

1 VIRGINIA ACTS OF ASSEMBLY — CHAPTER

2 *An Act to amend and reenact §§ 18.2-251.1:2 and 32.1-127 of the Code of Virginia, relating to medical*
 3 *cannabis; administration to terminally ill patients; report.*

4 [H 75]

5 Approved

6 **Be it enacted by the General Assembly of Virginia:**7 **1. That §§ 18.2-251.1:2 and 32.1-127 of the Code of Virginia are amended and reenacted as follows:**8 **§ 18.2-251.1:2. Possession or distribution of medical cannabis; hospitals, nursing homes, and**
 9 **certified nursing facilities; hospice and hospice facilities; assisted living facilities.**10 No person employed by a *hospital*, nursing home, hospice, hospice facility, or assisted living facility and
 11 authorized to possess, distribute, or administer medications to patients or residents shall be prosecuted under
 12 Chapter 11 (§ 4.1-1100 et seq.) of Title 4.1 or § 18.2-248, 18.2-248.1, or 18.2-250 for the possession or
 13 distribution of cannabis oil for the purposes of storing, dispensing, or administering cannabis oil to a patient
 14 or resident who has been issued a valid written certification for the use of cannabis oil in accordance with
 15 § 4.1-1601.16 **§ 32.1-127. Regulations.**17 A. The regulations promulgated by the Board to carry out the provisions of this article shall be in
 18 substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established
 19 and recognized by medical and health care professionals and by specialists in matters of public health and
 20 safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the
 21 Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

22 B. Such regulations:

23 1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes
 24 and certified nursing facilities to ensure the environmental protection and the life safety of its patients,
 25 employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified
 26 nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing
 27 facilities, except those professionals licensed or certified by the Department of Health Professions; (iv)
 28 conditions under which a hospital or nursing home may provide medical and nursing services to patients in
 29 their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility
 30 security of hospitals, nursing homes, and certified nursing facilities;31 2. Shall provide that at least one physician who is licensed to practice medicine in the Commonwealth and
 32 is primarily responsible for the emergency department shall be on duty and physically present at all times at
 33 each hospital that operates or holds itself out as operating an emergency service;34 3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing
 35 hospitals and nursing homes by bed capacity and by type of specialty or service;36 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal
 37 law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. §
 38 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS
 39 regulations for routine contact, whereby the provider's designated organ procurement organization certified
 40 by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii)
 41 is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a
 42 similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of
 43 America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The
 44 hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in
 45 the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable
 46 tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The
 47 protocol shall ensure that the hospital collaborates with the designated organ procurement organization to
 48 inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to
 49 donate. The individual making contact with the family shall have completed a course in the methodology for
 50 approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved
 51 by the organ procurement organization and designed in conjunction with the tissue and eye bank community
 52 and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of
 53 the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement
 54 organization in educating the staff responsible for contacting the organ procurement organization's personnel
 55 on donation issues, the proper review of death records to improve identification of potential donors, and the
 56 proper procedures for maintaining potential donors while necessary testing and placement of potential

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

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

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

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

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

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

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

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

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

101 13. Shall require that each nursing home and certified nursing facility register with the Department of
102 State Police to receive notice of the registration, reregistration, or verification of registration information of
103 any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to
104 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
105 facility is located, pursuant to § 9.1-914;

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

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

114 16. Shall require that each nursing home and certified nursing facility shall, upon the request of the
115 facility's family council, send notices and information about the family council mutually developed by the
116 family council and the administration of the nursing home or certified nursing facility, and provided to the
117 facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six
118 times per year. Such notices may be included together with a monthly billing statement or other regular

119 communication. Notices and information shall also be posted in a designated location within the nursing
120 home or certified nursing facility. No family member of a resident or other resident representative shall be
121 restricted from participating in meetings in the facility with the families or resident representatives of other
122 residents in the facility;

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

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

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

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

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

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

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

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

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

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

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

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

233 28. During a public health emergency related to COVID-19, shall require each nursing home and certified
234 nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from
235 the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid
236 Services and the Board. Such protocol shall include provisions describing (i) the conditions, including
237 conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and
238 community, under which in-person visits will be allowed and under which in-person visits will not be
239 allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be
240 required to comply to protect the health and safety of the patients and staff of the nursing home or certified
241 nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff
242 support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing

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

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

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

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

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

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

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

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

299 D. All facilities licensed by the Board pursuant to this article which provide treatment or care for
 300 hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot
 301 numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be
 302 contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated
 303 clotting factor may be apprised of this contamination. Facilities which have identified a lot that is known to
 304 be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the

305 contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each
306 recipient who received treatment from a known contaminated lot at the individual's last known address.

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

309 F. Hospitals in the Commonwealth shall:

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

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

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

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

324 1. The date and time of the incident;

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

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

327 4. A description of where the incident occurred;

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

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

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

337 H. Each hospital shall:

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

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

344 I. As used in this section:

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

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

355 **2. That the Department of Health shall convene a work group consisting of representatives of the**
356 **Virginia Hospital & Health Care Association; representatives of the Virginia Health Care Association;**
357 **representatives of health care providers; and palliative, hospice, and hospital volunteers familiar with**
358 **issues associated with providing care to individuals experiencing chronic illness to discuss the**
359 **implementation process for providing cannabis products to patients within medical care facilities. The**
360 **work group shall assess any available federal guidance or proposed regulations on the use of cannabis**
361 **products or changes to the schedule for cannabis products under the federal Controlled Substances Act**
362 **(21 U.S.C. § 801 et seq.) as well as interaction with applicable state laws. Such work group shall**
363 **provide a report on its discussion, including written guidelines for the use of medical cannabis within**
364 **medical care facilities and the safe operations of medical care facilities, to the Chairs of the House**
365 **Committee on Health and Human Services and the Senate Committee on Education and Health by**

366 November 1, 2026.

ENROLLED

HB75ER