American Society of Addiction Medicine (ASAM) (or who has a Certificate of Added Qualifications in Addiction Psychiatry from the American Board of Psychiatry and Neurology), by July 20, 1996.

(e) In cooperation with the Local Advisory Boards, the Department of Health shall designate, in each region, a Comprehensive Addiction Care Center to serve as a model for hospital based addiction prevention, intervention, and treatment, by July 20, 1994.

(f) The Department of Health, in cooperation with the Department of Human Services, shall develop a bed need methodology for detoxification/rehabilitation units developed in conjunction with designated mental health screening centers by July 20, 1993.

8:100–8.6 Match patients with appropriate levels of care

(a) Based on the results of the standardized diagnostic criteria including the severity of addiction assessment established in N.J.A.C. 8:100–8.4(a), the Department of Health shall:

1. Determine appropriate treatment placement or level of care needed;

2. Structure a reimbursement system that is contingent upon appropriate patient placement;

3. Establish a case-management process to ensure follow-through with the prescribed treatment plan and the reporting of treatment outcomes at six month intervals for two years with at least once annual in person contact; and

4. Develop methods to assist patients to make informed choices about service settings offering the level of care needed, according to the severity of addiction assessment, and take into consideration degree of impairment when eliciting participation in treatment choices.

8:100–8.7 Expand outpatient treatment capacity

The Department of Health shall ensure universal access to less costly outpatient treatment by expanding outpatient treatment capacity, and develop a financing mechanism to guarantee access to the uninsured as described in N.J.A.C. 8:100–8.9.

8:100–8.8 Aftercare and relapse prevention

(a) The Department of Health shall amend licensing standards N.J.A.C. 8:42A, 8:42B, 8:43A, and 8:43G to provide that treatment facilities shall:

1. Utilize a uniform client record;

2. Perform a follow-up assessment using the uniform client record every six months for two years from assessment of addiction severity;

3. Promote the use of self-help programs for aftercare and relapse prevention; and

4. Submit data contained on the uniform client record to the Department of Health upon request.

8:100–8.9 Cost containment

(a) The Department of Health shall emphasize screening activities, outpatient expansion, and care for the uninsured to reduce the high costs associated with inpatient care by:

1. Structuring a reimbursement system that is contingent upon appropriate patient placement;

2. Appointing an implementation task force to review means of paying for universal access to addiction treatment based on severity of illness rather than insurance coverage;

3. Encouraging hospitals to develop lower cost effective addiction treatment programs;

4. Establishing a methodology for assuring addiction screening and assessment for all patients in addiction caused or exacerbated diagnostic-related categories in health care facilities and programs;

5. Establishing interagency referral agreements with facilities providing each of the levels of care for addiction; and

6. Encouraging drug and alcohol testing only as an adjunct to a comprehensive addiction screening and assessment.

(b) The Department of Health shall seek to have enacted legislative changes necessary to set aside funds from the New Jersey Health Care Trust Fund (N.J.A.C. 8:31B–4) to support screening and assessment for addiction in earlier stages of illness, and to demonstrate the efficacy and cost savings of these initiatives.

8:100–8.10 Administration

(a) The Department of Health shall promote the siting of new addictions programs by supporting legislation that would pre-empt local zoning ordinances in favor of establishing a Statewide master plan for locating facilities.

(b) The Department of Health shall seek to have enacted legislation to substantially increase alcoholic beverage and tobacco taxes, based on a percentage of price, which would earmark the proceeds for addiction prevention and treatment and establish a trust fund to pay for access to treatment for addicted persons and their family members.

(c) The Department of Health shall collaborate with the Department of Insurance to promote payment by all payers, including HMOs and PPOs, for all addiction screening and treatment based on severity of illness.

(d) The Department of Health shall develop reliable prevalence estimates for every addiction, which include adjustments for special populations and geographic variations. These estimates should include comorbidity with other addictions because of the high rates of cross-prevalence of each addiction with the other addictions.

(e) The Department of Health shall amend the rules governing the certificate of need process (N.J.A.C. 8:33 and 8:33K) to:

1. Establish a structure and process that ensures an accurate count of all addiction services provided by county and health planning region; and

2. Authorize the Local Advisory Committees on Alcoholism and Drug Abuse (LACADAs) to assist the Local Advisory Boards in their review of Certificate of Need applications for addiction services from their county.

(f) The Professional Advisory Committee of the Division of Alcoholism, Drug Abuse and Addiction Services and the Governor's Council on Alcoholism and Drug Abuse shall review planning and funding processes to assure consistency between municipal alliance plans, county alcoholism and drug abuse plans, LAB addiction services plans and the State Health Plan as funding determinations are made.

(g) Funding announcements, calls for demonstration projects, training opportunities and other communications from the Department will be disseminated through LABs, LACADAs and municipal alliances when timeframes and statutory authority allow.

(h) The Department of Health shall seek to have legislation enacted to collect fines imposed by the courts upon admitted compulsive gamblers, bookmakers and others involved in illegal gambling activities. These funds should be placed in a fund to finance treatment and intervention activities for gamblers in the same way Drug Enforcement Demand Reduction (DEDR) money is used to fund drug abuse prevention programs.

(i) The Department shall amend licensing rules (N.J.A.C. 8:42A, 8:42B, and 8:43A) to encourage revision of by-laws and admissions policies of drug and alcohol treatment centers to allow admission and treatment of compulsive gamblers, nicotine dependent and food addicted persons, and to assure that staff have received specialized training and patients are placed according to severity of addiction.

(j) The Department of Health shall cooperate with the Department of Community Affairs and the Department of Human Services to develop outreach programs for senior citizens with addiction problems. Few senior citizens currently enter treatment, but they account for a sizable portion of casino business. Senior citizens are not often involved with the criminal justice or other systems which frequently result in referrals of younger persons. Programs should be conducted through senior citizens' centers and health care agencies in conjunction with the county Offices on Aging.

(k) The Department of Health shall collaborate with other states which have initiated comprehensive addictions programs. Research findings, new treatment approaches, and prevention strategies should be shared. A combined effort should be made to encourage national planning and funding for these activities.

(*l*) In cooperation with the Department of Health, the Department of Human Services shall expand Medicaid coverage for addiction treatment services for pregnant addicted women, by January 20, 1993.

(m) The Department of Health, Office of Health Policy and Research, shall investigate and report on the advisability of amending rules for government contractors, to require hiring an established percentage of recovering addicted persons as a condition of receipt of contract.

(n) The Department of Health shall collaborate with the Departments of Community Affairs, Labor, and Human Services to increase outreach to disabled persons who are at higher risk of addiction than non-disabled persons, yet are underrepresented in treatment programs.

SUBCHAPTER 9. CARDIOVASCULAR DISEASE (CVD) SERVICES

8:100–9.1 Prevention of Smoking Initiation and Treatment for Nicotine Dependence Policies

(a) Smoking prevention activities and strategies shall be promoted actively by the Department of Health throughout New Jersey. These strategies shall include:

1. Countering the effects of cigarette advertising and promotion by providing public service announcements (PSAs) on the harmful effects of smoking and on the benefits of quitting smoking at any age;

2. Promoting prevention of initiation of smoking programs at the grade-school level by including instruction in the health education curriculum; and

3. Reducing access to tobacco by increasing the cost of cigarettes through an increase in the cigarette tax, with proceeds earmarked for nicotine dependence treatment and education activities, restricting the sale of tobacco to minors, and providing the necessary enforcement of access laws. The Department of Health shall convene a task force comprised of individuals from educational, business, and law enforcement sectors to develop fair, effective methods of enforcing the laws currently in effect.

(b) Nicotine dependence treatment activities and strategies shall be promoted actively by the Department of Health throughout New Jersey. In recognition that cigarette smoking, one of the most preventable causes of cardiovascular disease, is highly addictive, the policy recommendations directed at eliminating tobacco dependence are fully supported. Additional nicotine dependence treatment strategies include:

1. Increasing support for nonsmokers' rights by stiffening clean indoor air regulations and encouraging smoke-free environments through tax breaks to smoke-free employers who provide smoking cessation programs for employees, and providing the necessary enforcement of clean indoor air laws. The Department of Health shall convene a task force comprised of individuals from educational, business, and law enforcement sectors to develop fair, effective methods of enforcing the laws currently in effect;

2. Encouraging a "smoke free" New Jersey by increasing the availability of nicotine dependence treatment programs by providing insurance coverage for tobacco addiction treatment programs, and encouraging innovative programs targeted to high-risk populations such as pregnant women, minorities, and chemical industrial workers; and

3. Providing economic incentives such as decreased health and life insurance premiums to nonsmokers.

8:100–9.2 Cardiovascular Health Promotion Policy

(a) Cardiovascular health for all New Jersey communities and citizens shall be promoted through the promulgation of public policy by the Department of Health that supports healthy behaviors, creates supportive environments, and empowers individuals to maintain healthy choices in daily living. Specifically, the Department of Health shall:

1. Establish and maintain a Cardiovascular Health Promotion Disease Prevention Subcommittee as an advisory body to the Commissioner of Health through the Commissioner's Cardiac Services Committee, to serve as the mechanism for providing health promotion and disease prevention planning, implementation and evaluation;

2. Collaborate with the Department of Education to encourage the New Jersey school system to implement policies that integrate cardiovascular health education as part of the health curriculum in grades kindergarten through 12;

3. Collaborate with the Department of Agriculture to implement policies which support the integration of nutrition incentives within cardiovascular health promotion programs;

4. Collaborate with the Department of Environmental Protection and Energy, Division of Parks and Forestry, and the New Jersey Recreation and Parks Association to provide and maintain adequate, safe and accessible facilities for physical activity;

5. Collaborate with the Department of Labor to implement policies supporting cardiovascular health promotion and education in all worksites with 50 or more employees;

6. Coordinate within the appropriate divisions of the Department of Health to implement policies promoting cardiovascular health promotion and disease prevention programs in health care facilities and health departments;

7. Provide for technical assistance encouraging community organizations to carry out health promotion programs which create an environment which supports cardiovascular health;

8. Provide for, coordinate and enhance data sources to monitor the health behaviors and cardiovascular risk factors of New Jersey communities and citizens;

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.

Case Notes

Amendment to Health Care Facilities Planning Act prohibited only immediate and direct implementation of specific health planning decisions set forth in plan. Monmouth Medical Center v. State Dept. of Health, 272 N.J.Super. 297, 639 A.2d 1129 (A.D.1994), certification denied 137 N.J. 310, 645 A.2d 138.

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.

Case Notes

Under Health Care Cost Reduction Act, authority delegated to Department of Health (DOH) to adopt nonconflicting regulations, and permission to consider State Health Plan constituted sufficient safeguards to satisfy due process, certificate of need applications. Matter of Adoption of Regulations Governing State Health Plan, N.J.A.C. 8:100, 135 N.J. 24, 637 A.2d 1246 (1994).

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.

8:100–14.5 Prioritization of hospital capital expenditure limits

(a) Priority will be assigned to a Certificate of Need proposing a capital expenditure where the following factors are demonstrated within the application:

1. Community Need: A hospital will be deemed to have exhibited priority community need when it has the following characteristics:

i. Occupancy in excess of 90 percent in all services during the last calendar year preceding the application. Services that are proposed in the application to be closed may be excepted;

ii. The county in which the hospital is located has been determined to have a bed need; and

iii. The county's and hospital's rates of inpatient admission and length of stay have been demonstrated to be appropriate and not likely to decline as a result of changing medical practice or reimbursement policy;

2. Project Need:

i. The project is substantially directed to correcting Life Safety Code A or B level deficiencies, or other conditions posing imminent peril to health and safety of patients and staff; and

ii. The hospital has not implemented a major modernization or construction program in the affected areas of the project for a period in excess of 10 years. In addition, the overall average age of the physical plant exceeds 10 years based on the Department's calculations using generally accepted accounting principles; and

3. Project Goals: The certificate of need application has been submitted in order to address a priority or a specific recommendation that is identified in the State Health Plan, and is determined by the Department to be essential to achieving that goal. These in specific include hospital closure or merger applications that demonstrate significant cost savings to the health care system, or projects implementing ambulatory care initiatives that improve health care delivery patterns and reduce system expenditures.

(b) Projects shall demonstrate at least one of the prioritization criteria in (a) above. The strength of the demonstration and the number of prioritization factors demonstrated will be considered in the ranking of the projects. The projects will also be prioritized for affordability. Indicators of affordability are the total project cost, cost per adjusted admission, and the institution's ability to obtain low cost financing.

8:100–14.6 Nondiscrimination

All patients must have equal access to treatment for all services available in the hospital system. Any hospital which has been found to violate State or Federal laws prohibiting discrimination on the basis of race, age, religion, national origin, sex, sexual preference, handicap, ability to pay, or diagnosis (including AIDS), is not eligible for submission of a certificate of need for new or expanded services until such discrimination is remedied.

8:100–14.7 Criteria for assessing need for a hospital

(a) A hospital shall demonstrate that it will be efficiently operated. If the hospital has less than 200 beds and overall occupancy below 75 percent, need for continued operation shall be based on area need and/or geographic isolation.

(b) A hospital shall demonstrate overall financial viability based on standard measures of profitability, liquidity and debt structure.

(c) The need for capital investment shall be demonstrated by an assessment of the relative age and condition of a hospital's physical plant, which shall indicate that it has maintained a safe and efficient environment for delivering patient care services.

(d) A hospital shall demonstrate community need.

1. Community need may be demonstrated by the special consideration of unique service provision to a geographically isolated region, to a medically indigent population, or to persons with diseases or disabilities that may engender personal, institutional or political discrimination (for example, AIDS), as defined below:

i. Geographic isolation as used in this rule refers to the lack of an alternative hospital within 15 miles where at least 40 percent of service area residents use the hospital.

ii. Unique service provision to a medically indigent population can be demonstrated if the hospital provides services to a significant medically indigent population and there are no alternative providers.

iii. Unique service provision to a disproportionate share of persons with diseases or disabilities that may engender personal, institutional or political discrimination (for example, AIDS) can be demonstrated if a hospital serves as a clinical resource center for such patients and provides a significant level of services to these individuals in its service area.

2. Community need may be demonstrated by hospitals providing a needed regionalized tertiary care service. Regionalized tertiary care services include: cardiac surgery (adult and pediatric), trauma, organ transplant and neonatal intensive care.

3. The quality of care provided by a hospital will be considered in assessing community need. Priority will not be given to those facilities which exhibit significant levels of licensure deficiencies, penalty actions, validated consumer complaints, and adverse patient outcomes.

(e) If a hospital has demonstrated high community need, then its projects addressing any obsolete or unsound physical plant will receive priority attention.

8:100–14.8 Limitations on hospitals and areas with excess bed capacity

(a) A hospital recommended for transition from acute care services is not eligible to submit any certificate of need applications except for projects associated with its transition from acute care or projects essential to the safety of patients in accordance with the rules of the Department. Payment for capital expenditures for renovation of physical plant areas not requiring certificate of need approval will be limited. Alternative actions may be taken to effect this recommendation including a merger or consolidation resulting in an equivalent reduction in acute care beds.

(b) If a county's excess bed capacity for 1995, projected in accordance with the methodologies approved by the State Health Planning Board, exceeds the number of beds in any hospital in the county, the LAB in which that county is located shall develop a plan for bed reduction. A LAB plan shall also be developed for counties identified in N.J.A.C. 8:100–14.13 in which significant downsizing may be needed. The plan shall be approved by the State Health Planning Board and the Department before any certificate of need applications for major renovation or construction projects (in excess of $10 million) will be accepted from hospitals in the county. The Department may require initial implementation of the plan before accepting certificates of need from hospitals in the county. Exceptions may be granted by the Commissioner for projects that address physical plant conditions demonstrated to have a significant negative impact on patient care outcomes, or for areas in which the excess is addressed by this plan through a recommendation for a hospital to transition from acute care.

(c) The Department of Health will not recommend any special rate adjustment for a hospital which has been designated for phase out of all acute care inpatient services or closure of pediatric or obstetrical services, until such a plan has been approved by the hospital's board of trustees and appropriate regulatory agencies.

(d) The Department of Health may initiate a full rate review under N.J.A.C. 8:31B–3.52 for a hospital which has been recommended for phase out of all acute care services in the following circumstances:

1. Patient volume falls below an average daily census of 50, or to a level which the Department determines will result in adverse patient care outcomes or risk to patient safety; or

2. The hospital is financially insolvent.

Amended by R.1992 d.451, effective November 16, 1992.
See: 24 N.J.R. 2704(a), 24 N.J.R. 4262(b).
Rate review may be initiated in the case of either: (d)1 or (d)2.

8:100–14.9 Obstetric and pediatric services—Maternal and Child Health Consortia

(a) The Department of Health shall designate a network of regional Maternal and Child Health Consortia as specified in N.J.A.C. 8:100–4.3(a) and (c).

(b) Until such time that the Maternal and Child Health Consortia are designated and operational in a region, the Department will not accept certificate of need applications from hospitals requesting changes in their OB/GYN or pediatric bed complement. Exceptions may be granted by the Commissioner only where the applicant and LAB can document that serious access or quality problems will occur absent such certificate of need consideration.

(c) The Department of Health, the State Health Planning Board, and the Local Advisory Board shall utilize the criteria in N.J.A.C. 8:100–4.3 through 4.7 and N.J.A.C. 8:33 in reviewing certificate of need applications affecting an applicant's inpatient OB/GYN or pediatric service.

(d) Pediatric planning rules shall be proposed by the Commissioner with the advice of the pediatric clinical advisory committee as specified in N.J.A.C. 8:100–4.2, 4.3 and 4.7. The Maternal and Child Health Consortia shall submit certificate of need applications for pediatric designation status in accordance with the pediatric planning rules and N.J.A.C. 8:33. Certificate of need applications requesting designation status will be approved by the Commissioner based upon the State Health Plan and the adopted pediatric planning rules. Only hospitals that are appropriately designated through the pediatric designation process shall provide licensed pediatric beds. All hospitals that admit pediatric patients shall participate in the Maternal and Child Health Consortia.

8:100–14.10 Specialty acute care children's hospitals

(a) The two designated specialty acute care children's hospitals, at United Hospitals/University Hospital in Newark, and Cooper Medical Center in Camden, shall develop plans to become operational in accordance with the requirements listed in (c) through (f) below.

(b) The Department shall evaluate the need for the development of a third specialty acute care children's hospital, either as a joint program between Robert Wood Johnson Medical Center and St. Peter's Medical Center in New Brunswick or elsewhere in the State.

(c) All specialty acute care children's hospitals shall provide the following bed complement:

1. A minimum of 75 licensed pediatric beds which shall:

i. Operate at 75 percent occupancy within five years of designation; and

ii. Meet all licensing standards for inpatient pediatric beds at N.J.A.C. 8:43G.

2. A minimum of 12 pediatric intensive care unit (PICU) beds which shall:

i. Operate at 75 percent occupancy within two years of designation;

ii. Have a minimum of 1,000 annual admissions within two years of designation;

iii. Exist as a separate, identifiable unit; and

iv. Meet all licensing standards for PICU at N.J.A.C. 8:43G.

3. Neonatal intensive care bassinets with a regional perinatal center or community perinatal center-intensive designation and demonstrated compliance with applicable perinatal rules.

(d) All specialty acute care children's hospitals shall have at a minimum the following educational components:

1. A pediatric residency program with a full time program director, accredited and affiliated with a university medical school;

2. Research capability and programs;

3. The ability to serve as the core of a regional network to provide and advise on the provision of all clinical pediatric care;

4. The ability to serve as a Statewide pediatric education resource center for both health care professionals and the public; and

(e) Within one year of adoption of the pediatric planning rules as described in N.J.A.C. 8:100–14.9(d), all specialty acute care children's hospitals shall provide at a minimum the following services:

1. Pediatric inpatient services;

2. A pediatric trauma and prehospital care program;

3. Specialized ambulatory care programs; and

4. Accessible primary and preventive care.

(f) All specialty acute care children's hospitals shall have written affiliation, transfer, referral and consulting agreements with facilities meeting the requirements of a regional pediatric center.

(g) Until certificate of need applications are requested by the Commissioner in accordance with N.J.A.C. 8:33, no hospital may initiate the following pediatric subspecialty services:

1. Major chest surgery, including pediatric cardiac surgery;

2. Pediatric neurosurgery;

3. Pediatric solid organ transplants; and

4. Pediatric burn care.

8:100–14.11 Regional pediatric centers

(a) The Commissioner shall designate regional pediatric centers in accordance with the pediatric designation process at N.J.A.C. 8:100–14.9(d).

(b) An applicant for designation as a regional pediatric center shall provide the following bed complement:

1. A minimum of 30 licensed pediatric beds which shall:

i. Operate at 75 percent occupancy within two years of designation;

ii. Have a minimum of 1,500 annual admissions within two years of designation; and

iii. Meet all licensing standards for inpatient pediatric beds at N.J.A.C. 8:43G.

2. A minimum of six PICU beds which shall:

i. Operate at 75 percent occupancy within two years of designation;

ii. Exist as a separate, identifiable unit; and

iii. Meet all licensing standards for PICU at N.J.A.C. 8:43G.

3. Neonatal intensive care services with a regional perinatal center or community perinatal center-intensive designation and demonstrated compliance with applicable perinatal rules.

(c) An applicant for designation as a regional pediatric center shall have a pediatric residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME).

(d) In accordance with the pediatric planning rules as described in N.J.A.C. 8:100–14.9(d), an applicant for designation as a regional pediatric center shall provide at a minimum the following services:

1. Pediatric inpatient services, in accordance with regional services plan approved by the Maternal and Child Health Consortia;

2. A pediatric trauma and prehospital care program;

3. Specialized ambulatory care programs; and

4. Accessible primary and preventive care.

(e) An applicant for designation as a regional pediatric center shall have written affiliation, transfer, referral and consulting agreements with facilities meeting the requirements of a specialty acute care children's hospital and community pediatric centers.

8:100–14.12 Community pediatric centers

(a) The Commissioner shall designate community pediatric centers in accordance with the pediatric designation process at N.J.A.C. 8:100–14.9(d).

(b) An applicant for designation as a community pediatric center shall provide the following bed complement:

1. A minimum of 20 licensed pediatric beds which shall operate at 75 percent occupancy within two years of designation and meet all licensing standards for inpatient pediatric beds at N.J.A.C. 8:43G. This may be waived for existing facilities determined by the Department to be geographically isolated, offering care to historically underserved populations, or demonstrating unique community need.

2. A unit of less than 20 beds as identified in (b)1 above, which shall operate at 60 percent occupancy within two years of designation and meet all licensing standards for inpatient pediatric beds at N.J.A.C. 8:43G.

(c) An applicant for designation as a community pediatric center shall provide accessible primary and preventive care services.

(d) An applicant for designation as a community pediatric center shall have written affiliation, transfer, referral and consulting agreements with facilities meeting the requirements of regional pediatric centers and/or specialty acute care children's hospitals.

8:100–14.13 Specific recommendations

(a) While providing appropriate care, all hospitals shall take steps to achieve target occupancy levels identified in N.J.A.C. 8:100–14.2.

(b) Based upon the criteria contained in N.J.A.C. 8:100–4 and N.J.A.C. 8:100–14.3, 14.5, 14.7 and 14.8, certificate of need applications shall be consistent with the following list of responsibilities and provisions:

1. Local Advisory Board I shall submit to the State Health Planning Board and the Department of Health: a M/S bed need study for each county, an OB/GYN bed need study for Warren County which addresses consolidation of programs at one site, and a pediatric bed need study for Morris County and the city of Passaic. The LAB shall also submit a bed need study that addresses the conversion of St. Mary's and the need to continue the psychiatric inpatient programs currently provided at St. Mary's. The specific responsibilities of the hospitals in LAB I are listed by county as follows:

i. Morris County:

(1) All Morris County Hospitals shall participate in a LAB pediatric bed need study to determine where licensed pediatric bed reductions are warranted, and which hospital may apply for designation as a community pediatric center to best serve the inpatient needs of the children in the area.

(2) Chilton Memorial Hospital shall participate in a LAB M/S bed need study to determine whether licensed M/S bed reductions are warranted.

(3) Dover General Hospital shall reduce its number of licensed OB/GYN beds and shall participate in a LAB M/S bed study to determine whether licensed M/S bed reductions are warranted.

(4) Morristown Memorial Hospital may apply for designation as a joint regional pediatric center with Overlook Hospital in Union County.

ii. Passaic County:

(1) All hospitals located in the City of Passaic shall participate in a LAB pediatric bed need study to determine which unit may remain and apply for designation as a community pediatric center to best serve the inpatient needs of children in the area.

(2) Barnert Memorial Hospital may apply for designation as a community pediatric center.

(3) St. Joseph's Hospital may apply for designation as a regional pediatric center.

(4) St. Mary's Hospital should transition from inpatient acute care services by 1995.

(5) Wayne General Hospital shall eliminate its licensed OB/GYN unit or reduce its number of licensed OB/GYN beds.

iii. Sussex County:

(1) In addition to meeting the requirements of N.J.A.C. 8:100–14.8(b), the LAB area bed need study shall be approved by the State Health Planning Board and the Department of Health, before certificate of need applications related to inpatient acute care services may be submitted by Newton Memorial Hospital or Wallkill Valley Hospital. An exception may be made if the Department determines that a serious quality of care issue exists which requires immediate attention.

(2) Newton Memorial Hospital shall participate in the LAB M/S bed need study to determine whether M/S bed reductions are warranted. It may apply for designation as a community pediatric center.

(3) Wallkill Valley Hospital and Health Centers shall participate in the LAB M/S bed need study to determine whether M/S bed reductions are warranted.

iv. Warren County:

(1) In addition to meeting the requirements of N.J.A.C. 8:100–14.8(b), the LAB area bed need study shall be approved by the State Health Planning Board and the Department of Health, before certificate of need applications related to inpatient acute care services may be submitted by Hackettstown Community Hospital or Warren Hospital. An exception may be made if the Department determines a serious quality of care issue exists which requires immediate attention.

(2) Hackettstown Community Hospital shall participate in the LAB OB/GYN bed need study.

(3) Warren Hospital shall participate in the LAB OB/GYN bed need study. It may apply for designation as a community pediatric center.

2. Local Advisory Board II shall submit to the State Health Planning Board and the Department of Health a M/S bed need study that addresses the feasibility of maintaining M/S beds at Bergen Pines County Hospital. The specific responsibilities of the hospitals in LAB II are listed by county as follows:

i Bergen County:

(1) Bergen Pines County Hospital shall participate in a LAB study to determine if inpatient M/S services should remain at this facility.

(2) Engelwood Hospital may apply for designation as a community pediatric center.

(3) Hackensack Medical Center may apply for designation as a regional pediatric center.

(4) Holy Name Hospital may apply for designation as a community pediatric center.

(5) Saddle Brook Hospital should transition from inpatient acute care services by 1995.

(6) Pascack Valley Hospital shall reduce its number of licensed pediatric beds to 14 and may apply for designation as a community pediatric center, following the bed reduction.

(7) Valley Hospital may apply for designation as a community pediatric center.

ii. Hudson County:

(1) Bayonne Hospital shall eliminate its licensed OB/GYN unit or reduce its number of licensed OB/GYN beds. It may apply for designation as a community pediatric center.

(2) Christ Hospital may apply for designation as a community pediatric center.

(3) Greenville Hospital should transition from inpatient acute care services as Jersey City Medical Center implement its certificate of need for a replacement facility.

(4) Jersey City Medical Center may apply for designation as a regional pediatric center.

(5) Meadowlands Hospital Medical Center shall eliminate its licensed pediatric unit or consolidate its licensed pediatric beds at one site with an area hospital. Any consolidation shall include a reduction in the total number of licensed pediatric beds. If pediatric services are consolidated at Meadowlands, it may apply for designation as a community pediatric center following the pediatric bed consolidation. Also, it may apply for an OB/GYN licensed bed increase if occupancy meets the requirements in N.J.A.C. 8:43I.

(6) St. Francis Hospital shall consolidate its licensed pediatric beds at one site with St. Mary Hospital. The consolidation shall include a reduction in the total number of licensed pediatric beds. St. Francis Hospital or St. Mary Hospital may apply for designation as a community pediatric center at the single site, following the pediatric bed consolidation.

(7) St. Mary Hospital shall eliminate its licensed OB/GYN unit or reduce its number of OB/GYN beds. St. Mary shall consolidate its licensed pediatric beds at one site with St. Francis Hospital. The consolidation shall include a reduction in the total number of licensed pediatric beds, St. Mary Hospital or St. Francis Hospital may apply for designation as a community pediatric center at the single site, following the pediatric bed consolidation.

3. Local Advisory Board III shall submit to the State Health Planning Board and the Department of Health M/S bed need studies for Essex and Union Counties. The specific responsibilities of the hospitals in LAB III are listed by county as follows:

i. Essex County:

(1) Clara Maass Medical Center shall reduce its number of licensed pediatric beds or consolidate its pediatric service with an area hospital. Any consolidation shall include a reduction in the total number of licensed pediatric beds. If pediatric beds are maintained at Clara Maass, Clara Maass may apply for designation as a community pediatric center, following the pediatric bed reduction or consolidation. Clara Maass Medical Center shall participate in a LAB bed need study to determine if further acute care bed reductions are warranted.

(2) Columbus Hospital may apply for designation as a community pediatric center.

(3) Hospital Center at Orange may apply for designation as a community pediatric center.

(4) Irvington General Hospital and Newark Beth Israel Medical Center shall work with the LAB to

further consolidate and efficiently distribute acute care services between the two facilities.

(5) Montclair Community Hospital should continue discussions with area hospitals concerning joint programs and provide a written report to the LAB, the State Health Planning Board and the Department of Health by January 20, 1993.

(6) Mountainside Hospital shall eliminate its licensed pediatric unit and work with the LAB and the Department to ensure the hospital maintains adequate M/S capacity.

(7) Newark Beth Israel Medical Center may apply for a licensed OB/GYN bed increase if occupancy meets the requirements in N.J.A.C. 8:43I. Also, it may apply for designation as a regional pediatric center.

(8) St. Barnabas Medical Center may apply for a licensed OB/GYN bed increase if occupancy meets the requirements in N.J.A.C. 8:43I. Also, it may apply for designation as a regional pediatric center.

(9) St. James Hospital and St. Michael's Medical Center shall consolidate OB/GYN services at one site and shall participate in a LAB study to determine if other service consolidations are warranted.

(10) St. James Hospital may apply for designation as a community pediatric center.

(11) St. Michael's Medical Center may apply for designation as a community pediatric center.

(12) United Hospitals Medical Center, which has been designated as a specialty acute care children's hospital, shall participate in a LAB study to determine its future role in providing adult acute care services. It shall implement its approved certificate of need for a specialty acute care children's hospital.

ii. Union County:

(1) Elizabeth General Medical Center shall reduce its number of licensed OB/GYN beds. It may apply for designation as a community pediatric center.

(2) Muhlenberg Regional Medical Center shall participate in a LAB study to determine if M/S bed reductions are warranted. It may apply for designation as a community pediatric center.

(3) Overlook Hospital may apply for designation as a joint regional pediatric center with Morristown Memorial in Morris County.

(4) Rahway Hospital shall reduce its number of licensed OB/GYN beds. Rahway Hospital shall reduce its number of licensed pediatric beds to 17 and may apply for designation as a community pediatric center, following the pediatric bed reduction.

(5) St. Elizabeth's Medical Center shall reduce its number of licensed OB/GYN beds.

4. Local Advisory Board IV shall submit to the State Health Planning Board and the Department of Health M/S bed need studies for Mercer and Middlesex Counties. The LAB shall develop a strategy for acute care bed reductions in Mercer County including consideration of converting one existing facility to another needed service. The LAB shall submit a study recommending a plan to consolidate to one site pediatric and OB/GYN services at Helene Fuld Medical Center and St. Francis Medical Center. Also, it shall submit a study of Raritan Bay Medical Center and South Amboy Memorial Hospital to determine the appropriateness and feasibility of joint ventures, particularly to retain South Amboy's inpatient psychiatric programs in the county as South Amboy transitions from general acute care services. The specific responsibilities of the hospitals in LAB IV are listed by county as follows:

i. Hunterdon County:

(1) Hunterdon Medical Center may apply for designation as a community pediatric center.

ii. Mercer County:

(1) All Mercer County hospitals shall participate in the LAB M/S bed need study.

(2) In addition to meeting the requirements of N.J.A.C. 8:100–14.8(b), the LAB area bed need study shall be approved by the State Health Planning Board and the Department of Health, before certificate of need applications related to inpatient acute care services may be submitted by any hospital in the county. An exception may be made if the Department determines that a serious quality of care issue exists which requires immediate attention.

(3) Helene Fuld Medical Center shall participate in the LAB pediatric and OB/GYN bed need study to determine if it should eliminate its units, reduce the number of licensed beds or consolidate pediatric and OB/GYN services at one site with St. Francis Medical Center. Any consolidation shall include a reduction in the total number of licensed pediatric and OB/GYN beds. If pediatric services are consolidated at Helene Fuld, Helene Fuld may apply for designation as a community pediatric center following the pediatric bed consolidation.

(4) St. Francis Medical Center shall participate in the LAB pediatric and OB/GYN bed need study to determine if it should eliminate its units, reduce the number of licensed beds or consolidate pediatric and OB/GYN services at one site with Helene Fuld Medical Center. Any consolidation shall include a reduction in the total number of licensed pediatric and OB/GYN beds. If pediatric services are consolidated at St. Francis, St. Francis may apply for designation as a community pediatric center following the bed consolidation.

(5) Mercer Medical Center may apply for designation as a regional pediatric center.

(6) The Medical Center at Princeton may apply for designation as a community pediatric center.

iii. Middlesex County:

(1) John F. Kennedy Medical Center may apply for designation as a community pediatric center.

(2) Raritan Bay Medical Center shall participate in a LAB study to determine whether M/S bed reductions are warranted at its Perth Amboy division. It may apply for designation as a community pediatric center.

(3) Raritan Bay Medical Center and South Amboy Memorial Hospital shall participate in an LAB study to determine the appropriateness and feasibility of joint ventures, particularly to retain South Amboy's inpatient psychiatric programs in the county.

(4) Robert Wood Johnson University Hospital may apply for designation as a joint regional pediatric center with St. Peter's Medical Center.

(5) St. Peter's Medical Center may apply for an OB/GYN licensed bed increase if occupancy meets the requirements in N.J.A.C. 8:43I. It may apply for designation as a joint regional pediatric center with Robert Wood Johnson University Hospital.

(6) South Amboy Memorial Hospital should transition from inpatient acute care services by 1995.

iv. Somerset County:

(1) Somerset Medical Center may apply for designation as a community pediatric center.

5. Local Advisory Board V shall submit to the State Health Planning Board and the Department of Health M/S bed need studies for Camden, Cumberland and Salem Counties. The LAB shall submit a plan to maintain access to the psychiatric and substance abuse services currently being provided by Zurbrugg's Riverside Division as the hospital transitions form general acute care services. The specific responsibilities of the hospitals in LAB V are listed by county as follows:

i. Burlington County:

(1) Memorial Hospital of Burlington County may apply for an OB/GYN licensed bed increase if occupancy meets the requirements in N.J.A.C. 8:43I. It may apply for designation as a community pediatric center.

(2) Rancocas Hospital shall reduce its number of licensed pediatric beds to 10 and may apply for designation as a community pediatric center following the pediatric bed reduction.

(3) Zurbrugg Hospital should transition from inpatient acute care services by 1995.

ii. Camden County:

(1) Cooper Hospital/University Medical Center, which has been designated as a specialty acute care children's hospital, may apply for an OB/GYN licensed bed increase if occupancy meets the requirements in N.J.A.C. 8:43I.

(2) Kennedy Memorial Hospitals (Stratford Division) shall reduce its number of licensed pediatric beds to 10 and may apply for designation as a community pediatric center following the bed reduction.

(3) Kennedy Memorial Hospitals shall participate in a LAB bed need study to determine if M/S bed reductions are appropriate for its Stratford and Cherry Hill divisions.

(4) Our Lady of Lourdes Medical Center may apply for designation as a community pediatric center.

(5) West Jersey Hospital—Voorhees may apply for designation as a community pediatric center.

iii. Cumberland County:

(1) All Cumberland County hospitals shall participate in a LAB M/S bed need study.

(2) In addition to meeting the requirements of N.J.A.C. 8:100–14.8(b), the LAB area bed need study shall be approved by the State Health Planning Board and the Department of Health, before certificate of need applications related to inpatient acute care services may be submitted by any hospital in the county. An exception may be made if the Department determines that a serious quality of care issue exists which requires immediate attention.

(3) Newcomb Medical Center shall reduce its number of licensed OB/GYN beds, eliminate the unit or consolidate at one site with South Jersey Hospital System (Bridgeton Division). It may apply for designation as a community pediatric center.

(4) South Jersey Hospital System (Bridgeton Division) shall reduce its number of licensed OB/GYN beds, eliminate the unit or consolidate at one site with Newcomb Medical Center. South Jersey Hospital System (Bridgeton Division) shall reduce its number of licensed pediatric beds to 10 and may apply for designation as a community pediatric center following the pediatric bed reduction.

iv. Gloucester County:

(1) Kennedy Memorial Hospitals (Washington Division) shall implement its approved certificate of need for OB/GYN services and shall reduce its num-

ber of licensed OB/GYN beds if the minimum occupancy rate is not achieved.

(2) Underwood–Memorial Hospital shall reduce its number of licensed OB/GYN beds. Underwood–Memorial shall also reduce its number of licensed pediatric beds to 10 and may apply for designation as a community pediatric center following the pediatric bed reduction.

v. Salem County:

(1) All Salem County hospitals shall participate in a LAB M/S bed need study.

(2) In addition to meeting the requirements of N.J.A.C. 8:100–14.8(b), the LAB area bed need study shall be approved by the State Health Planning Board and the Department of Health, before certificate of need applications related to inpatient acute care services may be submitted by Elmer Community Hospital. An exception may be made if the Department determines that a serious quality of care issue exists which requires immediate attention.

6. Local Advisory Board VI shall submit to the State Health Planning Board and the Department of Health M/S bed need studies for Atlantic, Monmouth and Ocean Counties. The responsibilities of the hospitals in LAB VI are listed by county as follows:

i. Atlantic County:

(1) All Atlantic County hospitals shall participate in an LAB M/S bed need study.

(2) In addition to meeting the requirements of N.J.A.C. 8:100–14.8(b), the LAB area bed need study shall be approved by the State Health Planning Board and the Department of Health, before certificate of need applications related to inpatient acute care services may be submitted by any hospital in the county. An exception may be made if the Department determines that a serious quality of care issue exists which requires immediate attention.

(3) Atlantic City Medical Center (City Division) may apply for an OB/GYN licensed bed increase if occupancy meets the requirements in N.J.A.C. 8:43I. Also, it may apply for designation as a regional pediatric center. The Mainland Division shall eliminate its licensed pediatric unit.

(4) Shore Memorial Hospital shall reduce its number of licensed OB/GYN beds. It may apply for designation as a community pediatric center.

(5) William B. Kessler Memorial Hospital may apply for designation as a community pediatric center.

ii. Cape May County:

(1) There are no recommended changes to the number of beds in Cape May County.

iii. Monmouth County:

(1) Bayshore Community Hospital shall eliminate its licensed pediatric unit.

(2) CentraState Medical Center may apply for designation as a community pediatric center.

(3) Jersey Shore Medical Center may apply for designation as a joint regional pediatric center with Monmouth Medical Center.

(4) Monmouth Medical Center shall participate in the LAB M/S bed need study to determine if this facility should reduce its number of licensed M/S beds. It may apply for an OB/GYN licensed bed increase if occupancy meets the requirements in N.J.A.C. 8:43I. Also, it may apply for designation as a joint regional pediatric center with Jersey Shore Medical Center.

(5) Riverview Medical Center may apply for designation as a community pediatric center.

iv. Ocean County:

(1) Community Medical Center may apply for designation as a community pediatric center.

(2) Paul Kimball Medical Center shall reduce its number of licensed OB/GYN beds. It may apply for designation as a community pediatric center.

(3) Medical Center of Ocean County shall implement its approved certificate of need for OB/GYN services and shall reduce its number of licensed OB/GYN beds if the minimum occupancy rate is not achieved. The Brick Division may apply for designation as a community pediatric center.

(4) Southern Ocean County Hospital shall participate in a LAB study to determine if financial stability may best be achieved through merger with another hospital.

(c) All hospitals shall participate in bed need studies conducted by their LABs.

(d) Based on their determination of regional need, geographic availability of services, access for special populations, and quality of care, the Consortia and the LABs may recommend the retention of units that are recommended for elimination.

(e) The Department, in conjunction with the appropriate LABs, will convene transition teams to work closely with all involved parties including other State agencies to ensure that each transition from an inpatient acute care provider to another level of care is completed in a manner that maintains quality and access and is fair to current hospital patients, physicians and employees.

(f) Prior to proceeding with the implementation of the recommendations contained in this section, the Department of Health shall report to the State Health Planning Board and the Health Care Administration Board at or before their September meetings regarding the impact of changes resulting from the United States District Court decision in *United Wire, Metal and Machine Health and Welfare Reform, et al. v. Morristown Memorial Hospital, et al.,* Civil Action No. 90–2639 (May 27, 1992).

Amended by R.1992 d.451, effective November 16, 1992.
See: 24 N.J.R. 2704(a), 24 N.J.R. 4262(b).
Revised recommendations for closure and downsizing in response to comments and evaluation of the effect of the recommendations.

SUBCHAPTER 15. HIGH TECHNOLOGY SERVICES

8:100–15.1 High technology process development

(a) The Department of Health shall establish an orderly evaluation process for innovative, high-technology health care services and equipment, based on established criteria, that permits the analytical appraisal and initial limited diffusion of innovative equipment and/or services, prior to the further allocation of resources. Mechanisms shall include:

1. Establishment of a core clinical advisory group with representation from, at a minimum, the Medical Society of New Jersey, the New Jersey Bioethics Commission, the University of Medicine and Dentistry (UMDNJ), the Seton Hall University School of Graduate Medical Education, the New Jersey Hospital Association (NJHA), the New Jersey State Nurses Association (NJSNA), hospital clinical social workers, and home health professionals, to advise the Department of Health; and

2. Development of criteria that will be an elaboration of Statewide demonstration project criteria contained in current certificate of need rules, along with the commitment of sufficient Department of Health resources to permit a meaningful evaluation of demonstration activities.

8:100–15.2 Magnetic Resonance Imaging (MRI) Services and Resource Allocation Policy

(a) A certificate of need application shall be submitted by all existing MRI services in the State seeking to replace their MRI equipment, regardless of whether the service currently has certificate-of-need approval.

(b) The Department of Health shall continue and expand a utilization and data-monitoring system for MRI services to assist in the evaluation of their Statewide need.

(c) An appropriateness-review study of physician-investor and non-physician-investor MRI facilities shall be undertaken by the Department of Health to determine differential-use rates and variations in practice patterns.

8:100–15.3 Co.nputerized Tomography (CT) Services and Resource Allocation Policy

Computerized Tomography (CT) services shall be deregulated through the repeal of the CT rules (N.J.A.C. 8:33G), because virtually every acute-care provider in the State now has access to these services either on-site or through a contractual arrangement with a CT vendor.

8:100–15.4 Transplantation Services and Resource Allocation Policy

(a) The Department of Health will strengthen its efforts to support the existing transplant services provided in New Jersey and to seek to improve organ donation and compliance with the State's assured option law.

(b) The Department of Health shall convene a transplantation task force of out-of-State and in-State experts to evaluate future State transplant service needs for both solid organ and bone marrow programs. This evaluative effort will include an examination of organ distribution rules and their impact on the in-State availability of organ transplant services to New Jersey residents. Priority consideration will be given to the review of kidney and bone marrow transplantation policy. The findings of this task force shall be used in future discussions of transplantation services in the State Health Plan.

(c) Consideration of new or expanded solid organ transplantation services shall await the recommendations of the transplantation task force established in (b) above.

(d) A certificate of need shall be required for all bone marrow transplantation services, regardless of type. Consideration of new or expanded bone marrow transplantation services shall await the recommendations of the transplantation task force established in (b) above.

(e) The current regulatory standards for minimum volume, staff credentials and experience, infection control, and quality assurance (see N.J.A.C. 8:33Q) shall be maintained by all existing New Jersey transplant centers, in order to ensure high-quality services.

(f) All New Jersey residents with a demonstrated medical need for nonexperimental transplantation services shall be ensured access to a qualified transplant center without regard to ability to pay, race, or any other non-medical factors.

(g) The Department of Health, with advice from the expert task force established in (b) above, shall develop financing mechanisms to pay for transplantation services performed out-of-state.

8:100–15.5 Extracorporeal Shock Wave Kidney and Biliary Lithotripsy (ESWL and ESWBL) Services and Resource Allocation Policy

(a) Additional kidney and biliary lithotripsy services in New Jersey are not needed at this time. Statewide need for

kidney lithotripsy services has been met by the three existing providers and the potential need for biliary lithotripsy devices and services has been virtually eliminated by the widespread acceptance of the laparoscopic surgical procedure for gallstone removal (laparoscopic cholecystectomy).

(b) The Department shall establish a mechanism to monitor the quality and efficacy of care at approved Extracorporeal Shock–Wave Lithotripsy (ESWL) sites. Additional reporting requirements shall be established which include, but are not limited to, procedure failures, stone recurrence, and post-procedure infection data.

(c) The Department shall develop licensing standards for all ESWL sites, as well as for the other free-standing high-technology services discussed in this subchapter.

8:100–15.6 Interim Statewide Policies—Mobile High Technology Health Care Services

(a) The Department of Health shall develop certificate of need and licensing standards for all mobile high technology services, including new technology offered, or proposed to be offered, on a mobile basis. Until such standards are developed and promulgated, all applicants for a certificate of need for a mobile service that has been justified based on geographic isolation shall:

1. Provide documentation from the New Jersey Department of Transportation that the proposed mobile vehicle will be permitted on New Jersey roadways;

2. Describe how current fixed-site licensing requirements (for example, ambulatory care and/or hospital standards) or their equivalents will be maintained by the mobile service, and identify those that cannot be maintained demonstrating that this loss will not adversely affect quality of care;

3. Submit protocols for recalibration of equipment, including a listing of the equipment that requires recalibration, how often this will be done, and wherever possible, the manufacturer's recalibration recommendations;

4. Specify the infection-control protocols that will be employed for any invasive procedures and document how sterility will be consistently maintained in a mobile vehicle;

5. Submit proposed admission criteria for the mobile service proposed, as well as clinical criteria for exclusion;

6. Specify the protocols for addressing any emergency conditions that a patient may experience during the proposed procedure(s);

7. Submit a written Quality Assurance (QA) Plan that specifies the mechanisms for appropriate follow-up, quality assessments, responsible personnel for QA, etc.;

8. For applications accepted as "demonstration projects," submit an independently developed research protocol for evaluation of the proposed program, including, at a minimum, the data that will be collected and analyzed, frequency of data collection, norms against which the data will be evaluated, criteria for concluding that the demonstration program offers safe, effective, efficient, and affordable care, and the length of time necessary to demonstrate same; and

9. Document that the proposed service will be available to all who would benefit from it regardless of ability to pay.

8:100–15.7 Positron Emission Tomography (PET) Scanning Services and Resource Allocation Policy

The core clinical advisory group, established in N.J.A.C. 8:100–15.1, shall develop demonstration parameters for Positron Emission Tomography (PET) scanning within one year of the effective date of this rule. No certificate of need applications for Positron Emission Tomography scanners will be accepted until the recommendations of this technical committee are adopted by the Health Care Administration Board, either as a separate new (PET) rule or as an amendment to the State Health Plan.

SUBCHAPTER 16. SURGERY AND DIALYSIS (RESERVED)

SUBCHAPTER 17. REHABILITATION SERVICES (RESERVED)

SUBCHAPTER 18. LONG TERM CARE

8:100–18.1 Purpose

(a) The purpose of this subchapter is to foster a diverse but well coordinated array of high quality, affordable long-term care services which are readily accessible to those who need them. In so doing, the Department recognizes the long-term care population's heterogeneity: people's needs and preferences for care vary depending on the nature and degree of their functional impairments, availability of family and social supports, and so forth. The importance of consumer participation in decision-making about which services to use is underscored, along with the necessity of making information, assessment, case management, and referral resources available. The Department acknowledges the fact that most people would prefer to receive long-term care in their own homes; therefore, the expansion of home and community-based care is of the highest priority. As much as possible, long-term care should enable people to "age in place." When relocation cannot be avoided due to increasing debilitation, it should be to a homelike setting that affirms the individual's right to privacy, dignity, and a "normal" lifestyle, to the greatest extent possible.

(b) The Commissioners of the Departments of Health, Human Services, and Community Affairs should develop a memorandum of understanding to facilitate improved coordination of services for the elderly and disabled. A subcabinet level work group should be established by the Commissioners to carry out the intent of the memorandum of understanding.

8:100–18.2 Support services for family caregivers

(a) The Department shall enhance the ability of family caregivers to continue to care for their elderly or disabled relatives. Informal caregivers are a key component in the State's long term care system. Without the care provided by them, the State would be unable to meet the long term care needs of its residents through the existing formal system. It is essential that this valuable component of the long term care system be supported and enhanced through the expansion of community services. The Department of Health shall:

1. Expand respite care programs, such as the Respite Care (DHS) and Dementia Day Care Program (DOH). The Departments of Health and Human Services should investigate approaches that can be taken, including additional appropriations, to expand existing services to support family caregivers.

2. The Department of Health should expand the Caregiver Education and Support Program in the following ways:

i. Develop a curriculum for employed caregivers;

ii. Revise the caregiver manual;

iii. Develop a practicum for caregivers to gain hands-on experience in providing physical care safely; and

iv. Provide seminars for the facilitators to assist them in remaining current in their knowledge.

3. The Department of Health, in conjunction with the NJ Business and Industry Association, should develop seminars to educate and sensitize employers to the concerns of employees with caregiving responsibilities.

4. The Department of Health should encourage State legislation which would:

i. Offer tax incentives to private industry to develop new financing sources for long term care, such as employee benefits, life insurance conversion options, long-term care insurance, grants, etc.; and

ii. Allow family caregivers to deduct expenses incurred in caring for an aged or disabled relative, as they are currently able to do for child day care.

8:100–18.3 Adult day care services

(a) The Department of Health, in conjunction with the Departments of Human Services and Community Affairs, should review third party payment rates for adult day health care and adult day care and encourage uniformity.

(b) The Department of Health should encourage the development of adult day health care centers which target unserved and underserved populations. Adequate reimbursement should be provided to meet the staffing needs required appropriate to the level of care provided.

(c) The Department of Health, in conjunction with the Departments of Human Services and Community Affairs and the New Jersey Adult Day Care Association, should develop licensing standards for social day care centers and determine the appropriate licensing authority.

(d) The Department of Health, in conjunction with the Departments of Human Services and Community Affairs, should design a common data collection instrument for adult day care centers that would gather information on services provided, costs, volume of care, special populations served, licensure status, and staffing information.

8:100–18.4 In-home care services

(a) The Department of Health, in conjunction with the Departments of Human Services, Community Affairs, and Law and Public Safety, should design a common data collection instrument for home care services that would gather information on services provided, costs, volume of care, special populations served, licensure status, and staffing information.

(b) The Department of Health should extend NIRA (Nursing Incentive Reimbursement Awards) grants to home care providers for programs involving registered nurse education and retention, expanded and innovative roles for home health nurses, and care for special populations.

(c) The Department of Health, in conjunction with the State Board of Nursing and the Department of Higher Education, should collaborate to develop a standardized core curriculum for the training of aides that will be complemented with specialized modules for home health, long term care, and hospital care.

(d) The Department of Health, in conjunction with the Departments of Human Services and Community Affairs, should review third party payment rates for comparable home care services and encourage their uniformity.

(e) The Department of Health, in conjunction with the home care industry, should establish an advisory committee to investigate the extent of unmet need for home care services and to develop appropriate certificate of need requirements for home health agencies and other recommendations to improve access to high quality in-home care. The advisory committee should complete its deliberations and submit recommendations to the Commissioner of Health by June 30, 1993.

(f) The Department of Health, in conjunction with the Departments of Human Services and Community Affairs, should support legislative and regulatory initiatives and other programs to further protect vulnerable adults from abuse and neglect.

(g) The Department of Health should conduct a study to determine the need for additional inpatient hospices and identify appropriate reimbursement mechanisms. Any additional in-patient need may be considered as an alternative use for acute care hospitals transitioning to non-acute facilities.

(h) The Department of Health should pursue legislation requiring all agencies providing home care services to meet minimum licensing standards for areas such as patient services, continuity of care, quality assurance, supervision, training of personnel, etc.

8:100–18.5 Assessment, screening, and targeting of long-term care services

(a) The Department of Health should expand the current Geriatric Assessment Program to assure access to this service to residents of all 21 counties in the State.

(b) A uniform Statewide pre-admission screening program for nursing home services should be required by the Department of Health, to assure that people will be targeted to receive appropriate long-term care services regardless of their payment source. This preadmission screening should be offered in conjunction with information about all available, suitable long-term care options. The Department of Health should pursue legislation to accomplish this goal.

(c) The Department of Health, in conjunction with the Medical Society of New Jersey, New Jersey State Nurses Association, and other professional organizations, should design and offer continuing education on various geriatric and disability issues for health care professionals.

8:100–18.6 Nutritional services

(a) The Department of Health should support additional funding for the Department of Community Affairs, Division on Aging, to enable them to expand home-delivered meals for the elderly.

(b) The Department of Health should promote action by health care facilities to provide outpatient nutrition services, with an emphasis on minority and elderly populations.

(c) The Department of Health should mandate that nutrition be a core activity in "Recognized Public Health Activities and Minimum Standards of Performance for Local Boards of Health in New Jersey," and identify an adequate funding base.

(d) A mechanism should be established to enable the public to identify qualified nutrition professionals who meet minimum standards for practice.

8:100–18.7 Mental health services

(a) The Departments of Health and Community Affairs should assist the Department of Human Services with an evaluation of the adequacy of community based mental health services in meeting the needs of the elderly and disabled.

(b) The Departments of Health and Community Affairs should assist the Department of Human Services in developing training programs for mental health professionals in gerontology and gerontological psychiatry to enable them to recognize the special needs of gero-psychiatric clients. Conversely, long term care and residential health care providers should be trained to care for residents who present behavior problems.

(c) The Departments of Health and Community Affairs should assist the Department of Human Services in designing appropriate educational and informational programs for the elderly in order to reduce the stigma associated with mental health treatment and to increase access by elderly and disabled clients of mental health services.

8:100–18.8 Transportation services

The Departments of Health, Community Affairs and Human Services and New Jersey Transit should design a transportation survey to identify existing services, gaps, costs and recommendations for improvements.

8:100–18.9 Housing options for the frail elderly and disabled

(a) The Department of Health should assist the Department of Community Affairs in exploring ways to develop and fund programs for housing adaptations/modifications, household repairs, housekeeping, chore and yard services to enable the frail elderly and disabled to live better and keep up their homes.

(b) The Departments of Health and Community Affairs and the New Jersey Housing and Mortgage Finance Agency should explore ways in which the equity in an older person's home can be used to pay for long-term care services.

8:100–18.10 Improved information and coordination of services

(a) The Department of Health, in collaboration with the Department of Insurance, should promote awareness of long-term care insurance products and should disseminate information to assist consumers in evaluating these products.

(b) Long-term care consumers should have access to a single information source in each county which will enable them to make educated choices regarding all available care options in their area. To promote access to appropriate levels of care, one agency in each county should be designated by the Departments of Health, Human Services, and Community Affairs in consultation with the Local Advisory Board, as the primary information and referral center for all long-term care options. The Local Advisory Board, in collaboration with the Departments of Health, Human Services, and Community Affairs and each county information and referral center, should develop, maintain, and disseminate a current directory of the area's various long-term care options and supportive services.

(c) The Department of Health should design a Statewide media campaign focusing on long term care options with family caregivers as the audience.

(d) The Department of Health, in conjunction with the Departments of Human Services and Community Affairs, should develop and disseminate a public awareness campaign explaining adult day care and home care services and how to access them.

(e) To advance the development of long-term care options and improve coordination of services, the Department of Health, in collaboration with the Departments of Human Services and Community Affairs, Local Advisory Boards, and county-based agencies should hold regular information sharing sessions.

8:100–18.11 Care options for the long-term care population

(a) New Jersey residents who are in need of long-term care by virtue of their functional impairments and needs for assistance should have access to a variety of care options, so that each person may choose the least restrictive, most affordable alternative which will result in a satisfying quality of life. The Department of Health shall encourage the creation, expansion, and/or appropriate utilization of long-term care options such as, but not limited to:

1. Alternate family care placements;
2. Assisted living residencies;
3. Community Care Program for the Elderly and Disabled placements;
4. Adult day health care placements, for which four placements shall count as one long-term care placement;
5. Upgraded residential health care facilities, otherwise to be known as comprehensive personal care homes; and
6. Nursing home beds.

(b) The Department of Health, in collaboration with an advisory committee including participation by the Departments of Human Services and Community Affairs, consumers, and health and social service providers, shall formulate a transition/implementation plan to assure that new and expanded home and community-based care options become available in an expeditious manner, in accordance with the provisions of this subchapter. The transition/implementation plan shall allow reasonable time periods for the development of new or amended licensing standards and reimbursement mechanisms and the infrastructure which is necessary to assure a diverse but well coordinated system of long-term care options.

(c) The Department of Health should assure the orderly development of new long-term care services in areas of the State where there is an identified need. The need for long-term care placements of the types identified in (a)1 through 6 above shall be determined by a formula, projecting five years into the future for each county, as follows: 0.07 placements per 100 population age 20 to 64, plus 1.07 placements per 100 population age 65 to 74, plus 5.44 placements per 100 population age 75 to 84, plus 21.21 placements per 100 population age 85 and over.

1. In recognition of the uncertainty about when new and expanded alternatives to nursing home care will become available, the Department of Health shall assure the continued but controlled expansion of the nursing home bed supply in New Jersey. For the year 1992, the Department shall accept applications and give consideration to the certificate of need approval of up to 9.2 nursing home beds per 100 population age 75 and over in each county, based on population projections for 1997.

2. The Department of Health shall use two benchmarks to determine whether the number of new nursing home beds to be approved should be increased in 1993: a State legislature appropriation of Medicaid funds for initiation of the options identified in (a)1 through 5 above beginning in 1994; and submission by the Department of Human Services of a Federal Medicaid waiver request for new home and community-based long term care services, or, if a waiver is not required, an amendment to the Medicaid State Plan. In the event that the State legislature has not appropriated funds and the Department of Human Services has not submitted a Medicaid waiver request to the U.S. Health Care Financing Administration (or, if a waiver is not required, the Medicaid State Plan has not been amended) by July 31, 1993, the Department of Health shall give consideration to the certificate of need approval of up to 10.0 nursing home beds per 100 population age 75 and over in each county, based on population projections for 1998. In the event that the aforementioned benchmarks are achieved, the Department shall give consideration to the certificate of need approval of up to 9.2 nursing home beds per 100 population age 75 and over in each county, based on population projections for 1998.

(d) A proposal indicating the desired mix of new long-term care placement options should be developed for each county, taking into consideration local circumstances and consumers' diverse preferences. In each county where there is a need for new long-term care placements in accordance with (c) above, the Local Advisory Board shall establish a public process whereby the placement mix proposal may be devised with participation by area consumers, advocacy groups, health and social service providers, and others with an interest in long-term care. The number of placements allocated to each option identified in (a)1 through 6 above shall be specified in the proposal.

(e) The Department of Health should periodically conduct surveys of nursing home-eligible individuals and their families in New Jersey to determine their awareness of, preference for, access to, and satisfaction with various long-term care options. This information should be used to guide the future planning and development of services.

(f) By June 30, 1993, the Department of Health, in collaboration with the Departments of Human Services and Community Affairs, shall devise a formula to make available the options identified in (a)1 through 5 above in counties where no new long-term care placements are required in accordance with (c) above.

8:100–18.12 Alternate family care

(a) The Department of Health shall encourage and promote the development of high quality, accessible alternate family care programs, to be utilized by individuals who would prefer this alternative to nursing home care.

(b) The Department of Health, in collaboration with an advisory group, shall develop the requisite policies, procedures, and criteria to effectuate programs of alternate family care throughout New Jersey.

1. The advisory group referenced in (b) above shall include representation by the Departments of Community Affairs and Human Services as well as consumers and provider agencies.

2. Issues to be addressed in developing guidelines for alternate family care programs shall include but not be limited to:

i. Appropriate patient selection;

ii. Family screening;

iii. Family training;

iv. Quality assurance;

v. Protection against patient abuse; and

vi. Program evaluation.

(c) The Department of Health, in collaboration with the Attorney General, shall identify and endeavor to resolve potential guardianship, liability, and nursing practice issues to assure that alternate caregiving families may be trained to meet the nursing needs of patients who are placed in their homes.

8:100–18.13 Assisted living residences

(a) The Department of Health shall encourage and promote the development of high quality, accessible assisted living residences to be utilized by frail and disabled individuals including those who would prefer this alternative to nursing home institutionalization, but excluding those who are vegetative or who require ongoing, technically complex nursing care and supervision.

(b) The Department of Health, in collaboration with an advisory group, shall give consideration to the benefits and limitations of developing licensing, construction, and planning standards for assisted living residences as a means of promoting the orderly expansion of this long-term care alternative.

(c) Assisted living residences are intended to offer a maximum amount of privacy and independence in homelike surroundings, while meeting residents' needs for long-term care. To be recognized by the Department of Health as an assisted living residence, the building shall at a minimum offer:

1. A private, unfurnished room or apartment for each occupant (unless double occupancy is requested by the resident). As an optional feature, kitchenettes in each room or apartment should be permitted;

2. A private bath in each room or apartment;

3. A lockable door to each room or apartment (occupant holds the key);

4. Congregate dining; and

5. Availability of 24 hour personal care assistance and health services which are provided to each occupant as needed.

(d) To promote access to assisted living for low income elderly and disabled adults, the Departments of Health, Human Services, and Community Affairs should explore the feasibility of making assisted living available in existing HUD-subsidized housing for the elderly and disabled.

8:100–18.14 Residential health care and Class C boarding home facilities

(a) The Department of Health shall develop an enhanced level of residential health care in facilities that have the capacity to offer more supervision and personal care services than are traditionally offered in residential health care facilities and Class C boarding homes. This new type of facility shall be referred to as a "comprehensive personal care home." The Department of Health should convene an advisory committee to develop licensing and reimbursement standards and to identify that segment of the nursing home eligible population which would benefit most from comprehensive personal care homes.

(b) To assure the orderly development of long-term care options, certificate of need approval shall be required for the conversion of existing residential health care facilities to upgraded, service-enriched facilities to be known as "comprehensive personal care homes".

(c) The Departments of Health, Human Services, and Community Affairs should evaluate the current system of residential health care and Class C Boarding Homes, with the aim of eliminating duplicative oversight functions. The possibility of consolidating residential health care facility and Class C Boarding Home licensing within the Department of Community Affairs should be considered, insofar as it would not reduce the health maintenance and monitoring services and Supplemental Security Income payment for existing residential health care facility residents.

(d) The Departments of Health, Human Services, and Community Affairs should support legislative initiatives to increase the Supplemental Security Income state supplement for residential health care residents.

8:100–18.15 Continuing care retirement communities

(a) The Department of Health should recognize continuing care retirement communities (CCRCs) as a viable long-term care option. The minimum size requirements for CCRCs shall be eliminated, while maintaining a requirement for the construction of at least four independent living units for every one long-term care bed or assisted living unit or comprehensive personal care bed, up to a maximum of 120 long-term care beds, assisted living units and/or comprehensive personal care beds.

(b) Certificate of need applicants for new or expanding CCRCs shall document the potential demand for their projects by conducting and submitting a detailed marketing study.

8:100–18.16 Specialized long-term care services

(a) The Departments of Health and Human Services and Local Advisory Boards (LABs) should collaborate to develop strategies and criteria for improving access to long-term care services for persons requiring specialized long-term care. The circumstances under which specialized care should be regionalized should be identified.

(b) The Department of Health and LABs should annually conduct a survey to determine the number and characteristics of persons in each LAB region who need specialized long-term care services.

8:100–18.17 Alzheimer's Disease and other behavior problems

(a) Eligibility criteria and licensing standards for community-based long-term care services, such as adult day health care, should be reviewed to assure accessibility for persons with dementia and other behavior problems.

(b) The Department of Health should encourage research to determine the most cost-effective and efficient methods to care for persons with dementia and other behavior problems.

(c) The Department of Health in collaboration with Local Advisory Boards should ensure that Alzheimer's Disease family support groups are available and accessible in all counties in the State.

(d) The Department of Health should develop and offer training for caregivers and professionals/paraprofessionals in community agencies and long-term care facilities on the care of persons with dementia and other behavior problems.

8:100–18.18 Comprehensive rehabilitation

(a) The Department of Health shall continue to conduct planning for rehabilitation hospitals in accordance with the provisions of N.J.A.C. 8:33M, the Rehabilitation Hospital Policy Manual for Certificate of Need Review. However, N.J.A.C. 8:33M shall be amended to include a new, LAB region-specific, patient-origin and age-based adult bed-need methodology.