OFFERED FOR CONSIDERATION **2/06/2026**

SENATE BILL NO. 738
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the Senate Committee on Education and Health
on _____)
(Patron Prior to Substitute—Senator Jordan)

A BILL to amend and reenact § 32.1-127 of the Code of Virginia, relating to hospitals; emergency department physicians.

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-127 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-127. Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction, and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes, and certified nursing facilities to ensure the environmental protection and the life safety of its patients, employees, and the public; (ii) the operation, staffing, and equipping of hospitals, nursing homes, and certified 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 security of hospitals, nursing homes, and certified nursing facilities;

2. Shall provide that at least one physician who is licensed to practice medicine in the Commonwealth and is primarily responsible for the emergency department shall be on duty and physically present at all times at each hospital that operates or holds itself out as operating an emergency service. *No physician shall be required to be on duty and physically present for a psychiatric emergency department as defined in subsection A of § 37.2-809 that:*

a. Is co-located immediately adjacent to an emergency department that provides emergency medical treatment and has protocols requiring immediate physician response to all medical emergencies; or

b. Promotes itself to the community as only providing psychiatric services, does not offer itself to the community as providing emergency medical treatment, is located within the City of Hampton, and has:

(1) A written agreement in place with local emergency medical services providers stating that patients experiencing non-psychiatric emergency medical conditions will be transported to a facility that provides emergency medical treatment;

(2) A transfer agreement in place with a facility that provides emergency medical treatment stating that patients requiring non-psychiatric emergency medical services will be transferred to that facility;

(3) Video consultative services available with a physician at a facility that provides emergency medical treatment;

(4) A medical director who is a physician with onsite clinical oversight and quality improvement responsibilities for the psychiatric emergency department; and

(5) Licensed providers on duty at all times with Advanced Cardiovascular Life Support and Pediatric Advanced Life Support training as well as initial Basic Life Support resuscitation capabilities who are able to provide emergency medical treatment until qualified medical transport has arrived.

Hospitals with psychiatric emergency departments that meet the requirements for the exception provided in this subdivision shall report (i) the number of patients seen for non-psychiatric or substance abuse complaints or with non-psychiatric or substance abuse primary diagnoses, (ii) the number of patients requiring transfer via emergency medical services to a facility capable of providing emergency medical treatment, and (iii) the total number of patients evaluated in the psychiatric emergency department to the Chairs of the Senate Committee on Education and Health, the House Committee on Health and Human Services Committee, and the Behavioral Health Commission annually by November 1;

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

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS regulations for routine contact, whereby the provider's designated organ procurement organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of

America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer of the hospital or his designee knows of such opposition, and no donor card or other relevant document, such as an advance directive, can be found;

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

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

community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

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

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

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

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

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

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

13. Shall require that each nursing home and certified nursing facility register with the Department of

State Police to receive notice of the registration, reregistration, or verification of registration information of any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to 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 facility is located, pursuant to § 9.1-914;

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

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

16. Shall require that each nursing home and certified nursing facility shall, upon the request of the facility's family council, send notices and information about the family council mutually developed by the family council and the administration of the nursing home or certified nursing facility, and provided to the facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six times per year. Such notices may be included together with a monthly billing statement or other regular communication. Notices and information shall also be posted in a designated location within the nursing home or certified nursing facility. No family member of a resident or other resident representative shall be restricted from participating in meetings in the facility with the families or resident representatives of other residents in the facility;

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

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

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

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

21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a policy governing determination of the medical and ethical appropriateness of proposed medical care, which shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the proposed health care; and (iii) requirements for a written explanation of the decision reached by the interdisciplinary medical review committee, which shall be included in the patient's medical record. Such policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee

meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other remedies available at law, including seeking court review, provided that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the chief executive officer of the hospital within 14 days of the date on which the physician's determination that proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical record;

22. Shall require every hospital with an emergency department to establish a security plan. Such security plan shall be developed using standards established by the International Association for Healthcare Security and Safety or other industry standard and shall be based on the results of a security risk assessment of each emergency department location of the hospital and shall include the presence of at least one off-duty law-enforcement officer or trained security personnel who is present in the emergency department at all times as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based on identified risks for the emergency department, including trauma level designation, overall volume, volume of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from such violence, and prevalence of crime in the community, in consultation with the emergency department medical director and nurse director. The security plan shall also outline training requirements for security personnel in the potential use of and response to weapons, defensive tactics, de-escalation techniques, appropriate physical restraint and seclusion techniques, crisis intervention, and trauma-informed approaches. Such training shall also include instruction on safely addressing situations involving patients, family members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance abuse or who are experiencing a mental health crisis. Such training requirements may be satisfied through completion of the Department of Criminal Justice Services minimum training standards for auxiliary police officers as required by § 15.2-1731. The Commissioner shall provide a waiver from the requirement that at least one off-duty law-enforcement officer or trained security personnel be present at all times in the emergency department if the hospital demonstrates that a different level of security is necessary and appropriate for any of its emergency departments based upon findings in the security risk assessment;

23. Shall require that each hospital establish a protocol requiring that, before a health care provider arranges for air medical transportation services for a patient who does not have an emergency medical condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized representative with written or electronic notice that the patient (i) may have a choice of transportation by an

air medical transportation provider or medically appropriate ground transportation by an emergency medical services provider and (ii) will be responsible for charges incurred for such transportation in the event that the provider is not a contracted network provider of the patient's health insurance carrier or such charges are not otherwise covered in full or in part by the patient's health insurance plan;

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

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

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

27. Shall require each hospital with an emergency department to establish a protocol for the treatment and discharge of individuals experiencing a substance use-related emergency, which shall include provisions for (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to identify medical interventions necessary for the treatment of the individual in the emergency department and (ii) recommendations for follow-up care following discharge for any patient identified as having a substance use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a) the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection Y of

§ 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or other opioid antagonist used for overdose reversal, including information about accessing naloxone or other opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing order. Such protocols may also provide for referrals of individuals experiencing a substance use-related emergency to peer recovery specialists and community-based providers of behavioral health services, or to providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

28. During a public health emergency related to COVID-19, shall require each nursing home and certified nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid Services and the Board. Such protocol shall include provisions describing (i) the conditions, including conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and community, under which in-person visits will be allowed and under which in-person visits will not be allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be required to comply to protect the health and safety of the patients and staff of the nursing home or certified nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing home or certified nursing facility will take in the event of a technology failure, service interruption, or documented emergency that prevents visits from occurring as required by this subdivision. Such protocol shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided that such waiver or limitation is included in the patient's health record; and (c) a requirement that each nursing home and certified nursing facility publish on its website or communicate to each patient or the patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing facility's plan for providing visits to patients as required by this subdivision;

29. Shall require each hospital, nursing home, and certified nursing facility to establish and implement policies to ensure the permissible access to and use of an intelligent personal assistant provided by a patient,

in accordance with such regulations, while receiving inpatient services. Such policies shall ensure protection of health information in accordance with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as amended. For the purposes of this subdivision, "intelligent personal assistant" means a combination of an electronic device and a specialized software application designed to assist users with basic tasks using a combination of natural language processing and artificial intelligence, including such combinations known as "digital assistants" or "virtual assistants";

30. During a declared public health emergency related to a communicable disease of public health threat, shall require each hospital, nursing home, and certified nursing facility to establish a protocol to allow patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect consistent with guidance from the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services and subject to compliance with any executive order, order of public health, Department guidance, or any other applicable federal or state guidance having the effect of limiting visitation. Such protocol may restrict the frequency and duration of visits and may require visits to be conducted virtually using interactive audio or video technology. Any such protocol may require the person visiting a patient pursuant to this subdivision to comply with all reasonable requirements of the hospital, nursing home, or certified nursing facility adopted to protect the health and safety of the person, patients, and staff of the hospital, nursing home, or certified nursing facility;

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

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

33. Shall require every hospital with an emergency department, when conducting a urine drug screening

to assist in diagnosing a patient's condition, to include testing for fentanyl in such urine drug screening; and

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

C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified nursing facilities may operate adult day centers.

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

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

F. Hospitals in the Commonwealth shall:

1. Establish a workplace violence incident reporting system, through which each hospital shall document, track, and analyze any incident of workplace violence reported. The results of such analysis shall be used to make improvements in preventing workplace violence, including improvements achieved through continuing

education in targeted areas, including de-escalation training, risk identification, and violence prevention planning. Such reporting system shall (i) be clearly communicated to all employees, including to any new employees at the employee orientation, and (ii) include guidelines on when and how to report incidents of workplace violence to the employer, security agencies, and appropriate law-enforcement authorities;

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

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

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

1. The date and time of the incident;

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

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

4. A description of where the incident occurred;

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

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

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

H. Each hospital shall:

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

2. Send a report to the Department on an annual basis that includes, at a minimum, the number of incidents of workplace violence voluntarily reported by an employee pursuant to subsection F. Any report

made to the Department pursuant to this subdivision shall be aggregated to remove any personally identifiable information.

I. As used in this section:

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

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