

**HEALTH**

**HEALTH SYSTEMS BRANCH**

**DIVISION OF CERTIFICATE OF NEED AND LICENSING**

**CERTIFICATE OF NEED AND HEALTH CARE FACILITY LICENSURE PROGRAM**

**Hospital Licensing Standards**

**Adopted Amendment: N.J.A.C. 8:43G-1.2**

**Adopted New Rules: N.J.A.C. 8:43G-11A**

Proposed: June 19, 2017, at 49 N.J.R. 1650(a).

Adopted: December 19, 2017, by Christopher R. Rinn, Acting Commissioner,  
Department of Health (with the approval of the Health Care Administration Board).

Filed: December 19, 2017, as R.2018 d.048, **with non-substantial changes** not  
requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 26:2H-1 et seq., particularly 26:2H-5 and 5.32.

Effective Date: January 16, 2018.

Expiration Date: December 18, 2024.

**Summary of Public Comments and Agency Responses:**

During the 60-day public comment period that ended August 18, 2017, the New Jersey Department of Health (Department) received written comments from representatives of three organizations, as follows:

1. Aline Holmes, DNP, RN, Senior Vice President, Clinical Affairs, New Jersey Hospital Association, Princeton, NJ;
2. Stephanie Hunsinger, State Director, AARP New Jersey, Princeton, NJ; and

3. Ann Twomey, Health Professionals and Allied Employees, AFT/AFL-CIO, Emerson, NJ.

Quoted, summarized, and/or paraphrased below are the comments and the Department's responses. The numbers in parentheses following the comments correspond to the numbers representing the commenters above.

1. COMMENT: A commenter supports "the guidance put forth in the proposed regulations that mirror the intent of the statute" and "efforts to improve the knowledge of caregivers to provide routine medical tasks once [a patient is] discharged home from the hospital." (1)

2. COMMENT: A commenter stated, "[Our organization] strongly supported the authorizing legislation ... signed by Governor Christie on November 13, 2014, [and] worked with the NJ Hospital Association, community partners and legislative leaders throughout the legislative process." The commenter expressed support for the language of the proposal because it "follows the spirit and the letter of the authorizing legislation." Moreover, the commenter agrees with the Department "that [the proposed amendments and new rules would] have a positive social impact on patients and caregivers [and] expects ... positive ... health outcomes [for] patients and ... less stress and anxiety for ... caregivers, who often must learn about and manage after-care tasks on their own. Furthermore[,] we agree [with the Department] that training unpaid caregivers to perform after-care assistance likely would prevent patients from being rehospitalized[,] and that the proposed rules would result in positive outcomes for people, hospitals, and insurers." (2)

3. COMMENT: A commenter “supports the inclusion of a patient’s designated caregiver in the discharge planning process” and stated, “[e]xpanding the rights of patient caregivers is an important step to ensuring high-quality, cost-efficient solutions that enable caregivers to perform the very important work of tending to the needs of patients.” (3)

RESPONSE TO COMMENTS 1 THROUGH 3: The Department acknowledges the commenters’ support for the proposed amendment and new rules.

4. COMMENT: A commenter disagrees with the Department’s position that the proposed amendment and new rules would have a minimal economic impact on general acute care hospitals. See 49 N.J.R. 1650(a), 1651-52. The commenter pointed out that the Department was unable to estimate the amount of such costs, and stated, “Hospitals have been engaged in reform efforts to reduce hospital readmission rates prior to the implementation of the Affordable Care Act [2010] ... Hospitals have done this by adopting caregiver models, ... which had a cost associated with the reforms. It is our belief that the law has and will cost hospitals more by transitioning some of their reform efforts away from their current models and into the models prescribed by the new law.” (1)

RESPONSE: The Department reaffirms its position expressed in the proposed rulemaking’s Economic Impact statement, which is based on a report that an estimated annual \$17 billion is charged to the Federal Medicare program for unnecessary hospital readmissions. See, Robert Wood Johnson Foundation, “The Revolving Door: A Report on U.S. Hospital Readmissions,” February 2013, available at <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf404178>. See 49 N.J.R. 1651-52. The Department believes that training caregivers to perform necessary after-

care assistance tasks at the patient's residence would reduce hospital readmission rates, which likely would have an overall economic benefit for both hospitals and patients. The Department also considers providing for hospital patients' after-care needs as an inherent part of the discharge planning responsibilities of hospitals and the health care professionals who care for these patients. Furthermore, the Department is obligated to implement N.J.S.A. 26:2H-5.24 et seq., as written, and must ensure that the proposed amendment and new rules comport with the statute. For the foregoing reasons, the Department takes no action with respect to this comment.

5. COMMENT: A commenter stated, "[E]ducating caregivers on how to perform routine medical tasks ... is an important endeavor, [but] caregivers cannot and should not replace medical professionals when the severity of care requires it." (1)

RESPONSE: The Department notes that it makes no attempt to regulate the specific after-care assistance tasks for which hospitals are required to educate and instruct caregivers. After-care assistance tasks need not be routine, nor medical. Rather, it is the specific responsibility of the hospital and its discharge planning team to identify those necessary after-care assistance tasks that can be managed competently by a non-professional caregiver in the patient's residence after discharge and to arrange for the services of health care professionals to perform such tasks when necessary. As such, the Department takes no action regarding this comment.

6. COMMENT: A commenter stated, "While the proposed [new] rule[s use] the descriptor 'designated' with caregiver in most instances, there are ... instances where the term 'designated' is missing. We recommend, for the sake of consistency, and to

mirror the authorizing legislation, that the term ‘designated caregiver’ be used at 8:43G-11A.6(c), 8:43G-11A.7(c), and 8:43G-11A.7(d)3.” (2)

RESPONSE: The Department appreciates that the commenter noticed this inconsistency in the proposal. The Department has reviewed the statute and noted the language includes the terms “designated caregiver” and “caregiver” to refer to the same person. Therefore, it would be impossible to both “mirror the authorizing legislation” and achieve “consistency” in the proposed new rules as the commenter asks. However, upon adoption, the Department will change the term “designated caregiver” to the term “caregiver” in new N.J.A.C. 8:43G-11A, for consistency, as that term is defined at N.J.S.A. 26:2H-5.25 and cited at N.J.A.C. 8:43G-11A.3.

7. COMMENT: A commenter asked the Department to clarify the statement of purpose at proposed new N.J.A.C. 8:43G-11A.2 because it “does not include the requirement that the hospital provide the designated caregiver adequate and timely notification of discharge. While the discharge section (8:43G-11A.8) references this requirement, we believe that this critical step should also be highlighted in the statement of purpose.” (2)

RESPONSE: The Department does not believe it is necessary to include in the statement of purpose that hospitals must provide caregivers adequate and timely notification of discharge. Proposed new N.J.A.C. 8:43G-11A.2 would be a general statement of the subchapter’s purpose. Proposed new N.J.A.C. 8:43G-11A.8 effectively would implement the statute’s notice requirements for discharge or transfer to another facility. Therefore, the Department takes no action in response to this comment.

8. COMMENT: A commenter stated, “[Proposed new N.J.A.C. 8:43G-11A.2] carries forward a presumption outlined in the definition of patient (8:43G-11A.3) that the provisions of the Act only apply to inpatients who have been deemed eligible to return to their homes post-discharge.” The commenter further stated, “[T]he definition ...of ‘patient’ is too narrowly written in this proposal. [At N.J.A.C. 8:43G-11A.3,] a patient [means] a person ‘who is determined by the discharge planning team to be able to return to his or her residence upon discharge.’ This suggests that in order to qualify for the provisions of the Act, the discharge planning team must first assess at the time of designation that a patient will be discharged home.” The commenter maintains that “the authorizing legislation does not provide for so stark a limitation.” (2)

RESPONSE: The Department agrees that the statute does not define the term “patient,” and further offers, in light of the statute taken as a whole, that to implement the purpose of caregiver designation, the proposed new rules require such a definition to guide hospitals to the patients the law requires be offered such an opportunity. For example, N.J.S.A. 26:2H-5.25 defines the term “caregiver” as one who provides “after-care assistance to a patient in the patient’s residence,” and the term “residence” as the “dwelling that the patient considers to be the patient’s home. The term shall not include any rehabilitation facility, nursing home, assisted living facility, or group home licensed by the Department of Health.” When these statutorily defined terms are viewed together, it becomes clear that the intent of the statute is to require hospitals to offer the opportunity to designate a caregiver to those patients discharged to a residence, not a licensed facility. Therefore, when a hospital’s discharge planning team determines that a patient is being discharged home and not to a licensed facility, the statute requires the

hospital to offer the patient, and not every patient, consistent with the meaning of, “residence,” at N.J.S.A. 26:2H-5.25, the opportunity to designate a caregiver. Accordingly, the definition of “patient” at proposed new N.J.A.C. 8:43G-11A.3 is consistent with the statutory requirements for caregiver designations. As such, the Department takes no action regarding these comments.

9. COMMENT: A commenter “recommends [N.J.A.C. 8:43G-11A.8] regarding discharge be modified. Notification [precedes] instruction, in most instances, in the natural flow of discharge and that is why the authorizing legislation placed language for the provision between designation and instruction. We recommend that this entire section be moved after 8:43G-11A.5, be numbered 8:43G-11A.6 and all subsequent sections be renumbered accordingly.” (2)

RESPONSE: This comment does not address the substance of the rules, only its structure. The Department does not believe it is necessary to change the placement of N.J.A.C. 8:43G-11A.8 within the subchapter as the subchapter as written addresses the requirements of the statute and the suggested reordering of the rules in the subchapter offers no substantive improvement.

10. COMMENT: A commenter stated, “Clinicians from each discipline comprising the healthcare team should be mandatory participants in the development and implementation of discharge plans (e.g., physicians, staff nurses, social workers[,] etc[.]).” (3)

RESPONSE: The Department notes that, through the development of policies and procedures, hospitals independently establish their own operations, including discharge planning. The proposed amendment and new rules would neither restrict nor

limit hospitals from, as the commenter advocates, requiring all members of the health care team to participate in the discharge planning process. In addition, this particular matter is outside the scope of this rulemaking. For these reasons, the Department takes no action upon adoption in response to this comment.

11. COMMENT: A commenter stated, “Discharge planning rules must permit hospital-specific policy to take into account the patient care demands at a given time in a specific hospital unit, [so] that hospitals retain the flexibility to construct discharge planning protocol that truly reflects the ability of its health professionals to provide care to all patients in the hospital [as opposed to scheduling] aftercare assistance training around the caregiver [and allowing] the caregiver to choose how training is presented,” as set forth at proposed new N.J.A.C. 8:43G-11A.6 and 11A.7. (3)

RESPONSE: N.J.S.A. 26:2H-5.28.a requires a hospital to consult with a caregiver and issue a discharge plan for a patient’s after-care assistance needs prior to discharge “on a schedule that takes into consideration the severity of the patient’s condition, the setting in which care is to be delivered, and the urgency of the need for caregiver services.” In addition, N.J.S.A. 26:2H-5.28.b requires the hospital to accommodate a caregiver’s preferences for live or recorded training. The Department is obligated to implement each of these provisions, which would be accomplished through proposed new N.J.A.C. 8:43G-11A.6 and 11A.7. Therefore, no change upon adoption will be made in response to this comment.

12. COMMENT: A commenter supports the substance of proposed new N.J.A.C. 8:43G-11A.8 “because notification is mandatory, ... requiring [hospitals to make] multiple attempts to contact the caregiver should the first attempt be



unsuccessful.” However, the commenter noted that the proposed new rules would not specify the number of attempts required and the means of communication the hospital would use, that is, text or voicemail. The commenter recommends that the Department revise this rule with greater specificity “with respect to multiple attempts at contacting a patient’s designated caregiver.” (2)

13. COMMENT: Another commenter objects to proposed new N.J.A.C. 8:43G-11A.8 because it “[would require hospitals to make multiple] attempts at communication [with caregivers] involving [patient discharges and] transfers.” The commenter asserted, “[U]nderstaffing has an adverse effect on the ability of health professionals to meet all the demands of their patient in a timely manner.” (3)

RESPONSE TO COMMENTS 12 AND 13: The commenter correctly identified that proposed new N.J.A.C. 8:43G-11A.8 would not specify the frequency and manner of attempts a hospital would make to notify a caregiver of a patient’s impending discharge or transfer. The statute is silent on this matter. However, the proposed new rules would make clear that a hospital make a concerted effort to contact a caregiver. As such, the proposed new rules need not delineate a specific number of attempts or method of attempts, and the Department declines to take any action on adoption. The Department notes that the statutory requirements for hospitals to communicate with caregivers about discharge and transfers prior to discharge would be established at proposed new N.J.A.C. 8:43G-11A.8. For these reasons, the Department declines to take any action upon adoption in response to these comments.



## Federal Standards Statement

The Department is not adopting the amendments and new rules under the authority of, or to implement, comply with, or participate in, any program established under Federal law or a State law that incorporates or refers to any Federal law, standard, or requirement. The Department is adopting this rulemaking under the authority of N.J.S.A. 26:2h-5.32. Therefore, a Federal standards analysis is not required.

**Full text** of the adoption follows (additions to proposal indicated in boldface with asterisks **\*thus\***; deletions from proposal indicated in brackets with asterisks **\*[thus]\***):

### SUBCHAPTER 11A. **\*[DESIGNATED]\*** CAREGIVERS

#### 8:43G-11A.2 Purpose

The rules in this subchapter implement N.J.S.A. 26:2H-5.24 through 5.32, by requiring hospitals to offer patients who are able to return to their place of residence after discharge an opportunity to designate caregivers to perform after-care assistance tasks and to train these **\*[designated]\*** caregivers to competently perform post-hospital care as set forth in the patients' discharge plans.

#### 8:43G-11A.4 Designation of caregiver

(a) (No change from proposal.)

(b) The hospital's discharge planning team shall promptly document the following in a patient's medical record:

1. (No change from proposal.)

2. Contact information for the **\*[designated]\*** caregiver, as follows:

i. - iv. (No change from proposal.)

(c) (No change from proposal.)

(d) A patient or the patient's legally authorized decision maker has the right to:

1. (No change from proposal.)

2. Change or revoke the \*[designated]\* caregiver at any time prior to discharge.

(e) (No change from proposal.)

(f) The discharge planning team shall advise the patient and the \*[designated]\* caregiver that the \*[designated]\* caregiver is not obligated to perform any after-care assistance for the patient if the caregiver declines the designation.

8:43G-11A.6 Consultation with the \*[designated]\* caregiver

(a) The discharge planning team shall schedule after-care assistance training at a time convenient for the \*[designated]\* caregiver in accordance with N.J.A.C. 8:43G-11A.7.

(b) The discharge planning team shall meet with the \*[designated]\* caregiver at a time that takes into consideration:

1. - 3. (No change from proposal.)

(c) (No change from proposal.)

8:43G-11A.7 After-care assistance training

(a) A hospital shall ensure that after-care assistance training offered to the \*[designated]\* caregiver includes instructions on performing each after-care assistance task set forth in the patient's discharge plan.

(b) A hospital shall ensure that the \*[designated]\* caregiver has opportunities to:

1.- 2. (No change from proposal.)

(c) (No change from proposal.)

(d) The discharge planning team shall record promptly the following information in a patient's written discharge plan:

1. Name and contact information of the \*[designated]\* caregiver;
- 2.- 4. (No change from proposal.)

#### 8:43G-11A.8 Discharge

(a) The discharge planning team shall notify the \*[designated]\* caregiver in advance of the patient's discharge or transfer to another facility.

(b) The discharge planning team shall document promptly in the patient's medical record all attempts to contact the \*[designated]\* caregiver.

1. If required, the discharge planning team shall make multiple attempts to contact the \*[designated]\* caregiver.

(c) The inability of the discharge planning team to contact a \*[designated]\* caregiver shall not delay a patient's discharge or transfer.