26:2H-12.90 to 26:2H-12.95
LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2020 **CHAPTER:** 87

NJSA: 26:2H-12.90 to 26:2H-12.95 (Establishes certain requirements concerning State's preparedness and response to infectious disease outbreaks, including coronavirus disease 2019 (COVID-19) pandemic.)

BILL NO: A4476 (Substituted for S2790)

SPONSOR(S) Valerie Vainieri Huttle and others

DATE INTRODUCED: 7/30/2020

COMMITTEE: **ASSEMBLY:** Aging & Senior Services
Appropriations

SENATE: Health, Human Services & Senior Citizens
Budget & Appropriations

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** 8/27/2020

SENATE: 8/27/2020

DATE OF APPROVAL: 9/16/2020

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (Second Reprint enacted) Yes

A4476

INTRODUCED BILL (INCLUDES SPONSOR'S STATEMENT): Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes Aging & Senior Services
Appropriations

SENATE: No

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes

S2790

INTRODUCED BILL (INCLUDES SPONSOR'S STATEMENT): Yes

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes Health, Human Services
And Senior Citizens
Budget & Appropriations

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

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REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: Yes

"NJ NURSING HOME REFORMS INCLUDE HIGHER STAFF PAY," The Record, September 17, 2020

"DEMANDING ANSWERS – PROTESTERS SEEK PROBE OF DEATHS AT NJ VETS HOME," The Record, September 17, 2020

"Reforms coming for N.J. nursing homes, but big changes stall, Reforms coming to N.J. nursing homes in aftermath of huge number of deaths, but other major changes stalled Nursing," The Star-Ledger, September 17, 2020

RWH/CL

§§1-6 -
C.26:2H-12.90 to
26:2H-12.95
§8 - T&E

P.L. 2020, CHAPTER 87, ***approved September 16, 2020***
Assembly, No. 4476 ***(Second Reprint)***

AN ACT concerning the State's response to outbreaks, epidemics, and pandemics involving infectious diseases and supplementing Title 26 of the Revised Statutes and P.L.2005, c.222 (C.26:13-1 et seq.).

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. [2](New section)[2] a. There is established in the Department of Health the Long-Term Care Emergency Operations Center (LTCEOC), which shall serve as the centralized command and resource center for long-term care facility response efforts and communications during [2][1]any hazardous event, including, but not limited to,[1] infectious disease outbreaks, epidemics, and pandemics] a declared public health emergency[2] affecting or likely to affect one or more long-term care facilities. The LTCEOC shall [1][build off] enhance[1] and integrate with existing State, county, and local emergency response systems. [2][The LTCEOC shall be established and operational within 30 days after the effective date of this act.]2

b. The Department of Health shall have primary responsibility for the operations of the LTCEOC, but the Department of Human Services and other appropriate State agencies shall provide any staff support as shall be requested by the Commissioner of Health. The Commissioner of Health may additionally contract with a third party entity to provide staffing services as needed. At a minimum, the Commissioner of Health shall ensure that the LTCEOC has on call at all times such appropriate staff and consultants as are needed to respond to [2][an emerging or ongoing infectious disease outbreak, epidemic, or pandemic] a declared public health emergency[2] affecting or likely to affect one or more long-term care facilities, including representatives from [2][nursing homes, long-term care facilities, nursing home and long-term care facility staff, [1]general acute care hospitals, long-term care hospitals, psychiatric hospitals, home health and hospice agencies, Programs of All-Inclusive Care for the Elderly (PACE) organizations,[1]]2 county and local boards of

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Assembly ASE committee amendments adopted August 24, 2020.
[2]Assembly AAP committee amendments adopted August 24, 2020.

health, the Office of the New Jersey Long-Term Care Ombudsman, and the Office of Emergency Management in the New Jersey State Police, [2]the acute and post-acute health care industry,[2] as well as experts in public health, infection control, elder affairs, disability services, emergency response, and medical transportation.

c. The [2]primary responsibilities of the[2] LTCEOC shall [2]**[**establish**]** include, but shall not be limited to:

(1) establishing[2] ongoing, direct communication [2]**[**mechanisms and feedback loops, including an advisory council, to obtain real-time input from**]** with[2] the owners and staff of long-term care facilities, unions, advocates representing residents of long-term care facilities and their families, individuals with expertise in the needs of people with specialized health care needs, and such other stakeholders as the Commissioner of Health deems necessary and appropriate during [2]**[**an infectious disease outbreak, epidemic, or pandemic**]** a public health emergency[2] affecting or likely to affect one or more long-term care facilities [2], which may include the use of existing communication mechanisms and feedback loops in the Department of Health's Office of Disaster Resilience or Health Systems branch, as appropriate;

(2) providing technical assistance to the long-term care industry during the public health emergency, which may be facilitated through local health departments;

(3) ensuring supplies and equipment needed to respond to the public health emergency are acquired and distributed in an effective and efficient manner among long-term care facilities;

(4) utilizing the National Healthcare Safety Network database managed by the federal Centers for Disease Control and Prevention to:

(a) identify and respond to critical staffing shortages in long-term care facilities;

(b) if applicable, identify and respond to critical personal protective equipment or ventilator shortages in long-term care facilities;

(c) monitor facility capacity; and

(d) if applicable, monitor infectious disease case counts and deaths by facility; and

(5) ensuring all policies and guidance developed by the Department of Health in response to the public health emergency are effectively communicated to all long-term care industry stakeholders[2] .

d. [2]**[**The LTCEOC shall designate a staff person from the Department of Health who shall serve as the designated liaison to the long-term care industry during an infectious disease outbreak, epidemic, or pandemic affecting or likely to affect one or more long term care facilities.

e. The LTCEOC shall provide guidance to the State and to the Office of Emergency Management to ensure that: supplies needed to respond to an outbreak, epidemic, or pandemic involving an infectious disease are acquired and distributed in an effective and efficient manner among long-term care facilities; critical staffing shortages in long-term care facilities are identified and resolved quickly and effectively; issues that would jeopardize the health or safety of staff or residents of a long-term care facility, or that would impede or disrupt efforts to respond to an outbreak, epidemic, or pandemic involving an infectious disease, are promptly identified and addressed in an appropriate manner; and all policies and guidance are effectively communicated to all long-term care industry stakeholders to maximize the coordination and effectiveness of the State's response to an outbreak, epidemic, or pandemic involving an infectious disease affecting one or more long-term care facilities.

f. The LTCEOC may develop a data dashboard to collect and analyze real-time issues and challenges occurring in long-term care facilities during an outbreak, epidemic, or pandemic involving an infectious disease, as well as emerging issue areas and items of concern, so as to enable the appropriate authorities to direct a proactive response to those challenges and issues before the challenges and issues develop into matters of critical concern. Any dashboard developed by the LTCEOC may build from or incorporate materials from other data dashboards or similar features developed and maintained by any other entity of State, county, or local government, to the extent necessary to avoid duplication of work, facilitate communications and data sharing, and ensure the integrity, comprehensiveness, and utility of information included in the LTCEOC data dashboard.

g. The LTCEOC shall develop guidance and best practices in response to an outbreak, epidemic, or pandemic involving an infectious disease concerning, as appropriate, infection control, symptom monitoring, and the use of telemedicine and telehealth to provide contactless health care services. [1]**[**The guidance and best practices shall be transmitted to appropriate State, county, and local departments and agencies for dissemination to industry and to providers. The guidance and best practices may additionally be transmitted to federal agencies coordinating the national response to the outbreak, epidemic, or pandemic, if any, including, but not limited to, the federal Centers for Disease Control and Prevention, the federal Centers for Medicare and Medicaid Services, and the U.S. Department of Health and Human Services, as well as such international bodies, including the World Health Organization, as may be involved with the response to the outbreak, epidemic, or pandemic.**]**[1]

h.**]** <u>In the event of a public health emergency declared in response to an infectious disease outbreak, epidemic, or pandemic</u>

affecting or likely to affect one or more long-term care facilities, the LTCEOC, in consultation with other offices within the Department of Health and the Office of Emergency Management in the New Jersey Division of State Police, shall determine the need for the establishment of regional hubs capable of accepting patients who have, and are capable of transmitting, the infectious disease and who do not require hospitalization, which hubs shall comply with State and federal guidance regarding infection control practices related to the infectious disease. In the event of a surge in number of identified cases of the infectious disease, the LTCEOC shall actively monitor capacity levels at long-term care facilities and at regional hubs established pursuant to this subsection, if any, using the National Healthcare Safety Network database managed by the federal Centers for Disease Control and Prevention, and shall take steps to direct patient placements as necessary to manage capacity levels and ensure, to the extent possible, that no regional hub or long-term care facility exceeds safe capacity levels.

e.[2] As used in sections 1 through [2][3] 5[2] of P.L. , c. (C.) (pending before the Legislature as this bill), "infectious disease" means a disease caused by a living organism or other pathogen, including a fungus, bacteria, parasite, protozoan, virus, or prion. An infectious disease may, or may not, be transmissible from person to person, animal to person, or insect to person.

2. [2](New section)[2] a. No later than [2][90] 180[2] days after the effective date of this act, the Department of Health shall [1], in consultation with the Emergency Medical Services Task Force [2]and the Office of Emergency Management in the New Jersey Division of State Police[2] ,[1] institute a regional medical coordination center model for disaster response to facilitate regional capacity coordination and communication across county and local boards of health, hospitals, long-term care facilities, emergency medical services providers and other first responders, and entities providing medical transportation services, in the event of a public health emergency involving an outbreak, epidemic, or pandemic involving an infectious disease. At a minimum, the model shall include a system for [1][pairing] engaging the Level 1 trauma center in the region with[1] long-term care facilities, [1]federally qualified healthcare centers, home health agencies, hospice providers, medical transportation providers,[1] emergency medical services providers and other first responders, and entities providing medical transportation services [1][with a hospital located in the same region for the purpose of providing the long-term care facility, emergency medical services provider or other first responder, and medical transportation provider with consultative services regarding infectious diseases, infection control, and emergency resource

coordination, as well as support testing as may be needed**]** in its associated region. The Regional Level 1 Trauma Center and its associated regional medical coordination center shall make available their various clinical and non-clinical content experts and services are available for consultation and support to facilitate the implementation of evidence-based best practices and informed decision making[1].

b. The department shall identify appropriate sources of State, federal, and private funding to facilitate the implementation of this section, including, but not limited to, any funding or other support as may be available through the Federal Emergency Management Agency.

[2]**[**3. a. No later than 60 days after the effective date of this act, each long-term care facility shall develop plans, in coordination with the LTCEOC established pursuant to section 1 of this act, to maintain mandatory long-term care facility staffing levels by replacing facility staff members who are required to isolate or quarantine because of exposure to or infection with an infectious disease, particularly during periods when there is an outbreak, epidemic, or pandemic involving the infectious disease. [1]**[**Long-term care facility plans may include, but shall not be limited to:

(1) establishing staffing teams to provide temporary interim support in the event of staff shortages at the facility, which teams may be developed and operated in coordination with a general acute care hospital;

(2) executing contracts with other long-term care facilities and with general acute care hospitals located in the same region to provide staff support on an as-needed basis;

(3) utilizing the National Guard or other resources as may be deployed or otherwise made available to respond to an outbreak, epidemic, or pandemic involving the infectious disease; and

(4) utilizing the services of qualified volunteers, within the scope of the volunteers' training and experience, which volunteer services are coordinated through the LTCEOC.**]**[1]

b. During an outbreak, epidemic, or pandemic of an infectious disease affecting or likely to affect long-term care facilities, the Department of Health shall require long-term care facilities to provide the LTCEOC with an outline of the facility's regular staffing requirements, and to promptly notify the LTCEOC in the event any staff member tests positive for the infectious disease or is required to isolate or quarantine based on infection with or exposure to the infectious disease. The LTCEOC shall utilize the data submitted to it pursuant to this subsection to identify staffing needs throughout the State, anticipate potential staffing shortages, and develop strategies to promptly respond to anticipated shortages.

c. During an outbreak, epidemic, or pandemic involving an infectious disease, the LTCEOC shall establish a system for communicating test results for the infectious disease among long-term care facilities for individuals who are employed or providing services at multiple facilities, provided that such system is limited to ensuring facilities are on notice of which employees of the facility have tested positive for the infectious disease and otherwise includes safeguards against the unlawful disclosure of personal identifying information and private health information. Facilities receiving information about an employee through the system established under this subsection shall not use or disseminate the reported information for any purpose other than to ensure the facility's staffing needs are met and to identify and prevent against the possible transmission of the infectious disease at the facility through possible contact with the identified employee.**]**[2]

[2]**[**4. The Department of Health shall develop plans for the placement of patients who acquire an infectious disease during an outbreak, epidemic, or pandemic involving the infectious disease but who do not require hospitalization, which plan shall apply in the event of a surge in cases of the infectious disease that exceeds safe capacity levels in long-term care facilities. At a minimum, the placement plan shall include protocols for the rapid establishment of at least three regional hubs capable of accepting patients who have, and are capable of transmitting, the infectious disease and who do not require hospitalization, which hubs shall comply with State and federal guidance regarding infection control practices related to the infectious disease. In the event of a surge in cases of the infectious disease, the LTCEOC shall actively monitor capacity levels at long-term care facilities and at any regional hubs established under this section, and shall take steps to direct patient placements as necessary to manage capacity levels and ensure, to the extent possible, that no regional hub or long-term care facility exceeds safe capacity levels.**]**[2]

[2]**[**5.**]** 3. (New section)[2] a. [2]**[**No later than 30 days after the effective date of this act, the Department of Health shall develop a plan and provide guidance to long-term care facilities on how the facilities can comply with and implement federal guidance on accepting new residents at the facility and allowing in-person visits with residents of the facility during the ongoing coronavirus disease 2019 (COVID-19) pandemic, which guidance shall be developed in consultation with the LTCEOC established pursuant to section 1 of this act. The guidance shall, at a minimum**]** During an infectious disease outbreak occurring at a long-term care facility, or an epidemic or pandemic of an infectious disease affecting or likely to affect a long-term care facility, each long-term care facility shall[2] :

(1) [2]**[**require each long-term care facility to have:

(a) adequate isolation rooms or isolation capabilities to allow for effective cohorting of both residents and staff;

(b) an adequate minimum supply of personal protective equipment and test kits for COVID-19 on hand; and

(c) sufficient staff, which may be augmented through contingency plans and training programs, to enable the facility to fully meet its responsibilities to residents as well as to ensuring the safety of staff and residents**]** separate residents who test positive for or who are suspected of having contracted the infectious disease from those who have not tested positive for, and are not suspected of having contracted, the infectious disease[2] ;

(2) [2]**[**define acceptable models of cohorting, appropriate staffing levels and staffing ratios, standards and protocols for distribution and use of personal protective equipment, and standards and protocols for COVID-19 testing**]** follow guidance issued by the federal Centers for Disease Control and Prevention or other appropriate entities as may be identified by the Commissioner of Health with regard to determining whether a resident who has contracted the infectious disease is recovered from the infectious disease, and the appropriate procedures and protocols for interactions between those residents and staff and other residents at the facility[2] ; and

(3) [2]**[**establish standards and procedures for ensuring distribution of personal protective equipment and COVID-19 test kits to facilities that are unable to obtain them on their own**]** comply with current orders, guidance, and directives concerning admissions and readmissions to the facility[2] .

b. [2]**[**The department shall establish a centralized online resource to answer frequently asked questions and provide educational sessions, focus groups, and support services to the long-term care industry in implementing the guidance developed pursuant to subsection a. of this section.

c. Each long-term care facility in the State shall submit to the department, prior to admitting new residents to the facility and allowing in-person visits with residents of the facility to resume, an attestation of compliance with federal requirements and the guidelines issued pursuant to subsection a. of this section. If, at any time after resuming new admissions and in-person visitations, the long-term care facility identifies issues or encounters circumstances that require a modified approach to new admissions and in-person visits or that require ending new admissions or in-person visits, the facility shall promptly report those issues or circumstances to the LTCEOC.

d.**]**[2] [1]**[**No general acute care hospital shall discharge any patient to a long-term care facility during the COVID-19 pandemic unless the facility has**]** The Department of Health shall establish a

mechanism by which hospitals can identify long-term care facilities that [2][have][1] submitted an attestation to the department pursuant to subsection c. of this section and][2] [1][is] are[1] currently accepting [2][new residents] admissions and readmissions of residents to the facility[2] .

[2][e. The LTCEOC shall establish a compliance check system comprising, as appropriate, testing, assistance, and clinical teams, to:

(1) periodically evaluate the ability of long-term care facilities to resume admitting new residents and allow in-person visits with residents; and

(2) render assistance to long-term care facilities as needed, including staff support and assistance in obtaining personal protective equipment, COVID-19 testing kits, or other necessary resources.

f. In developing guidance pursuant to subsection a. of this section, the department shall plan for potential or anticipated changes in federal policy that could affect the ability of long-term care facilities, or health care professionals in general, to respond to the COVID-19 pandemic, including changes that could restrict professional scope of practice or coverage under a health benefits plan for services provided to long-term care facility residents.][2]

[2][6. a. No later than 30 days after the effective date of this act, the Department of Health shall develop standards and protocols for COVID-19 testing in long-term care facilities in order to minimize the risk that staff and residents of long-term care facilities may be exposed to COVID-19 through interaction with other persons present at the facility.

b. The standards and protocols developed pursuant to subsection a. of this section shall:

(1) prioritize use of the most effective forms and methods of testing as are currently available;

(2) provide guidance for long-term care facilities to implement comprehensive testing using the facility's own resources and funding;

(3) establish methods to avoid duplicative testing of staff members employed by or providing professional services at more than one long-term care facility, including facilitating communication among facilities employing or utilizing the services of the same professionals;

(4) require long-term care facilities to provide on-site testing services to facility staff at a frequency as shall be required by the Department of Health;

(5) include protocols for establishing mobile testing units [1][, supported by a general acute care hospital,][1] on an expedited basis when needed to respond to COVID-19 testing demands; and

(6) in the event that it becomes necessary to establish routine testing at a long-term care facility, allow for use of the least invasive, most cost-effective method of testing that is consistent with department guidelines and best practices for infection control and reducing the risk of COVID-19 transmission.

c. The standards and protocols developed pursuant to subsection a. of this section may include:

(1) specific testing requirements based on local infection rates and risk factors;

(2) protocols for determining when testing will be limited to those symptomatic for COVID-19, when testing will be mandated for all visitors to a long-term care facility, and when testing will be at the discretion of the long-term care facility;

(3) a mechanism for long-term care facilities to partner with a general acute care hospital in the region for the purpose of providing or supporting COVID-19 testing at the long-term care facility; and

(4) the establishment of a network of preferred clinical laboratories for the purposes of performing COVID-19 testing.

d. The LTCEOC established pursuant to section 1 of this act shall support COVID-19 testing protocols in long-term care facilities through the coordinated distribution of available supplies and other resources to long-term care facilities and by assisting facilities to identify and access available sources of funding.

e. The Commissioner of Health, the Commissioner of Human Services, and the Commissioner of Banking and Insurance shall jointly develop strategies to ensure reimbursement of COVID-19 tests performed pursuant to this section through health benefits plans, Medicaid and NJ FamilyCare, Medicare, and State and federal funds made available for this purpose.**]**[2]

[2]**[**7.**]** 4. (New section)[2] The Commissioner of Health and the Commissioner of Human Services shall take steps to ensure available and appropriate sources of federal funding provided to states in response to the COVID-19 pandemic are made available to long-term care facilities. The commissioners may condition awards of funding made pursuant to this section on long-term care facilities providing regular reports on how the funding is used, including any evidence as may be needed to confirm the facilities are complying with all terms and conditions that attach to the funding, as well as information concerning steps the facility is taking to improve the facility's preparedness and response to the COVID-19 pandemic, including establishing and updating staff and patient safety and isolation protocols, expanding access to personal protective equipment and COVID-19 testing, and making improvements to the facility's equipment and physical plant that will help prevent the spread of communicable diseases within the facility.

²[8.] 5. (New section)² a. ²[No later than 60 days after the effective date of this act, the Department of Health shall coordinate with appropriate State and federal entities to consolidate all State and federal data reporting related to the COVID-19 pandemic through the NJHA PPE, Supply & Capacity Portal maintained by the New Jersey Hospital Association. The department shall migrate the NJHA portal onto department systems and shall communicate the changes made pursuant to this subsection to long-term care facilities. The department may enter into such agreements with the New Jersey Hospital Association as are necessary to implement the provisions of this subsection.

b. No later than 30 days after the effective date of this act, the department shall undertake a review of State, federal, county, and local reporting requirements for long-term care facilities related to COVID-19 and take steps to standardize and consolidate the reporting requirements for the purpose of reducing the administrative demand on the facilities of complying with reporting requirements and improving the utility of the reported data and the ability to share the data across systems, including systems maintained by other State departments and agencies, county and local agencies, and federal authorities.

c. No later than 90 days after the effective date of this act, the department shall centralize its internal COVID-19 and long-term care facility data reporting and storage systems for the purpose of improving the utility of the reported data and the ability to share the data across systems, including systems maintained by other State departments and agencies, county and local agencies, and federal authorities charged with responding to the COVID-19 pandemic. At a minimum, the centralized systems shall:

(1) incorporate a function that automatically transmits alerts concerning long-term care facilities that report COVID-19 metrics exceeding established thresholds for new COVID-19 cases and COVID-19-related deaths to governmental points-of-contact at departments, agencies, and entities having jurisdiction over the long-term care facility or that are otherwise to be involved in the COVID-19 response at the facility; and

(2) receive and compile complaints concerning long-term care facilities received from any other State department or agency, which complaints shall be reviewed by the department on a regular basis for the purpose of identifying and formulating an appropriate response to facilities with chronic, repeat, or acute issues presenting a threat to the health or safety of residents and staff at the facility.

d. The department shall provide support to smaller long-term care facilities to assist the facilities in upgrading and enhancing their health information technology systems to allow for ready communication with State, county, and local entities to which the facilities are required to report or with which the facilities are required to communicate regarding COVID-19. Support provided

to the facilities under this section shall include, as necessary, staff support, technical assistance, and financial support, including identifying available State, federal, and private sources of funding as may be available to the facilities to upgrade and enhance their health information technology systems.**]** During a public health emergency involving an infectious disease affecting or likely to affect a long-term care facility, the long-term care facility shall report to the National Healthcare Safety Network database managed by the federal Centers for Disease Control and Prevention, at least twice per week:

(1) counts of residents and facility personnel with suspected cases of the infectious disease and who have a laboratory test confirming infection with the infectious disease;

(2) counts of residents and facility personnel whose death is suspected to have been, or was confirmed by laboratory test to have been, caused by the infectious disease;

(3) the total number of authorized resident beds and the current resident census;

(4) staffing shortages;

(5) the quantity of personal protective equipment, hand hygiene supplies, cleaning supplies, and sanitization supplies, along with an assessment of the number of days that will be supported by current inventory;

(6) for facilities with ventilator-dependent units, ventilator capacity and the quantity of ventilator supplies, along with an assessment of the number of days that will be supported by current inventory; and

(7) any other metrics as the Commissioner of Health shall require as an essential or relevant component of the State's response to the infectious disease outbreak, epidemic, or pandemic in long-term care facilities.

b. To facilitate the enforcement of P.L.2019, c.330 (C.26:2H-18.79), commencing with the onset of influenza season each year and for the duration of that influenza season, each long-term care facility and home health employer in the State shall report to the National Healthcare Safety Network database managed by the federal Centers for Disease Control and Prevention the number of employees who have received the influenza vaccination, the number of employees who have not received the influenza vaccination due to an authorized medical exemption, and the number of employees who have not received the influenza vaccination who do not have a valid medical exemption.

c. A long-term care facility that fails to submit a report required pursuant to subsection a. or subsection b. of this section shall be liable to a civil penalty of $2,000 for each report that is not submitted. A civil penalty assessed pursuant to this section shall be collected by and in the name of the Department of Health in summary proceedings before a court of competent jurisdiction

pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).[2]

[2]6. (New section) a. No later than 270 days after the effective date of this act, each long-term care facility shall implement or upgrade to an electronic health record system certified by the Office of the National Coordinator for Health Information Technology in the U.S. Department of Health and Human Services that is capable of information sharing through industry standard data interoperability, including application programming interface Health Level 7 or fast healthcare interoperability technology. Use cases built on this technology shall include the bi-directional capability for admission discharge and transfer and continuity of care through the clinical data architecture. Long-term care facilities interoperability for these use cases shall be achieved by connecting to the New Jersey Health Information Network.

b. Subject to the availability of funding for this purpose, the Department of Health shall make grants available to long-term care facilities to provide assistance in implementing or upgrading to an electronic health record system that meets the requirements of subsection a. of this section, which grants shall be distributed to long-term care facilities based on demonstrated need.[2]

[2]7. Section 1 of P.L.2019, c.243 (C.26:2H-12.87) is amended to read as follows:

1. a. As used in this section:

"Cohorting" means the practice of grouping patients who are or are not colonized or infected with the same organism to confine their care to one area and prevent contact with other patients.

"Department" means the Department of Health.

"Endemic level" means the usual level of given disease in a geographic area.

"Isolating" means the process of separating sick, contagious persons from those who are not sick.

"Long-term care facility" means a nursing home, assisted living residence, comprehensive personal care home, residential health care facility, or dementia care home licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

"Long-term care facility that provides care to ventilator-dependent residents" means a long-term care facility that has been licensed to provide beds for ventilator care.

"Outbreak" means any unusual occurrence of disease or any disease above background or endemic levels.

b. Notwithstanding any provision of law to the contrary, the department shall require long-term care facilities to develop an outbreak response plan within 180 days after the effective date of this act, which plan shall be customized to the facility, based upon national standards and developed in consultation with the facility's

infection control committee, if the facility has established an infection control committee. At a minimum, each facility's plan shall include, but shall not be limited to:

(1) a protocol for isolating and cohorting infected and at-risk patients in the event of an outbreak of a contagious disease until the cessation of the outbreak;

(2) clear policies for the notification of residents, residents' families, visitors, and staff in the event of an outbreak of a contagious disease at a facility;

(3) information on the availability of laboratory testing, protocols for assessing whether facility visitors are ill, protocols to require ill staff to not present at the facility for work duties, and processes for implementing evidence-based outbreak response measures;

(4) policies to conduct routine monitoring of residents and staff to quickly identify signs of a communicable disease that could develop into an outbreak; **[**and**]**

(5) policies for reporting outbreaks to public health officials in accordance with applicable laws and regulations; and

(6) a documented strategy for securing more staff in the event of an outbreak of infectious disease among staff or another emergent or non-emergent situation affecting staffing levels at the facility during an outbreak of an infectious disease.

c. (1) In addition to the requirements set forth in subsection b. of this section, the department shall require long-term care facilities that provide care to ventilator-dependent residents to include in the facility's outbreak response plan written policies to meet staffing, training, and facility demands during an infectious disease outbreak to successfully implement the outbreak response plan, including either employing on a full-time or part-time basis, or contracting with on a consultative basis, the following individuals:

(a) an individual certified by the Certification Board of Infection Control and Epidemiology; and

(b) a physician who has completed an infectious disease fellowship.

(2) Each long-term care facility that provides care to ventilator-dependent residents shall submit to the department the facility's outbreak response plan within 180 days after the effective date of this act.

(3) The department shall verify that the outbreak response plans submitted by long-term care facilities that provide care to ventilator-dependent residents are in compliance with the requirements of subsection b. of this section and with the requirements of paragraph (1) of this subsection.

d. (1) Each long-term care facility that submits an outbreak response plan to the department pursuant to subsection c. of this section shall review the plan on an annual basis.

(2) If a long-term care facility that provides care to ventilator-dependent residents makes any material changes to its outbreak response plan, the facility shall, within 30 days after completing the material change, submit to the department an updated outbreak response plan. The department shall, upon receiving an updated outbreak response plan, verify that the plan is compliant with the requirements of subsections b. and c. of this section.

e. (1) The department shall require a long-term care facility that provides care to ventilator-dependent residents to assign to the facility's infection control committee on a full-time or part-time basis, or on a consultative basis:

(a) an who is a physician who has completed an infectious disease fellowship; and

(b) an individual designated as the infection control coordinator, who has education, training, completed course work, or experience in infection control or epidemiology, including certification in infection control by the Certification Board of Infection Control and Epidemiology. The infection control committee shall meet on at least a quarterly basis and both individuals assigned to the committee pursuant to this subsection shall attend at least half of the meetings held by the infection control committee.[2]

(cf: P.L.2019, c.243, s.1)

[2][[1]9.] 8. (New section)[2] No later than 18 months after the effective date of this act, the Commissioner of Health shall prepare and submit a report to the Governor and, pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), to the Legislature, concerning the implementation of the provisions of this act and any recommendations for appropriate legislative or administrative actions as may be appropriate to advance or improve the State's infectious disease planning, preparedness, and response.[1]

[1][9.] [2][10.[1]] 9.[2] This act shall take effect immediately.

Establishes certain requirements concerning State's preparedness and response to infectious disease outbreaks, including coronavirus disease 2019 (COVID-19) pandemic.

ASSEMBLY, No. 4476

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED JULY 30, 2020

Sponsored by:
Assemblywoman VALERIE VAINIERI HUTTLE
District 37 (Bergen)
Assemblyman LOUIS D. GREENWALD
District 6 (Burlington and Camden)
Assemblyman CHRISTOPHER P. DEPHILLIPS
District 40 (Bergen, Essex, Morris and Passaic)

Co-Sponsored by:
Assemblyman Benson, Assemblywomen Speight, Dunn, Assemblyman Caputo, Assemblywomen McKnight, DiMaso, Reynolds-Jackson and Assemblyman Johnson

SYNOPSIS

Establishes certain requirements concerning State's preparedness and response to infectious disease outbreaks, including coronavirus disease 2019 (COVID-19) pandemic.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 8/24/2020)

AN ACT concerning the State's response to outbreaks, epidemics, and pandemics involving infectious diseases and supplementing Title 26 of the Revised Statutes and P.L.2005, c.222 (C.26:13-1 et seq.).

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. a. There is established in the Department of Health the Long-Term Care Emergency Operations Center (LTCEOC), which shall serve as the centralized command and resource center for long-term care facility response efforts and communications during infectious disease outbreaks, epidemics, and pandemics affecting or likely to affect one or more long-term care facilities. The LTCEOC shall build off and integrate with existing State, county, and local emergency response systems. The LTCEOC shall be established and operational within 30 days after the effective date of this act.

b. The Department of Health shall have primary responsibility for the operations of the LTCEOC, but the Department of Human Services and other appropriate State agencies shall provide any staff support as shall be requested by the Commissioner of Health. The Commissioner of Health may additionally contract with a third party entity to provide staffing services as needed. At a minimum, the Commissioner of Health shall ensure that the LTCEOC has on call at all times such appropriate staff and consultants as are needed to respond to an emerging or ongoing infectious disease outbreak, epidemic, or pandemic affecting or likely to affect one or more long-term care facilities, including representatives from nursing homes, long-term care facilities, nursing home and long-term care facility staff, county and local boards of health, the Office of the New Jersey Long-Term Care Ombudsman, and the Office of Emergency Management in the New Jersey State Police, as well as experts in public health, infection control, elder affairs, disability services, emergency response, and medical transportation.

c. The LTCEOC shall establish ongoing, direct communication mechanisms and feedback loops, including an advisory council, to obtain real-time input from the owners and staff of long-term care facilities, unions, advocates representing residents of long-term care facilities and their families, individuals with expertise in the needs of people with specialized health care needs, and such other stakeholders as the Commissioner of Health deems necessary and appropriate during an infectious disease outbreak, epidemic, or pandemic affecting or likely to affect one or more long-term care facilities.

d. The LTCEOC shall designate a staff person from the Department of Health who shall serve as the designated liaison to the long-term care industry during an infectious disease outbreak,

epidemic, or pandemic affecting or likely to affect one or more long term care facilities.

e. The LTCEOC shall provide guidance to the State and to the Office of Emergency Management to ensure that: supplies needed to respond to an outbreak, epidemic, or pandemic involving an infectious disease are acquired and distributed in an effective and efficient manner among long-term care facilities; critical staffing shortages in long-term care facilities are identified and resolved quickly and effectively; issues that would jeopardize the health or safety of staff or residents of a long-term care facility, or that would impede or disrupt efforts to respond to an outbreak, epidemic, or pandemic involving an infectious disease, are promptly identified and addressed in an appropriate manner; and all policies and guidance are effectively communicated to all long-term care industry stakeholders to maximize the coordination and effectiveness of the State's response to an outbreak, epidemic, or pandemic involving an infectious disease affecting one or more long-term care facilities.

f. The LTCEOC may develop a data dashboard to collect and analyze real-time issues and challenges occurring in long-term care facilities during an outbreak, epidemic, or pandemic involving an infectious disease, as well as emerging issue areas and items of concern, so as to enable the appropriate authorities to direct a proactive response to those challenges and issues before the challenges and issues develop into matters of critical concern. Any dashboard developed by the LTCEOC may build from or incorporate materials from other data dashboards or similar features developed and maintained by any other entity of State, county, or local government, to the extent necessary to avoid duplication of work, facilitate communications and data sharing, and ensure the integrity, comprehensiveness, and utility of information included in the LTCEOC data dashboard.

g. The LTCEOC shall develop guidance and best practices in response to an outbreak, epidemic, or pandemic involving an infectious disease concerning, as appropriate, infection control, symptom monitoring, and the use of telemedicine and telehealth to provide contactless health care services. The guidance and best practices shall be transmitted to appropriate State, county, and local departments and agencies for dissemination to industry and to providers. The guidance and best practices may additionally be transmitted to federal agencies coordinating the national response to the outbreak, epidemic, or pandemic, if any, including, but not limited to, the federal Centers for Disease Control and Prevention, the federal Centers for Medicare and Medicaid Services, and the U.S. Department of Health and Human Services, as well as such international bodies, including the World Health Organization, as may be involved with the response to the outbreak, epidemic, or pandemic.

h. As used in sections 1 through 3 of P.L. , c. (C.) (pending before the Legislature as this bill), "infectious disease" means a disease caused by a living organism or other pathogen, including a fungus, bacteria, parasite, protozoan, virus, or prion. An infectious disease may, or may not, be transmissible from person to person, animal to person, or insect to person.

2. a. No later than 90 days after the effective date of this act, the Department of Health shall institute a regional medical coordination center model for disaster response to facilitate regional capacity coordination and communication across county and local boards of health, hospitals, long-term care facilities, emergency medical services providers and other first responders, and entities providing medical transportation services, in the event of a public health emergency involving an outbreak, epidemic, or pandemic involving an infectious disease. At a minimum, the model shall include a system for pairing long-term care facilities, emergency medical services providers and other first responders, and entities providing medical transportation services with a hospital located in the same region for the purpose of providing the long-term care facility, emergency medical services provider or other first responder, and medical transportation provider with consultative services regarding infectious diseases, infection control, and emergency resource coordination, as well as support testing as may be needed.

b. The department shall identify appropriate sources of State, federal, and private funding to facilitate the implementation of this section, including, but not limited to, any funding or other support as may be available through the Federal Emergency Management Agency.

3. a. No later than 60 days after the effective date of this act, each long-term care facility shall develop plans, in coordination with the LTCEOC established pursuant to section 1 of this act, to maintain mandatory long-term care facility staffing levels by replacing facility staff members who are required to isolate or quarantine because of exposure to or infection with an infectious disease, particularly during periods when there is an outbreak, epidemic, or pandemic involving the infectious disease. Long-term care facility plans may include, but shall not be limited to:

(1) establishing staffing teams to provide temporary interim support in the event of staff shortages at the facility, which teams may be developed and operated in coordination with a general acute care hospital;

(2) executing contracts with other long-term care facilities and with general acute care hospitals located in the same region to provide staff support on an as-needed basis;

(3) utilizing the National Guard or other resources as may be deployed or otherwise made available to respond to an outbreak, epidemic, or pandemic involving the infectious disease; and

(4) utilizing the services of qualified volunteers, within the scope of the volunteers' training and experience, which volunteer services are coordinated through the LTCEOC.

b. During an outbreak, epidemic, or pandemic of an infectious disease affecting or likely to affect long-term care facilities, the Department of Health shall require long-term care facilities to provide the LTCEOC with an outline of the facility's regular staffing requirements, and to promptly notify the LTCEOC in the event any staff member tests positive for the infectious disease or is required to isolate or quarantine based on infection with or exposure to the infectious disease. The LTCEOC shall utilize the data submitted to it pursuant to this subsection to identify staffing needs throughout the State, anticipate potential staffing shortages, and develop strategies to promptly respond to anticipated shortages.

c. During an outbreak, epidemic, or pandemic involving an infectious disease, the LTCEOC shall establish a system for communicating test results for the infectious disease among long-term care facilities for individuals who are employed or providing services at multiple facilities, provided that such system is limited to ensuring facilities are on notice of which employees of the facility have tested positive for the infectious disease and otherwise includes safeguards against the unlawful disclosure of personal identifying information and private health information. Facilities receiving information about an employee through the system established under this subsection shall not use or disseminate the reported information for any purpose other than to ensure the facility's staffing needs are met and to identify and prevent against the possible transmission of the infectious disease at the facility through possible contact with the identified employee.

4. The Department of Health shall develop plans for the placement of patients who acquire an infectious disease during an outbreak, epidemic, or pandemic involving the infectious disease but who do not require hospitalization, which plan shall apply in the event of a surge in cases of the infectious disease that exceeds safe capacity levels in long-term care facilities. At a minimum, the placement plan shall include protocols for the rapid establishment of at least three regional hubs capable of accepting patients who have, and are capable of transmitting, the infectious disease and who do not require hospitalization, which hubs shall comply with State and federal guidance regarding infection control practices related to the infectious disease. In the event of a surge in cases of the infectious disease, the LTCEOC shall actively monitor capacity levels at long-term care facilities and at any regional hubs established under this section, and shall take steps to direct patient

placements as necessary to manage capacity levels and ensure, to the extent possible, that no regional hub or long-term care facility exceeds safe capacity levels.

5. a. No later than 30 days after the effective date of this act, the Department of Health shall develop a plan and provide guidance to long-term care facilities on how the facilities can comply with and implement federal guidance on accepting new residents at the facility and allowing in-person visits with residents of the facility during the ongoing coronavirus disease 2019 (COVID-19) pandemic, which guidance shall be developed in consultation with the LTCEOC established pursuant to section 1 of this act. The guidance shall, at a minimum:

(1) require each long-term care facility to have:

(a) adequate isolation rooms or isolation capabilities to allow for effective cohorting of both residents and staff;

(b) an adequate minimum supply of personal protective equipment and test kits for COVID-19 on hand; and

(c) sufficient staff, which may be augmented through contingency plans and training programs, to enable the facility to fully meet its responsibilities to residents as well as to ensuring the safety of staff and residents;

(2) define acceptable models of cohorting, appropriate staffing levels and staffing ratios, standards and protocols for distribution and use of personal protective equipment, and standards and protocols for COVID-19 testing; and

(3) establish standards and procedures for ensuring distribution of personal protective equipment and COVID-19 test kits to facilities that are unable to obtain them on their own.

b. The department shall establish a centralized online resource to answer frequently asked questions and provide educational sessions, focus groups, and support services to the long-term care industry in implementing the guidance developed pursuant to subsection a. of this section.

c. Each long-term care facility in the State shall submit to the department, prior to admitting new residents to the facility and allowing in-person visits with residents of the facility to resume, an attestation of compliance with federal requirements and the guidelines issued pursuant to subsection a. of this section. If, at any time after resuming new admissions and in-person visitations, the long-term care facility identifies issues or encounters circumstances that require a modified approach to new admissions and in-person visits or that require ending new admissions or in-person visits, the facility shall promptly report those issues or circumstances to the LTCEOC.

d. No general acute care hospital shall discharge any patient to a long-term care facility during the COVID-19 pandemic unless the facility has submitted an attestation to the department pursuant to

subsection c. of this section and is currently accepting new residents.

e. The LTCEOC shall establish a compliance check system comprising, as appropriate, testing, assistance, and clinical teams, to:

(1) periodically evaluate the ability of long-term care facilities to resume admitting new residents and allow in-person visits with residents; and

(2) render assistance to long-term care facilities as needed, including staff support and assistance in obtaining personal protective equipment, COVID-19 testing kits, or other necessary resources.

f. In developing guidance pursuant to subsection a. of this section, the department shall plan for potential or anticipated changes in federal policy that could affect the ability of long-term care facilities, or health care professionals in general, to respond to the COVID-19 pandemic, including changes that could restrict professional scope of practice or coverage under a health benefits plan for services provided to long-term care facility residents.

6. a. No later than 30 days after the effective date of this act, the Department of Health shall develop standards and protocols for COVID-19 testing in long-term care facilities in order to minimize the risk that staff and residents of long-term care facilities may be exposed to COVID-19 through interaction with other persons present at the facility.

b. The standards and protocols developed pursuant to subsection a. of this section shall:

(1) prioritize use of the most effective forms and methods of testing as are currently available;

(2) provide guidance for long-term care facilities to implement comprehensive testing using the facility's own resources and funding;

(3) establish methods to avoid duplicative testing of staff members employed by or providing professional services at more than one long-term care facility, including facilitating communication among facilities employing or utilizing the services of the same professionals;

(4) require long-term care facilities to provide on-site testing services to facility staff at a frequency as shall be required by the Department of Health;

(5) include protocols for establishing mobile testing units, supported by a general acute care hospital, on an expedited basis when needed to respond to COVID-19 testing demands; and

(6) in the event that it becomes necessary to establish routine testing at a long-term care facility, allow for use of the least invasive, most cost-effective method of testing that is consistent

with department guidelines and best practices for infection control and reducing the risk of COVID-19 transmission.

c. The standards and protocols developed pursuant to subsection a. of this section may include:

(1) specific testing requirements based on local infection rates and risk factors;

(2) protocols for determining when testing will be limited to those symptomatic for COVID-19, when testing will be mandated for all visitors to a long-term care facility, and when testing will be at the discretion of the long-term care facility;

(3) a mechanism for long-term care facilities to partner with a general acute care hospital in the region for the purpose of providing or supporting COVID-19 testing at the long-term care facility; and

(4) the establishment of a network of preferred clinical laboratories for the purposes of performing COVID-19 testing.

d. The LTCEOC established pursuant to section 1 of this act shall support COVID-19 testing protocols in long-term care facilities through the coordinated distribution of available supplies and other resources to long-term care facilities and by assisting facilities to identify and access available sources of funding.

e. The Commissioner of Health, the Commissioner of Human Services, and the Commissioner of Banking and Insurance shall jointly develop strategies to ensure reimbursement of COVID-19 tests performed pursuant to this section through health benefits plans, Medicaid and NJ FamilyCare, Medicare, and State and federal funds made available for this purpose.

7. The Commissioner of Health and the Commissioner of Human Services shall take steps to ensure available and appropriate sources of federal funding provided to states in response to the COVID-19 pandemic are made available to long-term care facilities. The commissioners may condition awards of funding made pursuant to this section on long-term care facilities providing regular reports on how the funding is used, including any evidence as may be needed to confirm the facilities are complying with all terms and conditions that attach to the funding, as well as information concerning steps the facility is taking to improve the facility's preparedness and response to the COVID-19 pandemic, including establishing and updating staff and patient safety and isolation protocols, expanding access to personal protective equipment and COVID-19 testing, and making improvements to the facility's equipment and physical plant that will help prevent the spread of communicable diseases within the facility.

8. a. No later than 60 days after the effective date of this act, the Department of Health shall coordinate with appropriate State and federal entities to consolidate all State and federal data

reporting related to the COVID-19 pandemic through the NJHA PPE, Supply & Capacity Portal maintained by the New Jersey Hospital Association. The department shall migrate the NJHA portal onto department systems and shall communicate the changes made pursuant to this subsection to long-term care facilities. The department may enter into such agreements with the New Jersey Hospital Association as are necessary to implement the provisions of this subsection.

b. No later than 30 days after the effective date of this act, the department shall undertake a review of State, federal, county, and local reporting requirements for long-term care facilities related to COVID-19 and take steps to standardize and consolidate the reporting requirements for the purpose of reducing the administrative demand on the facilities of complying with reporting requirements and improving the utility of the reported data and the ability to share the data across systems, including systems maintained by other State departments and agencies, county and local agencies, and federal authorities.

c. No later than 90 days after the effective date of this act, the department shall centralize its internal COVID-19 and long-term care facility data reporting and storage systems for the purpose of improving the utility of the reported data and the ability to share the data across systems, including systems maintained by other State departments and agencies, county and local agencies, and federal authorities charged with responding to the COVID-19 pandemic. At a minimum, the centralized systems shall:

(1) incorporate a function that automatically transmits alerts concerning long-term care facilities that report COVID-19 metrics exceeding established thresholds for new COVID-19 cases and COVID-19-related deaths to governmental points-of-contact at departments, agencies, and entities having jurisdiction over the long-term care facility or that are otherwise to be involved in the COVID-19 response at the facility; and

(2) receive and compile complaints concerning long-term care facilities received from any other State department or agency, which complaints shall be reviewed by the department on a regular basis for the purpose of identifying and formulating an appropriate response to facilities with chronic, repeat, or acute issues presenting a threat to the health or safety of residents and staff at the facility.

d. The department shall provide support to smaller long-term care facilities to assist the facilities in upgrading and enhancing their health information technology systems to allow for ready communication with State, county, and local entities to which the facilities are required to report or with which the facilities are required to communicate regarding COVID-19. Support provided to the facilities under this section shall include, as necessary, staff support, technical assistance, and financial support, including identifying available State, federal, and private sources of funding

as may be available to the facilities to upgrade and enhance their health information technology systems.

9. This act shall take effect immediately.

STATEMENT

This bill establishes certain requirements concerning the State's preparedness and response regarding infectious disease outbreaks, epidemics, and pandemics affecting long-term care facilities. Certain of the requirements established under the bill are specific to the coronavirus disease 2019 (COVID-19) pandemic, other requirements will apply to both the COVID-19 pandemic and to future infectious disease outbreaks, epidemics, and pandemics.

The bill establishes the Long-Term Care Emergency Operations Center (LTCEOC) in the Department of Health (DOH), which will serve as the centralized command and resource center for long-term care facility response efforts and communications during infectious disease outbreaks, epidemics, and pandemics affecting or likely to affect one or more long-term care facilities. The LTCEOC, which is to be established no later than 30 days after the effective date of the bill, is to build off and integrate with existing emergency response systems.

The DOH will have primary responsibility for the operations of the LTCEOC, but the Department of Human Services and other appropriate State agencies are to provide any staff support requested by the DOH. The DOH may additionally contract with a third party entity to provide staffing services as needed. At a minimum, the LTCEOC will be required to have on call at all times such appropriate staff and consultants as are needed to respond to an emerging or ongoing outbreak, epidemic, or pandemic, including representatives from nursing homes, long-term care facilities, nursing home and long-term care facility staff, county and local boards of health, the Office of the New Jersey Long-Term Care Ombudsman, and the Office of Emergency management in the New Jersey State Police, as well as experts in public health, infection control, elder affairs, disability services, emergency response, and medical transportation.

The LTCEOC will be required to establish ongoing, direct communication mechanisms and feedback loops, including an advisory council, to obtain real-time input from the owners and staff of long-term care facilities, unions, advocates representing residents of long-term care facilities and their families, individuals with expertise in the needs of people with specialized health care needs, and such other stakeholders as the DOH deems necessary and appropriate during an outbreak, epidemic, or pandemic affecting or potentially affecting long-term care facilities. The

LTCEOC will also designate a staff person from the DOH who will serve as designated liaison to the long-term care industry during an outbreak, epidemic, or pandemic.

The LTCEOC will provide guidance to the State and to the Office of Emergency Management to ensure that: supplies needed to respond to an outbreak, epidemic, or pandemic are acquired and distributed in an effective and efficient manner; critical staffing shortages in long-term care facilities are identified and resolved in an effective and efficient manner; issues that would jeopardize the health or safety of staff or residents of a long-term care facility, or that would impede or disrupt efforts to respond to an outbreak, epidemic, or pandemic are promptly identified and appropriately addressed; and all policies and guidance are effectively communicated to all long-term care industry stakeholders to maximize the coordination and effectiveness of the State's response to an outbreak, epidemic, or pandemic affecting long-term care facilities.

The LTCEOC will have the authority to develop a data dashboard to collect and analyze real-time issues and challenges occurring in long-term care facilities during an infectious disease outbreak, epidemic, or pandemic, as well as emerging issue areas and items of concern, so as to enable the appropriate authorities to direct a proactive response to those challenges and issues before the challenges and issues develop into matters of critical concern. Any dashboard developed by the LTCEOC may build from or incorporate materials from other data dashboards or similar features developed and maintained by any other entity of State, county, or local government, to the extent necessary to avoid duplication of work, facilitate communications and data sharing, and ensure the integrity, comprehensiveness, and utility of information included in the LTCEOC data dashboard.

The LTCEOC will be required to develop guidance and best practices in response to an infectious disease outbreak, epidemic, or pandemic concerning, as may be appropriate, infection control, symptom monitoring, and the use of telemedicine and telehealth to provide contactless health care services. The guidance and best practices are to be transmitted to appropriate State, county, and local departments and agencies for dissemination to industry and to providers. The guidance and best practices may additionally be transmitted to any federal and international agencies as may be involved with a national or international response to the infectious disease outbreak, epidemic, or pandemic.

The bill requires the DOH to institute, no later than 90 days after the effective date of the bill, a regional medical coordination center model for disaster response to facilitate regional capacity coordination and communication across county and local boards of health, hospitals, long-term care facilities, emergency medical services providers and other first responders, and entities providing

medical transportation, in the event of a public health emergency involving a communicable disease outbreak, epidemic, or pandemic. At a minimum, the model is to include a system for pairing long-term care facilities, emergency medical services providers and other first responders, and medical transportation entities with a hospital located in the same region for the purpose of providing the long-term care facility with consultative services regarding infectious diseases, infection control, and emergency resource coordination, as well as support testing as may be needed. The DOH is to identify appropriate sources of State, federal, and private funding to implement the regional medical coordination center model.

Within 60 days after the effective date of the bill, each long-term care facility will be required to develop plans, in coordination with the LTCEOC, to maintain mandatory long-term care facility staffing levels by replacing facility staff who isolate or quarantine because of infection with or exposure to an infectious disease, particularly during an outbreak, epidemic, or pandemic involving the infectious disease. These plans may include: establishing staffing teams to provide temporary interim support; executing contracts with other long-term care facilities and with general acute care hospitals located in the same region to provide staff support on an as-needed basis; utilizing the National Guard or other resources as may be deployed or otherwise made available in response to an outbreak, epidemic, or pandemic; and utilizing the services of qualified volunteers.

During an outbreak, epidemic, or pandemic involving an infectious disease, long-term care facilities are to provide the LTCEOC with an outline of the facility's regular staffing requirements and promptly notify the LTCEOC in the event any staff member tests positive for the infectious disease or is required to isolate or quarantine based on infection or exposure to the infectious disease. The LTCEOC will utilize this data to identify staffing needs throughout the State, anticipate potential staffing shortages, and develop strategies to promptly respond to anticipated shortages.

During an outbreak, epidemic, or pandemic involving an infectious disease, the LTCEOC will be required to establish a system for communicating test results for the infectious disease among long-term care facilities for individuals who are employed by or providing services in multiple facilities. The system will be limited to ensuring facilities are on notice of which employees of the facility have tested positive for the infectious disease, and will include safeguards against the unlawful disclosure of personal identifying information and private health information. Facilities receiving information about an employee through the system will be prohibited from using or disseminating the reported information for any purpose other than to ensure the facility's staffing needs are

met and to identify and prevent against the possible transmission of the infectious disease at the facility through contact with the identified employee.

The DOH will be required to develop plans for the placement of patients who contract an infectious disease during an outbreak, epidemic, or pandemic of the disease but who do not require hospitalization, which plan will apply in the event of a surge in new cases of the infectious disease that exceeds safe capacity levels in long-term care facilities. At a minimum, the placement plan is to include the rapid establishment of at least three regional hubs capable of accepting patients with the infectious disease who do not require hospitalization, which hubs are to comply with State and federal guidance regarding infection control practices related to the infectious disease. In the event of a surge in cases of the infectious disease, the LTCEOC will be required to actively monitor capacity levels at long-term care facilities and at regional hubs and take steps to direct patient placements as necessary to manage safe capacity levels.

Within 30 days after the effective date of the bill, the DOH will be required to develop a plan and provide guidance to long-term care facilities on how the facilities can comply with and implement federal guidance on accepting new residents at the facility and allow in-person visits with residents of the facility during the ongoing coronavirus disease 2019 (COVID-19) pandemic, which guidance is to be developed in consultation with the LTCEOC. The guidance is to include specific requirements related to isolation and cohorting, stockpiling and distributing personal protective equipment (PPE) and COVID-19 test kits, and staffing. The DOH will be required to establish a centralized online resource to answer frequently asked questions and provide educational sessions, focus groups, and support services to the long-term care industry in implementing the guidance developed under the bill.

In developing guidance, the DOH will be required to plan for potential or anticipated changes in federal policy that could affect the ability of long-term care facilities, or health care professionals in general, to respond to the COVID-19 pandemic, including changes that could restrict professional scope of practice or coverage under a health benefits plan for services provided to long-term care facility residents.

Each long-term care facility will be required to submit to the DOH, prior to admitting new residents to the facility and resuming in-person visitation with facility residents during the ongoing COVID-19 pandemic, an attestation of compliance with federal requirements and the guidelines issued under the bill. If, at any time after resuming new admissions and in-person visitations, the long-term care facility identifies issues or encounters circumstances that require a modified approach to new admissions and in-person visits or that require ending new admissions or in-person visits, the

facility will be required to promptly report those issues or circumstances to the LTCEOC. The bill prohibits general acute care hospitals from discharging any patient to a long-term care facility during the COVID-19 pandemic if the facility has not met these requirements.

The LTCEOC will be required to establish a compliance check system comprising, as appropriate, testing, assistance, and clinical teams, to periodically evaluate the ability of long-term care facilities to resume new admissions and in-person visitation and render assistance to the facilities as needed, including staff support and assistance in obtaining PPE, COVID-19 testing kits, or other necessary resources.

Within 30 days after the effective date of the bill, the DOH will be required to develop standards and protocols for COVID-19 testing in long-term care facilities in order to minimize the risk that staff and residents of long-term care facilities may be exposed to COVID-19 through interaction with other persons present at the facility. The standards and protocols are to prioritize use of the most effective forms and methods of testing, provide guidance for facilities to implement comprehensive testing using the facility's own resources and funding; establish methods to avoid duplicative testing of staff members employed by or providing professional services at more than one long-term care facility, require long-term care facilities to provide on-site testing services to facility staff, include protocols for establishing mobile testing units on an expedited basis when needed, and allow facilities flexibility in implementing routine testing if it becomes necessary.

The standards and protocols may additionally include specific testing requirements based on local infection rates and risk factors, protocols for determining in which situations testing will be mandatory, a mechanism for hospitals to provide or support COVID-19 testing in long-term care facilities, and the establishment of a network of preferred clinical laboratories for COVID-19 testing.

The LTCEOC will be required to support COVID-19 testing protocols in long-term care facilities through the coordinated distribution of available supplies and other resources to long-term care facilities and by assisting facilities with identifying and accessing available sources of funding.

The Commissioner of Health, the Commissioner of Human Services, and the Commissioner of Banking and Insurance will be required to jointly develop strategies to ensure reimbursement of COVID-19 tests performed under the bill through health benefits plans, Medicaid and NJ FamilyCare, Medicare, and State and federal funds made available for this purpose.

The bill requires the Commissioner of Health and the Commissioner of Human Services to take steps to ensure available and appropriate sources of federal funding provided to states in

response to the COVID-19 pandemic are made available to long-term care facilities. The commissioners may condition awards of funding on long-term care facilities providing regular reports on how the funding is used, including evidence of compliance with any conditions attached to the funding and information concerning the steps the facility is taking to improve the facility's preparedness and response to the COVID-19 pandemic.

The bill requires the DOH, no later than 60 days after the effective date of the bill, to coordinate with appropriate State and federal entities to consolidate all State and federal data reporting related to the COVID-19 pandemic through the NJHA PPE, Supply & Capacity Portal maintained by the New Jersey Hospital Association (NJHA). The DOH will migrate the NJHA portal onto DOH systems and communicate the change to long-term care facilities. The DOH will be authorized to enter into any necessary agreements with the NJHA.

No later than 30 days after the effective date of the bill, the DOH will be required to undertake a review of State, federal, county, and local reporting requirements for long-term care facilities related to COVID-19 and take steps to standardize and consolidate the reporting requirements in order to reduce the burden of compliance for facilities, improve the utility of the reported data, and improve the ability to share the data across systems. No later than 90 days after the effective date of the bill, the DOH is to centralize its internal COVID-19 and long-term care facility data reporting and storage systems to facilitate data sharing across systems. The centralized systems are to: (1) incorporate a function that automatically transmits alerts concerning COVID-19 outbreaks and deaths in long-term care facilities to appropriate governmental agencies, and (2) receive and compile complaints concerning long-term care facilities received from any other State department or agency to facilitate the response to chronic, repeat, or acute issues related to the health or safety of residents and staff at the facility.

The DOH will be required to provide support to smaller long-term care facilities to assist with upgrades and enhancements to their health information technology systems to allow for ready communication with State, county, and local entities regarding COVID-19. Support provided to the facilities may include staff support, technical assistance, and financial support.

ASSEMBLY AGING AND SENIOR SERVICES COMMITTEE

STATEMENT TO

ASSEMBLY, No. 4476

with committee amendments

STATE OF NEW JERSEY

DATED: AUGUST 21, 2020

The Assembly Aging and Senior Services Committee reports favorably and with committee amendments Assembly Bill No. 4476.

As amended by the committee, this bill establishes certain requirements concerning the State's preparedness and response regarding infectious disease outbreaks, epidemics, and pandemics affecting long-term care facilities. Certain of the requirements established under the bill are specific to the coronavirus disease 2019 (COVID-19) pandemic, other requirements will apply to both the COVID-19 pandemic and to future infectious disease outbreaks, epidemics, and pandemics.

The bill establishes the Long-Term Care Emergency Operations Center (LTCEOC) in the Department of Health (DOH), which will serve as the centralized command and resource center for long-term care facility response efforts and communications during any hazardous event, including, but not limited to, infectious disease outbreaks, epidemics, and pandemics affecting or likely to affect one or more long-term care facilities. The LTCEOC, which is to be established no later than 30 days after the effective date of the bill, is to enhance and integrate with existing emergency response systems.

The DOH will have primary responsibility for the operations of the LTCEOC, but the Department of Human Services and other appropriate State agencies are to provide any staff support requested by the DOH. The DOH may additionally contract with a third party entity to provide staffing services as needed. At a minimum, the LTCEOC will be required to have on call at all times such appropriate staff and consultants as are needed to respond to an emerging or ongoing outbreak, epidemic, or pandemic, including representatives from nursing homes, long-term care facilities, nursing home and long-term care facility staff, general acute care hospitals, long-term care hospitals, psychiatric hospitals, home health and hospice agencies, and Programs of All-Inclusive Care for the Elderly (PACE) organizations, county and local boards of health, the Office of the New Jersey Long-Term Care Ombudsman, and the Office of Emergency management in the New Jersey State Police, as well as experts in public health, infection control, elder affairs, disability services, emergency response, and medical transportation.

The LTCEOC will be required to establish ongoing, direct communication mechanisms and feedback loops, including an advisory council, to obtain real-time input from the owners and staff of long-term care facilities, unions, advocates representing residents of long-term care facilities and their families, individuals with expertise in the needs of people with specialized health care needs, and such other stakeholders as the DOH deems necessary and appropriate during an outbreak, epidemic, or pandemic affecting or potentially affecting long-term care facilities. The LTCEOC will also designate a staff person from the DOH who will serve as designated liaison to the long-term care industry during an outbreak, epidemic, or pandemic.

The LTCEOC will provide guidance to the State and to the Office of Emergency Management to ensure that: supplies needed to respond to an outbreak, epidemic, or pandemic are acquired and distributed in an effective and efficient manner; critical staffing shortages in long-term care facilities are identified and resolved in an effective and efficient manner; issues that would jeopardize the health or safety of staff or residents of a long-term care facility, or that would impede or disrupt efforts to respond to an outbreak, epidemic, or pandemic are promptly identified and appropriately addressed; and all policies and guidance are effectively communicated to all long-term care industry stakeholders to maximize the coordination and effectiveness of the State's response to an outbreak, epidemic, or pandemic affecting long-term care facilities.

The LTCEOC will have the authority to develop a data dashboard to collect and analyze real-time issues and challenges occurring in long-term care facilities during an infectious disease outbreak, epidemic, or pandemic, as well as emerging issue areas and items of concern, so as to enable the appropriate authorities to direct a proactive response to those challenges and issues before the challenges and issues develop into matters of critical concern. Any dashboard developed by the LTCEOC may build from or incorporate materials from other data dashboards or similar features developed and maintained by any other entity of State, county, or local government, to the extent necessary to avoid duplication of work, facilitate communications and data sharing, and ensure the integrity, comprehensiveness, and utility of information included in the LTCEOC data dashboard.

The LTCEOC will be required to develop guidance and best practices in response to an infectious disease outbreak, epidemic, or pandemic concerning, as may be appropriate, infection control, symptom monitoring, and the use of telemedicine and telehealth to provide contactless health care services.

As amended, the bill requires the DOH to institute, no later than 90 days after the effective date of the bill, a regional medical coordination center model for disaster response to facilitate regional capacity coordination and communication across county and local boards of

health, hospitals, long-term care facilities, emergency medical services providers and other first responders, and entities providing medical transportation, in the event of a public health emergency involving a communicable disease outbreak, epidemic, or pandemic. At a minimum, the model is to include a system for engaging the Level 1 trauma center in the region with long-term care facilities, federally qualified healthcare centers, home health agencies, hospice providers, medical transportation providers, long-term care facilities, emergency medical services providers and other first responders, and medical transportation entities in its associated region. The Regional Level 1 Trauma Center and its associated regional medical coordination center shall make available their various clinical and non-clinical content experts and services are available for consultation and support to facilitate the implementation of evidence-based best practices and informed decision making. The DOH is to identify appropriate sources of State, federal, and private funding to implement the regional medical coordination center model.

Within 60 days after the effective date of the bill, each long-term care facility will be required to develop plans, in coordination with the LTCEOC, to maintain mandatory long-term care facility staffing levels by replacing facility staff who isolate or quarantine because of infection with or exposure to an infectious disease, particularly during an outbreak, epidemic, or pandemic involving the infectious disease.

During an outbreak, epidemic, or pandemic involving an infectious disease, long-term care facilities are to provide the LTCEOC with an outline of the facility's regular staffing requirements and promptly notify the LTCEOC in the event any staff member tests positive for the infectious disease or is required to isolate or quarantine based on infection or exposure to the infectious disease. The LTCEOC will utilize this data to identify staffing needs throughout the State, anticipate potential staffing shortages, and develop strategies to promptly respond to anticipated shortages.

During an outbreak, epidemic, or pandemic involving an infectious disease, the LTCEOC will be required to establish a system for communicating test results for the infectious disease among long-term care facilities for individuals who are employed by or providing services in multiple facilities. The system will be limited to ensuring facilities are on notice of which employees of the facility have tested positive for the infectious disease, and will include safeguards against the unlawful disclosure of personal identifying information and private health information. Facilities receiving information about an employee through the system will be prohibited from using or disseminating the reported information for any purpose other than to ensure the facility's staffing needs are met and to identify and prevent against the possible transmission of the infectious disease at the facility through contact with the identified employee.

The DOH will be required to develop plans for the placement of patients who contract an infectious disease during an outbreak, epidemic, or pandemic of the disease but who do not require hospitalization, which plan will apply in the event of a surge in new cases of the infectious disease that exceeds safe capacity levels in long-term care facilities. At a minimum, the placement plan is to include the rapid establishment of at least three regional hubs capable of accepting patients with the infectious disease who do not require hospitalization, which hubs are to comply with State and federal guidance regarding infection control practices related to the infectious disease. In the event of a surge in cases of the infectious disease, the LTCEOC will be required to actively monitor capacity levels at long-term care facilities and at regional hubs and take steps to direct patient placements as necessary to manage safe capacity levels.

Within 30 days after the effective date of the bill, the DOH will be required to develop a plan and provide guidance to long-term care facilities on how the facilities can comply with and implement federal guidance on accepting new residents at the facility and allow in-person visits with residents of the facility during the ongoing coronavirus disease 2019 (COVID-19) pandemic, which guidance is to be developed in consultation with the LTCEOC. The guidance is to include specific requirements related to isolation and cohorting, stockpiling and distributing personal protective equipment (PPE) and COVID-19 test kits, and staffing. The DOH will be required to establish a centralized online resource to answer frequently asked questions and provide educational sessions, focus groups, and support services to the long-term care industry in implementing the guidance developed under the bill.

In developing guidance, the DOH will be required to plan for potential or anticipated changes in federal policy that could affect the ability of long-term care facilities, or health care professionals in general, to respond to the COVID-19 pandemic, including changes that could restrict professional scope of practice or coverage under a health benefits plan for services provided to long-term care facility residents.

Each long-term care facility will be required to submit to the DOH, prior to admitting new residents to the facility and resuming in-person visitation with facility residents during the ongoing COVID-19 pandemic, an attestation of compliance with federal requirements and the guidelines issued under the bill. If, at any time after resuming new admissions and in-person visitations, the long-term care facility identifies issues or encounters circumstances that require a modified approach to new admissions and in-person visits or that require ending new admissions or in-person visits, the facility will be required to promptly report those issues or circumstances to the LTCEOC. The bill requires the DOH to establish a system for general acute care

hospitals to determine which long-term care facilities are in compliance with these requirements and are accepting new residents.

The LTCEOC will be required to establish a compliance check system comprising, as appropriate, testing, assistance, and clinical teams, to periodically evaluate the ability of long-term care facilities to resume new admissions and in-person visitation and render assistance to the facilities as needed, including staff support and assistance in obtaining PPE, COVID-19 testing kits, or other necessary resources.

Within 30 days after the effective date of the bill, the DOH will be required to develop standards and protocols for COVID-19 testing in long-term care facilities in order to minimize the risk that staff and residents of long-term care facilities may be exposed to COVID-19 through interaction with other persons present at the facility. The standards and protocols are to prioritize use of the most effective forms and methods of testing, provide guidance for facilities to implement comprehensive testing using the facility's own resources and funding; establish methods to avoid duplicative testing of staff members employed by or providing professional services at more than one long-term care facility, require long-term care facilities to provide on-site testing services to facility staff, including protocols for establishing mobile testing units on an expedited basis when needed, and allow facilities flexibility in implementing routine testing if it becomes necessary.

The standards and protocols may additionally include specific testing requirements based on local infection rates and risk factors, protocols for determining in which situations testing will be mandatory, a mechanism for hospitals to provide or support COVID-19 testing in long-term care facilities, and the establishment of a network of preferred clinical laboratories for COVID-19 testing.

The LTCEOC will be required to support COVID-19 testing protocols in long-term care facilities through the coordinated distribution of available supplies and other resources to long-term care facilities and by assisting facilities with identifying and accessing available sources of funding.

The Commissioner of Health, the Commissioner of Human Services, and the Commissioner of Banking and Insurance will be required to jointly develop strategies to ensure reimbursement of COVID-19 tests performed under the bill through health benefits plans, Medicaid and NJ FamilyCare, Medicare, and State and federal funds made available for this purpose.

The bill requires the Commissioner of Health and the Commissioner of Human Services to take steps to ensure available and appropriate sources of federal funding provided to states in response to the COVID-19 pandemic are made available to long-term care facilities. The commissioners may condition awards of funding on long-term care facilities providing regular reports on how the funding is used, including evidence of compliance with any conditions attached

to the funding and information concerning the steps the facility is taking to improve the facility's preparedness and response to the COVID-19 pandemic.

The bill requires the DOH, no later than 60 days after the effective date of the bill, to coordinate with appropriate State and federal entities to consolidate all State and federal data reporting related to the COVID-19 pandemic through the NJHA PPE, Supply & Capacity Portal maintained by the New Jersey Hospital Association (NJHA). The DOH will migrate the NJHA portal onto DOH systems and communicate the change to long-term care facilities. The DOH will be authorized to enter into any necessary agreements with the NJHA.

No later than 30 days after the effective date of the bill, the DOH will be required to undertake a review of State, federal, county, and local reporting requirements for long-term care facilities related to COVID-19 and take steps to standardize and consolidate the reporting requirements in order to reduce the burden of compliance for facilities, improve the utility of the reported data, and improve the ability to share the data across systems. No later than 90 days after the effective date of the bill, the DOH is to centralize its internal COVID-19 and long-term care facility data reporting and storage systems to facilitate data sharing across systems. The centralized systems are to: (1) incorporate a function that automatically transmits alerts concerning COVID-19 outbreaks and deaths in long-term care facilities to appropriate governmental agencies, and (2) receive and compile complaints concerning long-term care facilities received from any other State department or agency to facilitate the response to chronic, repeat, or acute issues related to the health or safety of residents and staff at the facility.

The DOH will be required to provide support to smaller long-term care facilities to assist with upgrades and enhancements to their health information technology systems to allow for ready communication with State, county, and local entities regarding COVID-19. Support provided to the facilities may include staff support, technical assistance, and financial support.

As amended by the committee, the bill requires the DOH to prepare and submit a report to the Governor and the Legislature, no later than 18 months after the effective date of the bill, concerning the implementation of the provisions of the bill and any recommendations for appropriate legislative or administrative actions as may be appropriate to advance or improve the State's infectious disease planning, preparedness, and response.

COMMITTEE AMENDMENTS:

The committee amendments revise the duties of the Long Term Care Emergency Operations Center (LTCEOC) established under the bill to apply to any hazardous event, not just outbreaks of infectious disease.

The committee amendments provide that the LTCEOC may call to its assistance representatives of general acute care hospitals, psychiatric hospitals, home health and hospice agencies, and Programs of All-Inclusive Care for the Elderly (PACE) organizations, in addition to the private and public entities enumerated in the bill as introduced.

The committee amendments remove a requirement that guidance produced by the LTCEOC concerning infectious disease response be distributed to other State, national, and international entities.

The committee amendments revise the requirements for the establishment of a regional medical coordination center model to require the model be developed in consultation with the Emergency Medical Services Task Force. The committee amendments additionally replace a requirement that various health care entities be paired with a general acute care hospital that will provide support services, to instead provide that the model utilize a Level 1 Trauma center in each region to provide consultation and support services to facilitate evidence-based best practices and informed decision making.

The committee amendments remove language enumerating certain potential components of a long-term care facility's staffing replacement plans.

The committee amendments remove language prohibiting hospitals from discharging patients to long-term care facilities that do not have an approved new admissions and visitation plan in place to instead require the DOH to develop a mechanism for hospitals to identify facilities that have met the requirements to accept new residents.

The committee amendments revise a requirement that the mobile COVID-19 testing units be supported by a general acute care hospital.

The committee amendments add a requirement that the DOH report to the Governor and the Legislature concerning implementation of the provisions of the bill.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

ASSEMBLY, No. 4476

with committee amendments

STATE OF NEW JERSEY

DATED: AUGUST 24, 2020

The Assembly Appropriations Committee reports favorably and with committee amendments Assembly Bill No. 4476 (1R).

As amended by the committee, this bill establishes certain requirements concerning the State's preparedness and response regarding declared public health emergencies affecting long-term care facilities. Certain of the requirements established under the bill are specific to the coronavirus disease 2019 (COVID-19) pandemic, other requirements will apply to both the COVID-19 pandemic and to future public health emergencies.

The bill establishes the Long-Term Care Emergency Operations Center (LTCEOC) in the Department of Health (DOH), which will serve as the centralized command and resource center for long-term care facility response efforts and communications during any declared public health emergencies affecting or likely to affect one or more long-term care facilities. The LTCEOC is to enhance and integrate with existing emergency response systems.

The DOH will have primary responsibility for the operations of the LTCEOC, but the Department of Human Services and other appropriate State agencies are to provide any staff support requested by the DOH. The DOH may additionally contract with a third party entity to provide staffing services as needed. At a minimum, the LTCEOC will be required to have on call at all times such appropriate staff and consultants as are needed to respond to an emerging or ongoing outbreak, epidemic, or pandemic, including representatives from county and local boards of health, the Office of the New Jersey Long-Term Care Ombudsman, and the Office of Emergency management in the New Jersey State Police, the acute and post-acute health care industry, as well as experts in public health, infection control, elder affairs, disability services, emergency response, and medical transportation.

The primary responsibilities of the LTCEOC will include, but shall not be limited to:

(1) establishing ongoing, direct communication with the owners and staff of long-term care facilities and with associated entities

during a public health emergency, which may include the use of existing communication mechanisms and feedback loops in the DOH's Office of Disaster Resilience or Health Systems branch, as appropriate;

(2) providing technical assistance to the long-term care industry during the public health emergency, which may be facilitated through local health departments;

(3) ensuring supplies and equipment needed to respond to the public health emergency are acquired and distributed in an effective and efficient manner among long-term care facilities;

(4) utilizing the National Healthcare Safety Network (NHSN) database managed by the federal Centers for Disease Control and Prevention to identify shortages in staff and necessary equipment, monitor facility capacity levels, and track positive cases and deaths resulting from infectious diseases; and

(5) ensuring all policies and guidance developed by the DOH in response to the public health emergency are effectively communicated to all long-term care industry stakeholders.

As amended, the bill requires that, in the event of a public health emergency declared in response to an infectious disease outbreak, epidemic, or pandemic affecting long-term care facilities, the LTCEOC, in consultation with other offices within the DOH and the Office of Emergency Management (OEM) in the New Jersey Division of State Police, will determine whether it is necessary to establish regional hubs capable of accepting patients who have, and are capable of transmitting, the infectious disease and who do not require hospitalization. In the event of a surge in number of identified cases of the infectious disease, the LTCEOC will be required to actively monitor capacity levels at long-term care facilities using the NHSN database and at any regional hubs established under this subsection, and shall take steps to direct patient placements as necessary to manage capacity levels and ensure, to the extent possible, that no regional hub or long-term care facility exceeds safe capacity levels.

As amended, the bill requires the DOH to institute, no later than 180 days after the effective date of the bill, a regional medical coordination center model for disaster response to facilitate regional capacity coordination and communication across county and local boards of health, hospitals, long-term care facilities, emergency medical services providers and other first responders, and entities providing medical transportation, in the event of a public health emergency involving a communicable disease outbreak, epidemic, or pandemic. At a minimum, the model is to include a system for engaging the Level 1 trauma center in the region with long-term care facilities, federally qualified healthcare centers, home health agencies, hospice providers, medical transportation providers, long-term care facilities, emergency medical services providers and other first responders, and medical transportation entities in its associated

region. The Regional Level 1 Trauma Center and its associated regional medical coordination center shall make available their various clinical and non-clinical content experts and services are available for consultation and support to facilitate the implementation of evidence-based best practices and informed decision making. The DOH is to identify appropriate sources of State, federal, and private funding to implement the regional medical coordination center model.

As amended, the bill requires long-term care facilities, during an infectious disease outbreak occurring at the long-term care facility or an epidemic or pandemic affecting or likely to affect the long-term care facility, to separate residents who have tested positive for or who are suspected of having contracted the infectious disease from residents who have not tested positive for, and who are not suspected of having contracted, the infectious disease. Facilities will be required to comply with guidance concerning how to determine whether a resident who contracted the infectious disease is recovered from the disease, as well as procedures and protocols for interactions between those residents and other residents and staff at the facility. Facilities will further be required to comply with current orders, guidance, and directives concerning admissions and readmissions to the facility.

The bill, as amended, requires the DOH to establish a mechanism for hospitals to identify long-term care facilities that are currently accepting residents for admission or readmission to the facility.

As amended, the bill requires that, during a public health emergency involving an infectious disease affecting or likely to affect a long-term care facility, the long-term care facility will be required to report to the NHSN database, at least twice per week: (1) counts of residents and facility personnel with suspected cases of the infectious disease and who have a laboratory test confirming infection with the infectious disease; (2) counts of residents and facility personnel with suspected and confirmed deaths from the infectious disease; (3) the total number of authorized resident beds and the current resident census; (4) staffing shortages; (5) the quantity of personal protective equipment, hand hygiene supplies, cleaning supplies, and sanitization supplies, along with an assessment of the number of days that will be supported by current inventory; (6) for facilities with ventilator-dependent units, ventilator capacity and the quantity of ventilator supplies, along with an assessment of the number of days that will be supported by current inventory; and (7) any other metrics required by as the Commissioner of Health as an essential or relevant component of the State's response to the infectious disease outbreak, epidemic, or pandemic in long-term care facilities.

In addition, to facilitate the enforcement of P.L.2019, c.330 (C.26:2H-18.79), which requires health care facility employees to receive the annual influenza vaccination, during each influenza season, long-term care facilities and home health employers will be required to

report to the NHSN database the number of employees who have received the influenza vaccination, the number of employees who have not received the influenza vaccination due to an authorized medical exemption, and the number of employees who have not received the influenza vaccination who do not have a valid medical exemption.

A long-term care facility that fails to submit a required report to the NHSN will be liable to a civil penalty of $2,000 for each report that is not submitted.

As amended by the committee, the bill requires each long-term care facility, no later than 270 days after the effective date of the bill to implement or upgrade to an electronic health record system certified by the Office of the National Coordinator for Health Information Technology in the U.S. Department of Health and Human Services that is capable of information sharing through industry standard data interoperability, including application programming interface Health Level 7 or fast healthcare interoperability technology. Use cases built on this technology are to include the bi-directional capability for admission discharge and transfer and continuity of care through the clinical data architecture. Long-term care facilities interoperability for these use cases is to be achieved by connecting to the New Jersey Health Information Network.

Subject to the availability of funding for this purpose, the DOH will be required to make grants available to long-term care facilities to provide assistance in implementing or upgrading to an electronic health record system that meets these requirements, which grants will be distributed to long-term care facilities based on demonstrated need.

The bill requires long-term care facilities to include in the facility's statutorily-required outbreak response plan a documented strategy for securing more staff in the event of an outbreak of infectious disease among staff or other emergent or non-emergent situation affecting staffing levels at the facility during an outbreak of an infectious disease.

The bill requires the DOH to prepare and submit a report to the Governor and the Legislature, no later than 18 months after the effective date of the bill, concerning the implementation of the provisions of the bill and any recommendations for appropriate legislative or administrative actions as may be appropriate to advance or improve the State's infectious disease planning, preparedness, and response.

COMMITTEE AMENDMENTS:

The committee amendments revise the requirements for the Long Term Care Emergency Operations Center (LTCEOC) established under the bill to apply to declared states of public emergency, rather than any hazardous event. The amendments remove a requirement

that the LTCEOC be established within 30 days after the effective date of the bill.

The committee amendments revise the membership of the LTCEOC to remove requirements that representatives of specific entities within the long-term care industry be included on the LTCEOC, and instead provide that the Department of Health (DOH) is to have on call representatives from the acute and post-acute health care industry.

The committee amendments revise the specific duties of the LTCEOC to clarify that the LTCEOC will facilitate ongoing direct communications during a public health emergency, but will be authorized to use existing communications mechanisms available to certain entities with the DOH. The amendments further provide that the LTCEOC may utilize the National Healthcare Safety Network (NHSN) database managed by the federal Centers for Disease Control and Prevention to track data related to the emergency and will be tasked with ensuring all policies and guidance developed by the DOH in response to the public health emergency are effectively communicated to all long-term care industry stakeholders.

The committee amendments revise the requirements for the DOH to institute a regional medical coordination center model to provide that the DOH will have 180 days to institute the model, rather than 90 days, and that the model is to be instituted in consultation with the Office of Emergency Management, as well as the Emergency Medical Services Council.

The committee amendments remove certain language from the bill that would have required long-term care facilities to develop plans to address staffing shortages, and instead provide that each facility's statutorily-required outbreak response plan include a documented strategy for securing more staff in the event of an outbreak of infectious disease among staff or in other situations that may affect staffing levels at the facility during an infectious disease outbreak.

The committee amendments remove language from the bill that would have required long-term care facilities to report staffing information to the LTCEOC, and for the LTCEOC to institute a system for tracking employees who test positive for an infectious disease across employers.

The committee amendments add provisions requiring that, during infectious disease outbreaks, epidemics, and pandemics affecting a long-term care facility, the facility will be required to cohort residents, follow certain guidance concerning determining whether a resident who contracted an infectious disease is recovered from the disease and protocols and procedures concerning interactions between that resident and other residents and staff at the facility, and comply with current orders, guidance, and directives concerning resident admissions and readmissions to the facility.

The committee amendments remove language that would have required the DOH develop guidance for long-term care facilities to accept new residents and allow indoor visitation with residents and to develop an online resource center to facilitate new admissions and visitation, and for the LTCEOC to institute a compliance check system.

The committee amendments revise the requirement for the DOH to establish a mechanism for hospitals to identify long-term care facilities that have met certain requirements to accept new residents to the facility, which requirements were removed by committee amendment, to instead provide that the mechanism is to allow hospitals to identify long-term care facilities that are currently accepting admissions and readmissions of residents to the facility.

The committee amendments remove language that would have required the DOH to institute COVID-19 testing standards and protocols for long-term care facility residents and staff.

The committee amendments remove provisions from the bill that would have required the DOH to coordinate with other entities to streamline and consolidate COVID-19 data reporting for long-term care facilities, and to provide technical assistance to smaller long-term care facilities to upgrade and enhance their data systems.

The committee amendments add a requirement that long-term care facilities report certain information during an infectious disease outbreak, epidemic, or pandemic to the NHSN, including cases and deaths involving the infectious disease, resident capacity levels, staffing shortages, and quantities of essential equipment. Additionally, the committee amendments add a requirement that long-term care facilities and home health employers report certain data concerning employee influenza vaccinations during each flu season. Failure to make a required report will be punishable by a civil penalty of $2,000 per violation.

The committee amendments add a requirement that all long-term care facilities institute or upgrade electronic health records systems that meet certain requirements. Subject to the availability of funding, the amendments require the DOH to make grants available to support long-term care facilities in instituting or upgrading electronic health records systems, with the grants to be distributed based on demonstrated need.

FISCAL IMPACT:

The Office of Legislative Services (OLS) estimates that this bill, as amended, may result in an indeterminate increase in costs incurred by the Department of Health (DOH) in establishing the Long-Term Care Emergency Operations Center (LTCEOC) and in fulfilling the LTCEOC's duties, as outlined in the bill. These cost will be minimized to the extent that the department can: 1) reallocate resources from existing entities, such as the DOH's Office of Disaster

Resilience or Health Systems branch; 2) request and receive staff support from the Department of Human Services or other State agencies, as provided for in the bill; and 3) use existing communications mechanisms, as well as any overlap with current department duties, to fulfill the provisions of the bill. The OLS notes that any costs associated with the LTCEOC will only be realized during a public health emergency affecting or likely to affect one or more long-term care (LTC) facilities, the trigger for making the LTCEOC operational.

The OLS finds that the DOH may realize certain one-time cost increases under the bill in instituting a regional medical coordination center model and in submitting a report to the Governor and the Legislature concerning the implementation of the provisions of the bill.

The OLS estimates that nursing homes operated by the Division of Military and Veterans Affairs (DMAVA) and certain county governments may incur expenses in complying with the reporting requirements outlined in the bill and in upgrading facility electronic health records (EHR) systems. The OLS notes that the bill directs the DOH, subject to availability, to make grants to LTC facilities to provide assistance in upgrading an EHR system, which may minimize the impact of this provision on the above facilities. Currently, the DMAVA operates three facilities, while there are nine county facilities: three in Bergen County; two in Middlesex County; and one each in Atlantic County, Cape May County, Gloucester County, and Passaic County

LEGISLATIVE FISCAL ESTIMATE

[Second Reprint]

ASSEMBLY, No. 4476

STATE OF NEW JERSEY
219th LEGISLATURE

DATED: AUGUST 31, 2020

SUMMARY

Synopsis: Establishes certain requirements concerning State's preparedness and response to infectious disease outbreaks, including coronavirus disease 2019 (COVID-19) pandemic.

Type of Impact: One-time and annual increases in State and local expenditures; potential periodic increase in State revenue.

Agencies Affected: Department of Health; Department of Military and Veterans Affairs; Department of Human Services; University Hospital; certain county governments.

Office of Legislative Services Estimate

Fiscal Impact	Annual
State Cost Increase	Indeterminate
Potential State Revenue Increase	Indeterminate
Local Cost Increase	Indeterminate

- The Office of Legislative Services (OLS) estimates that this bill may result in an indeterminate increase in annual costs incurred by the Department of Health (DOH) in establishing the Long-Term Care Emergency Operations Center (LTCEOC) and in fulfilling the LTCEOC's duties, as outlined in the bill, to the extent that the department cannot minimize such costs with existing resources and staff. The OLS notes that any costs associated with the LTCEOC will be limited to expenses realized during a public health emergency affecting or likely to affect one or more long-term care (LTC) facilities, the trigger for making the LTCEOC operational.

- The DOH may realize certain one-time cost increases under the bill due to, for example, instituting a regional medical coordination center model and providing grants to LTC facilities regarding electronic health records (EHR) systems. The bill, however, provides for certain provisions that may minimize or eliminate some of the department's expenses.

- The OLS estimates that nursing homes operated by the Department of Military and Veterans Affairs (DMAVA) and certain county governments may incur minimal periodic expenses in complying with the reporting and infectious disease protocol requirements outlined in the bill,

as such provisions largely codify existing directives issued by the DOH. Such facilities may also incur costs in upgrading the facility's EHR systems, to the extent that these facilities do not currently meet the standards outlined in the bill and are not awarded grants made available for such purposes by the DOH, as provided for in the bill.

- The University Hospital, as a Level 1 trauma center and an independent non-profit legal entity that is an instrumentality of the State located in Newark, may incur certain costs in making clinical and non-clinical content experts available for consultation and support within the regional medical coordination center model established by the DOH under the bill.

- A provision imposing penalties on LTC facilities that fail to report certain information, as required under this bill, may increase State revenues by an indeterminate amount. As the number of facilities that may be penalized is unpredictable, the OLS is unable to determine the value of any revenue increase.

BILL DESCRIPTION

This bill establishes the LTCEOC in the DOH, which will serve as the centralized command and resource center for LTC facility response efforts and communications during any declared public health emergencies affecting or likely to affect one or more LTC facilities. The LTCEOC is to enhance and integrate with existing emergency response systems.

The DOH will have primary responsibility for the operations of the LTCEOC, but the Department of Human Services (DHS) and other appropriate State agencies are to provide any staff support requested by the DOH. The DOH may additionally contract with a third party entity to provide staffing services as needed. At a minimum, the LTCEOC will be required to have on call at all times such appropriate staff and consultants as are needed to respond to an emerging or ongoing outbreak, epidemic, or pandemic.

The primary responsibilities of the LTCEOC will include, but shall not be limited to:

(1) establishing ongoing, direct communication with the owners and staff of LTC facilities and with associated entities during a public health emergency, which may include the use of existing communication mechanisms and feedback loops in the DOH's Office of Disaster Resilience or Health Systems branch, as appropriate;

(2) providing technical assistance to the LTC industry during the public health emergency, which may be facilitated through local health departments;

(3) ensuring supplies and equipment needed to respond to the public health emergency are acquired and distributed in an effective and efficient manner among LTC facilities;

(4) utilizing the National Healthcare Safety Network (NHSN) database managed by the federal Centers for Disease Control and Prevention to identify shortages in staff and necessary equipment, monitor facility capacity levels, and track positive cases and deaths resulting from infectious diseases; and

(5) ensuring all policies and guidance developed by the DOH in response to the public health emergency are effectively communicated to all LTC industry stakeholders.

Additionally, the bill requires the LTCEOC to: 1) in consultation with other State offices, determine whether it is necessary to establish regional hubs capable of accepting LTC patients who have, and are capable of transmitting, the infectious disease and who do not require hospitalization; and 2) actively monitor capacity levels at LTC facilities and regional hubs in the event of a surge in number of identified cases of the infectious disease.

The bill requires the DOH to: 1) institute, and to identify the appropriate sources of funding to implement, a regional medical coordination center model, which must include the Level 1 trauma center in a region, for disaster response to facilitate regional capacity coordination and communication in the event of a public health emergency involving a communicable disease outbreak, epidemic, or pandemic; 2) establish a mechanism for hospitals to identify LTC facilities that are currently accepting residents for admission or readmission to the facility; 3) make grants available to LTC facilities to provide assistance in implementing or upgrading to an EHR system, subject to the availability of funding; and 4) prepare and submit a report to the Governor and the Legislature concerning the implementation the bill and any recommendations for action.

The bill requires LTC facilities, during an infectious disease outbreak occurring at the LTC facility or an epidemic or pandemic affecting or likely to affect the long-term care facility, to: 1) separate residents who have tested positive for or who are suspected of having contracted the infectious disease from other residents and to comply with any related guidance or protocols; and 2) report certain information regarding the facility's response to the infectious disease to the NHSN database, at least twice per week, or otherwise be liable to a civil penalty of $2,000 for each report that is not submitted. Outside of an infectious disease outbreak, an LTC is required to 1) include in the facility's statutorily-required outbreak response plan a documented strategy for securing more staff in the event that an outbreak of an infectious disease affects staffing levels at the facility; and 2) implement or upgrade to an EHR system, as described in the bill. During each influenza season, LTC facilities and home health employers will be required to report to the NHSN database certain information regarding the receipt of the influenza vaccination by employees.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS estimates that this bill may result in an indeterminate increase in annual costs incurred by the DOH in establishing the LTCEOC and in fulfilling the LTCEOC's duties, as outlined in the bill. These cost will be minimized to the extent that the department can: 1) reallocate resources from existing entities, such as the DOH's Office of Disaster Resilience or Health Systems branch; 2) request and receive staff support from the DHS or other State agencies, as provided for in the bill; and 3) use existing communications mechanisms, as well as any overlap with current department duties, to fulfill the provisions of the bill. The OLS notes that any costs associated with the LTCEOC will be limited to expenses realized during a public health emergency affecting or likely to affect one or more LTC facilities, the trigger for making the LTCEOC operational.

The OLS finds that the DOH may realize certain one-time cost increases under the bill in: instituting a regional medical coordination center model; establishing a mechanism for hospitals to identify LTC facilities receiving admissions; providing grants to LTC facilities regarding EHR systems; and complying with the reporting requirements established under the bill. The bill provides for certain provisions that may minimize or eliminate some of the department's expenses under the bill. For example, the DOH is authorized to identify and use non-State funds to implement the regional medical coordination center model. In addition, grants for EHR systems are subject to available funding.

The OLS estimates that nursing homes operated by the DMAVA and certain county governments may incur minimal expenses in complying with the reporting and infectious disease protocol requirements outlined in the bill, as such provisions largely codify existing directives issued by the department. For example, Executive Directive No. 20-026 requires all LTC facilities to report, at a minimum twice per week, COVID-19 cases, facility staffing, and supply information to the NHSN Long-Term Care Facility COVID-19 Module and reinforces DOH guidance regarding the separation of COVID-19 positive and negative residents.[1]

Nursing homes operated by the DMAVA and certain county governments may also incur costs in upgrading the facility's EHR systems, to the extent that such facilities do not currently meet the standards outlined in the bill. The OLS notes that the bill directs the DOH to award grants, subject to availability, to LTC facilities to provide assistance in upgrading an EHR system, which may minimize the impact of this provision on the above facilities. Currently, the DMAVA operates three facilities, while there are nine county facilities: three in Bergen County; two in Middlesex County; and one each in Atlantic County, Cape May County, Gloucester County, and Passaic County.

The OLS estimates that the University Hospital, as a Level 1 trauma center and an independent non-profit legal entity that is an instrumentality of the State located in Newark, may incur certain costs in making clinical and non-clinical content experts available for consultation and support within the regional medical coordination center model. As the scope of the University Hospital's role in the regional model is to be determined upon the enactment of the bill, the OLS cannot predict the cost of this provision.

A provision imposing penalties on LTC facilities that fail to report certain information, as required under this bill, may increase State revenues by an indeterminate amount. As the number of facilities that may be penalized is unpredictable, the OLS is unable to determine the value of any revenue increase.

Section:	*Human Services*
Analyst:	*Sarah Schmidt* *Senior Research Analyst*
Approved:	*Frank W. Haines III* *Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

[1] https://www.state.nj.us/health/legal/covid19/8-20_ExecutiveDirectiveNo20-026_LTCResumption_of_Svcs.pdf

SENATE, No. 2790

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED JULY 30, 2020

Sponsored by:
Senator JOSEPH P. CRYAN
District 20 (Union)
Senator JOSEPH F. VITALE
District 19 (Middlesex)

SYNOPSIS

Establishes certain requirements concerning State's preparedness and response to infectious disease outbreaks, including coronavirus disease 2019 (COVID-19) pandemic.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning the State's response to outbreaks, epidemics, and pandemics involving infectious diseases and supplementing Title 26 of the Revised Statutes and P.L.2005, c.222 (C.26:13-1 et seq.).

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. a. There is established in the Department of Health the Long-Term Care Emergency Operations Center (LTCEOC), which shall serve as the centralized command and resource center for long-term care facility response efforts and communications during infectious disease outbreaks, epidemics, and pandemics affecting or likely to affect one or more long-term care facilities. The LTCEOC shall build off and integrate with existing State, county, and local emergency response systems. The LTCEOC shall be established and operational within 30 days after the effective date of this act.

b. The Department of Health shall have primary responsibility for the operations of the LTCEOC, but the Department of Human Services and other appropriate State agencies shall provide any staff support as shall be requested by the Commissioner of Health. The Commissioner of Health may additionally contract with a third party entity to provide staffing services as needed. At a minimum, the Commissioner of Health shall ensure that the LTCEOC has on call at all times such appropriate staff and consultants as are needed to respond to an emerging or ongoing infectious disease outbreak, epidemic, or pandemic affecting or likely to affect one or more long-term care facilities, including representatives from nursing homes, long-term care facilities, nursing home and long-term care facility staff, county and local boards of health, the Office of the New Jersey Long-Term Care Ombudsman, and the Office of Emergency Management in the New Jersey State Police, as well as experts in public health, infection control, elder affairs, disability services, emergency response, and medical transportation.

c. The LTCEOC shall establish ongoing, direct communication mechanisms and feedback loops, including an advisory council, to obtain real-time input from the owners and staff of long-term care facilities, unions, advocates representing residents of long-term care facilities and their families, individuals with expertise in the needs of people with specialized health care needs, and such other stakeholders as the Commissioner of Health deems necessary and appropriate during an infectious disease outbreak, epidemic, or pandemic affecting or likely to affect one or more long-term care facilities.

d. The LTCEOC shall designate a staff person from the Department of Health who shall serve as the designated liaison to the long-term care industry during an infectious disease outbreak,

epidemic, or pandemic affecting or likely to affect one or more long term care facilities.

e. The LTCEOC shall provide guidance to the State and to the Office of Emergency Management to ensure that: supplies needed to respond to an outbreak, epidemic, or pandemic involving an infectious disease are acquired and distributed in an effective and efficient manner among long-term care facilities; critical staffing shortages in long-term care facilities are identified and resolved quickly and effectively; issues that would jeopardize the health or safety of staff or residents of a long-term care facility, or that would impede or disrupt efforts to respond to an outbreak, epidemic, or pandemic involving an infectious disease, are promptly identified and addressed in an appropriate manner; and all policies and guidance are effectively communicated to all long-term care industry stakeholders to maximize the coordination and effectiveness of the State's response to an outbreak, epidemic, or pandemic involving an infectious disease affecting one or more long-term care facilities.

f. The LTCEOC may develop a data dashboard to collect and analyze real-time issues and challenges occurring in long-term care facilities during an outbreak, epidemic, or pandemic involving an infectious disease, as well as emerging issue areas and items of concern, so as to enable the appropriate authorities to direct a proactive response to those challenges and issues before the challenges and issues develop into matters of critical concern. Any dashboard developed by the LTCEOC may build from or incorporate materials from other data dashboards or similar features developed and maintained by any other entity of State, county, or local government, to the extent necessary to avoid duplication of work, facilitate communications and data sharing, and ensure the integrity, comprehensiveness, and utility of information included in the LTCEOC data dashboard.

g. The LTCEOC shall develop guidance and best practices in response to an outbreak, epidemic, or pandemic involving an infectious disease concerning, as appropriate, infection control, symptom monitoring, and the use of telemedicine and telehealth to provide contactless health care services. The guidance and best practices shall be transmitted to appropriate State, county, and local departments and agencies for dissemination to industry and to providers. The guidance and best practices may additionally be transmitted to federal agencies coordinating the national response to the outbreak, epidemic, or pandemic, if any, including, but not limited to, the federal Centers for Disease Control and Prevention, the federal Centers for Medicare and Medicaid Services, and the U.S. Department of Health and Human Services, as well as such international bodies, including the World Health Organization, as may be involved with the response to the outbreak, epidemic, or pandemic.

h. As used in sections 1 through 3 of P.L. , c. (C.) (pending before the Legislature as this bill), "infectious disease" means a disease caused by a living organism or other pathogen, including a fungus, bacteria, parasite, protozoan, virus, or prion. An infectious disease may, or may not, be transmissible from person to person, animal to person, or insect to person.

2. a. No later than 90 days after the effective date of this act, the Department of Health shall institute a regional medical coordination center model for disaster response to facilitate regional capacity coordination and communication across county and local boards of health, hospitals, long-term care facilities, emergency medical services providers and other first responders, and entities providing medical transportation services, in the event of a public health emergency involving an outbreak, epidemic, or pandemic involving an infectious disease. At a minimum, the model shall include a system for pairing long-term care facilities, emergency medical services providers and other first responders, and entities providing medical transportation services with a hospital located in the same region for the purpose of providing the long-term care facility, emergency medical services provider or other first responder, and medical transportation provider with consultative services regarding infectious diseases, infection control, and emergency resource coordination, as well as support testing as may be needed.

b. The department shall identify appropriate sources of State, federal, and private funding to facilitate the implementation of this section, including, but not limited to, any funding or other support as may be available through the Federal Emergency Management Agency.

3. a. No later than 60 days after the effective date of this act, each long-term care facility shall develop plans, in coordination with the LTCEOC established pursuant to section 1 of this act, to maintain mandatory long-term care facility staffing levels by replacing facility staff members who are required to isolate or quarantine because of exposure to or infection with an infectious disease, particularly during periods when there is an outbreak, epidemic, or pandemic involving the infectious disease. Long-term care facility plans may include, but shall not be limited to:

(1) establishing staffing teams to provide temporary interim support in the event of staff shortages at the facility, which teams may be developed and operated in coordination with a general acute care hospital;

(2) executing contracts with other long-term care facilities and with general acute care hospitals located in the same region to provide staff support on an as-needed basis;

(3) utilizing the National Guard or other resources as may be deployed or otherwise made available to respond to an outbreak, epidemic, or pandemic involving the infectious disease; and

(4) utilizing the services of qualified volunteers, within the scope of the volunteers' training and experience, which volunteer services are coordinated through the LTCEOC.

b. During an outbreak, epidemic, or pandemic of an infectious disease affecting or likely to affect long-term care facilities, the Department of Health shall require long-term care facilities to provide the LTCEOC with an outline of the facility's regular staffing requirements, and to promptly notify the LTCEOC in the event any staff member tests positive for the infectious disease or is required to isolate or quarantine based on infection with or exposure to the infectious disease. The LTCEOC shall utilize the data submitted to it pursuant to this subsection to identify staffing needs throughout the State, anticipate potential staffing shortages, and develop strategies to promptly respond to anticipated shortages.

c. During an outbreak, epidemic, or pandemic involving an infectious disease, the LTCEOC shall establish a system for communicating test results for the infectious disease among long-term care facilities for individuals who are employed or providing services at multiple facilities, provided that such system is limited to ensuring facilities are on notice of which employees of the facility have tested positive for the infectious disease and otherwise includes safeguards against the unlawful disclosure of personal identifying information and private health information. Facilities receiving information about an employee through the system established under this subsection shall not use or disseminate the reported information for any purpose other than to ensure the facility's staffing needs are met and to identify and prevent against the possible transmission of the infectious disease at the facility through possible contact with the identified employee.

4. The Department of Health shall develop plans for the placement of patients who acquire an infectious disease during an outbreak, epidemic, or pandemic involving the infectious disease but who do not require hospitalization, which plan shall apply in the event of a surge in cases of the infectious disease that exceeds safe capacity levels in long-term care facilities. At a minimum, the placement plan shall include protocols for the rapid establishment of at least three regional hubs capable of accepting patients who have, and are capable of transmitting, the infectious disease and who do not require hospitalization, which hubs shall comply with State and federal guidance regarding infection control practices related to the infectious disease. In the event of a surge in cases of the infectious disease, the LTCEOC shall actively monitor capacity levels at long-term care facilities and at any regional hubs established under this section, and shall take steps to direct patient

placements as necessary to manage capacity levels and ensure, to the extent possible, that no regional hub or long-term care facility exceeds safe capacity levels.

5. a. No later than 30 days after the effective date of this act, the Department of Health shall develop a plan and provide guidance to long-term care facilities on how the facilities can comply with and implement federal guidance on accepting new residents at the facility and allowing in-person visits with residents of the facility during the ongoing coronavirus disease 2019 (COVID-19) pandemic, which guidance shall be developed in consultation with the LTCEOC established pursuant to section 1 of this act. The guidance shall, at a minimum:

(1) require each long-term care facility to have:

(a) adequate isolation rooms or isolation capabilities to allow for effective cohorting of both residents and staff;

(b) an adequate minimum supply of personal protective equipment and test kits for COVID-19 on hand; and

(c) sufficient staff, which may be augmented through contingency plans and training programs, to enable the facility to fully meet its responsibilities to residents as well as to ensuring the safety of staff and residents;

(2) define acceptable models of cohorting, appropriate staffing levels and staffing ratios, standards and protocols for distribution and use of personal protective equipment, and standards and protocols for COVID-19 testing; and

(3) establish standards and procedures for ensuring distribution of personal protective equipment and COVID-19 test kits to facilities that are unable to obtain them on their own.

b. The department shall establish a centralized online resource to answer frequently asked questions and provide educational sessions, focus groups, and support services to the long-term care industry in implementing the guidance developed pursuant to subsection a. of this section.

c. Each long-term care facility in the State shall submit to the department, prior to admitting new residents to the facility and allowing in-person visits with residents of the facility to resume, an attestation of compliance with federal requirements and the guidelines issued pursuant to subsection a. of this section. If, at any time after resuming new admissions and in-person visitations, the long-term care facility identifies issues or encounters circumstances that require a modified approach to new admissions and in-person visits or that require ending new admissions or in-person visits, the facility shall promptly report those issues or circumstances to the LTCEOC.

d. No general acute care hospital shall discharge any patient to a long-term care facility during the COVID-19 pandemic unless the facility has submitted an attestation to the department pursuant to

subsection c. of this section and is currently accepting new residents.

e. The LTCEOC shall establish a compliance check system comprising, as appropriate, testing, assistance, and clinical teams, to:

(1) periodically evaluate the ability of long-term care facilities to resume admitting new residents and allow in-person visits with residents; and

(2) render assistance to long-term care facilities as needed, including staff support and assistance in obtaining personal protective equipment, COVID-19 testing kits, or other necessary resources.

f. In developing guidance pursuant to subsection a. of this section, the department shall plan for potential or anticipated changes in federal policy that could affect the ability of long-term care facilities, or health care professionals in general, to respond to the COVID-19 pandemic, including changes that could restrict professional scope of practice or coverage under a health benefits plan for services provided to long-term care facility residents.

6. a. No later than 30 days after the effective date of this act, the Department of Health shall develop standards and protocols for COVID-19 testing in long-term care facilities in order to minimize the risk that staff and residents of long-term care facilities may be exposed to COVID-19 through interaction with other persons present at the facility.

b. The standards and protocols developed pursuant to subsection a. of this section shall:

(1) prioritize use of the most effective forms and methods of testing as are currently available;

(2) provide guidance for long-term care facilities to implement comprehensive testing using the facility's own resources and funding;

(3) establish methods to avoid duplicative testing of staff members employed by or providing professional services at more than one long-term care facility, including facilitating communication among facilities employing or utilizing the services of the same professionals;

(4) require long-term care facilities to provide on-site testing services to facility staff at a frequency as shall be required by the Department of Health;

(5) include protocols for establishing mobile testing units, supported by a general acute care hospital, on an expedited basis when needed to respond to COVID-19 testing demands; and

(6) in the event that it becomes necessary to establish routine testing at a long-term care facility, allow for use of the least invasive, most cost-effective method of testing that is consistent

with department guidelines and best practices for infection control and reducing the risk of COVID-19 transmission.

c. The standards and protocols developed pursuant to subsection a. of this section may include:

(1) specific testing requirements based on local infection rates and risk factors;

(2) protocols for determining when testing will be limited to those symptomatic for COVID-19, when testing will be mandated for all visitors to a long-term care facility, and when testing will be at the discretion of the long-term care facility;

(3) a mechanism for long-term care facilities to partner with a general acute care hospital in the region for the purpose of providing or supporting COVID-19 testing at the long-term care facility; and

(4) the establishment of a network of preferred clinical laboratories for the purposes of performing COVID-19 testing.

d. The LTCEOC established pursuant to section 1 of this act shall support COVID-19 testing protocols in long-term care facilities through the coordinated distribution of available supplies and other resources to long-term care facilities and by assisting facilities to identify and access available sources of funding.

e. The Commissioner of Health, the Commissioner of Human Services, and the Commissioner of Banking and Insurance shall jointly develop strategies to ensure reimbursement of COVID-19 tests performed pursuant to this section through health benefits plans, Medicaid and NJ FamilyCare, Medicare, and State and federal funds made available for this purpose.

7. The Commissioner of Health and the Commissioner of Human Services shall take steps to ensure available and appropriate sources of federal funding provided to states in response to the COVID-19 pandemic are made available to long-term care facilities. The commissioners may condition awards of funding made pursuant to this section on long-term care facilities providing regular reports on how the funding is used, including any evidence as may be needed to confirm the facilities are complying with all terms and conditions that attach to the funding, as well as information concerning steps the facility is taking to improve the facility's preparedness and response to the COVID-19 pandemic, including establishing and updating staff and patient safety and isolation protocols, expanding access to personal protective equipment and COVID-19 testing, and making improvements to the facility's equipment and physical plant that will help prevent the spread of communicable diseases within the facility.

8. a. No later than 60 days after the effective date of this act, the Department of Health shall coordinate with appropriate State and federal entities to consolidate all State and federal data

reporting related to the COVID-19 pandemic through the NJHA PPE, Supply & Capacity Portal maintained by the New Jersey Hospital Association. The department shall migrate the NJHA portal onto department systems and shall communicate the changes made pursuant to this subsection to long-term care facilities. The department may enter into such agreements with the New Jersey Hospital Association as are necessary to implement the provisions of this subsection.

b. No later than 30 days after the effective date of this act, the department shall undertake a review of State, federal, county, and local reporting requirements for long-term care facilities related to COVID-19 and take steps to standardize and consolidate the reporting requirements for the purpose of reducing the administrative demand on the facilities of complying with reporting requirements and improving the utility of the reported data and the ability to share the data across systems, including systems maintained by other State departments and agencies, county and local agencies, and federal authorities.

c. No later than 90 days after the effective date of this act, the department shall centralize its internal COVID-19 and long-term care facility data reporting and storage systems for the purpose of improving the utility of the reported data and the ability to share the data across systems, including systems maintained by other State departments and agencies, county and local agencies, and federal authorities charged with responding to the COVID-19 pandemic. At a minimum, the centralized systems shall:

(1) incorporate a function that automatically transmits alerts concerning long-term care facilities that report COVID-19 metrics exceeding established thresholds for new COVID-19 cases and COVID-19-related deaths to governmental points-of-contact at departments, agencies, and entities having jurisdiction over the long-term care facility or that are otherwise to be involved in the COVID-19 response at the facility; and

(2) receive and compile complaints concerning long-term care facilities received from any other State department or agency, which complaints shall be reviewed by the department on a regular basis for the purpose of identifying and formulating an appropriate response to facilities with chronic, repeat, or acute issues presenting a threat to the health or safety of residents and staff at the facility.

d. The department shall provide support to smaller long-term care facilities to assist the facilities in upgrading and enhancing their health information technology systems to allow for ready communication with State, county, and local entities to which the facilities are required to report or with which the facilities are required to communicate regarding COVID-19. Support provided to the facilities under this section shall include, as necessary, staff support, technical assistance, and financial support, including identifying available State, federal, and private sources of funding

as may be available to the facilities to upgrade and enhance their health information technology systems.

9. This act shall take effect immediately.

STATEMENT

This bill establishes certain requirements concerning the State's preparedness and response regarding infectious disease outbreaks, epidemics, and pandemics affecting long-term care facilities. Certain of the requirements established under the bill are specific to the coronavirus disease 2019 (COVID-19) pandemic, other requirements will apply to both the COVID-19 pandemic and to future infectious disease outbreaks, epidemics, and pandemics.

The bill establishes the Long-Term Care Emergency Operations Center (LTCEOC) in the Department of Health (DOH), which will serve as the centralized command and resource center for long-term care facility response efforts and communications during infectious disease outbreaks, epidemics, and pandemics affecting or likely to affect one or more long-term care facilities. The LTCEOC, which is to be established no later than 30 days after the effective date of the bill, is to build off and integrate with existing emergency response systems.

The DOH will have primary responsibility for the operations of the LTCEOC, but the Department of Human Services and other appropriate State agencies are to provide any staff support requested by the DOH. The DOH may additionally contract with a third party entity to provide staffing services as needed. At a minimum, the LTCEOC will be required to have on call at all times such appropriate staff and consultants as are needed to respond to an emerging or ongoing outbreak, epidemic, or pandemic, including representatives from nursing homes, long-term care facilities, nursing home and long-term care facility staff, county and local boards of health, the Office of the New Jersey Long-Term Care Ombudsman, and the Office of Emergency management in the New Jersey State Police, as well as experts in public health, infection control, elder affairs, disability services, emergency response, and medical transportation.

The LTCEOC will be required to establish ongoing, direct communication mechanisms and feedback loops, including an advisory council, to obtain real-time input from the owners and staff of long-term care facilities, unions, advocates representing residents of long-term care facilities and their families, individuals with expertise in the needs of people with specialized health care needs, and such other stakeholders as the DOH deems necessary and appropriate during an outbreak, epidemic, or pandemic affecting or potentially affecting long-term care facilities. The

LTCEOC will also designate a staff person from the DOH who will serve as designated liaison to the long-term care industry during an outbreak, epidemic, or pandemic.

The LTCEOC will provide guidance to the State and to the Office of Emergency Management to ensure that: supplies needed to respond to an outbreak, epidemic, or pandemic are acquired and distributed in an effective and efficient manner; critical staffing shortages in long-term care facilities are identified and resolved in an effective and efficient manner; issues that would jeopardize the health or safety of staff or residents of a long-term care facility, or that would impede or disrupt efforts to respond to an outbreak, epidemic, or pandemic are promptly identified and appropriately addressed; and all policies and guidance are effectively communicated to all long-term care industry stakeholders to maximize the coordination and effectiveness of the State's response to an outbreak, epidemic, or pandemic affecting long-term care facilities.

The LTCEOC will have the authority to develop a data dashboard to collect and analyze real-time issues and challenges occurring in long-term care facilities during an infectious disease outbreak, epidemic, or pandemic, as well as emerging issue areas and items of concern, so as to enable the appropriate authorities to direct a proactive response to those challenges and issues before the challenges and issues develop into matters of critical concern. Any dashboard developed by the LTCEOC may build from or incorporate materials from other data dashboards or similar features developed and maintained by any other entity of State, county, or local government, to the extent necessary to avoid duplication of work, facilitate communications and data sharing, and ensure the integrity, comprehensiveness, and utility of information included in the LTCEOC data dashboard.

The LTCEOC will be required to develop guidance and best practices in response to an infectious disease outbreak, epidemic, or pandemic concerning, as may be appropriate, infection control, symptom monitoring, and the use of telemedicine and telehealth to provide contactless health care services. The guidance and best practices are to be transmitted to appropriate State, county, and local departments and agencies for dissemination to industry and to providers. The guidance and best practices may additionally be transmitted to any federal and international agencies as may be involved with a national or international response to the infectious disease outbreak, epidemic, or pandemic.

The bill requires the DOH to institute, no later than 90 days after the effective date of the bill, a regional medical coordination center model for disaster response to facilitate regional capacity coordination and communication across county and local boards of health, hospitals, long-term care facilities, emergency medical services providers and other first responders, and entities providing

medical transportation, in the event of a public health emergency involving a communicable disease outbreak, epidemic, or pandemic. At a minimum, the model is to include a system for pairing long-term care facilities, emergency medical services providers and other first responders, and medical transportation entities with a hospital located in the same region for the purpose of providing the long-term care facility with consultative services regarding infectious diseases, infection control, and emergency resource coordination, as well as support testing as may be needed. The DOH is to identify appropriate sources of State, federal, and private funding to implement the regional medical coordination center model.

Within 60 days after the effective date of the bill, each long-term care facility will be required to develop plans, in coordination with the LTCEOC, to maintain mandatory long-term care facility staffing levels by replacing facility staff who isolate or quarantine because of infection with or exposure to an infectious disease, particularly during an outbreak, epidemic, or pandemic involving the infectious disease. These plans may include: establishing staffing teams to provide temporary interim support; executing contracts with other long-term care facilities and with general acute care hospitals located in the same region to provide staff support on an as-needed basis; utilizing the National Guard or other resources as may be deployed or otherwise made available in response to an outbreak, epidemic, or pandemic; and utilizing the services of qualified volunteers.

During an outbreak, epidemic, or pandemic involving an infectious disease, long-term care facilities are to provide the LTCEOC with an outline of the facility's regular staffing requirements and promptly notify the LTCEOC in the event any staff member tests positive for the infectious disease or is required to isolate or quarantine based on infection or exposure to the infectious disease. The LTCEOC will utilize this data to identify staffing needs throughout the State, anticipate potential staffing shortages, and develop strategies to promptly respond to anticipated shortages.

During an outbreak, epidemic, or pandemic involving an infectious disease, the LTCEOC will be required to establish a system for communicating test results for the infectious disease among long-term care facilities for individuals who are employed by or providing services in multiple facilities. The system will be limited to ensuring facilities are on notice of which employees of the facility have tested positive for the infectious disease, and will include safeguards against the unlawful disclosure of personal identifying information and private health information. Facilities receiving information about an employee through the system will be prohibited from using or disseminating the reported information for any purpose other than to ensure the facility's staffing needs are

met and to identify and prevent against the possible transmission of the infectious disease at the facility through contact with the identified employee.

The DOH will be required to develop plans for the placement of patients who contract an infectious disease during an outbreak, epidemic, or pandemic of the disease but who do not require hospitalization, which plan will apply in the event of a surge in new cases of the infectious disease that exceeds safe capacity levels in long-term care facilities. At a minimum, the placement plan is to include the rapid establishment of at least three regional hubs capable of accepting patients with the infectious disease who do not require hospitalization, which hubs are to comply with State and federal guidance regarding infection control practices related to the infectious disease. In the event of a surge in cases of the infectious disease, the LTCEOC will be required to actively monitor capacity levels at long-term care facilities and at regional hubs and take steps to direct patient placements as necessary to manage safe capacity levels.

Within 30 days after the effective date of the bill, the DOH will be required to develop a plan and provide guidance to long-term care facilities on how the facilities can comply with and implement federal guidance on accepting new residents at the facility and allow in-person visits with residents of the facility during the ongoing coronavirus disease 2019 (COVID-19) pandemic, which guidance is to be developed in consultation with the LTCEOC. The guidance is to include specific requirements related to isolation and cohorting, stockpiling and distributing personal protective equipment (PPE) and COVID-19 test kits, and staffing. The DOH will be required to establish a centralized online resource to answer frequently asked questions and provide educational sessions, focus groups, and support services to the long-term care industry in implementing the guidance developed under the bill.

In developing guidance, the DOH will be required to plan for potential or anticipated changes in federal policy that could affect the ability of long-term care facilities, or health care professionals in general, to respond to the COVID-19 pandemic, including changes that could restrict professional scope of practice or coverage under a health benefits plan for services provided to long-term care facility residents.

Each long-term care facility will be required to submit to the DOH, prior to admitting new residents to the facility and resuming in-person visitation with facility residents during the ongoing COVID-19 pandemic, an attestation of compliance with federal requirements and the guidelines issued under the bill. If, at any time after resuming new admissions and in-person visitations, the long-term care facility identifies issues or encounters circumstances that require a modified approach to new admissions and in-person visits or that require ending new admissions or in-person visits, the

facility will be required to promptly report those issues or circumstances to the LTCEOC. The bill prohibits general acute care hospitals from discharging any patient to a long-term care facility during the COVID-19 pandemic if the facility has not met these requirements.

The LTCEOC will be required to establish a compliance check system comprising, as appropriate, testing, assistance, and clinical teams, to periodically evaluate the ability of long-term care facilities to resume new admissions and in-person visitation and render assistance to the facilities as needed, including staff support and assistance in obtaining PPE, COVID-19 testing kits, or other necessary resources.

Within 30 days after the effective date of the bill, the DOH will be required to develop standards and protocols for COVID-19 testing in long-term care facilities in order to minimize the risk that staff and residents of long-term care facilities may be exposed to COVID-19 through interaction with other persons present at the facility. The standards and protocols are to prioritize use of the most effective forms and methods of testing, provide guidance for facilities to implement comprehensive testing using the facility's own resources and funding; establish methods to avoid duplicative testing of staff members employed by or providing professional services at more than one long-term care facility, require long-term care facilities to provide on-site testing services to facility staff, include protocols for establishing mobile testing units on an expedited basis when needed, and allow facilities flexibility in implementing routine testing if it becomes necessary.

The standards and protocols may additionally include specific testing requirements based on local infection rates and risk factors, protocols for determining in which situations testing will be mandatory, a mechanism for hospitals to provide or support COVID-19 testing in long-term care facilities, and the establishment of a network of preferred clinical laboratories for COVID-19 testing.

The LTCEOC will be required to support COVID-19 testing protocols in long-term care facilities through the coordinated distribution of available supplies and other resources to long-term care facilities and by assisting facilities with identifying and accessing available sources of funding.

The Commissioner of Health, the Commissioner of Human Services, and the Commissioner of Banking and Insurance will be required to jointly develop strategies to ensure reimbursement of COVID-19 tests performed under the bill through health benefits plans, Medicaid and NJ FamilyCare, Medicare, and State and federal funds made available for this purpose.

The bill requires the Commissioner of Health and the Commissioner of Human Services to take steps to ensure available and appropriate sources of federal funding provided to states in

response to the COVID-19 pandemic are made available to long-term care facilities. The commissioners may condition awards of funding on long-term care facilities providing regular reports on how the funding is used, including evidence of compliance with any conditions attached to the funding and information concerning the steps the facility is taking to improve the facility's preparedness and response to the COVID-19 pandemic.

The bill requires the DOH, no later than 60 days after the effective date of the bill, to coordinate with appropriate State and federal entities to consolidate all State and federal data reporting related to the COVID-19 pandemic through the NJHA PPE, Supply & Capacity Portal maintained by the New Jersey Hospital Association (NJHA). The DOH will migrate the NJHA portal onto DOH systems and communicate the change to long-term care facilities. The DOH will be authorized to enter into any necessary agreements with the NJHA.

No later than 30 days after the effective date of the bill, the DOH will be required to undertake a review of State, federal, county, and local reporting requirements for long-term care facilities related to COVID-19 and take steps to standardize and consolidate the reporting requirements in order to reduce the burden of compliance for facilities, improve the utility of the reported data, and improve the ability to share the data across systems. No later than 90 days after the effective date of the bill, the DOH is to centralize its internal COVID-19 and long-term care facility data reporting and storage systems to facilitate data sharing across systems. The centralized systems are to: (1) incorporate a function that automatically transmits alerts concerning COVID-19 outbreaks and deaths in long-term care facilities to appropriate governmental agencies, and (2) receive and compile complaints concerning long-term care facilities received from any other State department or agency to facilitate the response to chronic, repeat, or acute issues related to the health or safety of residents and staff at the facility.

The DOH will be required to provide support to smaller long-term care facilities to assist with upgrades and enhancements to their health information technology systems to allow for ready communication with State, county, and local entities regarding COVID-19. Support provided to the facilities may include staff support, technical assistance, and financial support.

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

STATEMENT TO

SENATE, No. 2790

with committee amendments

STATE OF NEW JERSEY

DATED: AUGUST 21, 2020

The Senate Health, Human Services and Senior Citizens Committee reports favorably and with committee amendments Senate Bill No. 2790.

As amended by the committee, this bill establishes certain requirements concerning the State's preparedness and response regarding infectious disease outbreaks, epidemics, and pandemics affecting long-term care facilities. Certain of the requirements established under the bill are specific to the coronavirus disease 2019 (COVID-19) pandemic, other requirements will apply to both the COVID-19 pandemic and to future infectious disease outbreaks, epidemics, and pandemics.

The bill establishes the Long-Term Care Emergency Operations Center (LTCEOC) in the Department of Health (DOH), which will serve as the centralized command and resource center for long-term care facility response efforts and communications during any hazardous event, including, but not limited to, infectious disease outbreaks, epidemics, and pandemics affecting or likely to affect one or more long-term care facilities. The LTCEOC, which is to be established no later than 30 days after the effective date of the bill, is to enhance and integrate with existing emergency response systems.

The DOH will have primary responsibility for the operations of the LTCEOC, but the Department of Human Services and other appropriate State agencies are to provide any staff support requested by the DOH. The DOH may additionally contract with a third party entity to provide staffing services as needed. At a minimum, the LTCEOC will be required to have on call at all times such appropriate staff and consultants as are needed to respond to an emerging or ongoing outbreak, epidemic, or pandemic, including representatives from nursing homes, long-term care facilities, nursing home and long-term care facility staff, general acute care hospitals, long-term care hospitals, psychiatric hospitals, home health and hospice agencies, and Programs of All-Inclusive Care for the Elderly (PACE) organizations, county and local boards of health, the Office of the New Jersey Long-Term Care Ombudsman, and the Office of

Emergency management in the New Jersey State Police, as well as experts in public health, infection control, elder affairs, disability services, emergency response, and medical transportation.

The LTCEOC will be required to establish ongoing, direct communication mechanisms and feedback loops, including an advisory council, to obtain real-time input from the owners and staff of long-term care facilities, unions, advocates representing residents of long-term care facilities and their families, individuals with expertise in the needs of people with specialized health care needs, and such other stakeholders as the DOH deems necessary and appropriate during an outbreak, epidemic, or pandemic affecting or potentially affecting long-term care facilities. The LTCEOC will also designate a staff person from the DOH who will serve as designated liaison to the long-term care industry during an outbreak, epidemic, or pandemic.

The LTCEOC will provide guidance to the State and to the Office of Emergency Management to ensure that: supplies needed to respond to an outbreak, epidemic, or pandemic are acquired and distributed in an effective and efficient manner; critical staffing shortages in long-term care facilities are identified and resolved in an effective and efficient manner; issues that would jeopardize the health or safety of staff or residents of a long-term care facility, or that would impede or disrupt efforts to respond to an outbreak, epidemic, or pandemic are promptly identified and appropriately addressed; and all policies and guidance are effectively communicated to all long-term care industry stakeholders to maximize the coordination and effectiveness of the State's response to an outbreak, epidemic, or pandemic affecting long-term care facilities.

The LTCEOC will have the authority to develop a data dashboard to collect and analyze real-time issues and challenges occurring in long-term care facilities during an infectious disease outbreak, epidemic, or pandemic, as well as emerging issue areas and items of concern, so as to enable the appropriate authorities to direct a proactive response to those challenges and issues before the challenges and issues develop into matters of critical concern. Any dashboard developed by the LTCEOC may build from or incorporate materials from other data dashboards or similar features developed and maintained by any other entity of State, county, or local government, to the extent necessary to avoid duplication of work, facilitate communications and data sharing, and ensure the integrity, comprehensiveness, and utility of information included in the LTCEOC data dashboard.

The LTCEOC will be required to develop guidance and best practices in response to an infectious disease outbreak, epidemic, or pandemic concerning, as may be appropriate, infection control, symptom monitoring, and the use of telemedicine and telehealth to provide contactless health care services.

As amended, the bill requires the DOH to institute, no later than 90 days after the effective date of the bill, a regional medical coordination center model for disaster response to facilitate regional capacity coordination and communication across county and local boards of health, hospitals, long-term care facilities, emergency medical services providers and other first responders, and entities providing medical transportation, in the event of a public health emergency involving a communicable disease outbreak, epidemic, or pandemic. At a minimum, the model is to include a system for engaging the Level 1 trauma center in the region with long-term care facilities, federally qualified healthcare centers, home health agencies, hospice providers, medical transportation providers, long-term care facilities, emergency medical services providers and other first responders, and medical transportation entities in its associated region. The Regional Level 1 Trauma Center and its associated regional medical coordination center shall make available their various clinical and non-clinical content experts and services are available for consultation and support to facilitate the implementation of evidence-based best practices and informed decision making. The DOH is to identify appropriate sources of State, federal, and private funding to implement the regional medical coordination center model.

Within 60 days after the effective date of the bill, each long-term care facility will be required to develop plans, in coordination with the LTCEOC, to maintain mandatory long-term care facility staffing levels by replacing facility staff who isolate or quarantine because of infection with or exposure to an infectious disease, particularly during an outbreak, epidemic, or pandemic involving the infectious disease.

During an outbreak, epidemic, or pandemic involving an infectious disease, long-term care facilities are to provide the LTCEOC with an outline of the facility's regular staffing requirements and promptly notify the LTCEOC in the event any staff member tests positive for the infectious disease or is required to isolate or quarantine based on infection or exposure to the infectious disease. The LTCEOC will utilize this data to identify staffing needs throughout the State, anticipate potential staffing shortages, and develop strategies to promptly respond to anticipated shortages.

During an outbreak, epidemic, or pandemic involving an infectious disease, the LTCEOC will be required to establish a system for communicating test results for the infectious disease among long-term care facilities for individuals who are employed by or providing services in multiple facilities. The system will be limited to ensuring facilities are on notice of which employees of the facility have tested positive for the infectious disease, and will include safeguards against the unlawful disclosure of personal identifying information and private health information. Facilities receiving information about an employee through the system will be prohibited from using or disseminating the reported information for any purpose other than to

ensure the facility's staffing needs are met and to identify and prevent against the possible transmission of the infectious disease at the facility through contact with the identified employee.

The DOH will be required to develop plans for the placement of patients who contract an infectious disease during an outbreak, epidemic, or pandemic of the disease but who do not require hospitalization, which plan will apply in the event of a surge in new cases of the infectious disease that exceeds safe capacity levels in long-term care facilities. At a minimum, the placement plan is to include the rapid establishment of at least three regional hubs capable of accepting patients with the infectious disease who do not require hospitalization, which hubs are to comply with State and federal guidance regarding infection control practices related to the infectious disease. In the event of a surge in cases of the infectious disease, the LTCEOC will be required to actively monitor capacity levels at long-term care facilities and at regional hubs and take steps to direct patient placements as necessary to manage safe capacity levels.

Within 30 days after the effective date of the bill, the DOH will be required to develop a plan and provide guidance to long-term care facilities on how the facilities can comply with and implement federal guidance on accepting new residents at the facility and allow in-person visits with residents of the facility during the ongoing coronavirus disease 2019 (COVID-19) pandemic, which guidance is to be developed in consultation with the LTCEOC. The guidance is to include specific requirements related to isolation and cohorting, stockpiling and distributing personal protective equipment (PPE) and COVID-19 test kits, and staffing. The DOH will be required to establish a centralized online resource to answer frequently asked questions and provide educational sessions, focus groups, and support services to the long-term care industry in implementing the guidance developed under the bill.

In developing guidance, the DOH will be required to plan for potential or anticipated changes in federal policy that could affect the ability of long-term care facilities, or health care professionals in general, to respond to the COVID-19 pandemic, including changes that could restrict professional scope of practice or coverage under a health benefits plan for services provided to long-term care facility residents.

Each long-term care facility will be required to submit to the DOH, prior to admitting new residents to the facility and resuming in-person visitation with facility residents during the ongoing COVID-19 pandemic, an attestation of compliance with federal requirements and the guidelines issued under the bill. If, at any time after resuming new admissions and in-person visitations, the long-term care facility identifies issues or encounters circumstances that require a modified approach to new admissions and in-person visits or that require ending new admissions or in-person visits, the facility will be required to

promptly report those issues or circumstances to the LTCEOC. The bill requires the DOH to establish a system for general acute care hospitals to determine which long-term care facilities are in compliance with these requirements and are accepting new residents.

The LTCEOC will be required to establish a compliance check system comprising, as appropriate, testing, assistance, and clinical teams, to periodically evaluate the ability of long-term care facilities to resume new admissions and in-person visitation and render assistance to the facilities as needed, including staff support and assistance in obtaining PPE, COVID-19 testing kits, or other necessary resources.

Within 30 days after the effective date of the bill, the DOH will be required to develop standards and protocols for COVID-19 testing in long-term care facilities in order to minimize the risk that staff and residents of long-term care facilities may be exposed to COVID-19 through interaction with other persons present at the facility. The standards and protocols are to prioritize use of the most effective forms and methods of testing, provide guidance for facilities to implement comprehensive testing using the facility's own resources and funding; establish methods to avoid duplicative testing of staff members employed by or providing professional services at more than one long-term care facility, require long-term care facilities to provide on-site testing services to facility staff, including protocols for establishing mobile testing units on an expedited basis when needed, and allow facilities flexibility in implementing routine testing if it becomes necessary.

The standards and protocols may additionally include specific testing requirements based on local infection rates and risk factors, protocols for determining in which situations testing will be mandatory, a mechanism for hospitals to provide or support COVID-19 testing in long-term care facilities, and the establishment of a network of preferred clinical laboratories for COVID-19 testing.

The LTCEOC will be required to support COVID-19 testing protocols in long-term care facilities through the coordinated distribution of available supplies and other resources to long-term care facilities and by assisting facilities with identifying and accessing available sources of funding.

The Commissioner of Health, the Commissioner of Human Services, and the Commissioner of Banking and Insurance will be required to jointly develop strategies to ensure reimbursement of COVID-19 tests performed under the bill through health benefits plans, Medicaid and NJ FamilyCare, Medicare, and State and federal funds made available for this purpose.

The bill requires the Commissioner of Health and the Commissioner of Human Services to take steps to ensure available and appropriate sources of federal funding provided to states in response to the COVID-19 pandemic are made available to long-term care facilities. The commissioners may condition awards of funding on

long-term care facilities providing regular reports on how the funding is used, including evidence of compliance with any conditions attached to the funding and information concerning the steps the facility is taking to improve the facility's preparedness and response to the COVID-19 pandemic.

The bill requires the DOH, no later than 60 days after the effective date of the bill, to coordinate with appropriate State and federal entities to consolidate all State and federal data reporting related to the COVID-19 pandemic through the NJHA PPE, Supply & Capacity Portal maintained by the New Jersey Hospital Association (NJHA). The DOH will migrate the NJHA portal onto DOH systems and communicate the change to long-term care facilities. The DOH will be authorized to enter into any necessary agreements with the NJHA.

No later than 30 days after the effective date of the bill, the DOH will be required to undertake a review of State, federal, county, and local reporting requirements for long-term care facilities related to COVID-19 and take steps to standardize and consolidate the reporting requirements in order to reduce the burden of compliance for facilities, improve the utility of the reported data, and improve the ability to share the data across systems. No later than 90 days after the effective date of the bill, the DOH is to centralize its internal COVID-19 and long-term care facility data reporting and storage systems to facilitate data sharing across systems. The centralized systems are to: (1) incorporate a function that automatically transmits alerts concerning COVID-19 outbreaks and deaths in long-term care facilities to appropriate governmental agencies, and (2) receive and compile complaints concerning long-term care facilities received from any other State department or agency to facilitate the response to chronic, repeat, or acute issues related to the health or safety of residents and staff at the facility.

The DOH will be required to provide support to smaller long-term care facilities to assist with upgrades and enhancements to their health information technology systems to allow for ready communication with State, county, and local entities regarding COVID-19. Support provided to the facilities may include staff support, technical assistance, and financial support.

As amended by the committee, the bill requires the DOH to prepare and submit a report to the Governor and the Legislature, no later than 18 months after the effective date of the bill, concerning the implementation of the provisions of the bill and any recommendations for appropriate legislative or administrative actions as may be appropriate to advance or improve the State's infectious disease planning, preparedness, and response.

COMMITTEE AMENDMENTS:

The committee amendments revise the duties of the Long Term Care Emergency Operations Center (LTCEOC) established under the

bill to apply to any hazardous event, not just outbreaks of infectious disease.

The committee amendments provide that the LTCEOC may call to its assistance representatives of general acute care hospitals, psychiatric hospitals, home health and hospice agencies, and Programs of All-Inclusive Care for the Elderly (PACE) organizations, in addition to the private and public entities enumerated in the bill as introduced.

The committee amendments remove a requirement that guidance produced by the LTCEOC concerning infectious disease response be distributed to other State, national, and international entities.

The committee amendments revise the requirements for the establishment of a regional medical coordination center model to require the model be developed in consultation with the Emergency Medical Services Task Force. The committee amendments additionally replace a requirement that various health care entities be paired with a general acute care hospital that will provide support services, to instead provide that the model utilize a Level 1 Trauma center in each region to provide consultation and support services to facilitate evidence-based best practices and informed decision making.

The committee amendments remove language enumerating certain potential components of a long-term care facility's staffing replacement plans.

The committee amendments remove language prohibiting hospitals from discharging patients to long-term care facilities that do not have an approved new admissions and visitation plan in place to instead require the DOH to develop a mechanism for hospitals to identify facilities that have met the requirements to accept new residents.

The committee amendments revise a requirement that the mobile COVID-19 testing units be supported by a general acute care hospital.

The committee amendments add a requirement that the DOH report to the Governor and the Legislature concerning implementation of the provisions of the bill.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]
SENATE, No. 2790

with committee amendments

STATE OF NEW JERSEY

DATED: AUGUST 24, 2020

The Senate Budget and Appropriations Committee reports favorably and with committee amendments Senate Bill No. 2790 (1R).

As amended by the committee, this bill establishes certain requirements concerning the State's preparedness and response regarding declared public health emergencies affecting long-term care facilities. Certain of the requirements established under the bill are specific to the coronavirus disease 2019 (COVID-19) pandemic, other requirements will apply to both the COVID-19 pandemic and to future public health emergencies.

The bill establishes the Long-Term Care Emergency Operations Center (LTCEOC) in the Department of Health (DOH), which will serve as the centralized command and resource center for long-term care facility response efforts and communications during any declared public health emergencies affecting or likely to affect one or more long-term care facilities. The LTCEOC is to enhance and integrate with existing emergency response systems.

The DOH will have primary responsibility for the operations of the LTCEOC, but the Department of Human Services and other appropriate State agencies are to provide any staff support requested by the DOH. The DOH may additionally contract with a third party entity to provide staffing services as needed. At a minimum, the LTCEOC will be required to have on call at all times such appropriate staff and consultants as are needed to respond to an emerging or ongoing outbreak, epidemic, or pandemic, including representatives from county and local boards of health, the Office of the New Jersey Long-Term Care Ombudsman, and the Office of Emergency management in the New Jersey State Police, the acute and post-acute health care industry, as well as experts in public health, infection control, elder affairs, disability services, emergency response, and medical transportation.

The primary responsibilities of the LTCEOC will include, but shall not be limited to:

(1) establishing ongoing, direct communication with the owners and staff of long-term care facilities and with associated entities during

a public health emergency, which may include the use of existing communication mechanisms and feedback loops in the DOH's Office of Disaster Resilience or Health Systems branch, as appropriate;

(2) providing technical assistance to the long-term care industry during the public health emergency, which may be facilitated through local health departments;

(3) ensuring supplies and equipment needed to respond to the public health emergency are acquired and distributed in an effective and efficient manner among long-term care facilities;

(4) utilizing the National Healthcare Safety Network (NHSN) database managed by the federal Centers for Disease Control and Prevention to identify shortages in staff and necessary equipment, monitor facility capacity levels, and track positive cases and deaths resulting from infectious diseases; and

(5) ensuring all policies and guidance developed by the DOH in response to the public health emergency are effectively communicated to all long-term care industry stakeholders.

As amended, the bill requires that, in the event of a public health emergency declared in response to an infectious disease outbreak, epidemic, or pandemic affecting long-term care facilities, the LTCEOC, in consultation with other offices within the DOH and the Office of Emergency Management (OEM) in the New Jersey Division of State Police, will determine whether it is necessary to establish regional hubs capable of accepting patients who have, and are capable of transmitting, the infectious disease and who do not require hospitalization. In the event of a surge in number of identified cases of the infectious disease, the LTCEOC will be required to actively monitor capacity levels at long-term care facilities using the NHSN database and at any regional hubs established under this subsection, and shall take steps to direct patient placements as necessary to manage capacity levels and ensure, to the extent possible, that no regional hub or long-term care facility exceeds safe capacity levels.

As amended, the bill requires the DOH to institute, no later than 180 days after the effective date of the bill, a regional medical coordination center model for disaster response to facilitate regional capacity coordination and communication across county and local boards of health, hospitals, long-term care facilities, emergency medical services providers and other first responders, and entities providing medical transportation, in the event of a public health emergency involving a communicable disease outbreak, epidemic, or pandemic. At a minimum, the model is to include a system for engaging the Level 1 trauma center in the region with long-term care facilities, federally qualified healthcare centers, home health agencies, hospice providers, medical transportation providers, long-term care facilities, emergency medical services providers and other first responders, and medical transportation entities in its associated region. The Regional Level 1 Trauma Center and its associated regional

medical coordination center shall make available their various clinical and non-clinical content experts and services are available for consultation and support to facilitate the implementation of evidence-based best practices and informed decision making. The DOH is to identify appropriate sources of State, federal, and private funding to implement the regional medical coordination center model.

As amended, the bill requires long-term care facilities, during an infectious disease outbreak occurring at the long-term care facility or an epidemic or pandemic affecting or likely to affect the long-term care facility, to separate residents who have tested positive for or who are suspected of having contracted the infectious disease from residents who have not tested positive for, and who are not suspected of having contracted, the infectious disease. Facilities will be required to comply with guidance concerning how to determine whether a resident who contracted the infectious disease is recovered from the disease, as well as procedures and protocols for interactions between those residents and other residents and staff at the facility. Facilities will further be required to comply with current orders, guidance, and directives concerning admissions and readmissions to the facility.

The bill, as amended, requires the DOH to establish a mechanism for hospitals to identify long-term care facilities that are currently accepting residents for admission or readmission to the facility.

As amended, the bill requires that, during a public health emergency involving an infectious disease affecting or likely to affect a long-term care facility, the long-term care facility will be required to report to the NHSN database, at least twice per week: (1) counts of residents and facility personnel with suspected cases of the infectious disease and who have a laboratory test confirming infection with the infectious disease; (2) counts of residents and facility personnel with suspected and confirmed deaths from the infectious disease; (3) the total number of authorized resident beds and the current resident census; (4) staffing shortages; (5) the quantity of personal protective equipment, hand hygiene supplies, cleaning supplies, and sanitization supplies, along with an assessment of the number of days that will be supported by current inventory; (6) for facilities with ventilator-dependent units, ventilator capacity and the quantity of ventilator supplies, along with an assessment of the number of days that will be supported by current inventory; and (7) any other metrics required by as the Commissioner of Health as an essential or relevant component of the State's response to the infectious disease outbreak, epidemic, or pandemic in long-term care facilities.

In addition, to facilitate the enforcement of P.L.2019, c.330 (C.26:2H-18.79), which requires health care facility employees to receive the annual influenza vaccination, during each influenza season, long-term care facilities and home health employers will be required to report to the NHSN database the number of employees who have received the influenza vaccination, the number of employees who have

not received the influenza vaccination due to an authorized medical exemption, and the number of employees who have not received the influenza vaccination who do not have a valid medical exemption.

A long-term care facility that fails to submit a required report to the NHSN will be liable to a civil penalty of $2,000 for each report that is not submitted.

As amended by the committee, the bill requires each long-term care facility, no later than 270 days after the effective date of the bill to implement or upgrade to an electronic health record system certified by the Office of the National Coordinator for Health Information Technology in the U.S. Department of Health and Human Services that is capable of information sharing through industry standard data interoperability, including application programming interface Health Level 7 or fast healthcare interoperability technology. Use cases built on this technology are to include the bi-directional capability for admission discharge and transfer and continuity of care through the clinical data architecture. Long-term care facilities interoperability for these use cases is to be achieved by connecting to the New Jersey Health Information Network.

Subject to the availability of funding for this purpose, the DOH will be required to make grants available to long-term care facilities to provide assistance in implementing or upgrading to an electronic health record system that meets these requirements, which grants will be distributed to long-term care facilities based on demonstrated need.

The bill requires long-term care facilities to include in the facility's statutorily-required outbreak response plan a documented strategy for securing more staff in the event of an outbreak of infectious disease among staff or other emergent or non-emergent situation affecting staffing levels at the facility during an outbreak of an infectious disease.

The bill requires the DOH to prepare and submit a report to the Governor and the Legislature, no later than 18 months after the effective date of the bill, concerning the implementation of the provisions of the bill and any recommendations for appropriate legislative or administrative actions as may be appropriate to advance or improve the State's infectious disease planning, preparedness, and response.

COMMITTEE AMENDMENTS:

The committee amendments revise the requirements for the Long Term Care Emergency Operations Center (LTCEOC) established under the bill to apply to declared states of public emergency, rather than any hazardous event. The amendments remove a requirement that the LTCEOC be established within 30 days after the effective date of the bill.

The committee amendments revise the membership of the LTCEOC to remove requirements that representatives of specific

entities within the long-term care industry be included on the LTCEOC, and instead provide that the Department of Health (DOH) is to have on call representatives from the acute and post-acute health care industry.

The committee amendments revise the specific duties of the LTCEOC to clarify that the LTCEOC will facilitate ongoing direct communications during a public health emergency, but will be authorized to use existing communications mechanisms available to certain entities with the DOH. The amendments further provide that the LTCEOC may utilize the National Healthcare Safety Network (NHSN) database managed by the federal Centers for Disease Control and Prevention to track data related to the emergency and will be tasked with ensuring all policies and guidance developed by the DOH in response to the public health emergency are effectively communicated to all long-term care industry stakeholders.

The committee amendments revise the requirements for the DOH to institute a regional medical coordination center model to provide that the DOH will have 180 days to institute the model, rather than 90 days, and that the model is to be instituted in consultation with the Office of Emergency Management, as well as the Emergency Medical Services Council.

The committee amendments remove certain language from the bill that would have required long-term care facilities to develop plans to address staffing shortages, and instead provide that each facility's statutorily-required outbreak response plan include a documented strategy for securing more staff in the event of an outbreak of infectious disease among staff or in other situations that may affect staffing levels at the facility during an infectious disease outbreak.

The committee amendments remove language from the bill that would have required long-term care facilities to report staffing information to the LTCEOC, and for the LTCEOC to institute a system for tracking employees who test positive for an infectious disease across employers.

The committee amendments add provisions requiring that, during infectious disease outbreaks, epidemics, and pandemics affecting a long-term care facility, the facility will be required to cohort residents, follow certain guidance concerning determining whether a resident who contracted an infectious disease is recovered from the disease and protocols and procedures concerning interactions between that resident and other residents and staff at the facility, and comply with current orders, guidance, and directives concerning resident admissions and readmissions to the facility.

The committee amendments remove language that would have required the DOH develop guidance for long-term care facilities to accept new residents and allow indoor visitation with residents and to develop an online resource center to facilitate new admissions and

visitation, and for the LTCEOC to institute a compliance check system.

The committee amendments revise the requirement for the DOH to establish a mechanism for hospitals to identify long-term care facilities that have met certain requirements to accept new residents to the facility, which requirements were removed by committee amendment, to instead provide that the mechanism is to allow hospitals to identify long-term care facilities that are currently accepting admissions and readmissions of residents to the facility.

The committee amendments remove language that would have required the DOH to institute COVID-19 testing standards and protocols for long-term care facility residents and staff.

The committee amendments remove provisions from the bill that would have required the DOH to coordinate with other entities to streamline and consolidate COVID-19 data reporting for long-term care facilities, and to provide technical assistance to smaller long-term care facilities to upgrade and enhance their data systems.

The committee amendments add a requirement that long-term care facilities report certain information during an infectious disease outbreak, epidemic, or pandemic to the NHSN, including cases and deaths involving the infectious disease, resident capacity levels, staffing shortages, and quantities of essential equipment. Additionally, the committee amendments add a requirement that long-term care facilities and home health employers report certain data concerning employee influenza vaccinations during each flu season. Failure to make a required report will be punishable by a civil penalty of $2,000 per violation.

The committee amendments add a requirement that all long-term care facilities institute or upgrade electronic health records systems that meet certain requirements. Subject to the availability of funding, the amendments require the DOH to make grants available to support long-term care facilities in instituting or upgrading electronic health records systems, with the grants to be distributed based on demonstrated need.

FISCAL IMPACT:

The Office of Legislative Services (OLS) estimates that this bill, as amended, may result in an indeterminate increase in costs incurred by the Department of Health (DOH) in establishing the Long-Term Care Emergency Operations Center (LTCEOC) and in fulfilling the LTCEOC's duties, as outlined in the bill. These cost will be minimized to the extent that the department can: 1) reallocate resources from existing entities, such as the DOH's Office of Disaster Resilience or Health Systems branch; 2) request and receive staff support from the Department of Human Services or other State agencies, as provided for in the bill; and 3) use existing communications mechanisms, as well as any overlap with current

department duties, to fulfill the provisions of the bill. The OLS notes that any costs associated with the LTCEOC will only be realized during a public health emergency affecting or likely to affect one or more long-term care (LTC) facilities, the trigger for making the LTCEOC operational.

The OLS finds that the DOH may realize certain one-time cost increases under the bill in instituting a regional medical coordination center model and in submitting a report to the Governor and the Legislature concerning the implementation of the provisions of the bill.

The OLS estimates that nursing homes operated by the Division of Military and Veterans Affairs (DMAVA) and certain county governments may incur expenses in complying with the reporting requirements outlined in the bill and in upgrading facility electronic health records (EHR) systems. The OLS notes that the bill directs the DOH to make funding available to LTC facilities to provide assistance in upgrading an EHR system, which may minimize the impact of this provision on the above facilities. Currently, the DMAVA operates three facilities, while there are nine county facilities: three in Bergen County; two in Middlesex County; and one each in Atlantic County, Cape May County, Gloucester County, and Passaic County.

LEGISLATIVE FISCAL ESTIMATE

[Second Reprint]

SENATE, No. 2790

STATE OF NEW JERSEY
219th LEGISLATURE

DATED: AUGUST 31, 2020

SUMMARY

Synopsis: Establishes certain requirements concerning State's preparedness and response to infectious disease outbreaks, including coronavirus disease 2019 (COVID-19) pandemic.

Type of Impact: One-time and annual increases in State and local expenditures; potential periodic increase in State revenue.

Agencies Affected: Department of Health; Department of Military and Veterans Affairs; Department of Human Services; University Hospital; certain county governments.

Office of Legislative Services Estimate

Fiscal Impact	Annual
State Cost Increase	Indeterminate
Potential State Revenue Increase	Indeterminate
Local Cost Increase	Indeterminate

- The Office of Legislative Services (OLS) estimates that this bill may result in an indeterminate increase in annual costs incurred by the Department of Health (DOH) in establishing the Long-Term Care Emergency Operations Center (LTCEOC) and in fulfilling the LTCEOC's duties, as outlined in the bill, to the extent that the department cannot minimize such costs with existing resources and staff. The OLS notes that any costs associated with the LTCEOC will be limited to expenses realized during a public health emergency affecting or likely to affect one or more long-term care (LTC) facilities, the trigger for making the LTCEOC operational.

- The DOH may realize certain one-time cost increases under the bill due to, for example, instituting a regional medical coordination center model and providing grants to LTC facilities regarding electronic health records (EHR) systems. The bill, however, provides for certain provisions that may minimize or eliminate some of the department’s expenses.

- The OLS estimates that nursing homes operated by the Department of Military and Veterans Affairs (DMAVA) and certain county governments may incur minimal periodic expenses in

complying with the reporting and infectious disease protocol requirements outlined in the bill, as such provisions largely codify existing directives issued by the DOH. Such facilities may also incur costs in upgrading the facility's EHR systems, to the extent that these facilities do not currently meet the standards outlined in the bill and are not awarded grants made available for such purposes by the DOH, as provided for in the bill.

- The University Hospital, as a Level 1 trauma center and an independent non-profit legal entity that is an instrumentality of the State located in Newark, may incur certain costs in making clinical and non-clinical content experts available for consultation and support within the regional medical coordination center model established by the DOH under the bill.

- A provision imposing penalties on LTC facilities that fail to report certain information, as required under this bill, may increase State revenues by an indeterminate amount. As the number of facilities that may be penalized is unpredictable, the OLS is unable to determine the value of any revenue increase.

BILL DESCRIPTION

This bill establishes the LTCEOC in the DOH, which will serve as the centralized command and resource center for LTC facility response efforts and communications during any declared public health emergencies affecting or likely to affect one or more LTC facilities. The LTCEOC is to enhance and integrate with existing emergency response systems.

The DOH will have primary responsibility for the operations of the LTCEOC, but the Department of Human Services (DHS) and other appropriate State agencies are to provide any staff support requested by the DOH. The DOH may additionally contract with a third party entity to provide staffing services as needed. At a minimum, the LTCEOC will be required to have on call at all times such appropriate staff and consultants as are needed to respond to an emerging or ongoing outbreak, epidemic, or pandemic.

The primary responsibilities of the LTCEOC will include, but shall not be limited to:

(1) establishing ongoing, direct communication with the owners and staff of LTC facilities and with associated entities during a public health emergency, which may include the use of existing communication mechanisms and feedback loops in the DOH's Office of Disaster Resilience or Health Systems branch, as appropriate;

(2) providing technical assistance to the LTC industry during the public health emergency, which may be facilitated through local health departments;

(3) ensuring supplies and equipment needed to respond to the public health emergency are acquired and distributed in an effective and efficient manner among LTC facilities;

(4) utilizing the National Healthcare Safety Network (NHSN) database managed by the federal Centers for Disease Control and Prevention to identify shortages in staff and necessary equipment, monitor facility capacity levels, and track positive cases and deaths resulting from infectious diseases; and

(5) ensuring all policies and guidance developed by the DOH in response to the public health emergency are effectively communicated to all LTC industry stakeholders.

Additionally, the bill requires the LTCEOC to: 1) in consultation with other State offices, determine whether it is necessary to establish regional hubs capable of accepting LTC patients who have, and are capable of transmitting, the infectious disease and who do not require hospitalization; and 2) actively monitor capacity levels at LTC facilities and regional hubs in the event of a surge in number of identified cases of the infectious disease.

The bill requires the DOH to: 1) institute, and to identify the appropriate sources of funding to implement, a regional medical coordination center model, which must include the Level 1 trauma center in a region, for disaster response to facilitate regional capacity coordination and communication in the event of a public health emergency involving a communicable disease outbreak, epidemic, or pandemic; 2) establish a mechanism for hospitals to identify LTC facilities that are currently accepting residents for admission or readmission to the facility; 3) make grants available to LTC facilities to provide assistance in implementing or upgrading to an EHR system, subject to the availability of funding; and 4) prepare and submit a report to the Governor and the Legislature concerning the implementation the bill and any recommendations for action.

The bill requires LTC facilities, during an infectious disease outbreak occurring at the LTC facility or an epidemic or pandemic affecting or likely to affect the long-term care facility, to: 1) separate residents who have tested positive for or who are suspected of having contracted the infectious disease from other residents and to comply with any related guidance or protocols; and 2) report certain information regarding the facility's response to the infectious disease to the NHSN database, at least twice per week, or otherwise be liable to a civil penalty of $2,000 for each report that is not submitted. Outside of an infectious disease outbreak, an LTC is required to 1) include in the facility's statutorily-required outbreak response plan a documented strategy for securing more staff in the event that an outbreak of an infectious disease affects staffing levels at the facility; and 2) implement or upgrade to an EHR system, as described in the bill. During each influenza season, LTC facilities and home health employers will be required to report to the NHSN database certain information regarding the receipt of the influenza vaccination by employees.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS estimates that this bill may result in an indeterminate increase in annual costs incurred by the DOH in establishing the LTCEOC and in fulfilling the LTCEOC's duties, as outlined in the bill. These cost will be minimized to the extent that the department can: 1) reallocate resources from existing entities, such as the DOH's Office of Disaster Resilience or Health Systems branch; 2) request and receive staff support from the DHS or other State agencies, as provided for in the bill; and 3) use existing communications mechanisms, as well as any overlap with current department duties, to fulfill the provisions of the bill. The OLS notes that any costs associated with the LTCEOC will be limited to expenses realized during a public health emergency affecting or likely to affect one or more LTC facilities, the trigger for making the LTCEOC operational.

The OLS finds that the DOH may realize certain one-time cost increases under the bill in: instituting a regional medical coordination center model; establishing a mechanism for hospitals to identify LTC facilities receiving admissions; providing grants to LTC facilities regarding EHR systems; and complying with the reporting requirements established under the bill. The bill provides for certain provisions that may minimize or eliminate some of the department's expenses under the bill. For example, the DOH is authorized to identify and use non-State funds to implement the regional medical coordination center model. In addition, grants for EHR systems are subject to available funding.

The OLS estimates that nursing homes operated by the DMAVA and certain county governments may incur minimal expenses in complying with the reporting and infectious disease protocol requirements outlined in the bill, as such provisions largely codify existing directives issued by the department. For example, Executive Directive No. 20-026 requires all LTC facilities to report, at a minimum twice per week, COVID-19 cases, facility staffing, and supply information to the NHSN Long-Term Care Facility COVID-19 Module and reinforces DOH guidance regarding the separation of COVID-19 positive and negative residents.[1]

Nursing homes operated by the DMAVA and certain county governments may also incur costs in upgrading the facility's EHR systems, to the extent that such facilities do not currently meet the standards outlined in the bill. The OLS notes that the bill directs the DOH to award grants, subject to availability, to LTC facilities to provide assistance in upgrading an EHR system, which may minimize the impact of this provision on the above facilities. Currently, the DMAVA operates three facilities, while there are nine county facilities: three in Bergen County; two in Middlesex County; and one each in Atlantic County, Cape May County, Gloucester County, and Passaic County.

The OLS estimates that the University Hospital, as a Level 1 trauma center and an independent non-profit legal entity that is an instrumentality of the State located in Newark, may incur certain costs in making clinical and non-clinical content experts available for consultation and support within the regional medical coordination center model. As the scope of the University Hospital's role in the regional model is to be determined upon the enactment of the bill, the OLS cannot predict the cost of this provision.

A provision imposing penalties on LTC facilities that fail to report certain information, as required under this bill, may increase State revenues by an indeterminate amount. As the number of facilities that may be penalized is unpredictable, the OLS is unable to determine the value of any revenue increase.

Section:	*Human Services*
Analyst:	*Sarah Schmidt* *Senior Research Analyst*
Approved:	*Frank W. Haines III* *Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

[1] https://www.state.nj.us/health/legal/covid19/8-20_ExecutiveDirectiveNo20-026_LTCResumption_of_Svcs.pdf

Governor Murphy Signs Legislative Package to Strengthen the Resiliency and Preparedness of New Jersey's Long-Term Care Industry

09/16/2020

Legislative Package Enacts Key Recommendations from Manatt Health's Review

TRENTON — Acting on a commitment to reform and build a more resilient long-term care industry, Governor Phil Murphy today signed a legislative package to address systemic challenges, mitigate the impact of COVID-19, and strengthen preparedness for future outbreaks. The legislative package enacts several recommendations made in Manatt Health's rapid review of the state's long-term care facilities, including wage enhancements for frontline staff, improved response coordination, and robust data reporting procedures. The legislative package received bipartisan support.

"The residents and staff of our long-term care facilities have borne an outsized burden of this pandemic," **said Governor Phil Murphy.** "While we know this has not been a tragedy unique to New Jersey, we will learn from this crisis and emerge as a national model for solving immediate challenges and building future resilience. These measures not only support our ongoing efforts to get things right for our long-term care residents, staff, and families, but also ensure we have strong measures in place to deal with bad actors in the industry who put profit before people."

The Governor signed the following bills into law:

A4476/S2790 (Vainieri Huttle, Greenwald, DePhillips/Cryan, Vitale) - Establishes certain requirements concerning State's preparedness and response to infectious disease outbreaks, including the COVID-19 pandemic.

A4481/S2787 (Moen, Sumter, Quijano, Gove/Codey, Rice) - Establishes New Jersey Task Force on Long-Term Care Quality and Safety**.**

A4482/S2758 (Tucker, Giblin, Chaparro/Cryan, Lagana) - Establishes minimum wage requirements for certain long-term care facility staff; establishes direct care ratio requirements for nursing homes; requires nursing home care rate study.

A4547/S2813 (Vainieri Huttle, Benson, Johnson/Vitale) - Authorizes temporary rate adjustment for certain nursing facilities; appropriates $62.3 million.

"This package of bills will improve the resiliency and quality of our long-term care facilities and strengthen their emergency preparedness," **said Health Commissioner Judith Persichilli.** "Most importantly, they provide the recognition the Certified Nursing Assistants deserve through wage increases and career ladder opportunities."

"We thank our partners in the Legislature for working together with us to advance our shared goal of supporting nursing home residents and the staff who work tirelessly to care for them," **Human Services Commissioner Carole Johnson said**. "Today's action will deliver new Medicaid funding of $130 million – a 10 percent increase – over the remainder of the fiscal year to nursing homes to increase wages for the frontline certified nursing aide workforce and to support facilities' compliance with health and safety directives, including COVID-19-related infection control, PPE, cleaning, staffing, and other needs. These are critical steps as we work across the state to continue to fight the virus and prepare for any potential second surge this fall."

"Long-term care centers were woefully underprepared and under-resourced to respond to a global pandemic. Many nursing and veterans homes in New Jersey have been cited for inadequate infection control policies, and few had consistent direct communication with hospitals and health departments before the pandemic. The system as a whole needs to be reformed," **said Assemblywoman Valerie Vainieri Huttle, Chair of the Assembly Aging and Senior Services Committee**. "It is also critically important that we support the certified nurse aides in

long-term care centers who are on the COVID-19 front lines day in and day out. They dedicate their lives to caring for our most vulnerable, and now they put their health at risk every day they're on the job. If there's ever a time to enhance wages for our severely underpaid and overworked nurse aides, it's now."

"COVID-19 has taken an immense toll on our long-term care community. This legislation is a combination of Manatt Health's recommendations and the Senate Health Committee's extensive discussions with stakeholders and concerned residents," **said Senator Joseph Vitale, Chair of the Senate Health, Human Services and Senior Citizens Committee.** "Long-term care facilities service some of our state's most vulnerable communities. At the onset of this pandemic our mothers, fathers and grandparents faced a compromised, exposed and impossible situation. These laws will help ensure that New Jersey does not ever let that happen again."

"Over the past six months, nursing home workers across New Jersey have heroically risen to the challenges of COVID-19 and put their lives on the line to protect their vulnerable patients," **said Milly Silva, Executive Vice President of 1999SEIU United Healthcare Workers East**. "Critically, this legislative package recognizes the essential nature of their work and the need for our state to have a stable, healthy and growing caregiver workforce. We applaud Gov. Murphy and our legislative leadership for taking these important steps to reform the nursing home industry."

"We applaud Governor Murphy and the NJ Legislature for passing this long-term care reform package, which makes significant and necessary improvements to protect residents and staff at New Jersey nursing homes and other long-term care facilities," **said Stephanie Hunsinger, AARP New Jersey State Director**. "It is a tragedy that more than 7,100 residents and staff in New Jersey's long-term care facilities have died due to COVID-19, and we must ensure this never happens again. These bills implement critical measures to save lives."

"These bills are an important part of refocusing our priorities and, as a society, valuing the care delivered to New Jersey residents as they age," **said NJHA President and CEO Cathy Bennett.** "That requires good policy, sufficient resources and the engagement of all stakeholders including the frail elderly, their loved ones, and the healthcare workers and long term care facilities who help care for them."

A-4476

"The COVID-19 pandemic did not create the problems in long-term care; it merely exacerbated them," **said Assembly Majority Leader Lou Greenwald.** "Without adequate staffing, emergency response plans or central channels of communication with health officials, long-term care facilities were unequipped to keep residents and staff safe in the early critical days of the pandemic. Though no one could have predicted the toll COVID-19 would take, long-term care centers could have been more prepared. Going forward, a centralized command center devoted to long-term care will help us make sure these facilities have the resources they need to prepare for and respond to emergencies."

"This necessary bipartisan legislation acts upon the lessons learned from the Covid-19 response, **said Assemblyman Chris DePhillips**. "In particular, the new Long Term Care Emergency Operations Center will provide greater preparation and coordination across the state in the event of a future outbreak. Moreover, the legislation will ensure that long-term care facilities are more closely tied to the system of care in the state and have emergency plans in place to respond to a public health emergency."

"The fatal consequences of the COVID pandemic fell the hardest on nursing homes, veterans' homes and other long term care facilities that are home to our most vulnerable population of residents," **said Senator Joe Cryan.** "It is tragically obvious that there was an absence of safeguards to prevent and respond to the outbreak. We need to use the hard lessons of this experience to help prevent anything like this from happening again. This includes preventive safeguards, action plans to contain any outbreaks and better pay for the frontline workers who care for the residents."

A-4481

In a joint statement, Assemblymembers Bill Moen, Shavonda Sumter, and Annette Quijano said:

"The COVID-19 pandemic has exposed longstanding problems in our long-term care system. Not only do we need to address staffing shortages, quality of care concerns and emergency preparedness, but we will need to assess how we can modernize an outdated system to best fit the needs of our most vulnerable residents. The work of this task force will help us reform long-term care in New Jersey, including the expansion of home and community-based services, enhancing the use of telemedicine and optimizing resident wellness and infection control."

"Without question, our state has an obligation to ensure that those living in long-term care facilities are provided with the highest level of care to maintain their quality-of-life, while also allowing for family members to play an active role in their lives," **said Assemblywoman Dianne Gove**. "To that end, I've supported the establishment of a Task Force on Long-Term Care Quality and Safety so that New Jersey, moving forward, can and will develop and implement more effective policies that benefit our most vulnerable citizens."

"COVID-19 devastated our long-term care community and it pains me to hear about how helpless the residents and staff members were at the height of this pandemic," **said Senator Richard Codey.** "Establishing the New Jersey Task Force on Long-Term Care Quality and Safety would allow us to develop and implement improvements across the board. Our most vulnerable residents and their caretakers deserve better and this legislation would make sure improvements are realized."

"COVID-19 swept through our long-term care facilities with such devastating speed, nobody knew what to do or how to handle the situation," **said Senator Ronald C. Rice.** "The task force will ensure we develop strict procedures and workplace safety to make sure we are adequately prepared the next time an event like this comes around."

A-4482

"Nurses in long-term care facilities help residents bathe, dress, eat, use the restroom, and manage their medical care. Though they deliver vital care to our most vulnerable, they are often underpaid and overworked," **said Assemblywoman Cleopatra Tucker.** "Now amid a global pandemic, they are putting their own health on the line every day. They deserve to be better compensated for their essential work."

"There are often staffing shortages and retention issues in long-term care facilities, in part because staff are poorly paid and may need to work multiple jobs to make ends meet," **said Assemblyman Tom Giblin.** "Providing pay increases will undoubtedly attract quality workers to the profession and help facilities retain their staff, which in turn will ensure residents are better cared for."

"Direct care staff are the unsung heroes of healthcare. Like all frontline workers, they have gone the extra mile to respond to COVID-19," **said Assemblywoman Annette Chaparro.** "They dedicate their lives to helping our elderly or disabled loved ones live with dignity. It's time we paid them a dignified wage in return."

A-4547

"Nursing homes are not only battling a public health emergency; many are also facing a fiscal emergency," **said Assemblyman Dan Benson**. "Without the resources to adequately pay nursing staff or enforce infection control measures, it will become even more difficult to retain nurses and keep residents and staff safe. By increasing Medicaid reimbursements, we can provide financial relief to nursing homes so that they may improve their COVID-19 response and better care for residents."

"As we look to a potential second wave of COVID-19 in the fall, we must make sure long-term care facilities have the resources needed to mitigate the spread of the virus," **said Assemblyman Gordon Johnson.** "This includes, perhaps most importantly, the heroic CNAs who care for elderly and disabled residents in long-term care facilities and often work multiple shifts at several facilities to make ends meet. Increased wages will mean current CNAs won't have to stretch themselves thin financially, as well as help to attract new staff hires, which in turn will improve quality of care for residents."