HEALTH

HEALTH SYSTEMS BRANCH

DIVISION OF CERTIFICATE OF NEED AND LICENSING

Hospital Licensing Standards

Definitions, Support Person

Patient Rights

Adopted Amendments: N.J.A.C. 8:43G-1.2 and 4.1

Proposed: April 7, 2025, at 57 N.J.R. 645(a).

Adopted: , 2025, by Jeffrey A. Brown, Acting Commissioner, Department of Health, with the approval of the Health Care Administration Board.

Filed: , 2025, as R. 2025 d. , **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 26:2H-5 and 26:4C-2.

Effective Date: , 2025.

Expiration Date: April 13, 2027.

Summary of Public Comments and Agency Responses:

The Department of Health (Department) received comments from the following:

1. Lea Chen;

2. Christopher E. Miller, Author, Political Scientist, and Advocate for People with Disabilities, Neptune City, NJ;

3. Gwen Orlowski, Executive Director, Disability Rights New Jersey, Trenton, NJ;

4. Jean Publie; and

5. Christine Stearns, Chief, Government Relations and Policy, New Jersey Hospital Association, Princeton, NJ.

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

1. COMMENT: A commenter "applaud[s]" the proposed rulemaking and states that support staff ensure that a patient who needs assistance with activities of daily living (ADLs) receive the care such a patient needs, "including "facilitating communication with doctors and the treatment team and everyday assistance with feeding and other activities that the staff at the hospital do not have time to perform." The commenter states that adoption of the proposed amendments would result in "improved patient care and treatment because direct support professionals are a part of life. Without them [, a patient who needs assistance with ADLs] cannot be successful." The commenter states that being a hospital patient "is a very scary time. Having a disability exacerbates that fear because [of] the consequences of understaffing." The commenter states that the proposed amendments would improve "the patient experience [and] well-being and … providing peace of mind for people with disabilities, [their] families, and … support staff." The commenter thanks the Department for making "this change a reality for [people] who require supports [and states that New Jersey] will see an increase of positive outcomes due to this change for both patients and hospital staff." (2)

2. COMMENT: A commenter supports the proposed amendments and states that in promulgating the proposed amendments, the Department is "operating within the

scope of its authority" pursuant to the Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq. (HCFPA). The commenter notes that the proposed rulemaking would "solidify" as a patient right, consistent with a memorandum the Department issued during the COVID-19 pandemic and a superseding waiver permitting the designation of a second support person, the requirement that a support person be allowed to accompany a patient with a disability in hospital settings. The commenter "appreciates DOH's decision to promulgate the right to appoint a support person and make the right applicable to all patients," and states that the proposed rulemaking "serves as a reflection of [the Department's] commitment to the public policy outlined in [the HCFPA]."

The commenter states that the proposed amendments would "[mark] a positive shift to a 'patient- [and] family-centered care' approach as a basic right for all patients [(citation omitted)]. Using the Bill of Rights for Hospital Patients at N.J.S.A. 26:2H-12.84 as a cornerstone, combined with the unprecedented lived experiences of the COVID pandemic, this addition offers assurance that the patients of [New Jersey] will not be forced to face grave medical situations without a family member or other natural support by their side."

The commenter describes the difficult conditions that the early days of the COVID-19 pandemic imposed on hospital staff and patients, during which, the commenter states, hospitals were "overcrowded and critically understaffed," and patients were "denied a support person or visitation. Many patients were barely able to communicate for themselves because of compromised respiratory status, hypoxia, and resulting altered mental status." The commenter quotes a June 2020 news report in

which “a nurse recounts working during the pandemic: ‘… So many patients were dying, and we were the only ones there to hold their hands in the end. All of us are still traumatized’ [(citation omitted)].” The commenter describes the effect of isolation precautions used during the pandemic (masking, gloves, and gowns) as “alienating” patients and cites research indicating that restricted family presence during COVID-19 “dehumanized patients,” that is, resulted in patients being “treated in way that disregard[ed] their humanity and individuality [(citation omitted)].” The commenter states that the “absence of family presence took its toll on patients and healthcare providers alike” and that the proposed amendments would ensure “that the presence of a constant support person can help prevent the repetition of the trauma and alienation of the early days of the COVID-19 pandemic and meet vital accessibility needs of people with disabilities.”

The commenter “recognizes that the Department … took important steps to ensure that two groups of patients would have access to support people during the pandemic,” citing a Department Executive Directive that allowed patients to designate a support person in labor and delivery settings, and a Department Guidance Memorandum and Waiver that permitted individuals with disabilities to designate up to two support people, “but defined disability relatively narrowly [(citations omitted)].” The commenter states that the proposed amendments “allowing all patients to designate support people” would ensure “that the presence of a constant support person can help prevent the repetition of the trauma and alienation of the early days of the COVID-19 pandemic and meet vital accessibility needs of people with disabilities and all hospital

patients." The commenter states that the "move to extend that right to all patients will benefit everyone, particularly people with disabilities."

The commenter states that the proposed amendments authorizing a support person to "have 24-hour access to be with the patient, be allowed to accompany the patient to all areas of the hospital and … be the point person of communication for the patient's care team" would enable "the support person to serve as a full-time emotional support and advocate for the patient at all points during [the patient's] hospital stay." The commenter supports the proposed definition of the term, "support person," at N.J.A.C. 8:43G-1.2, as proposed for amendment, which the commenter states would "actively [reflect] the important role that support people play for individuals with disabilities and other patients in the acute care hospital setting."

The commenter particularly supports paragraph 4 of the proposed definition, which would allow a patient to designate a second support person, because "[a]llowing a patient to select multiple support people could help cover the full range of needs and support that is required of a hospitalized patient. The 24-hour responsibility should not fall on one individual alone.… Allowing the addition of additional support people will help mediate some of the effects of caregiver burnout," which the commenter describes as "'a state of physical, emotional and mental exhaustion that happens while you're taking care of someone else' [(citation omitted)]."

The commenter states that the proposed amendment establishing a definition of the term, "support person" would result in "better patient outcomes and satisfaction. [A] support person will serve as a point-person for the medical team, a companion, and an advocate. Having a support person has been shown to create better communication

between the medical team, patient, and family." The commenter cites research indicating "that family presence 'decreases anxiety and increases satisfaction for patient and families,'" and provides the benefit of "more supportive and successfully communicative care [(citations omitted)]."

The commenter states that the proposed amendments "could [bolster] the efficacy of the bill of rights for hospital patients. The right to 'considerate and respectful care,' 'to be assessed and treated for pain,' to be 'informed by the physician of continuing healthcare requirements,' to 'continuity of care,' and to 'treatment without discrimination' [at N.J.S.A. 26:2H-12.8 would] without question be more successfully upheld with a chosen support person at one's side. These rights are not to be taken lightly. Each one, without full adherence, could result in an unwanted medical outcome or untimely death."

The commenter states that "[p]atients, including people with disabilities, enter a hospital because they need immediate medical attention. They have little control of how their bodies will react, or what treatments will be needed for their ailment. [The proposed amendments would give] patients, including all individuals with disabilities, the comfort of knowing that somebody that they trust will be there to hold their hands when they are scared, speak for them when they cannot, or console them with a final goodbye. Expanding this right permanently to all patients [would] improve their experience and care and help ensure the isolation and pain patients [experienced] during the early pandemic suffered never happens again." (3)

RESPONSE TO COMMENTS 1 AND 2: The Department acknowledges the commenters' support for the proposed amendments.

3. COMMENT: A commenter states that the “direct support professional does not perform the healthcare side of treatment. They provide physical assistance so [that patients who require assistance with ADLs] can receive the care [they] need.” The commenter states it “is critical to update waiver service programming materials and personal preference program materials to make sure that they reflect [the proposed amendments] and can be properly paid for their services.” (2)

RESPONSE: The Department of Human Services (DHS) administers the programs the commenter identifies; specifically, the Division of Developmental Disabilities administers the waiver servicing program, and the Division of Medical Assistance and Health Services administers the personal preference program. The Department will refer the commenter’s suggestion to the DHS for review and consideration.

4. COMMENT: A commenter states that defining “support person” to mean a person who is “18 years or older whom the patient selects” would acknowledge “that a patient may request, and need, a person [who] is outside [the patient’s] immediate family, or marital bond,” and that “[t]his approach is both consistent with the expansive reality of the variation in human relationships and will particularly benefit individuals with intellectual or developmental disabilities who need the assistance of a direct support professional …. Moreover, this definition aligns with other states’ approaches.” (3)

RESPONSE: The Department acknowledges the commenter’s support for the proposed amendment.

5. COMMENT: A commenter, a healthcare professional, states that “[w]hile the provision of an environment and resources to allow hospital visitors and accompanying

support can greatly facilitate healthcare and outcomes, allowing the presence of another person as a 'right' is a very dangerous proposal." The commenter has encountered "several victims of abuse (adults, children, and geriatric patients) [and] imagine[s that healthcare providers] in primary care see so much more. A 'yes' does not always truly mean permission or a desire to have another person in the room, and these situations require a delicate and nuanced approach. The ability to separate a potential abuser from a patient to confirm safety may be required and often needs to be done after rapport has been established. Sadly, this happens more often than [one] might think." (1)

RESPONSE: The Department acknowledges the commenter's perspective from lived experience. The Department agrees with the commenter's statement that situations of the type the commenter describes require tactful, delicate, and nuanced response by hospital personnel. However, the described situations might occur, regardless of whether a patient elects to designate a potential abuser as the patient's support person in accordance with the procedures that the proposed amendments would establish. The issue of a hospital's development of awareness training and response protocols to identify potential abuse situations involving patient visitors, including designated support persons, would exceed the scope of the proposed rulemaking, which is to implement a protocol by which a patient might designate a support person. Accordingly, the Department will make no change upon adoption in response to the comment.

6. COMMENT: A commenter states, "what is on paper at this [Department] and what they factually do are not the same things. [T]hey write it but when [one tries] to

make them follow what they write, [it's] another story. They don't stand up to their [rules] at any time." The commenter identifies "problems with this [Department] in relation [to] the annual meeting[s] of hospitals with their communit[ies] and this [Department] has done nothing to help a patient. [It's] a paper tiger. [One's] rights can vanish at any time on their written [rules]." (4)

RESPONSE: The Department understands the comment to state that the Department does not enforce its rules. This statement, and the statement that the Department "has done nothing to help [patients]," while being factually and demonstrably incorrect, do not address the proposed amendments and thus exceed the scope of the proposed rulemaking. Likewise, the commenter's reference to a hospital's annual community meeting does not relate to the proposed amendments and thus exceeds the scope of the proposed rulemaking. Therefore, the Department will make no change upon adoption in response to the comment.

7. COMMENT: A commenter "recognizes the importance of emotional support in a patient's healing process" and "appreciate[s] the Department's commitment to person-centered care and supporting patients' emotional well-being." (5)

RESPONSE: The Department acknowledges the comment.

8. COMMENT: A commenter states that the Economic Impact in the notice of proposal "minimizes [the] implications" of, and "fails to account for the substantial operational, staffing, compliance, and security costs hospitals would incur" upon the adoption of the proposed amendments. By underestimating these burdens, the Department has likely violated the Administrative Procedure Act … by failing to give the regulated community adequate notice of the true economic impact." The commenter

“urge[s] the Department to revisit its economic assessment to accurately reflect the financial and logistical consequences of implementation.” The commenter states that “some hospitals will face significant operational challenges in terms of adjusting staff workload and workflows, electronic medical record (EMR) changes, security protocols, [and the like,] to allow … 24/7 visitation. Having the building be accessible at all hours for multiple support persons increases the risk of workplace violence and would necessitate additional security personnel. These changes require time, resources, and careful planning. The Department must provide a reasonable implementation timeline and acknowledge these costs in its economic impact analysis.” (5)

RESPONSE: The Department disagrees with the commenter’s assertion that the proposed amendments would impose costs other than those the Economic Impact describes so substantially as to render the Economic Impact deficient and in violation of the APA, and that facilities would require additional time to implement the proposed amendments.

The Department previously instructed hospitals to allow patients to designate support persons during the Public Health Emergency caused by the COVID-19 pandemic (PHE), which began over five years ago. As described in the notice of proposal, a 2020 Executive Directive required hospitals to allow a patient to designate a support person to accompany a patient during labor, delivery, and the entire postpartum hospital stay, and a 2020 Guidance Memorandum directed hospitals to allow a designated support person to accompany a patient with a disability during hospitalization. See 57 N.J.R. 645(a).

The 2020 Guidance Memorandum required each hospital to establish operational, compliance, and security measures for its implementation. Hospitals would have incurred the expenses attendant to implementation of the 2020 Executive Directive and the 2020 Guidance Memorandum upon their issuance in 2020. The proposed amendments would not depart from the requirements of the 2020 Executive Directive and 2020 Guidance Memorandum to the extent that their adoption would require hospitals to incur new or differing costs associated with implementation. It is unlikely that the adoption of the proposed amendments, which would implement a patient's ability to be attended by a support person, would markedly change the number of (non-patient and non-staff) persons present in a hospital from the number who typically have been present during the last five years since the declaration of the PHE.

Moreover, in 2023, the Department provided hospitals additional advance notice of its intention to promulgate rulemaking to require hospitals to accommodate patient support persons as a permanent licensure standard. See Department, *Support Person for Patients* (March 22, 2023) (2023 Guidance Memorandum), available at https://www.nj.gov/health/healthfacilities/certificate-need/guidance ("Through the experience of the pandemic, the Department has concluded that a support person is, in fact, vital for all patients, not just those with disabilities, while in the emergency room or while hospitalized. The Department intends to amend N.J.A.C. 8:43G-4.1, which covers hospital patients' rights, to incorporate this new standard. The purpose of this memorandum is to advise hospitals of the Department's decision so that they may begin to adopt policies and procedures to address this new standard.")

The commenter provides no support for the statement that over the previous five years, compliance with the 2020 Executive Directive and the 2020 Guidance Memorandum, requiring a facility "to be accessible at all hours for multiple support persons" has increased "the risk of workplace violence" and has correspondingly increased the demand for security personnel. Indeed, the availability of support persons may alleviate some staffing pressures hospitals face. In 2023, approximately 10.9 percent of the State's population was estimated to live with a disability. *Disability Status by County, New Jersey, 2023*, Indicator Report, New Jersey State Health Assessment Data (Trenton, NJ) (Last Updated On 09/20/2024, Published on 10/30/2024), available at https://www-doh.nj.gov/doh-shad/indicator/view/Dem_Disability.County.html. Some members of this population require assistance with communication and ADLs. This is largely where the availability of a support person to provide a patient non-healthcare assistance (as described in Comments 1 and 2 above) could alleviate workload burdens on clinical and non-clinical hospital staff to perform their other duties.

The proposed amendment at N.J.A.C. 8:43G-1.2, establishing a definition of the term, "support person" at paragraph 3, would require a hospital to require the written authorization of a patient or the patient's legally authorized decision-maker to disclose health care information to a patient's support person. Other than this, and presumably the annotation of a patient's chart to reflect the identity of a patient's support person, in accordance with policies and procedures the hospital establishes, the proposed amendments would not materially add to a hospital's existing duty to maintain patient medical records pursuant to N.J.A.C. 8:43G-15, Medical Records. Moreover, the 2020

Executive Directive and 2020 Guidance Memorandum required hospitals to establish protocols to accommodate patient support persons, and the 2023 Guidance Memorandum provided further advance notice of the Department's intention to establish support person accommodation as a permanent requirement. Therefore, the Department disagrees with the commenter's assertion that the Economic Impact statement understates implementation costs or that hospitals will experience "significant operational challenges in terms of … electronic medical record (EMR) changes," that warrant deferred implementation of the proposed amendments.

Based on the foregoing, the Department will make no change upon adoption in response to the comment.

9. COMMENT: A commenter states that the "proposed rule introduces inconsistencies in the legal role of a 'support person,' conflating emotional support with clinical decision-making. The proposal specifies that when direct communication with the patient is impossible due to diminished capacity, the hospital must treat the support person as the primary contact. While it acknowledges that a support person may act as a decision-maker only if legally designated, other provisions imply that the support person becomes the de facto primary contact in cases of 'diminished capacity.' This is problematic for several reasons:

[(1)] 'Diminished capacity' lacks a clear legal definition and may invite inappropriate delegation of decision-making authority without due process.

[(2)] Under New Jersey law, even patients under guardianship retain certain mental health care rights, including the right to consent to inpatient treatment, despite the guardian's wishes.

[(3)] The practical result could be the marginalization of properly designated healthcare proxies, causing delays in care or miscommunication.

As for care team communications, the requirement to 'treat the primary support person as the main contact for the patients' providers' could result in the delay of provision of emergency care when the patient has a designated health care proxy decision maker. It could also lead to erroneous misunderstanding of health information if relayed second hand to the healthcare proxy who maintains legal decision making. Hospitals require clarity and legal consistency in determining who may receive protected health information (PHI) and make decisions on a patient's behalf. As currently drafted, the rule invites confusion and potential conflict with HIPAA, [S]tate mental health laws, and existing patient rights statutes. As noted above, patients who lack capacity may still have the right to object to care and assert their right to privacy."

The commenter states that the proposed amendments would "present a number of additional operational challenges. The requirement to treat the support person as the "main contact" may conflict with emergency care protocols and hinder timely clinical decisions." (5)

RESPONSE: The Department acknowledges that the use of the terms "main contact" and "diminished capacity," as used within subparagraph 5ii of the proposed definition of the term, "support person" at N.J.A.C. 8:43G-1.2, could conflict with facility protocols and otherwise result in confusion.

Paragraph 2 of the definition of the term, "support person," states that if a "patient loses decision-making capacity, a support person is not authorized to make decisions on behalf of the patient, unless that person is the patient's next of kin, guardian, or

legally authorized decision-maker through an advance directive." To ensure consistency with this provision, avoid conflict with State law, prevent conferring upon a patient's designated support person a measure of control that could impinge on the authority of a patient's legally authorized healthcare proxy decisionmaker, and for the reasons the commenter states, the Department will change the provision on adoption to delete the term, "main contact," and instead state that a patient's designated primary support person is to be "a point of contact," in addition to the patient and the patient's legally authorized healthcare proxy decisionmaker, and delete the reference to "diminished capacity."

10. COMMENT: A commenter states that the "proposed rule includes an override of public health emergency measures, which is surprising and concerning." While the commenter "understand[s] the need to address past isolation concerns during COVID-19, a blanket override may interfere with the [S]tate's ability to manage future infectious disease outbreaks or emergency scenarios. Hospitals must retain discretion to balance public safety with individual rights." (5)

RESPONSE: As the proposal Summary notes, the proposed amendments would establish in rule, as a patient right, measures that the Department introduced during the PHE to respond to hardships to patients and their families caused by separations related to the implementation of isolation precautions. See 57 N.J.R. 645(a). Subparagraph 5iv of the definition of the term, "support person" at N.J.A.C. 8:43G-1.2, as proposed for amendment, would allow a support person to accompany a patient during a public health emergency. However, this provision would not limit the Commissioner's authority pursuant to the Emergency Health Powers Act, N.J.S.A.

26:13-1 et seq., to adjust rules during a declared public health emergency. If a public health emergency were to occur in the future, the Department would review existing rules and develop rule waivers and issue guidance memoranda tailored to the event, as it did in 2020. Accordingly, the Department will make no change upon adoption in response to the comment.

11. COMMENT: A commenter states that the proposed rulemaking "fails to consider the unique safety and regulatory requirements of behavioral health. Behavioral health units are highly restrictive to ensure patient safety. Permitting support persons to accompany a behavioral health patient with unrestricted access into secure areas of the emergency department and hospital raises a number of concerns, including:

[(1)] A violation of [F]ederal law ([s]ee 42 U.S.C. 1320d-2; N.J.S.A. 26:5C-7 et seq.) and New Jersey [rules] providing heightened privacy protections for a patient [who] is receiving mental health care. (See N.J.A.C. 10:37-6.79)[.] Consequently, a support person who observes another patient on the unit receiving mental health care would constitute a regulatory violation.

[(2)] Support persons who are not easily distinguishable from patients increase the risk of the elopement and heighten the burden on staff to maintain a secure environment.

[(3)] Physical safety concerns for support persons located within a secure patient care unit where other mental health patients could suffer an untoward reaction and act out/strike out causing injury.

[(4)] Undermining the safety of staff and other patients, particularly when the support person is a contributor to the patient's condition. In some cases, family members or others acting as the patient's support person may be contributors to or antagonists of the mental health issues being treated, thereby undermining the patient's care."

The commenter states that the "definition of 'support person,' is overly broad, and the rule allows … an accumulation of individuals beyond the primary support person, raising questions about enforcement, space limitations, and privacy.

It is imperative that hospitals maintain the ability to use discretion in limiting support person access during certain procedures and when patient privacy and safety is at risk. To assist hospitals in the creation of new protocols, [the commenter] requests that hospitals be allowed to define 'areas where communication between hospital staff, professionals, and patients would normally take place' respective to the facility capacities and legal requirements of individual departments." (5)

RESPONSE: The Department agrees with the commenter's statement that support persons should not have "unrestricted access into secure areas." The proposed amendment at N.J.A.C. 8:43G-1.2, establishing a definition of the term "support person," states that a support person is to be allowed "in areas where communication between hospital staff, professionals, and patients would normally take place" and, at paragraph 6, states that a support person is to "adhere to hospital policies and procedures, other than visitation hours that ordinarily would apply."

The comment appears to conflate "areas where communication between hospital staff, professionals, and patients would normally take place" with areas at which

treatment would normally take place. The proposed amendments would not affect a hospital's autonomy over, and the responsibility to establish, revise as necessary, and implement, facility policies and procedures that protect the confidentiality and prevent unauthorized disclosures of all patients' health information, and ensure the health, safety, and welfare of patients, hospital staff, support persons, and others present in a hospital. The Department anticipates that a hospital would implement the proposed amendments through policies and procedures that identify appropriate methods and areas to accommodate safe and confidential communications with patients and their support persons, without compromising the safety and confidentiality protections of other patients, hospital employees, and other hospital visitors.

The laws that the commenter identifies as relevant to the confidentiality of mental health communications, in a hospital that the Department licenses pursuant to the HCFPA and N.J.A.C. 8:43G, are inapposite. 42 U.S.C. §1320d-2 establishes "Standards for information transactions and data elements" pursuant to Part C, Administrative Simplification, of the Social Security Act; N.J.S.A. 26:5C-7 establishes standards for "Confidentiality of AIDS, HIV infection records, information;" and N.J.A.C. 10:37-6.79 establishes standards for "Confidentiality of records" within a facility funded pursuant to the Community Mental Health Services Act and licensed pursuant to N.J.A.C. 10:37A through 10:37I.

The Department disagrees with the commenter's statement that the definition of the term, "support person" at N.J.A.C. 8:43G-1.2, as proposed for amendment, is overly broad. Many patients have no family or legally designated representative to accompany or assist them when they are hospitalized. The proposed amendments would allow

such patients to experience the caring support of friends, neighbors, or others to assist them with non-healthcare ADLs during their hospitalizations.

For the foregoing reasons, the Department will make no change upon adoption in response to the comment.

12. COMMENT: A commenter "recommends that documentation requirements for support persons align with those already in place for [d]esignated [c]aregivers and [h]ealthcare [p]roxies to ensure hospital staff can access information as quickly and as accurately as possible." (5)

RESPONSE: The New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 et seq., enables a patient to formalize a voluntary, informed choice to accept, to reject, or to choose among alternative courses of medical and surgical treatment in case of the patient's loss of decision-making capacity, and to appoint a "health care representative" by means of a "proxy directive." Likewise, the New Jersey Advance Directives for Mental Health Care Act, N.J.S.A. 26:2H-102 et seq., enables a patient to formalize direction of the patient's mental health treatment and appoint a "mental health care representative" by means of a "proxy directive" in case of the patient's loss of mental health care decision-making capacity. N.J.A.C. 8:43G-5, Hospital Administration and General Hospital-wide Policies, requires a hospital to establish policies and procedures to address a patient's advance directive, which might include a proxy directive. Th proposed amendments would not alter the application or implementation of these laws.

A hospital might elect to establish in its policies and procedures, as the commenter suggests, the requirement that hospital staff annotate a patient's chart to

reflect the identity of a patient's designated support persons in the same manner as it designates a patient's health care representative or mental health care representative; but the proposed amendments would not require a hospital to implement the proposed amendments in this manner. The Department defers to each hospital to implement the proposed amendments in the manner the hospital determines to be most appropriate and effective. Accordingly, the Department will make no change upon adoption in response to the comment.

13. COMMENT: A commenter states that the proposed amendments would "present a number of patient privacy concerns. Hospitals often provide care in shared spaces. Permitting support persons to remain present during intimate procedures ([for example], bathing, catheterization) may violate patient privacy and trigger HIPAA [Health Insurance Portability and Accountability Act of 1996] violations." (5)

RESPONSE: The proposed amendments would not require a hospital to navigate privacy concerns in shared patient spaces differently from how it already addresses these concerns. A hospital's policies and procedures should address the methods that the hospital implements to protect patient privacy. For example, use of physical barriers, such as curtains or privacy screens, technology, such as mobile devices and computers, spoken discretion, patient consent, and staff training in HIPAA compliance are all key components of maintaining patient privacy. It is not obvious from the comment how a support person's presence in attending a patient would affect a hospital's ability to implement privacy protection measures already in use in shared patient spaces. It would remain incumbent on a hospital to enforce its privacy

protection measures in all hospital settings and update its policies and procedures as necessary to accommodate this statutorily established patient right.

14. COMMENT: A commenter requests that hospitals be allowed to define “areas where communication between hospital staff, professionals, and patients would normally take place” respective to the facility capacities and legal requirements of individual departments. (5)

RESPONSE: A hospital has autonomy to develop its own policies and procedures. The proposed amendments would require a hospital to treat the availability of a support person as a patient right in the hospital’s policies and procedures but declines to impose requirements that describe how a hospital is to implement this right. Accordingly, the Department will make no change upon adoption in response to the comment.

15. COMMENT: A commenter states that the “requirement to document written consent to discuss ‘personally identifiable information’ (PII) appears to misuse terminology. The more accurate and legally recognized term is ‘protected health information’ (PHI).” (5)

RESPONSE: The Department agrees that the use of the phrase, “personally identifiable information,” is imprecise. Accordingly, the Department will make a change upon adoption at paragraph 3 of the definition of the term, “support person,” at N.J.A.C. 8:43G-1.2, as proposed for amendment, to delete the phrase, “personally identifiable information,” and replace it with the phrase, “protected health information.”

Summary of Agency-initiated Changes: The Department will make nonsubstantial changes upon adoption to correct a grammatical error and a punctuation

error, and to add a reference to the statutory term, “health care representative” as used in the Advance Directives for Health Care Act and the Advance Directives for Mental Health Care Act.

Federal Standards Statement

The Department is not adopting the proposed amendments pursuant to the authority of, or to implement, comply with, or participate in, any program established pursuant to Federal law or a State statute that incorporates or refers to any Federal law, standard, or requirements. Therefore, a Federal standards analysis is not required.

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

CHAPTER 43G

HOSPITAL LICENSING STANDARDS

SUBCHAPTER 1. GENERAL PROVISIONS

8:43G-1.2 Definitions

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

…

“Support person” means a person who is 18 years of age or older whom a patient selects to accompany the patient both in an emergency department and during hospitalization, in areas where communication *[between]* ***among*** hospital staff, professionals, and patients would normally take place.

1. (No change from proposal.)

2. *[If the patient loses decision-making capacity, a]* ***A*** support person is not authorized to make decisions on behalf of *[the]* ***a*** patient unless that person is the patient's next of kin, guardian, *[or]* legally authorized decision-maker *[through]* ***, or health care representative in accordance with*** an advance directive ***pursuant to N.J.S.A. 26:2H-53 et seq., or 26:2H-102 et seq***.

3. A hospital shall disclose a patient's *[personal identifiable]* ***protected health*** information to a support person only after the patient or the patient's legally authorized decision-maker provides written consent for the intended disclosure.

4. (No change from proposal.)

5. A hospital shall ensure that:

i. Notwithstanding visitation hours that ordinarily would apply, a patient's primary support person shall have 24-hour access to the patient in areas where communication *[between]* ***among*** hospital staff, professionals, and patients would normally take place;

ii. In addition to direct communication with a patient and the patient's legally-authorized representative (if any), or when *[such]* direct communication with the patient is not possible *[due to the patient's diminished capacity]*, the hospital shall treat the primary support person as *[the main]* ***a point of*** contact for the patient's providers; and

iii. Notwithstanding visitation hours that ordinarily would apply, a patient's other support persons shall have 24-hour access to the patient in

areas where communication *[between]* ***among*** hospital staff, professionals, and patients would normally take place; however, the hospital *[does]* ***shall*** not treat a non-primary support person as a ***point of*** contact for the patient's health care providers; and

iv. (No change from proposal.)

6. (No change from proposal.)

8:43G-4.1 Patient rights

(a) (No change from proposal.)

(b) Every New Jersey hospital patient shall have at least the following rights, none of which a hospital or any of its staff shall abridge:

1.-23. (No change.)

24. To be accompanied by a support person both in the emergency department and during hospitalization, in areas where communication *[between]* ***among*** hospital staff, professionals, and patients would normally take place*[.]*****;***

25.-32. (No change from proposal.)