

1 SENATE BILL NO. 332  
23 AMENDMENT IN THE NATURE OF A SUBSTITUTE  
45 (Proposed by the Senate Committee on Education and Health  
6

7 on \_\_\_\_\_)

8 (Patron Prior to Substitute—Senator Favola)

9 *A BILL to amend and reenact §§ 18.2-251.1:2 and 32.1-127 of the Code of Virginia, relating to medical  
10 cannabis; administration to terminally ill patients.*11 **Be it enacted by the General Assembly of Virginia:**12 **1. That §§ 18.2-251.1:2 and 32.1-127 of the Code of Virginia are amended and reenacted as follows:**13 **§ 18.2-251.1:2. Possession or distribution of medical cannabis; hospitals, nursing homes, and  
14 certified nursing facilities; hospice and hospice facilities; assisted living facilities.**15 No person employed by a *hospital*, nursing home, hospice, hospice facility, or assisted living facility and  
16 authorized to possess, distribute, or administer medications to patients or residents shall be prosecuted under  
17 Chapter 11 (§ 4.1-1100 et seq.) of Title 4.1 or § 18.2-248, 18.2-248.1, or 18.2-250 for the possession or  
18 distribution of cannabis oil for the purposes of storing, dispensing, or administering cannabis oil to a patient  
19 or resident who has been issued a valid written certification for the use of cannabis oil in accordance with  
20 § 4.1-1601.21 **§ 32.1-127. Regulations.**22 A. The regulations promulgated by the Board to carry out the provisions of this article shall be in  
23 substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established  
24 and recognized by medical and health care professionals and by specialists in matters of public health and  
25 safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the  
26 Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

## 27 B. Such regulations:

28 1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes  
29 and certified nursing facilities to ensure the environmental protection and the life safety of its patients,  
30 employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified  
31 nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing  
facilities, except those professionals licensed or certified by the Department of Health Professions; (iv)  
conditions under which a hospital or nursing home may provide medical and nursing services to patients in  
their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility

32 security of hospitals, nursing homes, and certified nursing facilities;

33 2. Shall provide that at least one physician who is licensed to practice medicine in the Commonwealth and

34 is primarily responsible for the emergency department shall be on duty and physically present at all times at

35 each hospital that operates or holds itself out as operating an emergency service;

36 3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing

37 hospitals and nursing homes by bed capacity and by type of specialty or service;

38 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal

39 law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. §

40 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS

41 regulations for routine contact, whereby the provider's designated organ procurement organization certified

42 by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii)

43 is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a

44 similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of

45 America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The

46 hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in

47 the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable

48 tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The

49 protocol shall ensure that the hospital collaborates with the designated organ procurement organization to

50 inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to

51 donate. The individual making contact with the family shall have completed a course in the methodology for

52 approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved

53 by the organ procurement organization and designed in conjunction with the tissue and eye bank community

54 and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of

55 the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement

56 organization in educating the staff responsible for contacting the organ procurement organization's personnel

57 on donation issues, the proper review of death records to improve identification of potential donors, and the

58 proper procedures for maintaining potential donors while necessary testing and placement of potential

59 donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the

60 family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative

61 officer of the hospital or his designee knows of such opposition, and no donor card or other relevant  
62 document, such as an advance directive, can be found;

63 5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or  
64 transfer of any pregnant woman who presents herself while in labor;

65 6. Shall also require that each licensed hospital develop and implement a protocol requiring written  
66 discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall  
67 require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and  
68 the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment  
69 services, comprehensive early intervention services for infants and toddlers with disabilities and their families  
70 pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and  
71 family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the  
72 other parent of the infant and any members of the patient's extended family who may participate in the  
73 follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of  
74 any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the  
75 community services board of the jurisdiction in which the woman resides to appoint a discharge plan  
76 manager. The community services board shall implement and manage the discharge plan;

77 7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for  
78 admission the home's or facility's admissions policies, including any preferences given;

79 8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of  
80 patients which shall include a process reasonably designed to inform patients of such rights and  
81 responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on  
82 admission, shall be consistent with applicable federal law and regulations of the Centers for Medicare and  
83 Medicaid Services;

84 9. Shall establish standards and maintain a process for designation of levels or categories of care in  
85 neonatal services according to an applicable national or state-developed evaluation system. Such standards  
86 may be differentiated for various levels or categories of care and may include, but need not be limited to,  
87 requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

88 10. Shall require that each nursing home and certified nursing facility train all employees who are  
89 mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures  
90 and the consequences for failing to make a required report;

91        11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or  
92        hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or  
93        treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give  
94        patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time  
95        not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital  
96        policies and procedures, by the person giving the order, or, when such person is not available within the  
97        period of time specified, co-signed by another physician or other person authorized to give the order;

98        12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer of  
99        the vaccination, that each certified nursing facility and nursing home provide or arrange for the  
100       administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal  
101       vaccination, in accordance with the most recent recommendations of the Advisory Committee on  
102       Immunization Practices of the Centers for Disease Control and Prevention;

103       13. Shall require that each nursing home and certified nursing facility register with the Department of  
104       State Police to receive notice of the registration, reregistration, or verification of registration information of  
105       any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to  
106       Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 within the same or a contiguous zip code area in which the home or  
107       facility is located, pursuant to § 9.1-914;

108       14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission,  
109       whether a potential patient is required to register with the Sex Offender and Crimes Against Minors Registry  
110       pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the potential patient  
111       will have a length of stay greater than three days or in fact stays longer than three days;

112       15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult  
113       patient to receive visits from any individual from whom the patient desires to receive visits, subject to other  
114       restrictions contained in the visitation policy including, but not limited to, those related to the patient's  
115       medical condition and the number of visitors permitted in the patient's room simultaneously;

116       16. Shall require that each nursing home and certified nursing facility shall, upon the request of the  
117       facility's family council, send notices and information about the family council mutually developed by the  
118       family council and the administration of the nursing home or certified nursing facility, and provided to the  
119       facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six

120 times per year. Such notices may be included together with a monthly billing statement or other regular  
121 communication. Notices and information shall also be posted in a designated location within the nursing  
122 home or certified nursing facility. No family member of a resident or other resident representative shall be  
123 restricted from participating in meetings in the facility with the families or resident representatives of other  
124 residents in the facility;

125 17. Shall require that each nursing home and certified nursing facility maintain, per facility, non-eroding  
126 general liability insurance coverage in a minimum amount of \$1 million per occurrence, and professional  
127 liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15 per patient  
128 occurrence, to compensate patients or individuals for injuries and losses resulting from the negligent acts of  
129 the facility. Failure to maintain such minimum insurance limits under this section shall result in revocation of  
130 the facility's license. Each nursing home and certified nursing facility shall provide at licensure renewal or  
131 have available to the Board proof of the insurance coverages as required by this section;

132 18. Shall require each hospital that provides obstetrical services to establish policies to follow when a  
133 stillbirth, as defined in § 32.1-69.1, occurs that meet the guidelines pertaining to counseling patients and their  
134 families and other aspects of managing stillbirths as may be specified by the Board in its regulations;

135 19. Shall require each nursing home to provide a full refund of any unexpended patient funds on deposit  
136 with the facility following the discharge or death of a patient, other than entrance-related fees paid to a  
137 continuing care provider as defined in § 38.2-4900, within 30 days of a written request for such funds by the  
138 discharged patient or, in the case of the death of a patient, the person administering the person's estate in  
139 accordance with the Virginia Small Estates Act (§ 64.2-600 et seq.);

140 20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that  
141 requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct verbal  
142 communication between the on-call physician in the psychiatric unit and the referring physician, if requested  
143 by such referring physician, and prohibits on-call physicians or other hospital staff from refusing a request for  
144 such direct verbal communication by a referring physician and (ii) a patient for whom there is a question  
145 regarding the medical stability or medical appropriateness of admission for inpatient psychiatric services due  
146 to a situation involving results of a toxicology screening, the on-call physician in the psychiatric unit to which  
147 the patient is sought to be transferred to participate in direct verbal communication, either in person or via  
148 telephone, with a clinical toxicologist or other person who is a Certified Specialist in Poison Information  
149 employed by a poison control center that is accredited by the American Association of Poison Control

150 Centers to review the results of the toxicology screen and determine whether a medical reason for refusing  
151 admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the  
152 referring physician;

153 21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a  
154 policy governing determination of the medical and ethical appropriateness of proposed medical care, which  
155 shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of  
156 proposed medical care in cases in which a physician has determined proposed care to be medically or  
157 ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is  
158 medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by  
159 the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the  
160 proposed health care; and (iii) requirements for a written explanation of the decision reached by the  
161 interdisciplinary medical review committee, which shall be included in the patient's medical record. Such  
162 policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to  
163 § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent  
164 medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee  
165 meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical  
166 decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other  
167 remedies available at law, including seeking court review, provided that the patient, his agent, or the person  
168 authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the  
169 chief executive officer of the hospital within 14 days of the date on which the physician's determination that  
170 proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical  
171 record;

172 22. Shall require every hospital with an emergency department to establish a security plan. Such security  
173 plan shall be developed using standards established by the International Association for Healthcare Security  
174 and Safety or other industry standard and shall be based on the results of a security risk assessment of each  
175 emergency department location of the hospital and shall include the presence of at least one off-duty  
176 law-enforcement officer or trained security personnel who is present in the emergency department at all times  
177 as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based  
178 on identified risks for the emergency department, including trauma level designation, overall volume, volume  
179 of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from  
180 such violence, and prevalence of crime in the community, in consultation with the emergency department

181 medical director and nurse director. The security plan shall also outline training requirements for security  
182 personnel in the potential use of and response to weapons, defensive tactics, de-escalation techniques,  
183 appropriate physical restraint and seclusion techniques, crisis intervention, and trauma-informed approaches.  
184 Such training shall also include instruction on safely addressing situations involving patients, family  
185 members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance  
186 abuse or who are experiencing a mental health crisis. Such training requirements may be satisfied through  
187 completion of the Department of Criminal Justice Services minimum training standards for auxiliary police  
188 officers as required by § 15.2-1731. The Commissioner shall provide a waiver from the requirement that at  
189 least one off-duty law-enforcement officer or trained security personnel be present at all times in the  
190 emergency department if the hospital demonstrates that a different level of security is necessary and  
191 appropriate for any of its emergency departments based upon findings in the security risk assessment;

192 23. Shall require that each hospital establish a protocol requiring that, before a health care provider  
193 arranges for air medical transportation services for a patient who does not have an emergency medical  
194 condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized  
195 representative with written or electronic notice that the patient (i) may have a choice of transportation by an  
196 air medical transportation provider or medically appropriate ground transportation by an emergency medical  
197 services provider and (ii) will be responsible for charges incurred for such transportation in the event that the  
198 provider is not a contracted network provider of the patient's health insurance carrier or such charges are not  
199 otherwise covered in full or in part by the patient's health insurance plan;

200 24. Shall establish an exemption from the requirement to obtain a license to add temporary beds in an  
201 existing hospital or nursing home, including beds located in a temporary structure or satellite location  
202 operated by the hospital or nursing home, provided that the ability remains to safely staff services across the  
203 existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's  
204 determination plus 30 days when the Commissioner has determined that a natural or man-made disaster has  
205 caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a  
206 shortage of hospital or nursing home beds or (ii) for a period of no more than the duration of the emergency  
207 order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to § 32.1-13, or the  
208 Commissioner, pursuant to § 32.1-20, has entered an emergency order for the purpose of suppressing a  
209 nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to  
210 the public life and health;

211        25. Shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure  
212      for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up  
213      treatment after discharge is informed that he (i) is expected to require outpatient physical therapy as a follow-  
214      up treatment and (ii) will be required to select a physical therapy provider prior to being discharged from the  
215      hospital;

216        26. Shall permit *hospital and* nursing home staff members who are authorized to possess, distribute, or  
217      administer medications to residents to store, dispense, or administer cannabis oil to a *patient or* resident who  
218      has been issued a valid written certification for the use of *medical* cannabis oil in accordance with § 4.1-1601;

219        27. Shall require each hospital with an emergency department to establish a protocol for the treatment and  
220      discharge of individuals experiencing a substance use-related emergency, which shall include provisions for  
221      (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to  
222      identify medical interventions necessary for the treatment of the individual in the emergency department and  
223      (ii) recommendations for follow-up care following discharge for any patient identified as having a substance  
224      use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have  
225      been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a)  
226      the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection Y of  
227      § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or  
228      other opioid antagonist used for overdose reversal, including information about accessing naloxone or other  
229      opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy  
230      operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or  
231      other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing  
232      order. Such protocols may also provide for referrals of individuals experiencing a substance use-related  
233      emergency to peer recovery specialists and community-based providers of behavioral health services, or to  
234      providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

235        28. During a public health emergency related to COVID-19, shall require each nursing home and certified  
236      nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from  
237      the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid  
238      Services and the Board. Such protocol shall include provisions describing (i) the conditions, including  
239      conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and  
240      community, under which in-person visits will be allowed and under which in-person visits will not be

241 allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be  
242 required to comply to protect the health and safety of the patients and staff of the nursing home or certified  
243 nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff  
244 support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing  
245 home or certified nursing facility will take in the event of a technology failure, service interruption, or  
246 documented emergency that prevents visits from occurring as required by this subdivision. Such protocol  
247 shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where  
248 appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a  
249 provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided  
250 that such waiver or limitation is included in the patient's health record; and (c) a requirement that each  
251 nursing home and certified nursing facility publish on its website or communicate to each patient or the  
252 patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing  
253 facility's plan for providing visits to patients as required by this subdivision;

254 29. Shall require each hospital, nursing home, and certified nursing facility to establish and implement  
255 policies to ensure the permissible access to and use of an intelligent personal assistant provided by a patient,  
256 in accordance with such regulations, while receiving inpatient services. Such policies shall ensure protection  
257 of health information in accordance with the requirements of the federal Health Insurance Portability and  
258 Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as amended. For the purposes of this subdivision,  
259 "intelligent personal assistant" means a combination of an electronic device and a specialized software  
260 application designed to assist users with basic tasks using a combination of natural language processing and  
261 artificial intelligence, including such combinations known as "digital assistants" or "virtual assistants";

262 30. During a declared public health emergency related to a communicable disease of public health threat,  
263 shall require each hospital, nursing home, and certified nursing facility to establish a protocol to allow  
264 patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect  
265 consistent with guidance from the Centers for Disease Control and Prevention and the Centers for Medicare  
266 and Medicaid Services and subject to compliance with any executive order, order of public health,  
267 Department guidance, or any other applicable federal or state guidance having the effect of limiting visitation.  
268 Such protocol may restrict the frequency and duration of visits and may require visits to be conducted  
269 virtually using interactive audio or video technology. Any such protocol may require the person visiting a

270 patient pursuant to this subdivision to comply with all reasonable requirements of the hospital, nursing home,  
271 or certified nursing facility adopted to protect the health and safety of the person, patients, and staff of the  
272 hospital, nursing home, or certified nursing facility;

273       31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients  
274 who are minors available to such patients through a secure website shall make such health records available  
275 to such patient's parent or guardian through such secure website, unless the hospital cannot make such health  
276 record available in a manner that prevents disclosure of information, the disclosure of which has been denied  
277 pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of  
278 § 54.1-2969 has not been provided;

279       32. Shall require that every hospital where surgical procedures are performed adopt a policy requiring the  
280 use of a smoke evacuation system for all planned surgical procedures that are likely to generate surgical  
281 smoke. For the purposes of this subdivision, "smoke evacuation system" means smoke evacuation equipment  
282 and technologies designed to capture, filter, and remove surgical smoke at the site of origin and to prevent  
283 surgical smoke from making ocular contact or contact with a person's respiratory tract;

284       33. Shall require every hospital with an emergency department, when conducting a urine drug screening  
285 to assist in diagnosing a patient's condition, to include testing for fentanyl in such urine drug screening; and

286       34. Shall establish fees for the issuance, change, or renewal of a hospital or nursing home license to cover  
287 the costs of operating the hospital and nursing home licensure and inspection program in a manner that  
288 ensures timely completion of inspections as set forth in § 32.1-126. In establishing such fees, the Board shall  
289 distribute the costs of operating the hospital and nursing home licensure and inspection program in an  
290 equitable manner across all hospitals or nursing homes and ensure that the amount of such fees shall change  
291 no more frequently than annually. Fee changes under this section shall only be initiated if the expenses  
292 allocated to the Hospital and Nursing Home Licensure and Inspection Program Fund established under  
293 § 32.1-130, plus any state or other funding sources appropriated for the hospital and nursing home licensure  
294 and inspection program, are shown to be more than 10 percent greater or less than the annual costs of  
295 operating the hospital and nursing home licensure and inspection program in a manner that ensures timely  
296 completion of inspections. This analysis shall be conducted separately for hospital fees and nursing home  
297 fees, and resulting fee changes shall be established such that fees are sufficient to cover unfunded expenses  
298 but not excessive.

299       C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified

300 nursing facilities may operate adult day centers.

301 D. All facilities licensed by the Board pursuant to this article which provide treatment or care for  
302 hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot  
303 numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be  
304 contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated  
305 clotting factor may be apprised of this contamination. Facilities which have identified a lot that is known to  
306 be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the  
307 contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each  
308 recipient who received treatment from a known contaminated lot at the individual's last known address.

309 E. Hospitals in the Commonwealth may enter into agreements with the Department of Health for the  
310 provision to uninsured patients of naloxone or other opioid antagonists used for overdose reversal.

311 F. Hospitals in the Commonwealth shall:

312 1. Establish a workplace violence incident reporting system, through which each hospital shall document,  
313 track, and analyze any incident of workplace violence reported. The results of such analysis shall be used to  
314 make improvements in preventing workplace violence, including improvements achieved through continuing  
315 education in targeted areas, including de-escalation training, risk identification, and violence prevention  
316 planning. Such reporting system shall (i) be clearly communicated to all employees, including to any new  
317 employees at the employee orientation, and (ii) include guidelines on when and how to report incidents of  
318 workplace violence to the employer, security agencies, and appropriate law-enforcement authorities;

319 2. Record all reported incidents of workplace violence as voluntarily reported by an employee; and

320 3. Adopt a policy that prohibits any person from discriminating or retaliating against any employee of the  
321 hospital for reporting to, or seeking assistance or intervention from, the employer, security agencies,  
322 law-enforcement authorities, local emergency services organizations, government agencies, or others  
323 participating in any incident investigation. Such policy shall comply with the provisions of § 40.1-27.3.

324 G. Each hospital in the Commonwealth shall maintain the record of reported incidents of workplace  
325 violence made pursuant to subsection F for at least two years and shall include in such record, at a minimum:

326 1. The date and time of the incident;

327 2. A description of the incident, including the job titles of the affected employee;

328 3. Whether the perpetrator was a patient, visitor, employee, or other person;

329        4. A description of where the incident occurred;

330        5. Information relating the type of incident, including whether the incident involved (i) a physical attack  
331        without a weapon; (ii) an attack with a weapon or object; (iii) a threat of physical force or use of a weapon or  
332        other object with the intent to cause bodily harm; (iv) sexual assault or the threat of sexual assault; or (v)  
333        anything else not listed in subdivisions (i) through (iv);

334        6. The response to and any consequences of the incident, including (i) whether security or law  
335        enforcement was contacted and, if so, their response and (ii) whether the incident resulted in any change to  
336        hospital policy; and

337        7. Information about the individual who completed the report, including such individual's name, job title,  
338        and the date of completion.

339        H. Each hospital shall:

340        1. Report the data collected and reported pursuant to subsection G to the chief medical officer and the  
341        chief nursing officer of such hospital on, at a minimum, a quarterly basis; and

342        2. Send a report to the Department on an annual basis that includes, at a minimum, the number of  
343        incidents of workplace violence voluntarily reported by an employee pursuant to subsection F. Any report  
344        made to the Department pursuant to this subdivision shall be aggregated to remove any personally  
345        identifiable information.

346        I. As used in this section:

347        "Employee of the hospital" or "employee" means an employee of the hospital or any health care provider  
348        credentialed by the hospital or engaged by the hospital to perform health care services on the premises of the  
349        hospital.

350        "Workplace violence" means any act of violence or threat of violence, without regard to the intent of the  
351        perpetrator, that occurs against an employee of the hospital while on the premises of such hospital and  
352        engaged in the performance of his duties. "Workplace violence" includes (i) the threat or use of physical force  
353        against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or  
354        stress, regardless of whether physical injury is sustained, and (ii) any incident involving the threat of using  
355        dangerous weapons or using common objects as weapons or to cause physical harm, regardless of whether  
356        physical injury is sustained.

357        **2. That the Department of Health, after consulting with stakeholders as it deems appropriate, shall**

358    **promulgate regulations in accordance with this act.**

359    **3. That the provisions of this act shall become effective upon the date that marijuana is federally**

360    **rescheduled from Schedule I to Schedule III under the federal Controlled Substances Act.**