

1 VIRGINIA ACTS OF ASSEMBLY — CHAPTER

2 *An Act to amend and reenact §§ 2.2-3705.5 and 32.1-127 of the Code of Virginia, relating to hospitals;*
 3 *reports of threats or acts of violence against health care providers; expansion of reporting requirements.*

4 [H 1489]

5 Approved

6 **Be it enacted by the General Assembly of Virginia:**7 **1. That §§ 2.2-3705.5 and 32.1-127 of the Code of Virginia are amended and reenacted as follows:**8 **§ 2.2-3705.5. Exclusions to application of chapter; health and social services records.**

9 The following information contained in a public record is excluded from the mandatory disclosure
 10 provisions of this chapter but may be disclosed by the custodian in his discretion, except where such
 11 disclosure is prohibited by law. Redaction of information excluded under this section from a public record
 12 shall be conducted in accordance with § 2.2-3704.01.

13 1. Health records, except that such records may be personally reviewed by the individual who is the
 14 subject of such records, as provided in subsection F of § 32.1-127.1:03.

15 Where the person who is the subject of health records is confined in a state or local correctional facility,
 16 the administrator or chief medical officer of such facility may assert such confined person's right of access to
 17 the health records if the administrator or chief medical officer has reasonable cause to believe that such
 18 confined person has an infectious disease or other medical condition from which other persons so confined
 19 need to be protected. Health records shall only be reviewed and shall not be copied by such administrator or
 20 chief medical officer. The information in the health records of a person so confined shall continue to be
 21 confidential and shall not be disclosed by the administrator or chief medical officer of the facility to any
 22 person except the subject or except as provided by law.

23 Where the person who is the subject of health records is under the age of 18, his right of access may be
 24 asserted only by his guardian or his parent, including a noncustodial parent, unless such parent's parental
 25 rights have been terminated, a court of competent jurisdiction has restricted or denied such access, or a parent
 26 has been denied access to the health record in accordance with § 20-124.6. In instances where the person who
 27 is the subject thereof is an emancipated minor, a student in a public institution of higher education, or is a
 28 minor who has consented to his own treatment as authorized by § 16.1-338 or 54.1-2969, the right of access
 29 may be asserted by the subject person.

30 For the purposes of this chapter, statistical summaries of incidents and statistical data concerning abuse of
 31 individuals receiving services compiled by the Commissioner of Behavioral Health and Developmental
 32 Services shall be disclosed. No such summaries or data shall include any information that identifies specific
 33 individuals receiving services.

34 2. Applications for admission to examinations or for licensure and scoring records maintained by the
 35 Department of Health Professions or any board in that department on individual licensees or applicants;
 36 information required to be provided to the Department of Health Professions by certain licensees pursuant to
 37 § 54.1-2506.1; information held by the Health Practitioners' Monitoring Program Committee within the
 38 Department of Health Professions that identifies any practitioner who may be, or who is actually, impaired to
 39 the extent that disclosure is prohibited by § 54.1-2517; and information relating to the prescribing and
 40 dispensing of covered substances to recipients and any abstracts from such information that are in the
 41 possession of the Prescription Monitoring Program (Program) pursuant to Chapter 25.2 (§ 54.1-2519 et seq.)
 42 of Title 54.1 and any material relating to the operation or security of the Program.

43 3. Reports, documentary evidence, and other information as specified in §§ 51.5-122 and 51.5-184 and
 44 Chapter 1 (§ 63.2-100 et seq.) of Title 63.2 and information and statistical registries required to be kept
 45 confidential pursuant to Chapter 1 (§ 63.2-100 et seq.) of Title 63.2.

46 4. Investigative notes; proprietary information not published, copyrighted or patented; information
 47 obtained from employee personnel records; personally identifiable information regarding residents, clients or
 48 other recipients of services; other correspondence and information furnished in confidence to the Department
 49 of Education in connection with an active investigation of an applicant or licensee pursuant to Chapter 14.1
 50 (§ 22.1-289.02 et seq.) of Title 22.1; other correspondence and information furnished in confidence to the
 51 Department of Social Services in connection with an active investigation of an applicant or licensee pursuant
 52 to Chapters 17 (§ 63.2-1700 et seq.) and 18 (§ 63.2-1800 et seq.) of Title 63.2; and information furnished to
 53 the Office of the Attorney General in connection with an investigation or litigation pursuant to Article 19.1
 54 (§ 8.01-216.1 et seq.) of Chapter 3 of Title 8.01 and Chapter 9 (§ 32.1-310 et seq.) of Title 32.1. However,
 55 nothing in this subdivision shall prevent the disclosure of information from the records of completed
 56 investigations in a form that does not reveal the identity of complainants, persons supplying information, or

57 other individuals involved in the investigation.

58 5. Information collected for the designation and verification of trauma centers and other specialty care
59 centers within the Statewide Emergency Medical Services System and Services pursuant to Article 2.1
60 (§ 32.1-111.1 et seq.) of Chapter 4 of Title 32.1.

61 6. Reports and court documents relating to involuntary admission required to be kept confidential
62 pursuant to § 37.2-818.

63 7. Information acquired (i) during a review of any child death conducted by the State Child Fatality
64 Review Team established pursuant to § 32.1-283.1 or by a local or regional child fatality review team to the
65 extent that such information is made confidential by § 32.1-283.2; (ii) during a review of any death conducted
66 by a family violence fatality review team to the extent that such information is made confidential by
67 § 32.1-283.3; (iii) during a review of any adult death conducted by the Adult Fatality Review Team to the
68 extent made confidential by § 32.1-283.5 or by a local or regional adult fatality review team to the extent that
69 such information is made confidential by § 32.1-283.6; (iv) by a local or regional overdose fatality review
70 team to the extent that such information is made confidential by § 32.1-283.7; (v) during a review of any
71 death conducted by the Maternal Mortality Review Team to the extent that such information is made
72 confidential by § 32.1-283.8; or (vi) during a review of any death conducted by the Developmental
73 Disabilities Mortality Review Committee to the extent that such information is made confidential by
74 § 37.2-314.1.

75 8. Patient level data collected by the Board of Health and not yet processed, verified, and released,
76 pursuant to § 32.1-276.9, to the Board by the nonprofit organization with which the Commissioner of Health
77 has contracted pursuant to § 32.1-276.4.

78 9. Information relating to a grant application, or accompanying a grant application, submitted to the
79 Commonwealth Neurotrauma Initiative Advisory Board pursuant to Article 12 (§ 51.5-178 et seq.) of Chapter
80 14 of Title 51.5 that would (i) reveal (a) medical or mental health records or other data identifying individual
81 patients or (b) proprietary business or research-related information produced or collected by the applicant in
82 the conduct of or as a result of study or research on medical, rehabilitative, scientific, technical, or scholarly
83 issues, when such information has not been publicly released, published, copyrighted, or patented, and (ii) be
84 harmful to the competitive position of the applicant.

85 10. Any information copied, recorded, or received by the Commissioner of Health in the course of an
86 examination, investigation, or review of a managed care health insurance plan licensee pursuant to
87 §§ 32.1-137.4 and 32.1-137.5, including books, records, files, accounts, papers, documents, and any or all
88 computer or other recordings.

89 11. Records of the Virginia Birth-Related Neurological Injury Compensation Program required to be kept
90 confidential pursuant to § 38.2-5002.2.

91 12. Information held by the State Health Commissioner relating to the health of any person subject to an
92 order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of
93 Title 32.1. However, nothing in this subdivision shall be construed to prevent the disclosure of statistical
94 summaries, abstracts, or other information in aggregate form.

95 13. The names and addresses or other contact information of persons receiving transportation services
96 from a state or local public body or its designee under Title II of the Americans with Disabilities Act, (42
97 U.S.C. § 12131 et seq.) or funded by Temporary Assistance for Needy Families (TANF) created under
98 § 63.2-600.

99 14. Information held by certain health care committees and entities that may be withheld from discovery
100 as privileged communications pursuant to § 8.01-581.17.

101 15. Data and information specified in § 37.2-308.01 relating to proceedings provided for in Article 16
102 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1 and Chapter 8 (§ 37.2-800 et seq.) of Title 37.2.

103 16. Records of and information held by the Smartchart Network Program required to be kept confidential
104 pursuant to § 32.1-372.

105 17. Information submitted to the acute psychiatric bed registry pursuant to § 37.2-308.1.

106 18. *Facility-level data and information relating to incidents of workplace violence in hospitals and*
107 *required to be kept confidential pursuant to subsection H of § 32.1-127. However, nothing in this subdivision*
108 *shall prevent the disclosure of statistical summaries in aggregate form according to the health planning*
109 *region where the incident occurred and with any personally identifiable information removed.*

110 **§ 32.1-127. Regulations.**

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

116 B. Such regulations:

117 1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes
118 and certified nursing facilities to ensure the environmental protection and the life safety of its patients,

119 employees, and the public; (ii) the operation, staffing, and equipping of hospitals, nursing homes and certified
120 nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes, and certified nursing
121 facilities, except those professionals licensed or certified by the Department of Health Professions; (iv)
122 conditions under which a hospital or nursing home may provide medical and nursing services to patients in
123 their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility
124 security of hospitals, nursing homes, and certified nursing facilities;

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

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

130 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal
131 law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. §
132 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS
133 regulations for routine contact, whereby the provider's designated organ procurement organization certified
134 by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii)
135 is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a
136 similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of
137 America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The
138 hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in
139 the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable
140 tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The
141 protocol shall ensure that the hospital collaborates with the designated organ procurement organization to
142 inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to
143 donate. The individual making contact with the family shall have completed a course in the methodology for
144 approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved
145 by the organ procurement organization and designed in conjunction with the tissue and eye bank community
146 and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of
147 the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement
148 organization in educating the staff responsible for contacting the organ procurement organization's personnel
149 on donation issues, the proper review of death records to improve identification of potential donors, and the
150 proper procedures for maintaining potential donors while necessary testing and placement of potential
151 donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the
152 family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative
153 officer of the hospital or his designee knows of such opposition, and no donor card or other relevant
154 document, such as an advance directive, can be found;

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

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

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

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

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

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

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

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

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

195 13. Shall require that each nursing home and certified nursing facility register with the Department of
196 State Police to receive notice of the registration, reregistration, or verification of registration information of
197 any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to
198 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
199 facility is located, pursuant to § 9.1-914;

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

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

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

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

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

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

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

243 admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the
244 referring physician;

245 21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a
246 policy governing determination of the medical and ethical appropriateness of proposed medical care, which
247 shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of
248 proposed medical care in cases in which a physician has determined proposed care to be medically or
249 ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is
250 medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by
251 the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the
252 proposed health care; and (iii) requirements for a written explanation of the decision reached by the
253 interdisciplinary medical review committee, which shall be included in the patient's medical record. Such
254 policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to
255 § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent
256 medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee
257 meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical
258 decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other
259 remedies available at law, including seeking court review, provided that the patient, his agent, or the person
260 authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the
261 chief executive officer of the hospital within 14 days of the date on which the physician's determination that
262 proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical
263 record;

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

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

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

303 25. Shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure
304 for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up

305 treatment after discharge is informed that he (i) is expected to require outpatient physical therapy as a follow-
306 up treatment and (ii) will be required to select a physical therapy provider prior to being discharged from the
307 hospital;

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

311 27. Shall require each hospital with an emergency department to establish a protocol for the treatment and
312 discharge of individuals experiencing a substance use-related emergency, which shall include provisions for
313 (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to
314 identify medical interventions necessary for the treatment of the individual in the emergency department and
315 (ii) recommendations for follow-up care following discharge for any patient identified as having a substance
316 use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have
317 been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a)
318 the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection Y of
319 § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or
320 other opioid antagonist used for overdose reversal, including information about accessing naloxone or other
321 opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy
322 operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or
323 other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing
324 order. Such protocols may also provide for referrals of individuals experiencing a substance use-related
325 emergency to peer recovery specialists and community-based providers of behavioral health services, or to
326 providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

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

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

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

365 31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients
366 who are minors available to such patients through a secure website shall make such health records available

367 to such patient's parent or guardian through such secure website, unless the hospital cannot make such health
 368 record available in a manner that prevents disclosure of information, the disclosure of which has been denied
 369 pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of
 370 § 54.1-2969 has not been provided;

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

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

378 34. Shall establish fees for the issuance, change, or renewal of a hospital or nursing home license to cover
 379 the costs of operating the hospital and nursing home licensure and inspection program in a manner that
 380 ensures timely completion of inspections as set forth in § 32.1-126. In establishing such fees, the Board shall
 381 distribute the costs of operating the hospital and nursing home licensure and inspection program in an
 382 equitable manner across all hospitals or nursing homes and ensure that the amount of such fees shall change
 383 no more frequently than annually. Fee changes under this section shall only be initiated if the expenses
 384 allocated to the Hospital and Nursing Home Licensure and Inspection Program Fund established under
 385 § 32.1-130, plus any state or other funding sources appropriated for the hospital and nursing home licensure
 386 and inspection program, are shown to be more than 10 percent greater or less than the annual costs of
 387 operating the hospital and nursing home licensure and inspection program in a manner that ensures timely
 388 completion of inspections. This analysis shall be conducted separately for hospital fees and nursing home
 389 fees, and resulting fee changes shall be established such that fees are sufficient to cover unfunded expenses
 390 but not excessive.

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

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

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

403 F. Hospitals in the Commonwealth *with an emergency department* shall:

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

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

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

416 G. Each hospital in the Commonwealth *with an emergency department* shall maintain the record of
 417 reported incidents of workplace violence made pursuant to subsection F for at least two years and shall
 418 include in such record; at a minimum:

419 1. The date and time of the incident;

420 2. A description of the incident, including the:

421 a. ~~The job titles~~ title category of the affected employee;

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

423 4. ~~A description of~~ c. The location category for where the incident occurred;

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

428 6. ~~The response to and any consequences of the incident, including (i) whether~~ e. The degree of physical

429 injuries to staff according to the following categories: (i) no injuries, (ii) injury not requiring medical
 430 treatment, (iii) injury requiring medical treatment without admission, (iv) injury requiring admission, and (v)
 431 fatality; and

432 f. Whether hospital security or hospital law enforcement or outside law enforcement was contacted and, if
 433 so, their response and (ii) whether the incident resulted in any change to hospital policy; and

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

436 H. Each hospital shall:

437 1. Report the facility-level data collected and reported pursuant to subsection G to the chief medical
 438 officer and or chief of staff, the chief nursing officer, the chief executive officer, and the medical staff
 439 executive committee of such hospital or an equivalent position on, at a minimum, a quarterly basis; and

440 2. ~~Send a report~~ Submit facility-level data collected and reported pursuant to subsection G to the
 441 Department on an annual basis that includes, at a minimum, the number of incidents of workplace violence
 442 voluntarily reported by an employee pursuant to subsection F. Any report made to the in aggregate with any
 443 personally identifiable information removed. In addition, the hospital shall include a statement regarding
 444 whether any changes were made to its workplace violence reporting policies or workplace violence
 445 prevention policies or other hospital policy as a result of workplace violence incidents reported during the
 446 reporting period. All information submitted to the Department pursuant to subsection H shall be confidential
 447 and shall be exempt from disclosure under the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

448 I. The Department pursuant to this subdivision shall be aggregated to remove:

449 1. Aggregate all facility-level data received pursuant to subsection H according to the health region
 450 where the incident occurred;

451 2. Remove from such data any personally identifiable information; and

452 3. Publish an annual report of such data in aggregate form according to the health planning region where
 453 the incident occurred and with any personally identifiable information removed from all data collected
 454 during the previous year.

455 F. J. As used in this section:

456 "Employee of the hospital" or "employee" means an employee of the hospital or, any health care provider
 457 credentialed by the hospital or engaged by the hospital to perform health care services on the premises of the
 458 hospital, and any contracted health care providers credentialed by or working in the hospital.

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

466 2. That the Board of Health shall promulgate regulations to implement the provisions of § 32.1-127 of
 467 the Code of Virginia, as amended by this act, by January 1, 2027.

468 3. That the Department of Health shall issue its first report pursuant to the requirements of subsection
 469 I of § 32.1-127 of the Code of Virginia, as amended by this act, no later than December 31, 2027.