MINUTES OF THE
HEALTH CARE ADMINISTRATION BOARD MEETING
Thursday, September 16, 2010

MEMBERS PRESENT:

Michael J. Bakers, Esq., Chairperson
Mary Kay Roberts, via teleconference
Ellsworth Havens, via teleconference
Joseph Roth, via teleconference
Anatasius Efstratiades, Esq., via teleconference
Christine Stearns
John Gontarski
Holly Gaenzle
Gregory Marks, via teleconference

EXCUSED:

Judy Persichilli
Mary Wachter

STAFF:

Dr. Rita Cominolli, Certificate of Need and Health Care Facility Licensure
Walter Kowalski, Office of Legal and Regulatory Affairs
Michele Stark, Office of Legal and Regulatory Affairs

CALL TO ORDER

Michael Baker, Chair, opened the meeting on Thursday, December 21, 2006 at 9:30 am located at the New Jersey Department of Health and Senior Services, Health and Agriculture Building, 1st Floor, Auditorium, Trenton, New Jersey.
(Whereupon, the proceedings began at approximately 9:15 a.m.)

MR. BAKER: You can begin.

MS. STARK: This is the formal meeting of the Health Care Administration Board. Adequate notice of this meeting has been published in accordance with the provisions of Chapter 231, Public Law 1975, C-10:4.10 of the State of New Jersey entitled, "Open Public Meetings Act." Notice was sent to the Secretary of State, who posted the notice in a public place. Notices were forwarded to 17 New Jersey newspapers, 2 New York newspapers, 2 wire services, 2 Philadelphia newspapers and the New Jersey Public Broadcasting Television Station.

I will call roll.

Mr. Gontarski?
MR. GONTARSKI: Here.
MS. STARK: Miss Gaenzle?
MS. GAENZLE: Here.
MS. STARK: Mr. Marks?
MR. MARKS: Present.
MS. STARK: Miss Persichilli is absent; Mr. Havens?
MR. HAVENS: Present.
MS. STARK: Mr. Roth?
MR. ROTH: Present.
MS. STARK: Mr. Efstratiades?
MR. EFSTRATIADES: Present.
MS. STARK: Miss Stearns?
MS. STEARNS: Present.
MS. STARK: Miss Wachter is absent; Miss Roberts?
MS. ROBERTS: Here.
MS. STARK: Mr. Baker?
MR. BAKER: Here.
MS. STARK: Nine members of the Board are present, which is a quorum.

MR. BAKER: Thank you. I have no report other than, I want to thank Mr. Gontarski for filling in for Miss Charbonneau. John, do you have a report?

MR. GONTARSKI: No. I don't, Mr. Chairman. I don't.

MR. BAKER: Okay. Then the first matter would be Approval of the Proposal of New Rules. Doctor.

DR. COMINOLLI: Good morning; I'm Dr. Rita Cominolli; I'm with the Office of Certificate of Need and Health Care Facility Licensure. The Department is requesting approval for the Proposal of New Rules and Amendment on Licensing Rules Governing Safe Patient Handling, codified at N.J.A.C. 8:43E-12 and 3.4.

These rules are consistent with the Safe Patient Handling Act, Public Law 2007, Chapter 225, N.J.S.A. 26:2H-14.15, et seq., which was approved on January 3, 2008.
This statute requires the Commissioner of Health and Senior Services to adopt rules and regulations to implement the act.

The proposed new rules at N.J.A.C. 8:43E-12 would apply to general hospitals, special hospitals, county and private psychiatric hospitals and nursing homes licensed by the Department of Health and Senior Services pursuant to Public Law 1971, Chapter 136, N.J.S.A. 26:2H-1 et seq., as amended.

State psychiatric hospitals and state developmental centers, also included in the statute, are not licensed by the Department. These facilities are regulated by the Department of Human Services.

Staff invited the Department of Human Services to stakeholder meetings and has forwarded them a copy of this proposal for use in crafting their own rules. In addition to the proposed new rules set forth at N.J.A.C. 8:43E-12, the Department is proposing an amendment at N.J.A.C. 8:43E-3.4(a) that sets forth monetary penalties. For violations of N.J.A.C. 8:43E-12 that result in actual harm or an immediate and serious risk of harm to facility staff, the amount would be $2,500 per violation, which may be assessed for each day noncompliance is found.

For other violations of N.J.A.C. 8:43E-12, the amount would be $1,000 per violation, which may be assessed for each day noncompliance is found. These specified penalties are consistent with penalties in other regulations developed by the Department and would only be incurred should a facility fail to comply with the subchapter which is mandated by statute.

The Department worked closely with the stakeholder group consisting of members from unions, hospital associations and long-term care associations. The group met on two separate occasions and thoroughly discussed the rules until consensus, though not unanimity was reached on each issue.

Before describing the rules, I'd like to point out a correction that with your approval ought to be made in the summary. So, if you have your copies of the Regulations, we're going to be looking at Pages 4 and 18. So, if you could turn to Page 4 first, okay. The third paragraph on Page 4 currently and incorrectly reads, "Proposed new N.J.A.C. 8:43E-12.5 would require a detailed written description of the program; the provision of copies to the Department upon request, healthcare workers at the facility, and collective bargaining agents representing these workers."

Now, if you turn to Page 18. On Page 18, the text of the rule states at N.J.A.C. 8:43E-(b) and (c), that a copy of the written description of the program shall be available upon request to the Department and within two days after a request to a health care worker or collective bargaining agent.

So, with your approval, we'll change the wording on Page 4 to read as follows: "Proposed new N.J.A.C. 8:43E-12.5 would require a detailed description of the program; the provision of copies upon request to the Department and within two business days after the request to healthcare workers at the facility, and collective bargaining agents representing these workers."

MR. BAKER: And the Department feels that is a technical, not a substantive change?

DR. COMINOLLI: Yes. That is a technical change.

MR. BAKER: Thank you.

DR. COMINOLLI: Now, I will describe the content of the rules. These proposed new rules at N.J.A.C. 8:43E-12 would include the following: Proposed new N.J.A.C. 8:43E-12.1, "authority, scope and purpose," would identify applicable facilities licensed by the Department, would describe the purpose of the subchapter, and we would specify that the subchapter would not limit the right of a patient to refuse the use of assisted patient handling.

Proposed new N.J.A.C. 8:43E-12.2 would establish definitions of the following words and terms used in the proposed new subchapter: assessment of patient's need for assisted patient handling; or patient assessment; assisted patient handling; committee; covered health care facility; or covered facility; health care worker; injury investigation; near miss; OSHA; patient; patient handling; retaliatory action; safe patient handling program; or program; and unassisted patient handling.

Proposed new N.J.A.C. 8:43E-12.3 would provide for the establishment, requirements, composition and responsibilities of the Safe Patient Handling Committee.

Proposed new N.J.A.C. 8:43E-12.4 would require the establishment, no later than January 3rd, 2011, of the safe patient handling program in each covered facility; the designation of a representative from administration who would be responsible for overseeing all aspects of the safe patient handling program; and the assurance of employee input.

Now, the proposed new N.J.A.C. 8:43E-12.5, and I will be using the corrected language, would require a detailed description of the program; the provision of copies upon request to the Department and within two business days after the request to health care workers at the facility and collective bargaining agents representing these workers and the translation of the description under specified circumstances.

Proposed new N.J.A.C. 8:43E-12.6 would require a covered facility to establish a written safe patient handling policy, would specify the content of the policy, would describe posting requirements and would mandate translation of the policy under specified circumstances.

Proposed new N.J.A.C. 8:43E-12.7 would require the Safe Patient Handling Committee to ensure the performance of assessments of patient need for assisted patient handling, and would provide standards and procedures for conducting these assessments.

Proposed new N.J.A.C. 8:43E-12.8 would require a covered facility, under the direction of the Safe Patient Handling Committee, to conduct a needs assessment for each unit within the facility to determine the type and quantity of assisted patient handling required and the units or areas within the facility where assisted patient handling is most needed.
Proposed new N.J.A.C. 8:43E-12.9 would require the Safe Patient Handling Committee to draft an implementation plan for the program, and would describe components of the implementation plan.

Proposed new N.J.A.C. 8:43E-12.10 would require the Safe Patient Handling Committee to establish a financial plan for a facility's program and would set forth the components of the plan.

Proposed N.J.A.C. 8:43E-12.11 would require the Safe Patient Handling Committee to be responsible for equipment selection, maintenance and usage, and would provide certain standards for equipment selection, maintenance and usage.

Proposed new N.J.A.C. 8:43E-12.12 would require a covered facility, under the direction of the Safe Patient Handling Committee, to conduct the initial training of health care workers by January 3rd, 2011, and/or at least quarterly thereafter. This section also would require interim training, would specify who would receive training, would require that training be conducted during paid work time, and would specify the content of the training program.

Proposed new N.J.A.C. 8:43E-12.13 would require the Safe Patient Handling Committee to develop materials for educating patients and their families about patient handling and would mandate that such information be included in facility admissions packages and in relevant discussions with patients and their families.

Proposed new N.J.A.C. 8:43E-12.14 would require a covered facility, under the direction of the Safe Handling Patient Committee, to require injury investigation, reporting and analysis, and would require certain standards for recordkeeping, investigation and reporting. This section also would require a covered facility to appoint an appropriate facility department to receive and analyze reports and to generate de-identified, aggregated data reports.

Proposed new N.J.A.C. 8:43E-12.15 would require the Safe Patient Handling Committee to evaluate de-identified, aggregated data and to recommend improvements regarding the program to the facility's governing body at least annually, or more frequently as needed. This section also would require the Safe Patient Handling Committee to have access to reports and data prior to de-identification and aggregation, as determined necessary by the committee, and to determine ways to increase patient acceptance of safe patient handling.

Proposed new N.J.A.C. 8:43E-12.16 would mandate that certain retaliatory actions would be prohibited and that a health care worker who refuses to perform a patient handling task pursuant to this section would promptly notify the supervisor.

Proposed new N.J.A.C. 8:43E-12.17 would mandate that a covered facility that violates the provisions of this subchapter would be subject to enforcement actions and penalties specified in N.J.A.C. 8:43E-3. At this point, the Department is requesting your approval for the initial publication in the New Jersey Register of these new rules and amendment, codified at N.J.A.C. 8:43E-12 and 3.4. Are there any questions?
MR. BAKER: Any questions from the Board Members? Is there anyone in the public that would like to be heard on this matter? Identify yourself, and if you could, limit your comments to three minutes. If you need extra time, let me know.

MR. INDYK: I'll be brief. John Indyk, with the Health Care Association, and we represent approximately 300 health care workers in the state. We have about 200 nursing facilities.

First, I want to thank the Department for its efforts and time spent on negotiating these rules and proponents. It's very painstaking, and I think it is a fair compromise that we've reached in the end, but the one area that we have concerns in both proposals, though, is used in the term, de-identify. No one understands what that means. Is it simply redacting the name of that individual, or the case? Let's say you got a safe patient handling issue where you got an individual who is 500 pounds, refused to use the Hoyer Lift, is enough to say a 500-pound individual who refused to use a Hoyer Lift, and you know who that individual was, Mr. Jones on the fourth floor.

So, I propose a definition, kind of, taken from HIPAA, but alone I don't think it works in this case because, you're dealing with not only the patient, but also potential employees and visitors. So, I got a draft, an amendment, that I asked the Board to consider, and for those that are on the phone it reads, de-identify means information that does not specifically identify either by name or other pre-assigned identification number, and that makes it a reasonable effort to prevent leading individuals who are involved from being identified.

So, I would ask your consideration in approving that definition and give us a better guidance on knowing how to de-identify the data.

MR. BAKER: Thank you. I'll ask the Department heads if they have any comment on this.

MR. INDYK: Thank you.

DR. COMINOLLI: The Department thinks this is a good point. And, actually, we're surprised that this didn't come up in one of the discussions that we had. It does make a good point. So, the question is, how we would go about – we would need to get input from all the stakeholders on this. So I believe that we would have to send this out for comment to the stakeholders.

And there are other issues, you know, other definitions that we would need to come up with a definition of. And in order of terms, we come up with a definition of, and I think the stakeholder group work well together by e-mail, coming up with something that is agreeable.

So, I think that is something that could be done and entered into these regulations before the register if that is an acceptable way to do this.

MR. BAKER: So, we're in initial publication during the review period, this is one of the comments the Department would consider.
MR. GONTARSKI: Well, that's one way. I know what she is proposing is, that --

MS. STEARNS: Let's wait and to table this so that it can all go forward.

MR. BAKER: Then that's fine.

MS. ROBERTS: Well, why don't we, since you got the flexibility, you send out to stakeholders to give you the green light, we could approve it based on that.

MS. STEARNS: I think, Mary Kay, what the doctor is suggesting, that we would table today's discussion that we would not approve for publication.

DR. COMINOLLI: No. Actually, what I'm suggesting, but only if this works according to legal and according to everyone on the Board, I was just suggesting to possible streamline the process to approve it knowing that we would, in the next few days, get consensus from the stakeholder committees. This seems like, considering all the other things we have to come to consensus, this seems like a pretty simple matter that we could send out e-mail, come up with a definition and just put it in now before it goes to the register if that's the process.

MR. GONTARSKI: I think -- yeah. If I may? What I would propose is that since we have the definition, if the stakeholders agree to the definition, at least before the Board, then we could proceed.

MR. BAKER: All right. Let me try to put together the mechanics of it. You're asking if we approve it subject to inclusion of this language if approved by the stakeholders?

MS. STEARNS: I don't think you can do that.

DR. COMINOLLI: But it's just the definition.

MS. STEARNS: Here's the thing, I don't have a problem with doing it, I would want to resolve the concern about the definition. I'd certainly want to do that. I'm not sure that as a Board --

MR. BAKER: We can approve subject to approval.

MS. STEARNS: -- we can condition subject to stakeholder. I'm just unclear if that is appropriate.

MR. BAKER: I don't know. Is the feeling of the Department that we approve it without it, that during the review period this would be a substitutive change and we would have to republish?

MR. GONTARSKI: I would think that that would be the case. I think this term is used already in 8:43E. This is not a new term.

MS. ROBERTS: But it is not defined anywhere.
MR. GONTARSKI: But it is not defined in 8:43E.

MR. BAKER: Okay.

MS. ROBERTS: I think -- I mean, this is just my two cents, Christine, we both witnessed it when we were in the legislature and they released a bill, act amended, and basically say, subject to the following amendment and they, kind of, give you a sense of what the amendment is.

I think John's language is pretty, you know -- this is a term of ours, the definition, and it probably isn't going to be that controversial. And if all of a sudden there is some sudden change or it raises three more definitions, then the Department, you know, can give its discretion to hold it up and present it to us at next month's meeting. But, I mean, I just want to give you guys the ability to move it forward if this language is acceptable to the stakeholder group.

DR. COMINOLLI: Okay. And then we won't know if it's acceptable to the group until I e-mail it out to them, because I certainly can't speak for all the stakeholders, and would need the time to e-mail it to them and ask for their, you know, quick response.

MR. BAKER: So, I realize this is implementing a new statute, is there a timeline that we're up against, or we are already well passed what the statute requires?

DR. COMINOLLI: Actually, both of these statutes became effective on January 3rd, 2008. And, actually, these -- there are implementation dates in both statutes which is due January 11th -- no, January 3rd, 2011. So, this has been a long process, and it has been a very thorough process. It has been long. And it seems that if we streamline it and move it along, you know, within the mechanics that have to be followed --

MR. BAKER: I acknowledge Christine's point and I think we've got only two choices. Then, one would be to approve it with this change included. And if the stakeholders don't like it, then you have to come back to us next month and we'll do it over. If they like it, then you can go ahead or hold it up for a month since the deadline is in January and we're not passed the deadline. So either way. And if you want to --

MR. EFSTRATIADES: Can I ask you a question? Do we have a defined group? You mentioned the stakeholders; I don't know who they are.

DR. COMINOLLI: Okay. The stakeholders group, if you give me one second I can tell you who they are.

MR. EFSTRATIADES: You don't have to go through the list.

DR. COMINOLLI: Okay. They are hospital associations, the long-term care associations and the health care workers union. They represent the hospital administration, plus a variety of unions with hospitals and unions for long-term care workers.
MR. EFSTRATIADES: Okay. And when you say approval by this group, is it unanimous, or the majority of the stakeholders?

DR. COMINOLLI: The way that this -- these two sets of regulations evolved was through consensus. We did not always have unanimity, but we got consensus from the folks. Some people gave in on one thing, and some people gave in on another thing.

MR. EFSTRATIADES: But I'm asking about this particular amendment.

DR. COMINOLLI: This particular -- this particular amendment wasn't presented to the stakeholders because it was just raised today.

MR. EFSTRATIADES: But if we approve it subject to approval by the stakeholders group, does that mean by all the stakeholders, or the majority of the stakeholders?

DR. COMINOLLI: I'd say by consensus, by the majority, because that's the way the rest of these rules were developed.

MS. GAENZLE: John, is this definition recognized elsewhere?

MR. GONTARSKI: There is no definition.

MR. BAKER: Yeah.

MS. GAENZLE: This is a new definition?

MR. BAKER: For us.

MR. GONTARSKI: Correct. But we've used the term and it's understood, you know.

MS. GAENZLE: The term has never been defined?

MR. GONTARSKI: Not to my knowledge. Not in any of our rules, no.

MR. BAKER: In that case, I don't see how we would want to include it without the Department's legal staff reviewing it and everybody signing off on the language. So, I would suggest, then, that we table this until the next meeting, unless overriding –

MS. STEARNS: Does this embody what the Department's understanding what you meant by de-identify is?

DR. COMINOLLI: Walt, do you have any comment?

MR. KOWALSKI: I know that –

MR. BAKER: Walter, come up so that we get you for the record. Give your name.

MR. KOWALSKI: I'm Walter Kowalski, I'm one of the attorneys that works for the Office of Legal Regulatory Affairs with the Department. We didn't discuss the specific
definition of de-identified data. John can confirm that. I think what the intent was to make sure that something is identified. There would be no way to identify --

**MR. BAKER:** The patient.

**MR. KOWALSKI:** Yeah. And I know that there is HIPAA standards that, you know, the facilities comply with. So, I think that was the intent of the proposal, but, you know, it is not specified by definition.

**MS. GAENZLE:** I'm just curious --

**MS. STEARNS:** I understand that, but I think – but as the people have indicated, the term is already used in existing regulations, so, therefore, the Department must have some understanding of what it means by that term. So, I guess that I'm going to question you a little bit to see if this definition that John has presented –

**MR. KOWALSKI:** We haven't had time to review the definition, but as I explained, I think that the intent of de-identify, there is no way that they can use other criteria backwards that aren't withheld to be able to disclose those persons patients.

**MS. GAENZLE:** Is there something particular about these rules that there is a need to define this term whereas it's been used in other rules with that definition?

**MR. KOWALSKI:** No. I think it's a, you know, it's a –

**MS. ROBERTS:** It is a good catch.

**MR. KOWALSKI:** No. It's just, you know, a standard practice, and one of those practices that really is ill-defined in terms of the rules.

**MS. GAENZLE:** So, just now is the time that we recognize that?

**MR. GONTARSKI:** Apparently it has been raised --

**MS. GAENZLE:** Okay.

**MR. GONTARSKI:** -- and we don't really have a --

**MS. GAENZLE:** Okay.

**MR. GONTARSKI:** -- definition.

**MS. ROBERTS:** But even if we can't really refer to the HIPAA, I was thinking if there was a way to refer to the HIPAA site.

**MR. KOWALSKI:** Well, there is, we could incorporate by reference. There is a HIPAA --

**MS. ROBERTS:** But that doesn't really get it done; right, in this context?
MR. KOWALSKI: I don't know. That's what Mr. Indyk tells us, so...

MR. INDYK: You're dealing with employees as well as the patients.

MR. KOWALSKI: That makes sense.

MR. BAKER: Let me run this past the Board Members. In order to keep this moving, we could adopt the rules for publication with this proposed language in it, and if it turns out that there is consensus, it gets published, if not, the Department comes back to us next month with an amendment and we republish -- we readopt for publication. And -- but the process is --

MS. STEARNS: Well, I would think it already has made its way to publication, so I think then it would go out to public comment.

MR. BAKER: I think we would have to come back again.

MS. STEARNS: But the Department, I believe, if I understand the process correctly, that when we get to the adoption phase, the Department could hold it back and make further changes if –

MR. KOWALSKI: Not substitutive changes.

MS. STEARNS: If you weren't going to adopt it, we could then continue. That would be no burdensome for the Department, then, holding it back at this point and having to propose the definition at a later date.

MR. KOWALSKI: After this is adopted, we couldn't make a substantive change on adoption.

MS. STEARNS: Right. But if you could hold back the definition and not adopt it –

MR. KOWALSKI: Right.

MS. STEARNS: -- so if this turns out to be not acceptable, but if it is acceptable, then by not -- if this was acceptable and we do not include it today, we know for sure that you are going to have additional pertinent steps through the process with this definition.

MR. KOWALSKI: Right. But we have to -- if it's not acceptable to the stakeholder, we would hold the proposal, and if I have problems with the proposal and find there are problems later on adoption, then we may not -- it's a substantive change between proposal and adoption, you may not be able to make an adoption, you know.

MR. GONTARSKI: The adoption can't be done without -- in other words, they can adopt the proposal -- they can adopt it without that definition going back to the definition?
MR. KOWALSKI: Well, if you put the definition in the proposal, it depends on whether it -- if we put the definition in the proposal and publish it, if taking out that definition is a substantive change upon adoption, then we can't do it because it would destroy the value of the initial Notice of Proposal, you know. It changes the substance of the proposal that we told the public that we were doing.

MR. BAKER: And then you would have to start the process all over again and --

MR. KOWALSKI: Yeah.

MR. BAKER: Are we, even though we're losing a month, are we better off waiting a month, getting it straightened out and then publishing rather than publishing, have it turn out not to be right, have to wait until the end of the comment period?

MR. GONTARSKI: I mean, the best suggestion might be to say, we approve it with the definition. If the stakeholders don't like the definition and if our legal says it's not a good idea, we bring it back to the Board.

MS. GAENZLE: Is the Board --

MR. BAKER: Go ahead, Anatasius.

MR. EFSTRATIADES: No. I think, do this. In the language they can say that they don't like it, and it comes back to the Board if they don't like it.

MS. STEARNS: Right.

MR. GONTARSKI: If they don't agree upon it there is no consensus like Rita said.

MR. EFSTRATIADES: Yeah. The difference between consensus and the majority, the consensus means they will all agree, all the language, the text language, so...

MR. GONTARSKI: I think the best thing to do is bring it back to the board and wait until next month. I'm sure, Rita, the stakeholders will get a reply soon.

MR. BAKER: Let's do that then. Thank you.

MR. KOWALSKI: You're welcome.

DR. COMINOLLI: Okay. So, I'd also just like to mention that this was the Safe Patient Handling, and the other set of recommendations is Violence Prevention in Health Care Facilities, the same issue will come up, because it also gets de-identified in the data, so I would suggest coming back for both of them next month.

MR. BAKER: I'm okay with that. Is everybody okay?

MS. STEARNS: Okay.

MR. BAKER: All right. Thank you.
MR. MARKS: I have a question.

DR. COMINOLLI: Yeah.

MR. MARKS: In light of that and looking at the time frame and with actually operating it, how realistic is Section 12.4 about January 3rd, 2011?

DR. COMINOLLI: Okay. Yes. That's a good question. That's what we, kind of, grappled with. As I mentioned, both of these -- both of the statutes were effective January 3rd, 2008. And both of them include implementation dates 36 months from January 3rd, 2008, and for the date January 3rd, 2011, comes from.

So, technically, people in a facility are supposed to be in compliance with the statute even prior to the regulations coming out. That's the way these things always work. Regulations always lag behind the statute. But facilities should be in compliance with that date of January 3rd, 2011. And that's directly from statute.

It will seem like an aberration because, by the time these rules are adopted and published in their final adoption in the New Jersey Register, they will be passed January 3rd, 2011, date, but that date is valid based on the record date and the statute and what is stated in the statute.

MR. MARKS: Okay. Thank you.

MR. BAKER: And that happens on a regular basis?

DR. COMINOLLI: Yes.

MR. BAKER: Thanks, Greg. Any other questions? (No response.)

MR. BAKER: Okay. We didn't even move this, so we don't need to table it. We can go on to any new business.

DR. COMINOLLI: Thank you, everybody.

MR. BAKER: Thank you. But just to check it, is there anyone who wanted to speak on the violence -- in the audience wanted to speak on the violence prevention?

MR. INDYK: Same issue.

MR. BAKER: Same issue, okay. Thank you.

MS. STEARNS: I just wanted to be sure that the Department doesn't want to proceed including this definition leaving yourself the option to come back next month and change it if you’re –

DR. COMINOLLI: At this point, I think my feeling is that we developed a really good set of, not just a good set of stakeholders, but a good rapport with the stakeholders.
So, at this point I would prefer not to tell the stakeholders what we already presented, and now we're coming after the fact –

**MS. STEARNS:** Okay.

**DR. COMINOLLI:** -- but to go with them up front and say, we didn't want to proceed without getting approval on the rest.

**MS. STEARNS:** Okay. That makes sense.

**DR. COMINOLLI:** So, I would suggest that.

**MR. BAKER:** Okay. Thank you.

**DR. COMINOLLI:** Okay.

**MR. GONTARSKI:** It may also affect our internal review process. Hopefully we'll be back next month.

**MR. BAKER:** Okay. Great.

**MS. GAENZLE:** Are we looking at a time on this?

**MR. BAKER:** I think they'd like to come back next month. If anybody on the Board would like the presentation, we can go forward today.

**MS. GAENZLE:** Well, the only thing that I'm thinking is, that, and I don't know if this would be any issues, but it could be addressed for the next time they come, so it gives us –

**MR. BAKER:** Okay. So the next meeting will be quicker. All right. Did we lose anyone, or –

**DR. COMINOLLI:** Is everyone still on the phone?

(Members confirming they are still on the phone.)

**MR. BAKER:** Okay. I should phrase that question differently. Okay. Stick with us a little bit longer then. At least the next meeting will be quick.

**DR. COMINOLLI:** I'm Dr. Cominolli, a member of the Department's Office of CN and Health Care Facility Licensure. And the Department is requesting approval for the proposal of New Rules and Amendment on Licensing Rules Governing Violence Prevention in Health Care Facilities, codified at N.J.A.C. 8:43E-11 and 3.4.

These rules are consistent with the "Violence Prevention in Health Care Facilities Act," Public Law 2007, Chapter 236, N.J.S.A. 26:2H-5.1 et seq., which was approved on January 3rd, 2008.
This statute requires the Commissioners of Health and Human Services to adopt rules and regulations to implement the act. The proposed new rules at N.J.A.C. 8:43E-11 and 3.4 would apply to general hospitals, special hospitals, county and private psychiatric hospitals and nursing homes licensed by the Department of Health and Senior Services pursuant to Public Law 1971, Chapter 136, N.J.A.C. 26:2H-1 et seq., as amended.

The Department of Human Services is authorized to regulate State psychiatric hospitals and State developmental centers that are also included in the statute. Staff invited the Department of Human Services to stakeholder meetings and has forwarded them a copy of this proposal for use in crafting their own rules.

In addition to the proposed new rules set forth at N.J.A.C. 8:43E-11, the Department is proposing an amendment at N.J.A.C. 8:43E-3.4(a) that sets forth monetary penalties. For violations of N.J.A.C. 8:43E-11 that result in injury to a health care worker, the amount would be $5000 per violation, which may be assessed for each day noncompliance is found.

For violations of N.J.A.C. 8:43E-11 not resulting in injury to a health care worker, the amount would be $2500 per violation, which may be assessed for each day noncompliance is found.

These specified penalties are consistent with penalties in other regulations developed by the Department and would only be incurred should a facility fail to comply with this subchapter which is mandated by statute. The Department worked closely with a stakeholder group consisting of members from unions, hospital associations and long-term care associations. The group met on two separate occasions and thoroughly discussed the rules until consensus, though not unanimity was reached on each issue.

Before describing the rules, I'd like to point out a correction that with your approval ought to be made in the Summary. It is similar to the one that we discussed previously in the Safe Patient Handling.

We'll be focusing on the bottom of Page 4, and the top of Page 24. Okay. The paragraph at the bottom of Page 4 currently and incorrectly reads, "Proposed N.J.A.C. 8:43E-11.9 would require that copies of the violence prevention plan be made available upon request to the Commissioner of Health and Senior Services, health care workers and collective bargaining agents."

Now, if you turn to the text of the rule at the top of Page 24, there the wording reads, "A covered facility shall make a copy of the violence prevention plan available within two business days of the request, to any health care worker or collective bargaining agent who represents health care workers at the facility." So, with your approval, we would like to make this technical change, which would change the wording at the bottom of Page 4 to read as follows, "Proposed new N.J.A.C. 8:43E-11.9 would require that copies of the violence prevention plan be made available upon request to the Commissioner of Health and Senior Services, and within two business days after a request to any health care worker or bargaining agent who represents health care workers at the facility."
Now, I will describe the content of those rules. These proposed new rules at N.J.A.C. 8:43E-11 would include the following: Proposed new N.J.A.C. 8:43E-11.1, Scope and Purpose, would identify the covered facilities to which these rules apply and indicate that the purpose of this subchapter is to establish violence prevention programs in each of the covered health care facilities in order to protect health care workers from violence, minimize damage from violence, maintain a safe environment and retain health care workers.

Proposed new N.J.A.C. 8:43E-11.2 would establish definitions of the following words and terms used in the new proposed subchapter: covered health care facility or facility, credible verbal threat of assault or harm, direct patient or resident contact, health care worker, incident investigation, in-house crisis response team, job task analysis, OSHA, retaliatory action, violence, violent act or incident and zero-tolerance policy.

Proposed new N.J.A.C. 8:43E-11.3 would require a covered health care facility to establish a workplace violence prevention program within three months of adoption of these rules. This section would also require a covered facility to allow health care workers and others to participate in the violence prevention program through means developed by the Violence Prevention Committee.

Proposed new N.J.A.C. 8:43E-11.4 would mandate the establishment, composition and responsibilities of a Violence Prevention Committee.

Proposed new N.J.A.C. 8:43E-11.5 would specify the conditions under which the violence prevention program and committee could be operated at the system level.

Proposed new N.J.A.C. 8:43E-11.6 would require the Violence Prevention Committee to develop and maintain a detailed, written violence prevention plan within six months of the effective date of this subchapter, and would specify components of this plan.

Proposed new N.J.A.C. 8:43E-11.7 would require the Violence Prevention Committee to complete an annual violence risk assessment for a covered facility and would identify the components of such an assessment.

Proposed new N.J.A.C. 8:43E-11.8 would require the identification and implementation of methods to reduce identified risks.

Proposed new N.J.A.C. 8:43E-11.9, and I will be reading the corrected wording, would require that copies of the violence protection plan be made available upon request to the Commissioner of Health and Senior Services, and within two business days after a request to any health care worker or collective bargaining agent who represents health care workers at the facility. This section also would describe the circumstances under which translation of the plan would mandate and exclude from the public any information in the plan or pose a threat to security if made public.
Proposed new N.J.A.C. 8:43E-11.10 would mandate violence prevention training and would specify participants, methods, content and the need for periodic review and revision of the training.

Proposed new N.J.A.C. 8:43E-11.11 would require a Violence Prevention Committee to establish procedures for incident handling, investigation and reporting.

Proposed N.J.A.C. 8:43E-11.12 would require the covered facility to keep a record of all violent acts, and would specify record maintenance requirements and time frames for access to the records by employees and the Department. This section also would provide that records created and maintained would not be subject to disclosure under OPRA.

Proposed new N.J.A.C. 8:43E-11.13 would require covered facilities to provide post-incident response to health care workers injured during a violent act, and would establish procedures for medical and psychological care.

Proposed new N.J.A.C. 8:43E-11.14 would specify that retaliatory action may not be taken against any health care worker for reporting violent incidents. Retaliatory action shall have the same meaning as found in N.J.S.A. 34:19-2.

Proposed new N.J.A.C. 8:43E-11.15 would provide that a covered health care facility that violates the provisions of this subchapter would be subject to penalties and enforcement actions specified in N.J.A.C. 8:43E-3. At this point, the Department is requesting your approval for the initial publication in the New Jersey Register of these new rules and amendment, codified at N.J.A.C. 8:43E-11 and 3.4. So, if there are any questions on this?

MR. BAKER: Thank you, doctor.

Any questions from the Board Members? (No response.)

MR. BAKER: Is there anyone in the public who would like to be heard?

MR. INDYK: I'll acknowledge for the record that HCANJ has the same comment with regard to the definition of de-identified. Thank you.

MR. BAKER: Please come up and identify yourself, and if you can, please stick to three minutes.

MS. GILLIGAN LETO: Okay. Thank you. Good morning; and thank you for the opportunity to speak briefly in support of the regulations before you today. My name is Cecelia Gilligan Leto, and I am project coordinator for the New Jersey Work Environment Council, Safe Work, Safe Care Program. The New Jersey Work Environment Council is in alliance with the labor community and environmental organizations.

I am here this morning on behalf of WEC and the health professionals and allied employees representing 12,000 nurses and health care workers in hospitals and other
health care facilities throughout New Jersey. We wanted to express our support for both safe patient handling and workplace violence prevention regulations as currently written.

The experiences of our participating organizations confirm that state and national statistics demonstrate that unsafe patient lifts and transfers and violence in health care workplaces compromise the safety and health of both patients and caregivers, and increase health care costs.

Signed into law on January 2008, the Safe Patient Handling Act and Prevention of Violence in Health Care Facilities Act, protects nurses, caregivers and patients from preventable and costly injuries.

Both of these laws were passed after considerable formal negotiations among the stakeholders during which representatives of the industry associations and health care workers made compromises to address each others concerns. During the summer and fall of 2009, as the regulations were being written, the Department of Health posted several half-day long meetings during which stakeholders reviewed and critiqued drafts of the regulations.

Once, again, all parties made compromises to come up with realistic and responsible regulations. Many facilities in New Jersey already are moving forward with safe patient handling and violence prevention programs. We need the consistency and guidance that comes with regulations and enforcement. Thank you.

**MR. BAKER:** Thank you. Any questions from the Board Members; no.

Thank you.

I think what we will do, then, is not close the public portions, but keep them open since there may be changes that the Department will suggest or not, and then there'll certainly be comments from the public.

We look forward from hearing from you at the next meeting. The only comment that I have for other business, folks may have been hearing rumors for about the last couple of years about an executive branch study group trying to figure out whether all of the committees in the Department, such as AGAP and State Health Planning Board and others, are needed. And I guess they're getting pretty close to the conclusions and there may be some consolidations of the boards, including ours.

So, Ruth will keep us posted further, but we may go from three boards to two boards to one board or no boards. I don't think a final decision has been made yet.

Thank you, all.

**DR. COMINOLLI:** Thank you.

(Whereupon, the proceeding was adjourned at approximately 10:15 a.m.)