

SENATE BILL NO. 536
 AMENDMENT IN THE NATURE OF A SUBSTITUTE
 (Proposed by the House Committee for Courts of Justice
 on March 4, 2026)
 (Patron Prior to Substitute—Senator Obenshain)

A BILL to amend and reenact §§ 8.01-581.15, 8.01-243, and 32.1-127 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 8.01-581.15:1, relating to medical malpractice actions; limitation on recovery; prejudgment interest; limitation on collection; statute of limitations; insurance requirements for nursing homes.

Be it enacted by the General Assembly of Virginia:

1. That §§ 8.01-581.15, 8.01-243, and 32.1-127 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 8.01-581.15:1 as follows:

§ 8.01-581.15. Limitation on recovery in certain medical malpractice actions.

A. In any verdict returned against a health care provider in an action for malpractice where the act or acts of malpractice occurred on or after August 1, 1999, which is tried by a jury or in any judgment entered against a health care provider in such an action which is tried without a jury, the total amount recoverable for any injury to, or death of, a patient shall not exceed the following; corresponding amount:

a	August 1, 1999, through June 30, 2000	\$1.50 million
b	July 1, 2000, through June 30, 2001	\$1.55 million
c	July 1, 2001, through June 30, 2002	\$1.60 million
d	July 1, 2002, through June 30, 2003	\$1.65 million
e	July 1, 2003, through June 30, 2004	\$1.70 million
f	July 1, 2004, through June 30, 2005	\$1.75 million
g	July 1, 2005, through June 30, 2006	\$1.80 million
h	July 1, 2006, through June 30, 2007	\$1.85 million
i	July 1, 2007, through June 30, 2008	\$1.925 million
j	July 1, 2008, through June 30, 2012	\$2.00 million
k	July 1, 2012, through June 30, 2013	\$2.05 million
l	July 1, 2013, through June 30, 2014	\$2.10 million
m	July 1, 2014, through June 30, 2015	\$2.15 million
n	July 1, 2015, through June 30, 2016	\$2.20 million
o	July 1, 2016, through June 30, 2017	\$2.25 million
p	July 1, 2017, through June 30, 2018	\$2.30 million
q	July 1, 2018, through June 30, 2019	\$2.35 million
r	July 1, 2019, through June 30, 2020	\$2.40 million
s	July 1, 2020, through June 30, 2021	\$2.45 million
t	July 1, 2021, through June 30, 2022	\$2.50 million
u	July 1, 2022, through June 30, 2023	\$2.55 million
v	July 1, 2023, through June 30, 2024	\$2.60 million
w	July 1, 2024, through June 30, 2025	\$2.65 million
x	July 1, 2025, through June 30, 2026	\$2.70 million
y	July 1, 2026, through June 30, 2027	\$2.75 million
z	July 1, 2027, through June 30, 2028	\$2.80 million
aa	July 1, 2028, through June 30, 2029	\$2.85 million
ab	July 1, 2029, through June 30, 2030	\$2.90 million
ac	July 1, 2030, through June 30, 2031	\$2.95 million

In any verdict returned against a health care provider in an action for malpractice where the act or acts of

48 malpractice occurred on or after July 1, ~~2031~~ 2027, which is tried by a jury or in any judgment entered
49 against a health care provider in such an action which is tried without a jury, the total amount recoverable for
50 any injury to, or death of, a patient shall not exceed ~~\$3~~ \$6 million. ~~Each annual increase shall apply to the act~~
51 ~~or acts of malpractice occurring on or after the effective date of the increase. On July 1, 2029, and every two~~
52 ~~years thereafter, the total amount recoverable pursuant to this section shall be adjusted pursuant to the cost-~~
53 ~~of-living adjustment compounded annually over the preceding two-year period by the annual percentage~~
54 ~~reflected in the medical care component most recently published in the Consumer Price Index for All Urban~~
55 ~~Consumers (CPI-U) in the South region, as published by the Bureau of Labor Statistics of the U.S.~~
56 ~~Department of Labor, and rounded to the nearest \$10,000.~~

57 B. Where the act or acts of malpractice occurred prior to August 1, 1999, the total amount recoverable for
58 any injury to, or death of, a patient shall not exceed the limitation on recovery set forth in this statute as it was
59 in effect when the act or acts of malpractice occurred.

60 C. *In an action for malpractice where the act or acts of malpractice occurred on or after July 1, 2027,*
61 *when a judge or jury awards prejudgment interest against a health care provider, and the total verdict plus*
62 *interest exceeds the total amount recoverable pursuant to subsection A, the patient may recover up to two*
63 *years of prejudgment interest in addition to the total amount recoverable. The jury, or in cases tried without*
64 *a jury, the judge, has discretion over whether to award prejudgment interest and, if so, to fix the date from*
65 *which it begins to accrue.*

66 In interpreting this section, the definitions found in § 8.01-581.1 shall be applicable.

67 **§ 8.01-581.15:1. Limitation on collection against personal assets in certain medical malpractice**
68 **actions.**

69 *A patient shall not pursue, collect, or execute upon a judgment against the personal income or assets of a*
70 *health care provider sued in his individual capacity for medical malpractice unless the court finds that (i)*
71 *such provider's conduct amounted to complete neglect of the patient's safety or was willful and malicious or*
72 *intentionally fraudulent or (ii) such provider failed to maintain or be covered by an insurance policy with*
73 *available per claim limits equal to the limitations on recovery in certain medical malpractice actions*
74 *established pursuant to § 8.01-581.15.*

75 **§ 8.01-243. Personal action for injury to person or property generally; extension in actions for**
76 **malpractice against health care provider.**

77 A. Unless otherwise provided in this section or by other statute, every action for personal injuries,
78 whatever the theory of recovery, and every action for damages resulting from fraud, shall be brought within

79 two years after the cause of action accrues.

80 B. Every action for injury to property, including actions by a parent or guardian of an infant against a
81 tort-feasor for expenses of curing or attempting to cure such infant from the result of a personal injury or loss
82 of services of such infant, shall be brought within five years after the cause of action accrues. An infant's
83 claim for medical expenses pursuant to subsection B of § 8.01-36 accruing on or after July 1, 2013, shall be
84 governed by the applicable statute of limitations that applies to the infant's cause of action.

85 C. The two-year limitations period specified in subsection A shall be extended in actions for malpractice
86 against a health care provider as follows:

87 1. ~~In cases arising out of a foreign object having no therapeutic or diagnostic effect being left in a patient's~~
88 ~~body, for a period of one year from the date the object is discovered or reasonably should have been~~
89 ~~discovered;~~

90 2. ~~In cases in which fraud, concealment, or intentional misrepresentation prevented discovery of the injury~~
91 ~~within the two-year period, for one year from the date the injury is discovered or, by the exercise of due~~
92 ~~diligence, reasonably should have been discovered; and~~

93 3. ~~In a claim for the negligent failure to diagnose a malignant tumor, cancer, or an intracranial, intraspinal,~~
94 ~~or spinal schwannoma, for a period of one year from the date the diagnosis of a malignant tumor, cancer, or~~
95 ~~an intracranial, intraspinal, or spinal schwannoma is communicated to the patient by a health care provider,~~
96 ~~provided that the health care provider's underlying act or omission was on or after July 1, 2008, in the case of~~
97 ~~a malignant tumor or cancer or on or after July 1, 2016, in the case of an intracranial, intraspinal, or spinal~~
98 ~~schwannoma. Claims under this section for the negligent failure to diagnose a malignant tumor or cancer,~~
99 ~~where the health care provider's underlying act or omission occurred prior to July 1, 2008, shall be governed~~
100 ~~by the statute of limitations that existed prior to July 1, 2008. Claims under this section for the negligent~~
101 ~~failure to diagnose an intracranial, intraspinal, or spinal schwannoma, where the health care provider's~~
102 ~~underlying act or omission occurred prior to July 1, 2016, shall be governed by the statute of limitations that~~
103 ~~existed prior to July 1, 2016 if such malpractice was not reasonably known or discoverable to the patient; in~~
104 ~~such instance, such action shall be brought within two years from the earlier of (i) when the act of~~
105 ~~malpractice is conveyed to the patient by another health care provider; (ii) when the patient had actual~~
106 ~~notice of the act of malpractice; or (iii) when, through reasonable diligence, the patient should have known of~~
107 ~~the act of malpractice.~~

108 However, the provisions of this subsection shall not apply to extend the limitations period beyond 10
109 years from the date the cause of action accrues, except that the provisions of subdivision A 2 of § 8.01-229

110 shall apply to toll the statute of limitations in actions brought by or on behalf of a person under a disability.

111 *If the provisions of this subsection or the provisions of § 8.01-229 do not apply to an act of medical*
112 *malpractice, the two-year statute of limitations prescribed by subsection A shall apply to such act of medical*
113 *malpractice.*

114 D. Every action for injury to the person, whatever the theory of recovery, resulting from sexual abuse
115 occurring during the infancy or incapacity of the person as set forth in subdivision 6 of § 8.01-249 shall be
116 brought within 20 years after the cause of action accrues.

117 D1. For a cause of action accruing on or after July 1, 2020, every action for injury to the person, whatever
118 the theory of recovery, resulting from sexual abuse, other than those actions specified in subsection D, shall
119 be brought within 10 years after the cause of action accrues.

120 D2. Notwithstanding the provisions of subsections D and D1, every action for injury to the person,
121 whatever the theory of recovery, resulting from sexual abuse occurring when the person was 18 years old or
122 older by a person of authority over a victim shall be brought within 15 years after the cause of action accrues.
123 For the purposes of this subsection, "person of authority" means a person in a position of trust having
124 influence over the victim's life.

125 E. Every action for injury to property brought by the Commonwealth against a tort-feasor for expenses
126 arising out of the negligent operation of a motor vehicle shall be brought within five years after the cause of
127 action accrues.

128 **§ 32.1-127. Regulations.**

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

134 B. Such regulations:

135 1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes
136 and certified nursing facilities to ensure the environmental protection and the life safety of its patients,
137 employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified
138 nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing
139 facilities, except those professionals licensed or certified by the Department of Health Professions; (iv)

140 conditions under which a hospital or nursing home may provide medical and nursing services to patients in
141 their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility
142 security of hospitals, nursing homes, and certified nursing facilities;

143 2. Shall provide that at least one physician who is licensed to practice medicine in the Commonwealth and
144 is primarily responsible for the emergency department shall be on duty and physically present at all times at
145 each hospital that operates or holds itself out as operating an emergency service;

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

148 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal
149 law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. §
150 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS
151 regulations for routine contact, whereby the provider's designated organ procurement organization certified
152 by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii)
153 is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a
154 similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of
155 America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The
156 hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in
157 the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable
158 tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The
159 protocol shall ensure that the hospital collaborates with the designated organ procurement organization to
160 inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to
161 donate. The individual making contact with the family shall have completed a course in the methodology for
162 approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved
163 by the organ procurement organization and designed in conjunction with the tissue and eye bank community
164 and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of
165 the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement
166 organization in educating the staff responsible for contacting the organ procurement organization's personnel
167 on donation issues, the proper review of death records to improve identification of potential donors, and the
168 proper procedures for maintaining potential donors while necessary testing and placement of potential

169 donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the
170 family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative
171 officer of the hospital or his designee knows of such opposition, and no donor card or other relevant
172 document, such as an advance directive, can be found;

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

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

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

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

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

198 10. Shall require that each nursing home and certified nursing facility train all employees who are

199 mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures
200 and the consequences for failing to make a required report;

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

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

213 13. Shall require that each nursing home and certified nursing facility register with the Department of
214 State Police to receive notice of the registration, reregistration, or verification of registration information of
215 any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to
216 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
217 facility is located, pursuant to § 9.1-914;

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

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

226 16. Shall require that each nursing home and certified nursing facility shall, upon the request of the
227 facility's family council, send notices and information about the family council mutually developed by the
228 family council and the administration of the nursing home or certified nursing facility, and provided to the

229 facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six
230 times per year. Such notices may be included together with a monthly billing statement or other regular
231 communication. Notices and information shall also be posted in a designated location within the nursing
232 home or certified nursing facility. No family member of a resident or other resident representative shall be
233 restricted from participating in meetings in the facility with the families or resident representatives of other
234 residents in the facility;

235 17. Shall require that each nursing home and certified nursing facility maintain, per facility, non-eroding
236 general liability insurance coverage in a minimum amount of \$1 million per occurrence, and professional
237 liability coverage in an amount at least equal to ~~the recovery limit set forth in § 8.01-581.15~~ \$3 million per
238 patient occurrence, to compensate patients or individuals for injuries and losses resulting from the negligent
239 acts of the facility. Failure to maintain such minimum insurance limits under this section shall result in
240 revocation of the facility's license. Each nursing home and certified nursing facility shall provide at licensure
241 renewal or have available to the Board proof of the insurance coverages as required by this section;

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

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

250 20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that
251 requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct verbal
252 communication between the on-call physician in the psychiatric unit and the referring physician, if requested
253 by such referring physician, and prohibits on-call physicians or other hospital staff from refusing a request for
254 such direct verbal communication by a referring physician and (ii) a patient for whom there is a question
255 regarding the medical stability or medical appropriateness of admission for inpatient psychiatric services due
256 to a situation involving results of a toxicology screening, the on-call physician in the psychiatric unit to which
257 the patient is sought to be transferred to participate in direct verbal communication, either in person or via
258 telephone, with a clinical toxicologist or other person who is a Certified Specialist in Poison Information

259 employed by a poison control center that is accredited by the American Association of Poison Control
260 Centers to review the results of the toxicology screen and determine whether a medical reason for refusing
261 admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the
262 referring physician;

263 21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a
264 policy governing determination of the medical and ethical appropriateness of proposed medical care, which
265 shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of
266 proposed medical care in cases in which a physician has determined proposed care to be medically or
267 ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is
268 medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by
269 the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the
270 proposed health care; and (iii) requirements for a written explanation of the decision reached by the
271 interdisciplinary medical review committee, which shall be included in the patient's medical record. Such
272 policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to
273 § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent
274 medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee
275 meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical
276 decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other
277 remedies available at law, including seeking court review, provided that the patient, his agent, or the person
278 authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the
279 chief executive officer of the hospital within 14 days of the date on which the physician's determination that
280 proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical
281 record;

282 22. Shall require every hospital with an emergency department to establish a security plan. Such security
283 plan shall be developed using standards established by the International Association for Healthcare Security
284 and Safety or other industry standard and shall be based on the results of a security risk assessment of each
285 emergency department location of the hospital and shall include the presence of at least one off-duty
286 law-enforcement officer or trained security personnel who is present in the emergency department at all times
287 as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based
288 on identified risks for the emergency department, including trauma level designation, overall volume, volume
289 of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from

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

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

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

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

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

329 27. Shall require each hospital with an emergency department to establish a protocol for the treatment and
330 discharge of individuals experiencing a substance use-related emergency, which shall include provisions for
331 (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to
332 identify medical interventions necessary for the treatment of the individual in the emergency department and
333 (ii) recommendations for follow-up care following discharge for any patient identified as having a substance
334 use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have
335 been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a)
336 the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection Y of
337 § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or
338 other opioid antagonist used for overdose reversal, including information about accessing naloxone or other
339 opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy
340 operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or
341 other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing
342 order. Such protocols may also provide for referrals of individuals experiencing a substance use-related
343 emergency to peer recovery specialists and community-based providers of behavioral health services, or to
344 providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

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

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

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

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

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

383 31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients
384 who are minors available to such patients through a secure website shall make such health records available
385 to such patient's parent or guardian through such secure website, unless the hospital cannot make such health
386 record available in a manner that prevents disclosure of information, the disclosure of which has been denied
387 pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of
388 § 54.1-2969 has not been provided;

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

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

396 34. Shall establish fees for the issuance, change, or renewal of a hospital or nursing home license to cover
397 the costs of operating the hospital and nursing home licensure and inspection program in a manner that
398 ensures timely completion of inspections as set forth in § 32.1-126. In establishing such fees, the Board shall
399 distribute the costs of operating the hospital and nursing home licensure and inspection program in an
400 equitable manner across all hospitals or nursing homes and ensure that the amount of such fees shall change
401 no more frequently than annually. Fee changes under this section shall only be initiated if the expenses
402 allocated to the Hospital and Nursing Home Licensure and Inspection Program Fund established under
403 § 32.1-130, plus any state or other funding sources appropriated for the hospital and nursing home licensure
404 and inspection program, are shown to be more than 10 percent greater or less than the annual costs of
405 operating the hospital and nursing home licensure and inspection program in a manner that ensures timely
406 completion of inspections. This analysis shall be conducted separately for hospital fees and nursing home
407 fees, and resulting fee changes shall be established such that fees are sufficient to cover unfunded expenses
408 but not excessive.

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

410 nursing facilities may operate adult day centers.

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

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

421 F. Hospitals in the Commonwealth shall:

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

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

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

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

436 1. The date and time of the incident;

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

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

439 4. A description of where the incident occurred;

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

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

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

449 H. Each hospital shall:

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

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

456 I. As used in this section:

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

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

467 **2. That not later than June 30, 2029, and at each two-year interval thereafter, the Department of**

468 Planning and Budget shall submit to the Virginia Code Commission the updated dollar amounts that
469 will become effective on July 1 pursuant to the provisions of this act for purposes of amending
470 § 8.01-581.15 of the Code of Virginia, as amended by this act.