

**State of Board of Health
Agenda
December 15, 2022 – 9:00 a.m.
Perimeter Center, Boardroom 2**

Call to Order and Welcome	Gary Critzer, Chair
Introductions	Mr. Critzer
Review of Agenda	Alexandra Jansson, MPP
Approval of September 22, 2022 Minutes	Mr. Critzer
Commissioner’s Report	Colin Greene, MD, MPH State Health Commissioner
Regulatory Action Update	Michael Capps, MPH Acting Legislative and Regulatory Coordinator
Break	
Public Comment Period	
<u>Lunch Presentation</u>	
Opioids and Substance Misuse: Data and Program Efforts	Liz Zaunick, Overdose Data to Action Grant Coordinator Lauren Yerkes, Injury and Violence Prevention Epidemiologist Office of Family Health Services
<u>Regulatory Action Items</u>	
Regulations Governing Campgrounds 12VAC5-450 (Fast Track Amendments)	Julie Henderson Director Office of Environmental Health Services
Regulations Governing Vital Records 12VAC5-550 (Fast Track Amendments)	Seth Austin Director Office of Vital Records
Regulations for the Licensure of Hospitals in Virginia 12VAC5-410 (Fast Track Amendments)	Rebekah Allen, JD Senior Policy Analyst Office of Licensure and Certification
Regulations for the Licensure of Nursing Facilities 12VAC5-371 (Fast Track Amendments)	Ms. Allen

Non-Regulatory Action Items

Board of Health Annual Report:
Plan for Well-Being

Khalida Willoughby, MS
Director
Center for Community Health Improvement

Public Policy Agenda Follow Up

Joseph Hilbert

Electronic Meeting Policy

Ms. Jansson

Other Business

Adjourn

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**State Board of Health
September 22, 2022 - 9:00am
Perimeter Center, Boardroom 2**

Members Present: Gary Critzer, Chair; Michael Desjadon; Melissa Green; Elizabeth Ruffin Harrison; Anna Jeng; Lee Jones; Patricia Kinser, PhD; Wendy Kline, MD, Vice Chair; Patricia O'Bannon; Holly Puritz, MD; Maribel Ramos; Jim Shuler; Stacey Swartz, PharmD; Ann B.R. Vaughters, MD; Mary Margaret Whipple

Dr. Puritz attended remotely due to work obligations that required she be physically present in Norfolk. Ms. Ramos participated remotely due to a temporary medical condition (contagious disease) from her home in Alexandria. Dr. Kinser participated virtually due to a temporary medical condition (contagious disease) from her home in Richmond.

VDH Staff Present: Michael Capps, Senior Policy Analyst; Tiffany Ford, Deputy Commissioner for Administration; Colin Greene, State Health Commissioner; Joe Hilbert, Deputy Commissioner for Governmental and Regulatory Affairs; Parham Jaber, Deputy Commissioner for Community Health Services; Alexandra Jansson, Senior Policy Analyst; Lilian Peake, State Epidemiologist and Director, Office of Epidemiology; Maria Reppas, Director, Office of Communications.

Other Staff Present: Robin Kurz, JD, Senior Assistant Attorney General

Call to Order

Mr. Critzer called the meeting to order at 9:03am.

Introductions

Mr. Critzer welcomed those in attendance to the meeting. Mr. Critzer then started the introductions of the Board members and VDH staff present.

Review of Agenda

Ms. Jansson reviewed the agenda and the items contained in the Board's binder.

Approval of June 23, 2022 Minutes

Dr. Swartz made the motion to approve the minutes from the June 23, 2022 meeting with Ms. Whipple seconding the motion. The minutes were approved unanimously by voice vote with 2 abstentions from Mrs. O'Bannon and Ms. Harrison who were absent from the previous meeting.

Commissioner's Report

Dr. Greene provided the Commissioner's Report to the Board. He updated the Board on key issues and projects VDH is engaged in including:

- Agency Stars
- COVID-19 Update
- Monkeypox Update
- Opioid Abatement Authority/Substance Misuse
- Partnership for Petersburg
- Infrastructure Grant/Collaboration with DBHDS
- Emergency Preparedness Summit/Hurricane Season
- Facilities Broadband Initiative

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- Electronic Health Record Initiative
- Public Policy Agenda

There was discussion regarding partnerships and help with change management; COVID in southwest and rural Virginia and outreach strategies to increase vaccinations; bivalent vaccine supply and distributions; flu trends; and if there was any impact to women's health or abortion access in Virginia as a result of the *Dobbs* decision.

Regulatory Action Update

Michael Capps reviewed the summary of all pending VDH regulatory actions.

Since the June 2022 meeting, the Commissioner approved four regulatory actions on behalf of the Board while the Board was not in session. First, the Commissioner approved three Notices of Intended Regulatory Action (NOIRAs) for the Virginia Hearing Impairment Identification and Monitoring System (12VAC5-80); Regulations Governing Tourist Establishment Swimming Pools and Other Public Pools (12VAC5-460); and Swimming Pool Regulations Governing the Posting of Water Quality Results (12VAC5-462). These NOIRAs followed periodic reviews and will update the respective Regulations by removing outdated information and incorporating recommendations and national best practices. The Commissioner also approved final exempt action for the Food Regulation (12VAC5-421) to comply with Chapter 393 of the 2022 Acts of Assembly, removing the requirement that an establishment that sells only prepared food have a certified food protection manager on site during all hours of operation.

Since the June 2022 meeting the Commissioner has taken no non-regulatory action on behalf of the Board while the Board was not in session.

Mr. Capps advised the Board that there are 18 periodic reviews in progress:

- 12 VAC 5-20 Regulations for the Conduct of Human Research
- 12 VAC 5-110 Regulations for the Immunization of School Children
- 12 VAC 5-125 Regulations for Bedding and Upholstered Furniture Inspection Program
- 12 VAC 5-150 Regulations for the Sanitary Control of Storing, Processing, Packing or Repacking of Oysters, Clams and Other Shellfish
- 12 VAC 5-160 Regulations for the Sanitary Control of the Picking, Packing and Marketing of Crab Meat for Human Consumption
- 12 VAC5-191 State Plan for the Children with Special Health Care Needs Program
- 12 VAC 5-200 Regulations Governing Eligibility Standards and Charges for Health Care Services to Individuals
- 12 VAC 5-216 Methodology to Measure Efficiency and Productivity of Health Care Institutions
- 12 VAC 5-217 Regulations of the Patient Level Data System
- 12 VAC 5-218 Rules and Regulations Governing Outpatient Data Reporting
- 12 VAC 5-220 Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations
- 12 VAC 5-407 Regulations for the Submission of Health Maintenance Organization Quality of Care Performance Information
- 12 VAC 5-408 Regulation for the Certificate of Quality Assurance of Managed Care Health Insurance Plan (MCHIP) Licensees
- 12 VAC 5-410 Regulations for the Licensure of Hospitals in Virginia
- 12 VAC 5-431 Sanitary Regulations for Hotels
- 12 VAC 5-508 Regulations Governing the Virginia Physician Loan Repayment Program

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- 12 VAC 5-510 Guidelines for General Assembly Nursing Scholarships
- 12 VAC 5-540 Rules and Regulations for the Identification of Medically Underserved Areas in Virginia

Since the June 2022 meeting, the Executive Branch completed the review of three regulatory actions while the Board was not in session – a NOIRA for the Regulations Governing Tourist Establishment Swimming Pools and Other Public Pools (12VCA5-460), a NOIRA for the Swimming Pool Regulations Governing the Posting of Water Quality Results (12VAC5-462), and Fast Track amendments to the Sewage Handling and Disposal Regulations (12VAC5-610).

There was discussion regarding [Virginia Regulatory Town Hall](#) and how the public can use the site to follow the progress of regulatory actions.

Public Comment Period

There were six persons signed up for public comment at the meeting. Mary Ann Mundt spoke about her husband's death and hospital safety around COVID-19 protocols. Barbara Zeller shared a continuation of Mrs. Mundt's story and COVID-19 therapeutics. Doris Knick shared comments regarding vaccine safety and an upcoming forum hosted by the Virginia Medical Freedom Alliance around therapeutics. Tricia Stall spoke about standardized COVID-19 protocols and therapeutics and mentioned the upcoming forum as well. Susan Franz spoke about a therapeutics webinar hosted by VDH, COVID-19 treatment protocols and vaccine safety. Pamela Burnham shared concerns about COVID-19 vaccine safety. Speakers also shared comments which are included at the end of the minutes document.

Final Exempt Amendments to Regulations for the Immunization of School Children

Laurie Forlano presented the final exempt amendments to the Board. This amendment to the Regulations for the Immunization of School Children is necessary to maintain conformity with the Code of Virginia following language added in Chapter 1223 of the 2020 General Assembly Regular Session. As a result of that action, the list of minimum requirements for school required immunization in § 32.1-46 was amended to include additional vaccine requirements. This amendment to the regulations will bring them into compliance with the list specified in the Code of Virginia.

Prior to this Final Exempt Action, the Virginia Department of Health (VDH) published a Notice of Intended Regulatory Action followed by a 60-day public comment period, as required by § 32.1-46 subsection C. VDH received 26 comments. Twenty-four were in opposition to the action (11 generally for choice and against mandates, 10 concerns over HPV vaccine, 1 provided no explanation, 1 minimize chemicals in children, and 1 misunderstood action), one appeared to be for the action, and one was categorized as N/A because no comment was left and the title was "protect our children" which could go either way.

The proposed amendments seek to update the Regulations for the Immunization of School Children in order to adhere to the minimum immunization requirements specified in § 32.1-46. The proposed amendments are consistent with language added to the Code of Virginia as a result of Chapter 1223 of the 2020 Regular Session.

Dr. Klein made the motion to approve the final exempt regulations with Dr. Swartz seconding the motion. The proposed regulation was approved unanimously by voice vote.

Proposed Regulation for Sexual Assault Survivor Treatment and Transfer

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Rebekah Allen presented the proposed regulation to the Board. Chapter 725 (2020 Acts of Assembly) created Article 8 of Chapter 5 of Title 32.1 of the Code of Virginia, which requires the Board to promulgate regulations to effectuate the act, specifically the standards for review and approval of sexual assault survivor (SAS) transfer plans (§ 32.1-162.15:5), pediatric sexual assault survivor (PSAS) transfer plans (§ 32.1-162.15:5 and subsection C of § 32.1-162.15:6), SAS treatment plans (subsection A of §32.1-162.15:4), and PSAS treatment plans (subsection B of § 32.1-162.15:6). As the requirement to have such plans extends to hospitals, clinics, and physician's offices, there is no already existing regulatory chapter that would best fit this mandate, so the Virginia Board of Health intends to promulgate a new regulatory chapter for these standards.

Dr. Klein made a motion to approve the proposed regulation with Dr. Swartz seconding the motion. There was discussion regarding the need for these regulations to ensure access to care for survivors and PSAS treatment and transfer requirements including Sexual Assault Forensic Examiner staffing availability, the costs to pediatric facilities, differences between treatment and transfer plans, and mandated reporting. The proposed regulation was approved unanimously by voice vote.

Proposed Regulation for Prescription Drug Price Transparency

Ms. Allen presented the proposed regulation to the Board. The rationale or justification for the regulatory change is that the General Assembly enacted Chapter 304 (2021 Acts of Assembly, Special Session I) to require VDH to adopt regulations standards for prescription drug price transparency and reporting. The regulations require that reporting entities provide vital information about prescription drug pricing, which is a driver of increased healthcare costs in the Commonwealth. The goal of the regulatory change is to increase transparency of prescription drug pricing and to identify factors that may be leading to increased healthcare costs from prescription drugs. The regulation must contain the specification of prescription drugs for the purpose of data collection and procedures for auditing information provided by health carriers, pharmacy benefits managers, wholesale distributors, and manufacturers, as well as a schedule of civil penalties for failure to report the information required, based on the severity of the violation. The specification must include information required pursuant to §§ 32.1-23.4, 38.2-3407.15:6, 54.1-3436.1, and 54.1-3442.02 of the Code of Virginia.

Ms. Whipple made a motion to approve the proposed regulation with Dr. Shuler seconding the motion. There was discussion about price transparency importance and the role of pharmacy benefits managers. Mr. Desjardon made a motion to amend the proposed regulation with Ms. Green seconding the motion. The regulation was approved as amended unanimously by voice vote.

Final Amendments to Private Well Regulations

Ms. Henderson presented the Final Amendments to the Board. There have not been significant revisions to the Regulations since their adoption in 1990. The Regulations establish the minimum location and construction requirements for private wells installed in the Commonwealth. In August 2016, the VDH began a periodic review of the Regulations and formed a Private Well Regulations Workgroup. The purpose of the workgroup was to assist VDH in the development of proposed revisions to the Regulations.

The Proposed Regulations were published in Volume 38 Issue 11 of the Virginia Register of Regulations on January 17, 2022, and advertised a public comment period ending March 18, 2022. The intent of this regulatory action is to explore amendments to the Regulations based on

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current industry standards, all public comments received, and feedback received from the Private Well Regulations Workgroup. The purpose is to ensure the Regulations (i) are protective of public health and the environment, (ii) address changes in current standards and practices, (iii) clarify regulatory language, and (iv) exhibit improved consistency with other regulations related to private wells and groundwater resources. No substantive changes have been made between the Proposed and Final Stages.

Dr. Jeng made a motion to approve the final amendments with Ms. Harrison seconding the motion. There was discussion about climate change, shallow soil, salt water intrusion, drinking water wells inclusion, and adjacent property owner approvals. The final amendments were approved unanimously by voice vote.

Fast Track Amendments to Regulations for the Licensure of Home Care Organizations

Ms. Allen presented the Fast Track Amendments to the Board. Chapter 172 (2022 Acts of Assembly) amended Code of Virginia § 32.1-162.9 to change home care organization (HCOs) licenses from an annual license to a three-year license. This act also mandated that the fee for renewal of an HCO license shall be \$1,500 until such time as the Board of Health may amend or repeal regulations for the licensure of home care organizations. The regulatory change is essential to protect the health, safety, or welfare of citizens because VDH cannot provide adequate inspection and oversight for HCOs if it is losing funding equal to roughly three full-time HCO inspectors. The goal of the regulatory change is to preserve VDH's current fee revenue and to eliminate inconsistencies in receiving and processing license changes and exemption requests.

It is anticipated that this action will be noncontroversial and therefore appropriate for the fast-track process because the fee amount for the new three-year HCO licenses is the same amount on a per-year basis as what the regulations mandate for a one-year license (i.e., \$500 for the prior one-year license, now \$1,500 for a three-year license) and the vast majority of HCOs are already utilizing the forms created by VDH to communicate changes to their licenses or requests for an exemption.

Dr. Schuler made the motion to approve the fast track amendments with Dr. Jeng seconding the motion. There was discussion regarding continuing education maintenance and documentation, oversight maintenance, survey and inspection process frequency and license extension to 3 years. The Fast Track amendments were approved unanimously by voice vote.

Final Amendments to the Regulations for Disease Reporting and Control

Dr. Peake presented the final amendments to the Board. The Regulations for Disease Reporting and Control provide information about the process and procedures for reporting diseases to the Virginia Department of Health (VDH), including what diseases must be reported, who must report them and other details related to reporting and disease control. VDH is proposing an amendment to the regulations to ensure all health providers report necessary public health information. This regulatory action separates COVID-19 from the category "coronavirus, severe" on the reportable disease list; removes the requirement for COVID-19 to be rapidly reportable; requires COVID-19 case and laboratory report forms be submitted electronically; clarifies that the category "laboratory directors" includes any entity that holds CLIA Certificates of Waiver; adds ethnicity and hospitalization status (if applicable) to the fields required to be reported by all parties related to COVID-19; and adds "coronavirus, severe" to the list of infectious diseases that shall be reported to persons practicing funeral services.

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Dr. Vaughters made a motion to approve the final amendments with Dr. Klein seconding the motion. The final amendments were approved unanimously by voice vote.

2023 Meeting Dates

Ms. Jansson presented the dates for the 2023 meetings of the Board of Health as follows:

Thursday March 23

Thursday June 15

Thursday September 15

Friday December 15

There was no objection to these dates for the 2023 meeting dates, and they were adopted by consensus.

Other Business

No other business was presented for discussion.

Adjourn

The meeting adjourned at 12:37pm



Read The CDC Disclaimer

VAERS COVID Vaccine Adverse Event Reports

Reports from the Vaccine Adverse Events Reporting System. Our default data reflects all VAERS data including the "nondomestic" reports. [?](#)

All VAERS COVID Reports [?](#) US/Territories/Unknown

1,407,409 Reports Through September 9, 2022 [?](#)

30,935

DEATHS

177,050

HOSPITALIZATIONS

135,259

URGENT CARE

205,430

DOCTOR OFFICE VISITS

My name is Pamela Burnham and I am a nurse with more than 20 years of experience, primarily in Critical Care. I have been an Independent Nurse Consultant/Educator since 2015 with a primary focus on cancer patients of Specialized Programs of Research Centers.

I am a mom of three and a grandmother. I have never been anti-VAX and was compliant with all of the hospital healthcare requirements until 2015. However, after extensive review of vaccine research I find myself full of regret for having vaccinated my children. And the so-called COVID "vaccine" is not even a traditional vaccine but rather a largely untested experimental genetic injection, the first of its kind, with unknown long-term risks ~~in terms of cancer, fertility issues in men and women, autoimmune disease, neurological disease,~~ *etc.*

Early on during the COVID crisis, many of us nurses cued in on the lies and propaganda being told to the public about the one-size-fits-all uni-treatment narrative promulgated by NIH, CDC and FDA. We knew very early on that hundreds of thousands of people would die if we didn't do something and we found ways to keep up with and share information ~~among ourselves.~~ *the* Our groups formed a network of actively involved individuals who helped thousands of Covid affected people, especially here in VA. We developed and shared promising treatment protocols using repurposed FDA-approved medications and nutritional therapies ~~that were being~~ *developed by groups* that have evolved into the highly regarded medical freedom organizations, American Frontline doctors and Frontline Covid Critical Care (FLCCC). We developed a network of deep researchers, doctors, pharmacists, nurses, rescuers, attorneys, ~~exemption filing experts who were,~~ *or* and still all working to help as many people as possible by sharing the truth to counter the public health system's uni-narrative.

Breath

I help answer questions for people from all over the world who are experiencing horrible side effects from the shots, ~~repeated debilitating illnesses, heartbreaking family tension and rejection, work related difficulties,~~ *hid* functional activity breakdown, isolation, etc, from the draconian lockdowns, mandates, social restrictions, ~~like~~ *like* ~~striking the unvaccinated,~~ *striking the unvaccinated,* violation or suspension of our fundamental human and constitutional rights and freedom, and brutal censorship and intimidation of scientific or medical viewpoint that dissents from the uni-narrative.

Today I want to share with you some of that truth that we believe would ~~have~~ *help* many Virginians make informed decisions and would have saved many lives had they known.

For example, during pregnancy, we've always been told to avoid taking any medications, including Tylenol. Mothers to-be are being terrified into ^{getting} the EUA shots and told they are safe and effective. They are far from that with upwards of 70% risk of miscarriage in those injected in the first and second trimester.

~~For example~~, 80% of children have already had covid with little to no symptoms and likely have lifetime natural immunity. On the other hand, nearly 30% of young people under age 20 who are injected with 2 Pfizer shots develop myocarditis.

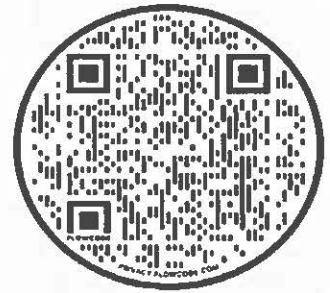
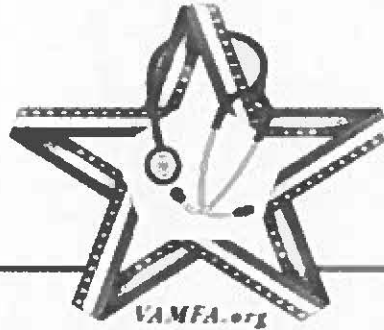
^{reports}
~~For example~~, reports from the UK government's Office of National Statistics confirm that the triple vaccinated account for 91% of Covid deaths and over 24,000 unexplained deaths in 2022.

^{There is an}
~~For example~~, the urgent need to create specific research and treatment centers for the vaccine-injured who are trapped in a horrendous situation of pain and limitation. Many suicides are taking place across the globe.

^{in these shots}
~~For example~~, these shots contain mRNA which produces the Spike Protein that interacts with the immune system and may be the most toxic substance ever introduced to the human body. Many trillions of spike protein particles are produced with each injection, cause suppression of natural immune function and inflammation, crosses the blood brain barrier, affects the heart, causes many neurological disorders including tremors, lethargy, stroke, Bell's Palsy, and ALS-type disorders as well as cardiovascular disease, blood clots, and menstrual irregularities and miscarriages.

This is not an Us versus You situation. We stand for Informed Consent, Freedom of Speech and from viewpoint Censorship. We need to stand together, resist the uni-narrative and fight for freedom. (Board members and Dr. Greene, help restore scientific integrity and our trust with an honest, uncensored and open scientific dialogue between doctors and medical scientists about all the evidence. I'll look for you at the Forum on October 1st

VIRGINIA MEDICAL
FREEDOM ALLIANCE



VIRGINIA'S COVID MANAGEMENT:

A PUBLIC FORUM

Saturday October 1, 2022

Life Church • 8378 Atlee Rd

Mechanicsville VA 23116 • 1:00-4:00PM

Invited Speakers Include:

- Robert Malone MD
- Paul Marik MD

Invited Guests include:

- Gov Glenn Youngkin
- Lt Gov Winsome Sears
- Atty Gen Jason Miyares
- 140 Virginia Legislators
- And most importantly YOU!

*Virginia Government Health Officials have repeatedly
declined to participate*

*Follow the QR code or go to VAMFA.org for more
information and to register.*



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August 16, 2022

Dear Virginians:

The Virginia Medical Freedom Alliance (VAMFA) is a non-partisan coalition of Virginia doctors, allied healthcare professionals, organizations, and citizens who are concerned and alarmed by the public health system's encroachment on the ability of healthcare professionals to provide evidence-based ethical care to Virginians during the two-plus years of the COVID-19 pandemic. On July 19, 2022, we respectfully and urgently asked the Virginia Department of Health Commissioner Dr. Colin Greene and his medical scientists to participate with the VAMFA-selected independent expert medical scientists in a forum open to the public to present the evidence in reference to the prevention and treatment of Covid-19 and the use of vaccines. We also requested that Dr. Greene conduct an in-person VDH tour at multiple representative locations throughout the Commonwealth to listen to the people about their experiences related to the public health management of COVID. There has been no response.

Prior to our July letter, members of the VAMFA participated in a June 29, 2022, VDH-sponsored "open forum conversation on COVID-19 therapeutics" in which they would "be answering your questions and discussing the changing landscape of therapeutics in Virginia." We entered many questions into the chat stream. but were disappointed when they were ignored. The webinar facilitator stated that the VDH COVID-19 Therapeutics Group only focuses on interventions that have an FDA emergency use authorization (EUA) for COVID and that "VDH staff do not have the ability to respond to questions regarding medications that are not authorized by the FDA for the treatment of Covid-19." The VDH response to specific VAMFA concerns about the safety or efficacy of these products was that all have clinical trial data that is "very supportive regarding their safety and efficacy in treating COVID-19," they "use reliable sources of data" (defined as CDC, FDA and peer-reviewed articles) to inform Virginia professionals and they "must follow the NIH treatment guidelines." Questions and concerns about the COVID vaccines were deflected by promising to "facilitate getting them to our colleagues in the vaccine space and answered." We have heard nothing since then. After about thirty minutes all of us were suddenly dropped from the webinar without any warning. Some who were able to log back in were again dropped. This is a blatant example of the dangers facing all Virginians when open dialogue is prevented.

Many of the healthcare professionals that participated in the VDH June 29 COVID therapeutics forum have been treating patients with COVID-19 for more than two years. They know that hundreds of peer-reviewed studies clearly show that aggressive prevention and early outpatient multidrug treatment could have prevented 75 to 80 percent of hospitalizations and deaths attributed to COVID.ⁱ Early in the pandemic, a group of world-renowned critical care doctors and scientists collaborated as the Frontline COVID-19 Critical Care Alliance (FLCCC) to quickly develop robust prevention and treatment protocols.ⁱⁱ These protocols repurposed and incorporate multiple common, inexpensive, remarkably safe and effective FDA-approved oral medications and over-the-counter immune-fortifying nutritional therapeutics.ⁱⁱⁱ COVID is completely treatable; the standard of care is these multidrug FLCCC protocols

THE COVID VACCINE & CHILDREN

A SECOND OPINION



The number of **DEATHS & ADVERSE REACTIONS** reported after the COVID vaccine is staggering.

VAERS¹, the US Government database that tracks vaccine reactions, shows a total of **1,205,755 adverse reactions** and **26,396 deaths** following the COVID-19 vaccine (as of 3/25/22)². This is **more reports than from all previous vaccines combined**. This number is likely underreported. An HHS funded study³ shows that the VAERS system captures only 1-10% of total vaccine reactions.

Multiple well funded studies have demonstrated the negligible risk to healthy children from COVID-19. A large German study⁴ showed **zero deaths for children ages 5-11** and a case fatality rate of three per million in all children without comorbidities. And a Johns Hopkins study⁵ of 48,000 children **showed a zero mortality rate** in children under 18 without comorbidities. Another study in *Nature Medicine*⁶ showed children under 18 without comorbidities had **virtually no risk of death**.

Healthy children face virtually **ZERO RISK** of death from COVID.



THE CLINICAL TRIALS for children 2 to < 5 years old **FAILED**.

Pfizer's application for EUA of two doses of its vaccine **failed in clinical trials**⁷ as it did not produce antibodies in children 2 to <5 years old. **They were forced to withdraw the application** in February 2022, and will now apply to the FDA for a three-dose series once more data is available in April.

A study in *Nature Communications*⁸ suggests **children's bodies clear the virus more easily** than adults. Another study in *Nature Immunology*⁹ demonstrates how **children efficiently mount effective immune responses**: "immune systems that naturally generate robust, cross-reactive and sustained immune responses to SARS-Cov-2 ..."

Children's bodies are uniquely suited to handle COVID-19 with a **SURVIVAL RATE OF 99.995%**



REFERENCES

1. [digital.ahrq.gov/ahrq-funded-projects/electronic-support-public-health-vaccine-adverse-event-reporting-system](https://www.fda.gov/oc/ohrt/ahrq-funded-projects/electronic-support-public-health-vaccine-adverse-event-reporting-system)
2. medalerts.org/vaersdb/findfield.php?TABLE=ON&GROUP1=CAT&EVENTS=ON&VAX=COVID19
3. [digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf](https://www.fda.gov/oc/ohrt/publication/r18hs017045-lazarus-final-report-2011.pdf)
4. [medrxiv.org/content/10.1101/2021.11.30.21267048v1](https://www.medrxiv.org/content/10.1101/2021.11.30.21267048v1)
5. [thefederalist.com/2021/07/21/johns-hopkins-study-found-zero-covid-deaths-among-healthy-kids](https://www.thefederalist.com/2021/07/21/johns-hopkins-study-found-zero-covid-deaths-among-healthy-kids)
6. [nature.com/articles/s41591-021-01578-1](https://www.nature.com/articles/s41591-021-01578-1)
7. [cnn.com/2021/12/17/health/pfizer-vaccine-children/index.html](https://www.cnn.com/2021/12/17/health/pfizer-vaccine-children/index.html)
8. [nature.com/articles/s41467-021-22236-7](https://www.nature.com/articles/s41467-021-22236-7)
9. [nature.com/articles/s41590-021-01089-8](https://www.nature.com/articles/s41590-021-01089-8)



Children's Health Defense
childrenshealthdefense.org



COVID SHOTS & KIDS

A GUIDE FOR PARENTS + CAREGIVERS
ABOUT **INFORMED CONSENT** FOR COVID
SHOTS IN INFANTS AND CHILDREN.



Did you know you have the right to “informed consent” before receiving a medical procedure for yourself or your dependents—especially when the procedure is experimental and used under an emergency use authorization?

Did you know by law you must be informed of the significant known or potential adverse effects of the treatment? Is your practitioner or healthcare worker doing their part in sharing this information?

Please read the following information carefully so that you can make an **informed decision** for the children in your life.

- Did you know there are no long-term safety data for COVID-19 vaccination of young children**, and the proposal is to vaccinate children under an Emergency Use Authorization (EUA)? These facts establish that vaccinating small children for COVID-19 is an experiment, not a standard medical procedure.
- Did you know that children have a 99.995% recovery rate?** And there’s a large body of medical literature indicating that **almost zero healthy children under five years old have died from COVID.**
- Did you know that COVID vaccines do not prevent transmission, nor do they prevent infection?** There is no statistically valid evidence that they prevent severe disease or death in children. Current mRNA injections were formulated based on the original Wuhan strain and were not tested for benefits against current variants in clinical trials.
- Did you know that most children are already immune? Natural immunity is superior to vaccine-induced immunity**, and vaccinating the already immune is superfluous and potentially harmful. CNBC reported in April 2022, “An estimated 95% of the U.S. population ages 16 and older had developed antibodies against the virus either through vaccination or infection as of December, according to a CDC survey of blood donor samples.” In February of 2022, the CDC said over **75% of children already have partial or full immunity to COVID.**
- Did you know that unnecessary vaccination will put children at elevated risk of vaccine harm** when it appears that most are already immune and will obtain NO benefit?
- Did you know** that multiple studies have suggested that **vaccinating after infection increases the risk of vaccine-induced side effects such as myocarditis?**

Good Afternoon State Health Commissioner & Board of Health Members,

My name is Doris Knick. As a member of the Virginia Medical Freedom Alliance (VAMFA), I request that the State Health Commissioner and each of you Board members participate in the Oct. 1st Open Public Forum hosted by VAMFA. ***It is your opportunity to start restoring scientific integrity and healing Virginians' shattered trust in their medical establishment***

You continue to deny the evidence in the Vaccine Adverse Events Reporting System (VAERS). None of us will ever be okay with the number of deaths and injuries from these Covid Shots. These are real people's lives that have been lost & impacted, not just statistics!

Here's a visual from the [Red Box Summaries on openvaers.com](https://www.redboxsummaries.com) since you don't seem to be aware of VAERS or its 1.4 million COVID vaccine Adverse Event Reports worldwide. (Banner of Injuries)

These Injuries are REAL and HORRIFYING COMMON, not RARE, yet the massive scope of the harm from the COVID injection is not represented in its VDH advertisements, FAQs or in the informed consenting process.

Did you know that more than 60% of the reports in the world are from the U.S.? In the past 2 ½ years, more than 865,000 Americans have filed adverse event reports related to the jab!

This includes 14,438 people who died after their Covid injections.

Let me repeat that: More than 14,000 Americans died.

Another 13,000 people had a LIFE-THREATENING reaction and almost 69,000 required hospitalization.

Shockingly, almost 15,000 Americans, most in the prime of their lives, are now PERMANENTLY DISABLED.

34,000 had a Severe Allergic Reaction with more than 2,000 of those almost dying of immediate anaphylactic shock.

6,000 suffered a Heart Attack and almost 9,000 more developed Myocarditis or Pericarditis.

Almost 1,800 pregnant U.S. women miscarried after being jabbed.

I could go on and on.

These Covid injections are NOT SAFE. PERIOD. End of discussion. There's no reason to even look at effectiveness if it's not safe. But to add injury to injury, this injection is also not effective in preventing transmission or infection with the COVID virus. All this is intolerable for an illness with an average 99.8% survival rate.

So where's VDH's evidence supporting your endless claims of safe and effective?

At your June 23rd quarterly meeting I shared the current VAERS data with you, but the summary sheet I provided is missing from the Public Record of that meeting. Why?

We demand that the COVID injections be immediately halted in Virginia.

We demand full and transparent investigations into the injuries and deaths caused by the COVID injections, by researchers without conflicts of interest and that the results be rapidly reported publicly.

I again urge you to participate in the Forum on October 1st, *to present your evidence supporting the COVID emergency orders, regulations and other policies that you recommended and continue to promote, and their health outcomes.* You still have time to take a first step toward acting on VDH's stated mission to protect the health and promote the well-being of all Virginians.

Mary Ann Mundt -

The hospital protocol killed my husband.

On January 8, 2021, my husband was weak and fell. I called for rescue to ask for assistance in getting him up. They insisted on taking him to the hospital. He did not want to go. We had done our research and knew hospitals were a dangerous place. As they took him away, I gave him his cell phone so we could communicate.

There was no need to believe that Bud had been exposed to Covid, but when he arrived at the hospital, they did their PCR test and said that he tested positive for Covid. We knew the tests were highly unreliable and expected this to happen at the hospital. We heard stories.

The ER doctor called me and told me they were giving Bud Remdesivir and going to put him on the ventilator. I immediately replied "Absolutely Not! Bud does not want either of those things for treatment".

The nurses told me that Bud had a UTI. I went over and picked him up and brought him home. I called our family doctor who put him on Levaquin. He initially was improving.

However, he was likely exposed to Covid in the hospital because he began to develop Covid symptoms. I called America's Frontline Doctors (AFLDS) and they helped get me some Ivermectin. He also received Monoclonal antibodies on Jan 18.

On January 19th(?) I called rescue again. They took him to the ER and kept him there. They wouldn't let him have his phone. The doctors wouldn't speak to me or let me in. For 3 days the doctors avoided me. I stood in the lobby every day waiting to speak to the doctors and waiting for a phone call, for someone, anyone to answer my questions and update on my husband's status.

I called Senator Bryce Reeves. I told him what was going on and the doctors lied when they told him they called me. I had my phone with me the entire time and was in the lobby of the hospital.

Reeves finally got them to call me and they set up a meeting with the nurses on the floor. I had the POA and Living Will that clearly stated "No Remdesivir" and "No Vent!"

I contact a doctor from the Front Line COVID-19 Critical Care Alliance (FLCCC). She advised me on all the aspects of the treatment protocol for hospitalized patients. Certain doctors tried to fight everything she advised. Some doctors were willing to help provide the correct supplements and additional recommendation from the FLCCC protocol, then the other doctors would come back in and change them. They gave him the wrong steroids and the wrong antibiotics. They kept saying, "It is not on our protocol" i.e., the hospital protocol. They agreed to give him crushed Vitamin C instead of IV Vitamin C as was recommended.

After battling between hospital doctors, on January 26th, he was able to get well enough to be moved from ICU to the Step Down unit. The doctors in the Step Down unit cut back on his supplements and meds. They refused Ivermectin and Hydroxychloroquine (HCQ).

On January 27th at 4:52am, the nurse called me and told me that Bud was angry. I tried to make arrangements to get him home on oxygen or to another hospital per the FLCCC doctor's recommendation. I wanted to get him to MCV where we knew Bud's heart doctor, but he progressively got worse to a point where he was having a lot of trouble breathing and was exhausted.

They made a deal with me and Bud saying that they would give Bud the meds we were requesting if I/we agreed to put him on the ventilator. We agreed and he was put on it for a couple days. They again refused to follow the FLCCC protocol. They followed the hospital protocol instead, which likely included remdesivir because they said he needed to go on dialysis because his kidneys were failing. I went into the ICU to see him and he was basically dead. He was cold, pale, terribly swollen, and his vent tube was bloody, as if he had been coughing up blood.

They called me later and told me they did CPR on him two times and he did not recover. They said he died of a cardiac arrest.

This is one example of the chaos created by rigid inflexible protocols. Doctors are not treating the patient, they are just following a protocol. My husband would be alive if the hospital would have followed the FLCCC protocol. My husband would be alive if I was allowed to visit and advocate for him. My husband would be alive if the hospital would have treated him like a human being instead of another statistic. I was repeatedly lied to and no one is being held accountable. Hospital protocols killed my husband and thousands of Covid patients because of rigid inflexibility. Members of the Virginia Department of Health are also responsible because you refused to look at the evidence in support of alternative treatment. The FLCCC protocol and other protocols save lives and you refused to listen to international experts working within the state of Virginia. Your arrogance is shameful.

Good Afternoon State Health Commissioner & Board of Health Members,

My name is Doris Knick. As a member of the Virginia Medical Freedom Alliance (VAMFA), I request that the State Health Commissioner and each of you Board members participate in the Oct. 1st Open Public Forum hosted by VAMFA. ***It is your opportunity to start restoring scientific integrity and healing Virginians' shattered trust in their medical establishment***

You continue to deny the evidence in the Vaccine Adverse Events Reporting System (VAERS). None of us will ever be okay with the number of deaths and injuries from these Covid Shots. These are real people's lives that have been lost & impacted, not just statistics!

Here's a visual from the [Red Box Summaries on openvaers.com](#) since you don't seem to be aware of VAERS or its 1.4 million COVID vaccine Adverse Event Reports worldwide. (Banner of Injuries)

These Injuries are REAL and HORRIFYING COMMON, not RARE, yet the massive scope of the harm from the COVID injection is not represented in its VDH advertisements, FAQs or in the informed consenting process.

Did you know that more than 60% of the reports in the world are from the U.S.? In the past 2 ½ years, more than 865,000 Americans have filed adverse event reports related to the jab!

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Hello VDH Members and Commissioner Greene.

I'm Tricia Stall, from Mathews County, a retired RN & Virginia Medical Freedom Alliance member advocating for all Virginians in support of Medical Freedom.

I personally lost 3 dear hospitalized friends, 2 in Sentara & one at Riverside, due to improper care, including "standardized Covid care protocols" promulgated by the CDC and NIH. It is heartbreaking to accept that these precious friends died needlessly due to rigid adherence to delayed treatment with novel, risky and expensive patented drugs. Early treatment with safe and inexpensive off-patent medications and nutritional therapies that are proven effective might have avoided hospitalization and death entirely. For example, I & my 90 yo "diabetic" mother contracted Covid in June 25 & responded quickly WITHOUT hospitalization thanks to having ivermectin available at symptom onset.

This is a critical time in Virginia to support Medical Freedom for all Virginians. That includes stopping "public health" bureaucrats, hospital systems and pharmacies from using chilling intimidation and retribution, including loss of licensure or employment, to essentially prohibit doctors from rendering individualized, ethical patient care based on their professional experience. It also chills Pharmacists from actually filling doctor's valid prescriptions. VAMFA supports the unrestricted availability of and access to all preventive and treatment options by all patients and doctors in Virginia. The declaration of a so-called public health "emergency" does not give government the authority to interfere with the private doctor-patient relationship. It does not permit government to violate the fundamental and inalienable human right of personal informed choice about bodily autonomy.

I implore each of you to please participate in or at least attend the Virginia Covid Management Public Forum on Oct 1 from 1-4:00 pm at Life Church, 8378 Atlee Rd., Mechanicsville. It is one way to help fulfill your VDH mission to be responsive to we the people of Virginia.

Thank you.

I'm Susan Franz, a retired nurse, from Williamsburg.

I participated in the June 29 VDH webinar described as an "open forum conversation on COVID-19 therapeutics." It was only after several of us were suddenly dropped from the call for asking questions about Ivermectin and Hydroxychloroquine that we were made aware of a Guidance Document for these webinars which stated only EUA COVID-19 treatments were to be discussed. They also failed to answer multiple questions we asked about safety issues regarding some of the novel drugs.

Dozens of peer-reviewed studies clearly show that aggressive prevention and early outpatient treatment could have prevented at least 75 to 80 percent of the hospitalizations and deaths attributed to COVID. If VDH would enthusiastically promote, or just *permit*, the widespread use of these proven medications there would likely be no need for a vaccine or expensive new investigational drugs, particularly ones that are neither safe nor effective. Why is VDH still aggressively promoting the risky COVID injections when there are far more effective and inexpensive medications that have been used safely for decades in millions of people?

VDH has violated doctors' legal right to prescribe an FDA-approved medication for any reason they deem appropriate in their professional judgment. Why is the Virginia healthcare system intimidating and persecuting doctors with loss of licensure or employment for having a different scientific viewpoint about the best way to treat individual patients?

It appears that a CDC-NIH uni-narrative or protocol controls what VDH is allowed to do or not do. This government tyranny of the experts is endangering the health of Virginians. Despite the CDC insisting that the vaccine is safe and effective, has VDH or this Board done your own critical and independent analysis of the voluminous adverse event information about Virginians that has been collected? Are you aware of the numbers of world class athletes dying on sports fields after being coerced to be injected to keep their jobs? Are you aware that Denmark just discontinued vaccines for anyone under the age of 60 due to their adverse effect profiles? Are you aware of the large and atypical fibrous clot-like formations found in autopsies of vaccinated individuals?

You have been invited to participate in an open public forum on October 1 to discuss the evidence about all treatments for COVID-19. World-renowned Virginians Dr. Robert Malone, the inventor of the mRNA technology, and Dr. Paul Marik will be there to discuss these issues. You should be too. Your participation would help restore our faith that you care about scientific integrity, truth and the health of Virginians more than merely complying with the CDC and NIH.

Imtiyaz Ahmad Khan (22), youth Cricket player from Pulwama district of Kashmir collapsed due to a cardiac

arrest and died while playing cricket in Anantnag district of Kashmir. He was rushed to hospital but declared DoA.

[News Story](#) [News Story2](#)

20. 02/09/2022 Spain

Cristhian Stuani (35), Uruguayan footballer who plays in Spain for Girona suffered from benign cardiac arrhythmia and is "resting for a month." [News Story](#) [News Story2](#)

21. 01/09/2022 Scotland Dead

Mike Wilson (46), Triathlete and super-fit doctor suffered a cardiac arrest and died while swimming in a loch in Scotland, while training for a triathlon. [News Story](#)

August 2022

22. 31/08/2022 Texas, USA

Zaidyn Ward (14), high school American football running back collapsed due to a cardiac arrest during a game after scoring a touchdown. Lacey Steel, a Monterey trainer resuscitated him. His heart actually stopped twice then he had a seizure and was rushed to the Fort Worth hospital. He is scheduled for open heart surgery. [News Story](#) [News Story2](#)

23. 30/08/2022 Ontario, Canada Dead

Eli Palfreyman (20), Ayr Centennials Junior Ice Hockey captain collapsed and died during a pre-season tournament match. [News Story](#) [News Story2](#) [News Story3](#)

24. 30/08/2022 Ohio, USA Dead

Kooper McCabe (17), high school student American

Footballer and wrestler died unexpectedly. [News Story](#)
[News Story2](#)

25. 28/08/2022 England Dead

Ray McGloin (64), Tri-Rivington triathlete died suddenly. He has competed in 7 Ironman events, 20 half Ironman events, as well as ultra-distance swimming, running and cycling events, and started his own triathlon club to coach others.
[News Story](#) [News Story2](#)

26. 28/08/2022 Germany Dead

Rolf Felber (67), Triathlete collapsed shortly after the start of the swim (1st leg of the event), in an Ironman triathlon in Germany. He was quickly resuscitated and taken to hospital, but he died on the way. [News Story](#) [News Story2](#)

27. 27/08/2022 New Hampshire, USA Dead

Unnamed (46), Hiker from Quebec, Canada, hiking on Mt. Washington in New Hampshire, USA, collapsed as he reached the summit and died despite assistance from medical personnel on the spot. [News Story](#) [News Story2](#)

28. 25/08/2022 South Africa Dead

Phakamile Ntshiza (47), Adventist Athletic Club Runner collapsed due to a cardiac arrest and died around the half-way mark in the Comrades Marathon in South Africa. Mzameleni Mthembu also died and 72 other runners were hospitalized. [News Story](#) [News Story2](#) [News Story3](#)

29. 25/08/2022 South Africa Dead

Mzameleni Mthembu (43), experienced ultra-marathon runner collapsed due to a cardiac arrest and died 12km from the end of the 90km Comrades Marathon in South Africa. Phakamile Ntshiza also died and 72 other runners were hospitalized. [News Story](#) [News Story2](#)

30. 25/08/2022 Dorn, Dead

30. 23/08/2022 Peru Dead

Bernardino Soncco Hanco (40), Kenamari Football

collapsed on the pitch due to a cardiac arrest and died in the “Copa Nuñoa” football tournament. [News Story](#)

31. 25/08/2022 California, USA Dead

Carter Stone (15), American Footballer high school student went into hospital for a routine shoulder operation, but he died unexpectedly. Doctors revealed that Carter “had a tumour on his heart likely formed by undiagnosed T-cell leukaemia and the family was not aware of it.” [News Story](#)
[News Story2](#)

32. 25/08/2022 Massachusetts, USA Dead

Kieron Smith (51), Wrestling coach at a high school in Massachusetts for over 20 years died suddenly. [News Story](#)

33. 23/08/2022 Scotland Dead

Rab Wardell (37), cyclist who won the elite men’s title at the Scottish MTB XC Championships. Just a few days later, he died in his sleep of a “cardiac arrest.” [News Story](#) [News Story2](#)

34. 23/08/2022 North Carolina, USA

Grigor Dimitrov (31), Tennis player had been comfortably winning a match in the Winston-Salem Open tennis tournament but suddenly retired after he “experienced dizziness and shortness of breath.” [News Story](#) [News Story2](#)

35. 23/08/2022 Spain Dead

Dani Gómez (18), Peñas Huesca Basketball Club Basketball player died suddenly and unexpectedly. [News Story](#) [News Story2](#)

36. 22/08/2022 Portugal Dead
Mário Cunha (31), former C.D. Cerveira Footballer retired in 2020, died of “unknown causes.” [News Story](#)
37. 22/08/2022 England Dead
Ben Benn (30), Halifax RUFC Rugby Union (and other clubs) player died suddenly. [News Story](#) [News Story2](#)
38. 21/08/2022 Argentina
Manuela Bugueno (30), female amateur Runner and Chilean doctor collapsed with a cardiac arrest close to the finish line of the Buenos Aires half-marathon in Argentina. She received immediate attention and was resuscitated, then transferred to hospital. [News Story](#) [News Story2](#)
39. 20/08/2022 Switzerland Dead
Unnamed (36), Cyclist collapsed and died whilst competing in the Grand Raid mountain bike race in Valais, Switzerland. Resuscitation attempts failed. [News Story](#) [News Story2](#)
40. 20/08/2022 Norway Dead
Audun Heimdal (25), World elite Orienteerer and ski orienteerer died with cancer. [News Story](#) [News Story2](#)
41. 19/08/2022 California, USA Dead
Unnamed (19), Hiker was hiking in California with a large group, including his father. He went for a swim on his own in a lake and was found dead. When a helicopter arrived, the young man had already died. [News Story](#) [News Story2](#)
42. 19/08/2022 Italy Dead
Filippo Dalla Venezia (18), Mogliano Rugby Rugby Union U19 player was found lifeless at home. [News Story](#)
43. 19/08/2022 Germany

Malaika Mihambo (28), was Olympic long jump champion in Tokyo 2020. In August 2022, she competed in European Championships in Germany where she won silver, but now suffers from circulatory problems and shortness of breath. [News Story](#). [News Story2](#)

44. 19/08/2022 Virginia, USA Dead

Riddick Parker (49), former Seattle Seahawks, New England Patriots and Baltimore Ravens American Football player died unexpectedly while riding his bicycle. [News Story](#). [News Story2](#)

45. 19/08/2022 England Dead

Stewart Bondi (69), very keen runner from Devon, England and a founder of a tough marathon on the South West Coast Path. His nickname was "Rambo." His body was found by the cliffs on the coast after an apparent fall. [News Story](#). [News Story2](#)

46. 19/08/2022 Brazil Dead

Pietra Medeiros (20), Taboao Magnus SP Futsal player died in hospital due to complications from autoimmune hepatitis. [News Story](#). [News Story2](#)

47. 19/08/2022 Georgia, USA

Yordan Alvarez (25), Houston Astros Baseballer was playing in Georgia against the Atlanta Braves when he was short of breath. He was taken to hospital for treatment. [News Story](#). [News Story2](#)

48. 19/08/2021 Indiana, USA Dead

Devyn Williams (18), Volleyball playing student at Indiana University died unexpectedly. The cause of death "was found to be related to an asthma attack." Devyn was vaccinated with the Pfizer vaccine in April 2021. [News Story](#). [News Story2](#). [News Story3](#)

49. 18/08/2022 Florida, USA Dead

Luke Knox (22), Florida International University American Football player died suddenly. [News Story](#) [News Story2](#) [News Story3](#)

50. 17/08/2022 Germany Dead

Unnamed (Age), Footballer collapsed and died after taking part in a friendly football match. [News Story](#) [News Story2](#)

51. 17/08/2022 Missouri, USA

Davis Dwight (17), Baseballer and high school student collapsed during baseball practice from cardiac arrest. Coaches revived him with CPR. [News Story](#) [News Story2](#)

52. 17/08/2022 Peru Dead

Michele Gironella (25), Italian Footballer was on holiday in Peru where he collapsed due to a cardiac arrest while playing in a local football match. He never recovered. [News Story](#) [News Story2](#)

53. 16/08/2022 Belgium Dead

Kevin Revillod (26), Standard FC Onoz Footballer collapsed from a cardiac arrest and died during training despite resuscitation attempts. [News Story](#) [News Story2](#)

54. 16/08/2022 Austria

Katrin Beierl (29), very successful bobsleigh pilot who won the overall two-man bobsleigh World Cup rankings in 2020/21 season, the first Austrian ever, suffered a stroke while on holiday and spent time in hospital in Vienna, Austria. [News Story](#) [News Story2](#)

55. 16/08/2022 Germany

Tim Nowak (27), decathlete abandoned the 2022 European Championships in Germany due to serious circulatory

problems. He was unable to compete in the fifth discipline over 400 meters. “Unfortunately, my competition ends in the hospital. After the high jump I collapsed for unknown reasons. I would have given anything to finish this competition.” [News Story](#)

56. 15/08/2022 Romania Dead

Alessia Maria Raiciu (18), Agronomia Bucharest Basketball and national team player died suddenly on her 18th birthday. [News Story](#)

57. 15/08/2022 Michigan, USA Dead

Tyler Edwards (27), high school basketball coach died unexpectedly of a suspected cardiac arrest. [News Story](#)

58. 14/08/2022 Northern Ireland Dead

Molly White (Age), St James’ Swifts Footballer died suddenly. [News Story](#) [News Story2](#)

59. 14/08/2022 Italy Dead

Giovanni Malvestio (48), Cyclist suffered a cardiac arrest while cycling, was seen staggering to the ground. Bystanders provided first aid, but he died before an ambulance arrived. [News Story](#)

60. 13/08/2022 England

Pablo Martinez (21), Chippenham Town FC Footballer collapsed on the pitch in a match against Chelmsford. His condition was later said to have stabilised. Match abandoned. [News Story](#) [News Story2](#)

61. 11/08/2022 French Guiana Dead

Djouby Laura (20), USC de Roura Footballer had a cardiac arrest after a training session and could not be revived. [News Story](#)

62. 11/08/2022 Northern Ireland Dead

Dominic Oscar (19), St Michael's ABC Boxer died suddenly. [News Story](#). [News Story2](#)

63. 10/08/2022 Illinois, USA Dead

Avery Gilbert (18), Trinity International University American Football freshman at Trinity International University had only been on campus for 3 days, when was found collapsed and died later in hospital. [News Story](#). [News Story2](#)

64. 10/08/2022 Brazil Dead

Maurice Miranda (40), former São Paulo Football player suffered a cardiac arrest at home. He was taken to hospital but died. [News Story](#). [News Story2](#)

65. 10/08/2022 Maharashtra, India Dead

Sameer Jivangikar (Age), Runner and real estate agent but also a keen runner collapsed and died due to a sudden cardiac arrest while driving home after a training session. [News Story](#). [News Story2](#)

66. 10/08/2022 Argentina Dead

Aleli (9), Pioneras FIF Football goalkeeper for a children's football team in Argentina. She died suddenly. [News Story](#)

67. 10/08/2022 North Carolina, USA

Sam Hartman (22), Wake Forest University Athletics American Football we will miss an 'extended period of time' due to a "mystery condition." [News Story](#). [News Story2](#)

68. 10/08/2022 Germany Dead

Unnamed (28), Water Skier died while water skiing. "Police believe the cause of death was medical." [News Story](#)

69. 09/08/2022 South Africa

Rick Hendriks (12), Rugby Union player suffered a cardiac arrest on 9th August 2022, on a rugby field in Pretoria,

South Africa. He was airlifted to hospital. Four days later, it was reported that he regained consciousness. [News Story](#)

70. 09/08/2022 Telangana, India Dead

Thushar Aamra Bedwa (32), Cricket player and software employee in Hitec City, Telangana, India was playing cricket with friends in the evening when he complained of chest pain and collapsed. He was taken to hospital but he died. Doctors suspect a cardiac arrest. [News Story](#)

71. 09/08/2022 Virginia, USA Dead

Caitlyn Gable (20), Bluefield University Rams Softball player died in her sleep. [News Story](#)

72. 09/08/2022 Belgium Dead

Claude Gomez (53), former R. E. Virton Footballer in the 1980's and 1990's suffered a cardiac arrest on a bike ride with friends, and died. [News Story](#) [News Story2](#)

73. 09/08/2022 Belgium

Tim Wellens (31), Lotto Soudal professional cyclist has ended racing activities due to heart problems. "I felt disturbing palpitations. Not only in the race, but also in training and at rest. My cardiologist found this far from reassuring." [News Story](#)

74. 08/08/2022 Belgium Dead

Jurgen Groothaerd (44), KVV Zelzate Football youth coach suffered a cerebral thrombosis and died while cycling to work. [News Story](#)

75. 07/08/2022 Malaysia Dead

Marc Marie (52), Hiker was on holiday in Malaysia and hiking with friends in the mountains, when he suddenly collapsed. A rescue team sent to the scene immediately performed CPR but he died. [News Story](#)

76. 07/08/2022 California, USA Dead
Braden Fahey (12), middle school American Footballer lost consciousness after football practice at Clayton Valley Charter High School in California. Recorded as a “severe medical emergency.” He was rushed to hospital on Friday evening and died on Sunday. [News Story](#) [News Story2](#) [News Story3](#) [News Story4](#)
77. 07/08/2022 California, USA Dead
Brian Reynolds (50), Swimmer, golfer, and former American football youth team coach trained for months to be ready for a 1½ mile swimming event off the California coast. He was said to be in “great shape” for the swim, but during the event he “suffered an unknown medical incident” and died. [News Story](#)
78. 07/08/2022 France Dead
Laura Domecq (21), French AS Monaco women’s footballer died suddenly. [News Story](#) [News Story2](#) [News Story3](#)
79. 06/08/2022 Chile Dead
Cristian Cáceres (38), Union Cordillera Football goalkeeper. Suffered a cardiac arrest in the second half of a match and died on the way to hospital. [News Story](#) [News Story2](#)
80. 06/08/2022 Connecticut, USA Dead
Djemayley Vernet (16), American Football player died unexpectedly after a series of seizures. [News Story](#)
81. 05/08/2022 Germany Dead
Marco Memenga (38), FC Brookmerland Football player scored a goal and then died during the cup match with BW Filsum in Germany. [News Story](#)
82. 05/08/2022 Ireland Dead

Dillon Quirke (24), Clonoulty Rossmore Hurling player collapsed in a match against Kilruane McDonaghs. He

received instant medical attention on the pitch, then transferred by ambulance to hospital where he later died.

[News Story](#) [News Story2](#)

83. 05/08/2022 Kentucky, USA Dead

Aaron Crawford (18), Knott County Central HS American Football player and wrestler. He had a cardiac arrest and died. [News Story](#) [News Story2](#) [News Story3](#)

84. 05/08/2022 Italy Dead

Teun Elbers (19), Dutch SV TOP Footballer was on a family holiday in Italy, collapsed and died while on a walk. His body was found by a passer-by. [News Story](#) [News Story2](#) [News Story3](#)

85. 04/08/2022 New Zealand Dead

Unnamed school girl (12), Runner “collapsed while running in an Auckland (New Zealand) park. She died in hospital the same evening. [News Story](#)

86. 03/08/2022 Botswana Dead

Unnamed girl (15), Mexican Girls Football player collapsed during training and died at the hospital. [News Story](#)

87. 02/08/2022 Florida, USA Dead

Lars Tate (56), former Georgia Bulldogs American Football, and later for Tampa Bay Buccaneers and Chicago Bears. He had very recently been diagnosed with cancer and died suddenly before he was due to begin chemotherapy. [News Story](#) [News Story2](#)

88. 02/08/2022 Ireland Dead

Frank O'Dwyer (Age), Cyclist and accident & emergency (A&E) consultant at a hospital in Kilkenny, Ireland. During

the Tour de Kilkenny. He had an "incident" during the event and died a few days later. [News Story](#) [News Story2](#)

89. 02/08/2022 Arizona, USA Dead

Cesar Vazquez (17), Peoria Centennial High School American Footballer died over night. [News Story](#) [News Story2](#)

90. 02/08/2022 Georgia, USA Dead

Tony Jones (Age), Lubbock Christian University Basketball player died unexpectedly. [News Story](#) [News Story2](#) [News Story3](#)

91. 01/08/2022 Germany Dead

Mario Pirner (48), Esslingen Handball player died unexpectedly. [News Story](#)

92. 01/08/2022 Mississippi, USA Dead

Phillip Laster (17), American Footballer and high school student collapsed while working out with the football team, and died at the local hospital. [News Story](#)

July 2022

93. 31/07/2022 Croatia Dead

Mato Matic (20), HNK Mladost Football goalkeeper for. Played a match on Saturday and died on Sunday. No further details available. [News Story](#) [News Story2](#)

94. 31/07/2022 Italy Dead

Giuseppe Fortunato (44), Cyclist and master watchmaker who had a passion for cycling. Died suddenly in his sleep. [News Story](#) [News Story2](#)

95. 31/07/2022 France Dead

Anthony Janiec (37), Lion Truck Racing champion

collapsed due to a cardiac arrest and died. [News Story](#)
[News Story2](#)

96. 31/07/2022 Wyoming, USA Dead
Jay Collins (41), former Idaho Stampede Basketballer who played for several clubs before moving into coaching. Died suddenly overnight. [News Story](#) [News Story2](#)
97. 31/07/2022 New York, New York Dead
Param Dhaliwal (23), former West Kelowna Warriors Ice Hockey player was found Dead in a hotel in New York. [News Story](#) [News Story2](#)
98. 31/07/2022 Wales Dead
Gareth Lewis (42), Rugby Union coach. He coached Caerphilly Rugby Club and at schools. He also served in various roles at the Welsh Rugby Union. He died “following a short illness.” [News Story](#)
99. 31/07/2022 Germany Dead
Sabine Oberdieck (55), Dressage star was a lawyer who rode and trained dressage horses in Germany very successfully. She died unexpectedly. [News Story](#) [News Story2](#)
100. 30/07/2022 Nova Scotia, Canada
Satchel Tate (12), Hammonds Plains Baseballer was playing in an U-13 baseball tournament for his team Hammonds Plains, in Canada. During the match he suffered a stroke. [News Story](#) [News Story2](#)
101. 29/07/2022 Victoria, Australia Dead
Rohan Cosgriff (17), Waubra Football Netball Club Footballer. The student with a keen interest in playing football and looking after race horses died suddenly. [News Story](#) [News Story2](#)

102. 28/07/2022 Ontario, Canada Dead
Candace Nayman (27), Triathlete and medical doctor
collapsed during the swim section of a triathlon and died a few days later. She is the fifth doctor in the Greater Toronto Area (GTA) to die unexpectedly in July 2022. [News Story](#) [News Story2](#)
103. 28/07/2022 Germany Dead
Rok Kosir (46), successful judoka in his native Slovenia and in Germany where he took up coaching. He died suddenly and unexpectedly. [News Story](#) [News Story2](#)
104. 27/07/2022 Iowa, USA Dead
Lily Ernst (20), UNI Panthers Swimmer and student died suddenly. No further details available. [News Story](#) [News Story2](#) [News Story3](#)
105. 27/07/2022 Croatia Dead
Maro Perak (39), Mixed Martial Arts exponent, the “world heavyweight and light heavyweight champion.” He died suddenly. [News Story](#) [News Story2](#) [News Story3](#)
106. 24/07/2022 Wisconsin, USA Dead
Derek Gray (20), UW-Whitewater Basketballer and psychology student. collapsed due to a cardiac arrest during a training session and died suddenly. Suspected blood clot. No further information available. [News Story](#) [News Story2](#) [News Story3](#)
107. 23/07/2022 Italy Dead
Andrea Musiu (20), Footballer was playing a football game with friends in his home town of Cagliari, Italy. He collapsed at the end of the game, received immediate attention from spectators and then ambulance staff, but died. [News Story](#) [News Story2](#)

108. 22/07/2022 Pennsylvania, USA Dead
Jerry Ward (46), well-known bodybuilder who also judged contests and ran his own training company. Died unexpectedly in bed after complaining of “rib pain.” [News Story](#) [News Story2](#)
109. 21/07/2022 Australia Dead
Justin Crawford (45), Hawthorn Australian Rules Footballer died suddenly. Further details awaited. [News Story](#)
110. 21/07/2022 South Carolina, USA Dead
Phil Petty (43), former University of South Carolina American Footballer from 1998-2001. Died after a short illness. [News Story](#) [News Story2](#)
111. 18/07/2022 France
Jonathan Castroviejo (35), Ineos Grenadiers Cyclist, one of five to quit the Tour de France due to breathing problems. Victor Lafay said “Castroviejo can’t breathe either.” [News Story](#)
112. 18/07/2022 France
Pierre Rolland (35), B&B Hotels p/b KTM Cyclist, one of five to quit the Tour de France due to breathing problems. Victor Lafay said Rolland had “no strength, and then impossible to breathe.” [News Story](#)
113. 18/07/2022 France
Oliver Naesen (31), AG2R Citroën Cyclist, one of five out of the Tour de France due to breathing problems. Victor Lafay reported Naesen had “no strength, and then impossible to breathe.” [News Story](#)
114. 18/07/2022 British Columbia, Canada
Doug Eyolfson (59), Runner and emergency physician in Manitoba, Canada. Suddenly collapsed with a cardiac

arrest while marathon training in the park while visiting Vancouver. On 20th July 2022 he confirmed on Twitter that he was booked for a heart by-pass operation. In a May 11th 2021 Twitter post he treated his covid vaccination light-heartedly, saying "I think the microchip is faulty. I'm only getting basic cable." A CBC News article reported about the former MP: "Liberal Eyolfson and New Democrat Chung-Mowat support mandatory vaccines." [News Story](#) [News Story2](#) [News Story3](#)

115. 17/07/2022 Wales

Ryan Jones (41), Rugby Union captain of the Wales team. Diagnosed with early-onset dementia aged 41. [News Story](#)

116. 17/07/2022 France

Alexis Renard (23), Cofidis team Cyclist. Suffered sudden onset of a heart rhythm disorder at the Tour de France. One of five to pull out of the tour. Set to have surgery. "During exercise, I have a heart rate that increases like everyone else," Renard said. "But when I stop cycling, the intensity is always the same." [News Story](#)

117. 16/07/2022 Ontario, Canada Dead

Paul Hannam (50's), Runner, medical doctor, Olympic sailor and marathon runner. Was Chief of Emergency Medicine and Program Medical Director at North York General Hospital (NYGH). Collapsed and died unexpectedly while out for a run. [News Story](#) [News Story2](#)

118. 15/07/2022 France

Victor Lafay (26), Cofidis Cyclist taking part in the Tour De France. One of five to pull out of the tour. "I'm having a very hard time breathing. I feel like I don't have enough oxygen, pain everywhere..." [News Story](#) [News Story2](#)

119. 15/07/2022 Russia Dead

119. 15/07/2022 Russia Dead

Aleksandr Kozlov (29), Footballer described as one of the top football talents of a generation. He played for the Russian youth national team and played his first Champions League game at the age of 17. Suffered a blood clot during a training session and died. [News Story](#)

120. 15/07/2022 Georgia, USA Dead

Paul Duncan (35), Denver Broncos American Footballer collapsed due to a cardiac arrest after going for a run in his neighbourhood. He died. [News Story](#) [News Story2](#)

121. 15/07/2022 New Jersey, USA Dead

Anthony Joseph Zeoli (16), Skateboarder & Snowboarder and high school student. Died unexpectedly. [News Story](#)

122. 15/07/2022 New South Wales, Australia Dead

Carl Robinson (41), Surfer and realestate agent He suddenly collapsed in the sea during a morning surf. Surfers and paramedics performed CPR but were unable to save him. [News Story](#)

123. 14/07/2022 Western Australia, Australia Dead

Unnamed (50's), Wind Surfer had been wind surfing off the coast of Shoal water, Western Australia. Found Dead in the sea. [News Story](#) [News Story2](#)

124. 13/07/2022 Mississippi, USA Dead

Rashard Anderson (45), former Carolina Panthers American Footballer was first-round pick in 2000, played in 27 games with nine starts over two seasons with the team. Died suddenly. [News Story](#) [News Story2](#)

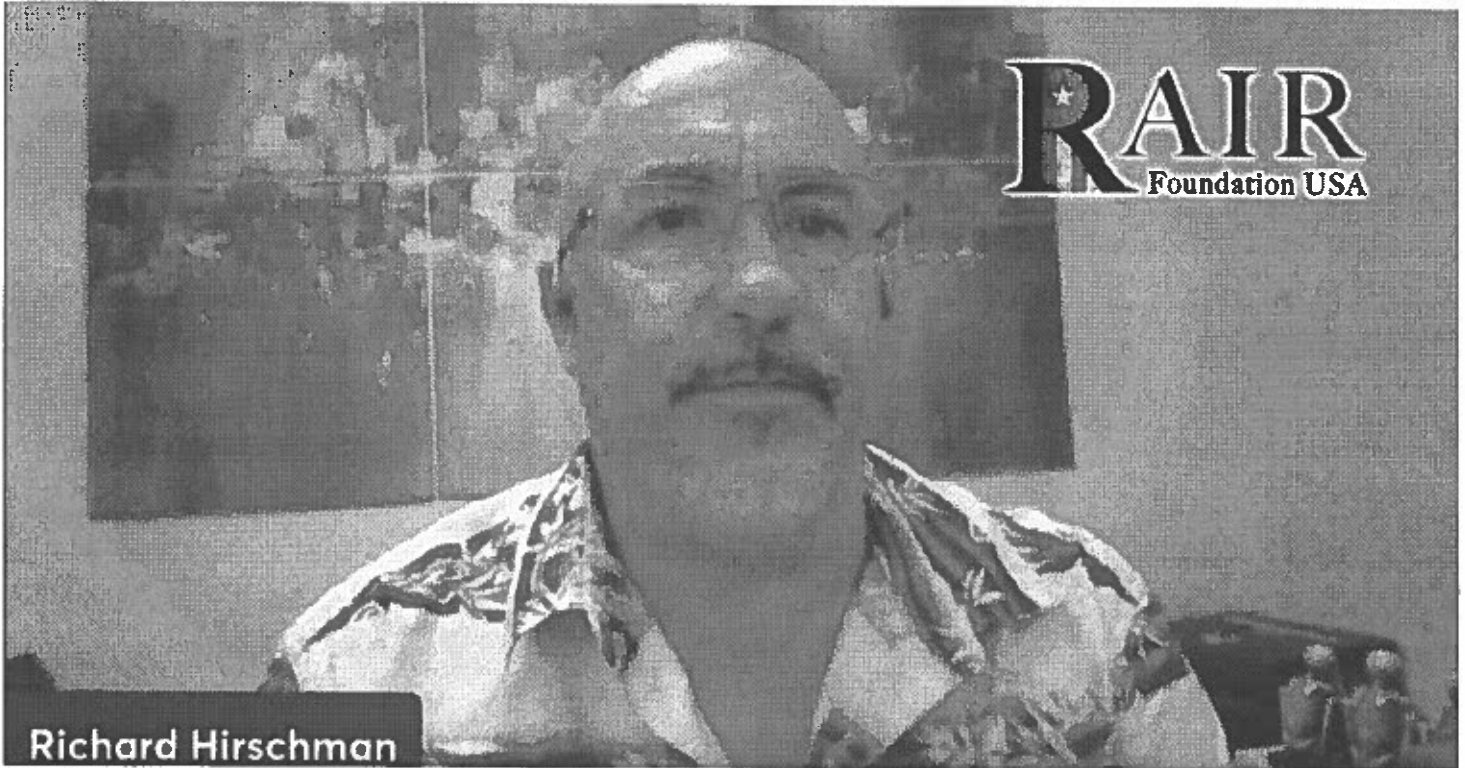
125. 13/07/2022 Argentina Dead

Néstor Flores (37), amateur Footballer and police inspector in the town of Rivadavia. After the match, he went home,

Embalmer Sounds Alarm: Massive Increase in Strange Blood Clots and Cancer, 'It's not Normal, It's Drastic' (Exclusive Interview)



Miranda Sellick September 16, 2022 29 comments 5 min read



“I’ve talked to so many other embalmers, and we are all seeing the same thing, but governments don’t want to look at it.” – Richard Hirschman

In an exclusive interview with RAIR Foundation USA, an Alabama-based embalmer and licensed funeral director revealed a massive increase in strange blood clots found in the bodies that he is now embalming.

Richard Hirschman, who has been an embalmer since 2001, has noticed “a change of condition of bodies since the roll-out of mRNA vaccines.” These changes include the huge increase in people with blood clots, the strange nature of these blood clots, and patients who have died of cancer without any of the tell-tale signs, such as hair loss and emaciation. “Unfortunately, there is a new normal,” he says.

Hirschman has embalmed thousands of bodies during the course of his career. Last year, he handled over 600 himself. So he knows the signs to look for, and he knows what blood looks like. “In all my years of embalming, we would run across clots from time to time,” he says, “but since May last year, something about the blood has changed. It’s not normal. It’s drastic.”

When Hirschman first started seeing anomalies, he thought it strange, “but when you see the same thing over and over, you start to realize that something’s not right.”

Hirschman and many of his colleagues in the industry noticed an increase in clotting during the pandemic, “but it wasn’t until the roll-out of the vaccine that these really unusual fibrous structures started appearing.”

He describes a normal blood clot as having a texture like grape jelly or jam. If you were to pick it up, it would likely disintegrate in your fingers. Before 2021, blood clots would appear in between five and 10 percent of bodies. These days, says Hirschman, those numbers are more like 85 percent. "The majority of bodies I embalm are clotted," he says. "Out of 358 bodies this year, only around 60 were not clotted, and a half of those were heavily clotted. Prior to last year, it wasn't like that. Nothing like what we see now."

What is more, these clots are unlike anything he's ever seen before. He describes them as "a white fibrous structure, like calamari, a rubber band or spaghetti. Even the small ones are unusual looking, like worms. They resemble a small parasite." Typically, blood clots come out of veins during the embalming process, very, very rarely out of an artery. However, Hirschman recently took one out of an artery 33 inches long. "Normally, I wouldn't be able to pull a clot of that length without it falling apart," he explains. "It's the white, fibrous length that's unusual. I cannot possibly imagine that being inside a healthy person."

Hirschman suspects the vaccine is causing these clots. "The reason why I feel the vaccine is related is that I have found these strange structures inside of people who supposedly never had covid but had been vaccinated."

Looking back, Hirschman sees a date correlation. "It was January 2021 when they really started pushing the vaccines," he recalls. "I have never been so busy in all my life. I was running into clots like crazy: even in February and March, the clotting was huge. Initially, it was in elderly people, and those were the first they tried to protect."

Typically, Hirschman's patients have been in their late 60s, 70s, and 80s. But he's seeing increasingly younger bodies, "some in their 20s, too," he says, but just not as many as elsewhere because Alabama has a low vaccination rate amongst young people, according to the embalmer. "I know they are dying, though; I'm hearing about it everywhere," he says. "But it seems like in Alabama, people are waking up."

Not so for 17-year-old Ohio football player Kaden Clymer, who recently had six feet of strange clots removed from his legs. Mainstream media continues to deny any link between these clots and the covid-19 vaccine, even though Clymer was diagnosed with inferior vena cava atresia, a disease that typically only affects men in their 30s.

Hirschman has also noticed a change in the bodies he is receiving who have died from cancer. Typically, these people have tumors, hair loss and are emaciated due to their struggle with the disease and harsh treatments. "Lately, had I not been told these people had cancer, I'd not have known. People are getting cancers and are dead before they know it," he says. "They don't live long enough to go through the stages." His observations jive precisely with reports from a senior Swedish physician and researcher, Dr. Ute Kruger, who recently expressed alarm at the extraordinary rates of aggressive cancers she is now seeing.

Hirschman would like to understand what's going on. He's sent three dozen clots out for analysis, some of them to Mike Adams, who runs an ISO-17025 accredited lab in Texas. Adams has compared these clots to the blood of unvaccinated individuals and has concluded that these are not blood clots because they lack iron, potassium, magnesium, and zinc.

"We have tested one of the clots from embalmer Richard Hirschman via ICP-MS. Also tested side by side, live human blood from an unvaccinated person," Adams told The Epoch Times.

But nobody knows quite what these things are, nor how they are caused. "I've talked to so many other embalmers, and we are all seeing the same thing," says Hirschman. "But governments don't want to look at it."

EXCLUSIVE: Fibrous clots harvested from dead bodies of vaccinated individuals found to contain higher concentrations of electrically conductive elements – Mike Adams tells Dean Ryan

Thursday, August 25, 2022 by: Belle Carter

Tags: Aluminum, badhealth, badmedicine, badscience, Big Pharma, biological weapon, Blood clots, COVID, Dangerous Medicine, Dean Ryan, fibrous clots, lab tests, metals, Mike Adams, pandemic, pharmaceutical fraud, real investigations, Richard Hirschman, Steve Kirsch, tin, Vaccine deaths, vaccines

This article may contain statements that reflect the opinion of the author

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(Natural News) The Health Ranger Mike Adams recently released the ICP-MS elemental analysis of the fibrous clots pulled out of the cadavers by whistleblower embalmer Richard Hirschman. The lab results confirmed the gooey blobs contained elements that are electrically conductive.

“The clots are almost entirely lacking the normal biomarkers of human life. Instead, it has higher concentrations of things associated with circuitry,” Adams said during a recent exclusive interview at “World at War” with Dean Ryan.

These self-assembling clots were pulled out of the bodies of dead people who have died suddenly in the weeks or months after receiving one or more Wuhan coronavirus (COVID-19) vaccinations. As per Adams’ report, these clots are harvesting electrically conductive elements out of the blood such as tin, aluminum and sodium.

“Tin has been harvested at 588 percent higher concentrations than what’s found in human blood. Aluminum is being found about 35 to 40 percent or higher and sodium is about 50 percent or higher in these clots,” he said.

Tin is used as a solder alloy in electrical circuits and circuit repair, whereas aluminum is the alternative to copper for electrical conductive wires in commercial residential wiring.

The Health Ranger added that blood samples from a healthy living person would include iron, potassium, magnesium, zinc, chlorine, phosphorus and so on. However, the post-vaccine clot sample only contains 4.4 percent of iron that would be seen in human blood, which confirmed that the mass is not a blood clot. Also, there is a near-total lack of potassium in the sample and it contains less than 0.6 percent of the potassium and magnesium compared to human blood.

“What we did is an elemental analysis using an inspected, audited and ISO-accredited laboratory for the elements. However, we did not conduct a radio frequency analysis, that could detect receiving or sending signals. That would have to be done by some other lab that specializes in these kinds of

technologies,” Adams said in response to Ryan’s inquiry about whether the electrically conductive elements could send or receive electromagnetic fields.

“But the question is leading in the right direction, that’s just not something that we can provide,” he added.

Ryan went on to say that people in Sweden dropped like flies when its 5G, the fifth generation of wireless technology, went up. “They were not getting any help in hospitals and so forth. We see strange behavior and people just mowing down. We’re just trying to connect the dots because this is some science fiction that is starting to become a science fact here,” Ryan said.

According to telephone companies, this technological advancement can provide higher speed, lower latency and one of the most robust technologies the world has ever seen. However, this development has been criticized to have environmental and health hazards, such as the elevated risk of brain cancer and acoustic neuroma.

As the clots have electrically conductive elements, Adams pointed to what happened to Dr. Charles Lieber, who was convicted by the Department of Justice for sharing secrets with communist China.

“His patents are all about nanocircuitry and bio interfaces at the cellular and subcellular level. So if you read his patents, it’s all self-assembling nanocircuits inside human structures. So, follow the yellow brick road and see where that leads,” said Adams, also a best-selling author, environmental scientist and multi-awarded journalist and publisher.

COVID-19 vaccines kill thousands of people daily

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“A rigorous analysis based on excess death data included anywhere from five to 12 million fatalities have likely occurred worldwide. And with these self-assembling clots continuing to gain size and mass inside the bodies of those who have received the mRNA experimental medicine injections, it is certain that many people who have not yet died from the vaccines will experience death in the coming months and years,” Adams said.

He likened the ones who have received the mRNA injections to walking time bombs. However, he said there’s a majority chance that if people stop taking them, they may be spared.

“If you took the vaccine, there’s a big chance that if you stop taking them, you may not die. There’s a slight chance that you are going to die if you got the wrong lot. The bottom line is to stop taking these shots. If you took it, pray to God that you didn’t get one of the lots that have these clots,” he said.

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COMMONWEALTH of VIRGINIA

Colin M. Greene, MD, MPH
State Health Commissioner

Department of Health
P O BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

MEMORANDUM

DATE: November 7, 2022

TO: Virginia State Board of Health

FROM: *Julie Henderson, Director; Office of Environmental Health Services*

SUBJECT: *(Fast Track Action - Amend Rules and Regulations Governing Campgrounds (12VAC5-450) Amend Regulations: Temporary Campground Water Quality/Handwashing Stations)*

Enclosed for your review is a Fast Track Action to amend the Rules and Regulations Governing Campgrounds (12VAC5-450) to clarify standards for water storage and distribution at temporary campgrounds. Temporary campgrounds are those associated with temporary events, such as fairs, festivals, or music concerts. These events often do not have permanent infrastructure, and thus basic sanitation needs are met through the use of portable toilets, and often, portable hand washing sinks. The current regulations provide that any tanks, hoses, or appurtenances that are used to distribute water shall be of “food-grade construction”; current industry design of the majority of portable hand washing sinks do not meet this requirement. The proposed regulatory amendment will exempt portable handwashing sinks from being of food grade construction, require water used in handwashing sinks to maintain certain water quality standards, and have signage informing the public that water hand washing stations is not for human consumption.

The Virginia Department of Health recommends that the Board act pursuant to its authority provided in § 35.1-11 of the Code of Virginia, and approve the Fast Track actions. Should the Board of Health approve the Fast Track action, it will be submitted for Executive Branch review. Following Executive Branch review and approval, the proposed regulations will be published in the Virginia Register of Regulations and on the Virginia Regulatory Town Hall website and a 30 day public comment period will begin. Fifteen days after the close of the public comment period the Regulations will become effective.



townhall.virginia.gov

Fast-Track Regulation Agency Background Document

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC5-450-187
VAC Chapter title(s)	Rules and Regulations for Campgrounds
Action title	Fast-track Amendments: Temporary Campground Water Quality/hand washing Sinks
Date this document prepared	Oct 25, 2022

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

The Virginia Department of Health (VDH) seeks to amend the Rules and Regulations Governing Campgrounds (12VAC5-450; hereinafter referred to as 'Regulations') to clarify standards for water storage and distribution at temporary campgrounds. Temporary campgrounds are those associated with temporary events, such as fairs, festivals, or music concerts. These events often do not have permanent infrastructure, and thus basic sanitation needs are met through the use of portable toilets, and often, portable hand washing sinks.

The Regulations provide that any tanks, hoses, or appurtenances that are used to distribute water shall be of food-grade construction. This requirement extends to any tanks or appurtenances providing water, including those associated with portable hand washing sinks. Current industry design of the majority of portable hand washing sinks do not meet this requirement through standard materials and design. As a result, the current regulation may discourage the use of portable hand washing sinks, and thus hand

washing, at temporary campgrounds. As hand washing is a primary component to reducing communicable disease, it is not the goal of the regulation to prohibit or discourage hand washing. VDH proposes to amend the Regulations to allow for the use of equipment that is more in line with industry standard, less burdensome to regulated entities, while protecting the public through signage stating that water in portable handwashing sinks is not for human consumption.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

"Board" or "State Board" means the State Board of Health.

"VRRM" means the Virginia Register of Regulations Form, Style and Procedure Manual for Publication of Virginia Regulations (April 2014).

Statement of Final Agency Action

Provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) the name of the agency taking the action; and 3) the title of the regulation.

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in the ORM procedures, "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

Consistent with Virginia Code § 2.2-4012.1, also explain why this rulemaking is expected to be noncontroversial and therefore appropriate for the fast-track rulemaking process.

The amendment was prompted by industry stakeholders notifying local health department staff that the food grade equipment requirement for portable hand washing sinks was unattainable, as many portable hand washing sinks did not certify equipment to meet such requirements.

This proposed rulemaking is expected to be noncontroversial because it relaxes the requirements related to water in portable handwashing sinks and is expected to be welcomed by the regulated industry, therefore appropriate for the fast-track process.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The promulgating agency is the State Board of Health.

Section 35.1-11 of the Code of Virginia states:

“The Board shall make, adopt, promulgate, and enforce regulations necessary to carry out the provisions of this title and to protect the public health and safety. In promulgating regulations, the Board shall consider the accepted standards of health including the use of precautions to prevent the transmission of communicable diseases, hygiene, sanitation, safety, and physical plant management.”

In addition, subsection A of § 35.1-17 of the Code of Virginia states:

“The regulations of the Board governing campgrounds shall include minimum standards for (i) an approved drinking water supply; (ii) an approved sewage disposal system; (iii) an approved solid waste disposal system; (iv) the proper maintenance of buildings, grounds, and equipment; (v) vector and pest control; (vi) toilet, swimming, and bathing facilities, including shower facilities; (vii) effective measures for the control of animals and pets; (viii) appropriate procedures and safeguards for hazardous situations, including specifically the maintenance and sale of propane gas or other explosives and combustibles; and (ix) a procedure for obtaining a license. B. The Board may in its sole discretion prescribe regulations for classes of campgrounds and different requirements for each class.”

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it is intended to solve.

The purpose of this regulatory change is to clarify standards for material used in the conveyance and storage of hand washing water at temporary campgrounds. Currently, the Regulations require any tanks, hoses, or appurtenances used to store or distribute water to be of “food-grade” construction. However, most portable hand washing sinks used by industry do not meet this standard. In traditional plumbed settings, hand washing water is considered potable water, and thus is required to meet the standard of water provided for drinking. In the settings of temporary campgrounds, temporary hand washing sinks, when used, provide extra sanitation for campers using portable toilets, but are not used as drinking water fountains.

The proposed amendment exempts portable hand washing sinks from meeting the full requirements applied to other water provided for drinking or showering in temporary campgrounds. To ensure this change has no adverse impact on public health, any portable hand washing sink that does not meet food-grade standards will be required to post a sign notifying campers not to drink the water.

Without this fast-track amendment, the current language potentially creates a hardship on temporary campground operators and portable hand washing sink distributors and service providers, could discourage hand washing and the use of hand washing sinks, or unintentionally promote certain brands or providers.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the “Detail of Changes” section below.

The proposed amendment exempts portable hand washing sinks at temporary campgrounds from meeting the existing construction requirement for water distribution or storage tanks, while displaying a sign stating "Hand washing water is not for drinking."

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

The primary advantage of this regulatory change is additional flexibility provided to campground operators and companies that supply portable sanitation facilities. The amendments align requirements to current industry standards, while still protecting public health through other existing provisions and the requirement for signage. This is not only a benefit to the public, but the agency will benefit from clearer and practical standards for portable hand washing sinks.

There are no known or anticipated disadvantages to the public or the Commonwealth associated with the proposed changes or pertinent matters of interest to the regulated community, government officials or the public.

Requirements More Restrictive than Federal

Identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements, or no requirements that exceed applicable federal requirements, include a specific statement to that effect.

There are no requirements in this regulatory action that exceed applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

Consistent with § 2.2-4007.04 of the Code of Virginia, identify any other state agencies, localities, or other entities particularly affected by the regulatory change. Other entities could include local partners such as tribal governments, school boards, community services boards, and similar regional organizations. "Particularly affected" are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

Other State Agencies Particularly Affected

There are no other state agencies particularly affected by this regulatory change.

Localities Particularly Affected

There are no localities particularly affected by this regulatory change.

Other Entities Particularly Affected

Temporary campground operators, portable hand washing sink distributors, and service providers will be affected by this change.

Economic Impact

Consistent with § 2.2-4007.04 of the Code of Virginia, identify all specific economic impacts (costs and/or benefits), anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Keep in mind that this is the proposed change versus the status quo.

Impact on State Agencies

<p><i>For your agency:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources</p>	<p>There are no projected costs, savings, fees or revenues anticipated to the agency due to this change; temporary campgrounds are already regulated and inspected by VDH.</p>
<p><i>For other state agencies:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.</p>	<p>There are no projected costs, savings, fees or revenues anticipated to other state agencies due to this change.</p>
<p><i>For all agencies:</i> Benefits the regulatory change is designed to produce.</p>	<p>There are no direct impacts on state agencies, with the potential exception of any state agency that hosts a temporary campground. These agencies may experience benefits as campground operators.</p>

Impact on Localities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a or 2) on which it was reported. Information provided on that form need not be repeated here.

<p>Projected costs, savings, fees or revenues resulting from the regulatory change.</p>	<p>There are no projected costs, savings, fees or revenues anticipated to localities due to this change.</p>
<p>Benefits the regulatory change is designed to produce.</p>	<p>There are no direct impacts on localities, but localities hosting temporary campgrounds may experience benefits as campground operators.</p>

Impact on Other Entities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a, 3, or 4) on which it was reported. Information provided on that form need not be repeated here.

<p>Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be</p>	<p>Temporary campground operators, portable hand washing sink distributors and service providers.</p>
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<p>affected, include a specific statement to that effect.</p>	
<p>Agency's best estimate of the number of such entities that will be affected. Include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that:</p> <ul style="list-style-type: none"> a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million. 	<p>There were approximately 45 temporary campground applications processed in CY 2021, and 35 in 2022 to date. VDH does not require submission of information regarding the ownership status or number of employees. There are 408 campgrounds currently permitted in the Commonwealth for 2022.</p> <p>Based on employing 500 or fewer employees, an estimated 95 to 100% of these campgrounds are small businesses.</p>
<p>All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to:</p> <ul style="list-style-type: none"> a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements. 	<p>There are no projected costs, for affected individuals, businesses or other entities resulting from the regulatory change for localities.</p>
<p>Benefits the regulatory change is designed to produce.</p>	<p>Amending the regulations will provide more flexibility to campgrounds and companies that provide portable sanitation equipment, with no negative impact to public health.</p>

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

This information has been reported in Table 1b of the ORM Economic Impact form.

Regulatory Flexibility Analysis

Consistent with § 2.2-4007.1 B of the Code of Virginia, describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the regulatory change.

This analysis has been reported in Table 1b of the ORM Economic Impact form.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below.

Consistent with § 2.2-4011 of the Code of Virginia, if an objection to the use of the fast-track process is received within the 30-day public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the agency shall: 1) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register and 2) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

If you are objecting to the use of the fast-track process as the means of promulgating this regulation, please clearly indicate your objection in your comment. Please also indicate the nature of, and reason for, your objection to using this process.

The Virginia Department of Health is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal and any alternative approaches, (ii) the potential impacts of the regulation, and (iii) the agency's regulatory flexibility analysis stated in this background document.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall website at: <https://townhall.virginia.gov>. Comments may also be submitted by mail, email or fax to
Briana Bill
109 Governor Street Richmond, VA 23235
(804) 584-6340
Fax number (804) 864-7475
briana.bill@vdh.virginia.gov.

In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

If an existing VAC Chapter(s) is being amended or repealed, use Table 1 to describe the changes between existing VAC Chapter(s) and the proposed regulation. If existing VAC Chapter(s) or sections are being repealed and replaced, ensure Table 1 clearly shows both the current number and the new number for each repealed section and the replacement section.

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
12VAC5-450-187		<p>This section provides standards for temporary campgrounds.</p> <p>Currently, the tanks, hoses, or appurtenances that are used to distribute water are required to be of food-grade construction, be disinfected between uses, and be protected from contamination and backflow</p>	<p>Change: Portable hand washing sinks are exempted from the requirement that tanks, hoses, or appurtenances used to distribute water be of food-grade construction, disinfected between uses, and protected from contamination and backflow. A requirement is added that the sinks maintain a one-parts-per million free chlorine residual, and display a sign stating "Hand washing water is not for drinking." Additionally, text amended to update regulatory citations, to comply with VRRM style requirements, and grammatical edits.</p> <p>Intent: To exempt portable handwashing sinks from unnecessary regulatory requirements.</p> <p>Rationale: Current regulation limits the use of tanks and accessories used to transport and convey water, including portable hand washing sinks at temporary campgrounds, to those made out of food grade material. This is not the industry standard for portable hand washing sinks and may negatively impact small business, with no associated public health rationale, as portable hand washing sinks are not used as drinking water fountains. The proposed language is in line with industry practice and easily understood.</p> <p>Impact: It will add flexibility for campground operators when procuring portable hand washing sinks, remove a limitation to businesses that rent portable sanitation equipment, and align regulations with industry standards. It is expected that more temporary campgrounds may elect to provide portable hand washing sinks due to the reduced regulatory requirements.</p>

1 **Project 7315 - Fast-Track**

2 **Department of Health**

3 **Amend Regulations: Temporary Campground Water Quality/Handwashing Stations**

4 **12VAC5-450-187. Temporary campgrounds.**

5 ~~Temporary campgrounds,~~ A temporary campground, as permitted under pursuant to
6 12VAC5-450-40 F, shall be exempt from ~~the following requirements of this chapter:~~

7 1. ~~Density~~ The density, size, and designation requirements of 12VAC5-450-70 B through
8 D. ~~However, temporary campgrounds~~ A permit holder shall establish a maximum
9 number of campsites and campers. ~~Temporary campground permit holders shall;~~ ensure
10 that the size, location, and orientation of campsites do not prohibit the safe and timely
11 evacuation of campsites in the event of an emergency; and ensure that vehicular traffic
12 routes and parking are located where they do not endanger ~~pose a safety risk to~~
13 campers.

14 2. ~~Permanent~~ The permanent water supply requirements of 12VAC5-450-80.

15 a. If the permit holder provides potable water ~~is provided~~ in the form of a waterworks
16 or private well, ~~then it must~~ the potable water shall comply with 12VAC5-450-80 A, B,
17 and D through I. If no piped water source is provided, ~~then~~ the permit holder shall
18 make available bottled water that complies with 21 CFR Part 129 ~~shall be available,~~
19 and shall advertise the unavailability of piped water ~~must be advertised to campers~~
20 prior to the ~~time of the~~ temporary camping event.

21 b. ~~Water may be transported in from a source that meets~~ If the permit holder
22 provides water that is transported to a temporary campground, the source of the
23 water shall meet the requirements of 12VAC5-450-80 A. ~~Water shall be~~ The permit
24 holder shall ensure that water is transported in tanks of food-grade construction and
25 ~~maintain~~ maintains a one-parts-per-million chlorine residual. With the exception of
26 portable hand washing sinks, the permit holder shall ensure that Any tanks, hoses, or
27 appurtenances that are used to distribute water ~~shall be~~ are of food-grade
28 construction, ~~be~~ disinfected between uses, and ~~be~~ protected from contamination and
29 backflow.

30 c. If the permit holder provides portable hand washing sinks, the permit holder shall
31 ensure that the sink water maintains a one-parts-per million chlorine residual, and
32 shall display a sign stating "Hand washing water is not for drinking."

33 3. The dump station and slop sink requirements of 12VAC5-450-90 D, E, and G.

34 a. ~~Greywater disposal barrels or approved equivalents shall be provided and~~
35 ~~serviced during the event unless all of the following conditions apply: (i) piped water~~
36 ~~is not available, (ii) portable showers and handwashing sinks are provided, and (iii)~~
37 ~~cooking and campfires are prohibited. Only water from cooking, washing, or bathing~~
38 ~~shall be disposed of in greywater barrels.~~

39 ~~b. a.~~ If self-contained camping units are present at the campground, the permit
40 holder shall ensure that a sewage handler who possesses a valid sewage handling
41 permit as required by 12VAC5-610 and any license required by the Board for
42 Waterworks and Wastewater Works Operators and Onsite Sewage System
43 Professionals Licensing Regulations (18VAC160-40 et seq.) and Title 54.1 of the
44 Code of Virginia shall be is available to pump holding tanks as appropriate during the
45 event. ~~Sewage handlers must possess a valid sewage handling permit as required~~
46 ~~by 12VAC5-610 and any licensure required by the Board for Waterworks and~~

47 ~~Wastewater Works Operators and Onsite Sewage Professionals in accordance with~~
48 ~~that board's regulations (18VAC160-30 and 18VAC160-40) and Title 54.1 of the~~
49 ~~Code of Virginia.~~

50 b. The permit holder shall service and provide greywater slop sinks or disposal
51 barrels at least daily during an event held at a temporary campgrounds when:

52 (1) Piped water is not available;

53 (2) Portable showers and hand washing sinks are provided; and

54 (3) Cooking and campfires are prohibited.

55 The permit holder shall ensure that water from cooking, washing, or bathing is
56 disposed of in greywater barrels.

57 4. ~~Permanent~~ The permanent sanitary facility requirements in 12VAC5-450-100 A, B,
58 and I. ~~However,~~ The permit holder shall provide portable toilet facilities ~~shall be provided~~
59 at the ratio of at least one toilet for every 75 campers, and shall ensure that at least one
60 toilet ~~shall comply~~ complies with the Americans with Disabilities Act (42 USC § 12101 et
61 seq.). No campsite ~~shall may~~ be farther than 500 feet from ~~any a~~ portable toilet. ~~Portable~~
62 ~~sinks and showers are not required, although~~ The permit holder shall provide hand
63 sanitizer ~~must be provided~~ in all portable toilets ~~where if~~ portable sinks are not provided.
64 ~~All portable units shall be serviced~~ The permit holder shall ensure that the portable
65 sanitary facilities are serviced at least daily during the event unless the applicant or
66 permit holder can demonstrate that they are provided in numbers significant there are
67 enough portable sanitary facilities to warrant a reduced-maintenance service schedule. If
68 the temporary campground has permanent bathroom facilities, the facilities may count
69 towards the required number of portable toilets. ~~Campers~~ The permit holder may
70 exclude campers who will be camping in self-contained camping units ~~shall not be~~
71 ~~counted toward~~ from the total number of campers ~~in~~ for the purposes of calculating the
72 required number of portable toilets.

73 **Statutory Authority**

74 § 35.1-11 and 35.1-17 of the Code of Virginia.

75 **Historical Notes**

76 Derived from Virginia Register Volume 35, Issue 5, eff. November 28, 2018.

Office of Regulatory Management

Economic Review Form

Agency name	Virginia Department of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 5-450
VAC Chapter title(s)	Rules and Regulations Governing Campgrounds
Action title	Fast-track Amendments: Temporary Campground Water Quality/Hand Washing Sinks
Date this document prepared	October 25, 2022

Table 1a: Costs and Benefits of the Proposed Changes (Primary Option)

(1) Direct Costs & Benefits	<ul style="list-style-type: none"> • This action would exempt portable hand washing sinks from the requirement that any tanks, hoses, or appurtenances that are used to distribute water shall be of food grade construction Temporary Campgrounds (12VAC5-450-187). <p>Direct Costs: The only potential direct cost associated with the proposed change would be the purchasing of the signage to be required if a temporary campground uses portable hand washing sinks without food-grade water equipment. On average the sign is \$16.00.</p> <p>Direct Benefits: As hand washing is a primary component to reducing communicable disease, it is not the intention of the Virginia Department of Health to prohibit or discourage handwashing. The benefit is the allowance to use equipment that is more in line with industry standard and less burdensome to the regulant population, while protecting the public through encouraging handwashing, ensuring portable hand washing sinks meet adequate disinfection requirements, and requiring signage informing the public that water used for hand washing is not for human consumption. The use of portable hand washing sinks is not required at temporary campgrounds, however, if used, the campground operator must comply with regulatory requirements that currently restrict the water equipment to certain standards and potentially increase the cost burden to provide a public health amenity that many campground operators and patrons want or expect at a temporary campground. In the settings of temporary</p>
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	<p>campgrounds, temporary hand washing sinks, when used, provide extra sanitation for campers using portable toilets, but are not used as drinking water fountains.</p> <p><u>Cost Calculation</u></p> <ul style="list-style-type: none"> • Average cost of portable food-grade sink: \$1,519 Number of temporary campgrounds as of September, 2022: 35 (\$1,519 * 35=\$53,165) *This is an estimate at a rate of one food-grade sink per temporary campground • Average cost of portable non food-grade sink: \$1,031.25 Number of temporary campgrounds as of September, 2022: 35 (\$1,031.25 * 35=\$36,093.75) *This is an estimate at a rate of one non food-grade sink per temporary campground • The difference in costs of portable food-grade and non-food grade sinks: \$17,071.25 yearly or \$487.75 per unit.
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(2) Quantitative Factors	Estimated Dollar Amount	Present Value	
Direct Costs	(a) \$5,600 = (10 years, \$16 per sign, ~35 temp. campgrounds per year)	(c) \$4,920	
Direct Benefits	(b) \$170,713 (10 years, \$487.76 per unit, 35 temp. campgrounds)	(d) \$149,990	
(3) Benefits-Costs Ratio	30.48	(4) Net Benefit	\$145,070

(5) Indirect Costs & Benefits	<p>Indirect Costs: The agency is unable to determine possible indirect costs associated with the proposed regulatory change as the change would reduce restrictions on providing portable hand washing sinks and therefore improve and increase the ability for use at temporary campgrounds.</p> <p>Indirect Benefits: Indirect benefits include removing the burden of complying with outdated requirements that do not align with current industry practices and added clarity to operational requirements that improve campground performance and protection of the health and safety of campers and the public. In addition, campground operators and companies that supply portable sanitation facilities may save an average of</p>
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	\$488 per portable sink by not replacing existing sinks that do not meet existing regulatory requirements.																																																
(6) Information Sources	<p>Monetary value of portable hand washing sinks gathered from online research (Poly John, MOBI, Monsam, Cambro, and Regency) and industry representative outreach (Crown Verity, Satellite,) to determine food grade construction and estimated cost per unit.</p> <p>The chart below provides additional information on the various types of handwashing stations and their costs.</p> <p>”USDA” means United States Department of Agriculture “FDA” means Food and Drug Administration “NSF” means National Science Foundation</p> <table border="1"> <thead> <tr> <th>Manufacturer</th> <th>USDA Food Grade?</th> <th>FDA Food Grade?</th> <th>NSF Listed?</th> <th>Average Cost?</th> <th>Spec Sheet Provided?</th> </tr> </thead> <tbody> <tr> <td>PolyJohn</td> <td>No</td> <td>No</td> <td>No</td> <td>\$700</td> <td>Link</td> </tr> <tr> <td>Crown Verity</td> <td>No</td> <td>Yes</td> <td>Yes-NSF/ANSI-2</td> <td>\$1600</td> <td>Link</td> </tr> <tr> <td>MOBI</td> <td>No</td> <td>No</td> <td>No</td> <td>\$525</td> <td>Link</td> </tr> <tr> <td>Monsam</td> <td>No</td> <td>Yes</td> <td>Yes</td> <td>\$2191</td> <td>Link</td> </tr> <tr> <td>Satellite</td> <td>No</td> <td>Yes-Resin Only</td> <td>Yes-Resin Only</td> <td>\$766</td> <td>Link</td> </tr> <tr> <td>Cambro</td> <td>No</td> <td>No</td> <td>No</td> <td>\$1200</td> <td>Link</td> </tr> <tr> <td>Regency</td> <td>No</td> <td>No</td> <td>No</td> <td>\$1700</td> <td>Link</td> </tr> </tbody> </table>	Manufacturer	USDA Food Grade?	FDA Food Grade?	NSF Listed?	Average Cost?	Spec Sheet Provided?	PolyJohn	No	No	No	\$700	Link	Crown Verity	No	Yes	Yes-NSF/ANSI-2	\$1600	Link	MOBI	No	No	No	\$525	Link	Monsam	No	Yes	Yes	\$2191	Link	Satellite	No	Yes-Resin Only	Yes-Resin Only	\$766	Link	Cambro	No	No	No	\$1200	Link	Regency	No	No	No	\$1700	Link
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Monsam	No	Yes	Yes	\$2191	Link																																												
Satellite	No	Yes-Resin Only	Yes-Resin Only	\$766	Link																																												
Cambro	No	No	No	\$1200	Link																																												
Regency	No	No	No	\$1700	Link																																												
(7) Optional	None																																																

Table 1b: Costs and Benefits under the Status Quo (No change to the regulation)

This table addresses current requirements and the implications of not making any changes. In other words, describe the costs and benefits of maintaining the current regulatory requirements as is.

<p>(1) Direct Costs & Benefits</p>	<ul style="list-style-type: none"> ● Current regulations for temporary campgrounds require that any tanks, hoses, or appurtenances that are used to distribute water shall be of food grade construction. <p>Direct Costs: Current industry design of the majority of portable hand washing sinks do not meet current regulatory construction requirements through standard materials and design, and may in effect discourage the use of such sinks, and thus prohibit or discourage handwashing at temporary campgrounds. The agency is unable to determine the direct monetary cost of reduced hand washing at temporary campgrounds but attests that the reduction of hand washing may jeopardize the safety, health and welfare of the public. Requiring portable hand washing sinks to be food grade would limit campground operators to select vendors, and may in effect, limit and target the market to specific providers. The ability to determine if a portable hand washing sink is of food grade construction can be difficult as various components of the sink design may be of different materials and certification, further burdening the industry on meeting compliance with the regulation.</p> <p><u>Cost Calculation</u></p> <ul style="list-style-type: none"> ● Average cost of portable food-grade sink: \$1,519 Number of temporary campgrounds as of September, 2022: 35 (\$1,519 * 35=\$53,165) <p>*This is an estimate at a rate of one food-grade sink per temporary campground.</p> <p>Direct Benefits: The agency did not identify a direct benefit of maintaining the current regulation related to portable hand washing sinks at temporary campgrounds.</p>	
<p>(2) Quantitative Factors</p>	<p>Estimated Dollar Amount</p>	<p>Present Value</p>
<p>Direct Costs</p>	<p>(a) \$531,650 (10 yrs, \$53,165 per year)</p>	<p>(c) \$467,113</p>

Direct Benefits	(b) \$0	(d) \$0	
(3) Benefits-Costs Ratio	0	(4) Net Benefit	-\$467,113
(5) Indirect Costs & Benefits	<p>Indirect Costs: Indirect costs may include unnecessary operational burden on temporary campground operations related to portable hand washing sinks. Maintaining the status quo could result in campground operators or companies that supply portable sanitation facilities having to replace existing sinks that do not meet existing regulatory requirements.</p> <p>Indirect Benefits: No indirect benefits were identified if the regulations were retained.</p>		
(6) Information Sources	Same as Table 1.a(6)		
(7) Optional	None		

Table 1c: Costs and Benefits under an Alternative Approach

This table addresses an alternative approach to accomplishing the objectives with different requirements. These alternative approaches may include the use of reasonably available alternatives in lieu of regulation, or information disclosure requirements or performance standards instead of regulatory mandates.

(1) Direct Costs & Benefits	<ul style="list-style-type: none"> ● This action requires the posting of a sign to inform the public the water in a portable handwashing station is not for human consumption. One alternative to the proposed regulations to remove the requirement of signage informing the public the water in a portable hand washing station is not for human consumption. Temporary Campgrounds (12VAC5-450-187). <ul style="list-style-type: none"> ○ Direct Costs: No direct quantitative costs were identified if the above proposed alternative is adopted. However, the consumption of water not intended for human consumption may lead to the transmission of disease, and without signage, the public may drink water from the sinks. Waterborne infection and diseases could result in significant burden on health and healthcare spending¹. ○ Direct Benefit: The average cost of a sign is \$16.00 	
(2) Quantitative Factors	Estimated Dollar Amount	Present Value

Direct Costs	(a) \$0.00	(c) \$0.00	
Direct Benefits	(b) \$5,600 = (10 years, \$16 per sign, ~35 temp. campgrounds per year)	(d) \$4,920	
(3) Benefits-Costs Ratio	\$0	(4) Net Benefit	\$4,920
(5) Indirect Costs & Benefits	<p>Indirect Costs: The agency is unable to determine any indirect cost associated with adopting the proposed alternative.</p> <p>Indirect Benefits: The agency is unable to determine any indirect benefit associated with adopting the proposed alternative.</p>		
(6) Information Sources	<p>¹Collier, Sarah A et al. "Estimate of Burden and Direct Healthcare Cost of Infectious Waterborne Disease in the United States." <i>Emerging infectious diseases</i> vol. 27,1 (2021): 140-149. doi:10.3201/eid2701.190676</p>		
(7) Optional	N/A		

Table 2: Impact on Local Partners

(1) Direct Costs & Benefits	<p>Direct Costs: Local partners or authorities such as the Virginia Restaurant, Lodging and Travel Association or Virginia Campground Association may be affected by this action in regards to notification and support to their constituents. Local and tribal governments, school divisions or other authorities are likely not affected by this action, unless they implement a local ordinance or other code specific to temporary campground facilities and portable hand washing provisions.</p> <p>Direct Benefits: No indirect benefits were identified for local partners.</p>
(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a) N/A
Direct Benefits	(b) N/A
(3) Indirect Costs & Benefits	<p>Indirect Costs: The agency is unable to determine any indirect cost to local partners associated with this proposed amendment.</p>

	Indirect Benefits: Potential indirect benefits to local partners associated with this proposed amendment may include improved public health protections during temporary events that involve permitted temporary campgrounds. The ability to easily provide portable hand washing sinks could improve event operations and public perception and approval through the providing of hand washing opportunities that increases public comfort and trust of an event, location, and community partners.
(4) Information Sources	N/A
(5) Assistance	N/A
(6) Optional	N/A

Table 3: Impact on Families

(1) Direct Costs & Benefits	<p>Direct Costs: The agency did not identify any direct costs to families related to the proposed amendment.</p> <p>Direct Benefits: The agency did not identify any direct benefits to families related to the proposed amendment.</p>
(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a) N/A
Direct Benefits	(b) N/A
(3) Indirect Costs & Benefits	<p>Indirect Costs: The agency is unable to determine the indirect cost to families regarding the proposed amendment.</p> <p>Indirect Benefits: The potential indirect benefits to families could include increased opportunities to wash hands during temporary camping events and thus improve the health and safety of the family.</p>
(4) Information Sources	N/A

(5) Optional	N/A
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Table 4: Impact on Small Businesses

(1) Direct Costs & Benefits	<p>Direct Costs: The agency did not identify any direct costs to small businesses related to this change.</p> <p>Direct Benefits: The direct benefits of amending the regulations to small businesses may include less regulatory burden, and therefore less potential cost to provide a public health amenity at temporary campgrounds that is often expected by the public. The agency is recommending the regulation be amended to minimize the economic impact on small businesses while maintaining appropriate regulatory standards to ensure the safety, health, and welfare of the public.</p>
(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a) N/A
Direct Benefits	(b) N/A
(3) Indirect Costs & Benefits	<p>Indirect Costs: The agency did not identify any indirect costs to small businesses associated with the change.</p> <p>Indirect Benefits: Indirect benefits may include the removal of unnecessary operational burden on temporary campground operations that could be reduced or removed through the proposed amendments. Amending the regulations may also reduce expenditures necessary to meet the current regulatory requirements.</p>
(4) Alternatives	<p>Alternatives to an amendment would include no action and to retain the regulation as is. As stated, this lack of change may maintain a status quo that is burdensome for the campground industry and small business. Review and consideration of amendments to the regulations is the only way for Virginia to stay current with industry standards and to ensure that the agency’s statutory requirements are executed in the least burdensome and most efficient and cost-effective manner possible while protecting the health, safety and welfare of the citizens of Virginia.</p>
(5) Information Sources	N/A

(6) Optional	N/A
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Changes to Number of Regulatory Requirements

For each individual VAC Chapter amended, repealed, or promulgated by this regulatory action, list (a) the initial requirement count, (b) the count of requirements that this regulatory package is adding, (c) the count of requirements that this regulatory package is reducing, (d) the net change in the number of requirements. This count should be based upon the text as written when this stage was presented for executive branch review. Five rows have been provided, add or delete rows as needed.

Table 5: Total Number of Requirements

	Number of Requirements			
Chapter number	Initial Count	Additions	Subtractions	Net Change
450	0	1	1	0



COMMONWEALTH of VIRGINIA

Colin M. Greene, MD, MPH
State Health Commissioner

Department of Health
P O BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

MEMORANDUM

DATE: November 7, 2022

TO: Virginia State Board of Health

FROM: Seth Austin, Director, Office of Vital Records

SUBJECT: Amending regulations following statutory changes – 12VAC5-550

Enclosed for your review are Fast Track amendments to the Board of Health Regulations Governing Vital Records (12VAC5-550-5 et seq.)

The purpose of the proposed amendments is to update definitions in the Virginia Administrative Code to provide clarity to Virginia regulations; repeal sections that are not regulatory in nature; updates forms used by sections impacted by the action; and conforms the requirements of the following sections to the Code of Virginia:

- 12VAC5-550-440, 12VAC5-550-450, 12VAC5-550-460: Amending death certificates and requirements to conform with §32.1-269.1
- 12VAC5-550-125: Stillbirth certificate fee removal to conform with §32.1-.258.1
- 12VAC5-550-520: Updating fees for vital records requests, amendments or delayed registrations to conform with §32.1-273
- 12VAC5-550-320: Change of sex on birth certificate requirements to conform with §32.1-261
- 12VAC5-550-130: Removing the item “race” on marriage and divorce certificates to conform with §§32.1-267, 32.1-268 and 32.1-268.1

The Board of Health is requested to approve the Fast Track Action; if approved it shall be published in the Virginia Register of Regulations. This will initiate a 30-day public comment period. The regulations become effective 15-days after the public comment period ends unless there is objection pursuant to Va. Code § 2.2-4012.1; in which case the Fast Track regulation will serve as Notice of Intended Regulatory Action and the standard rulemaking process shall be followed to promulgate the regulation.



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Fast-Track Regulation Agency Background Document

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC5-550
VAC Chapter title(s)	Board of Health Regulation Governing Vital Records
Action title	Amend Regulations Following Statutory Changes
Date this document prepared	11-14-2022

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

The purpose of the proposed amendments is to amend the Regulations to reflect several recent changes in the Code of Virginia, including changes to §32.258.1, §32.1-269.1, §32.1-261, and §32.1-267. Several sections will be repealed, as these sections were not regulatory in nature. The amendment to 12VAC5-550-520 changes the certification fee from \$10 to \$12 because this fee was changed in the Code and implemented several years ago.

Chapter 171 of the 2022 Acts of Assembly removed the authority to charge a fee to obtain a stillbirth certificates. The business operations of the Office of Vital Records have already been changed to conform to the new law, but the regulations have not yet been changed. Chapters 209, 210, and 211 of the 2020 Acts of Assembly removed race from the data to be collected regarding marriages, divorces, and annulments. Chapters 465 and 466 of the 2020 Acts of Assembly amended the process to change one's sex on a birth certificate. Chapters 116 and 117 of the 2022 Acts of Assembly changed the process and timelines associated with amending a death certificate.

The amendments improve the regulatory language used in the Virginia Administrative Code so that both the public and government organizations have better direction concerning the responsibilities and requirements needed to perform their duties. This should reduce time spent dealing with challenges to processes that are presented by members of the public and will make the operations of the Office of Vital Records more efficient.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

There are no acronyms used in this Agency Background Document that are not also defined in the "Definitions" section of the regulation.

Statement of Final Agency Action

Provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) the name of the agency taking the action; and 3) the title of the regulation.

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in the ORM procedures, "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

Consistent with Virginia Code § 2.2-4012.1, also explain why this rulemaking is expected to be noncontroversial and therefore appropriate for the fast-track rulemaking process.

Chapter 171 (2022) removed the authority to charge a fee to obtain a stillbirth certificates. Chapters 209, 210, and 211 (2020) removed race from the data to be collected regarding marriages, divorces, and annulments. Chapters 465 and 466 (2020) amended the process to change one's sex on a birth certificate. Chapters 116 and 117 (2022) changed the process and timelines associated with amending a death certificate. Additionally, sections 20, 30, 50, and 60 will be repealed because the provisions do not meet the statutory definition of a "regulation" in § 2.2-4001.

The rulemaking is expected to be non-controversial because the substantive changes being made are to comply with changes to the Code of Virginia. Additionally, the style and form changes are not substantive but will make the regulations clearer and more readable for both the public and agency staff.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the

promulgating agency to regulate this specific subject or program, as well as a reference to the agency’s overall regulatory authority.

The regulation is promulgated by the State Board of Health under the authority of §§ 32.1-12 and 32.1-250 of the Code of Virginia.

Section 32.1-12 grants the Board of Health the legal authority to make, adopt, promulgate, and enforce regulations necessary to carry out the provisions of Title 32.1 of the Code and other laws of the Commonwealth administered by it. Section 32.1-250 of the Code of Virginia requires the Board of Health to install, maintain and operate the only system of vital records throughout the Commonwealth.

Specific changes being made are authorized by Chapters 209, 210, 211, 465, and 466 (2020) and 116, 117, and 171 (2022). The fee amount in Section 520 is being updated to reflect the amount in Item 290 A, Chapter 2 of the 2022 Acts of Assembly, Special Session I.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it is intended to solve.

This fast track action is essential to ensure the regulations that govern the business processes of the Office of Vital Records are aligned with the Code of Virginia. The Office of Vital records has also increased the clarity, accuracy, and completeness of the regulations governing vital records.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the “Detail of Changes” section below.

- 12VAC5-550-5. Definitions are updated to make the Regulations easier to understand.
- 12VAC5-550-20, 12VAC5-550-30, 12VAC5-550-50, and 12VAC5-550-60 have been repealed. These provisions do not meet the statutory definition of a "regulation" in § 2.2-4001 and are unnecessary.
- 12VAC5-550-125. Certificate of birth resulting in a stillbirth. The changes remove the fee for this type of vital record.
- 12VAC5-550-130. Marriage return and certificate items. The changes identify the specific form that will be used for this action, which facilitates the removal of race as a certificate item.
- 12VAC5-550-140. Report of divorce or annulment. The changes identify the specific form that will be used for this action, which facilitates the removal of race as a certificate item.
- 12VAC5-550-320. Change of Sex. The changes identify the specific form that will be used for this action, clarify the language, and conform the regulation to the Code of Virginia.
- 12VAC5-550-440. Applications for correction. The changes update the timeframe for amending a death certificate and clarify how the amendment can be accomplished consistent with the Code.

- 12VAC5-550-450. Evidence required for corrections or amendments. The changes add to and clarify the requirements for changes made to a death record.
- 12VAC5-550-460. Methods of correcting or altering certificates. The changes define “amendment” to bring consistency and clarity to the regulations.
- 12VAC5-550-520. Fees. This fee is being updated to reflect Item 290 A, Chapter 2 of the 2022 Acts of Assembly, Special Session I.
- 12VAC5-550-9998 FORMS. Forms that are only used internally by OVR staff are being removed, the effective dates of all necessary forms are being updated, along with links to the documents.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

The primary advantages to the public, the agency, and the Commonwealth include the enhanced integrity of the regulations governing Vital Records and in turn the system of vital records within the Commonwealth. There are no known disadvantages to the public, regulated entities, business entities, or the Commonwealth.

Requirements More Restrictive than Federal

Identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements, or no requirements that exceed applicable federal requirements, include a specific statement to that effect.

There are no requirements of this proposal which are more restrictive than applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

Consistent with § 2.2-4007.04 of the Code of Virginia, identify any other state agencies, localities, or other entities particularly affected by the regulatory change. Other entities could include local partners such as tribal governments, school boards, community services boards, and similar regional organizations. “Particularly affected” are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. “Locality” can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

- Other State Agencies Particularly Affected: No other agency will be affected by these fast track amendments.

- Localities Particularly Affected: There are no localities that will be affected by these fast track amendments.
- Other Entities Particularly Affected: Members of the public filing or amending vital records are affected by the process changes – however, because the regulatory changes are to comply with previous changes in the Code, no other entity will be affected solely by the regulatory changes.

Economic Impact

Consistent with § 2.2-4007.04 of the Code of Virginia, identify all specific economic impacts (costs and/or benefits), anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Keep in mind that this is the proposed change versus the status quo.

Impact on State Agencies

<i>For your agency:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources	The projected cost to the Virginia Department of Health to implement and enforce this regulatory proposal is negligible. It will not interrupt or affect business operations within the Office of Vital Records.
<i>For other state agencies:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.	There is no projected cost to other state agencies to implement and enforce this regulatory proposal.
<i>For all agencies:</i> Benefits the regulatory change is designed to produce.	None

Impact on Localities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a or 2) on which it was reported. Information provided on that form need not be repeated here.

Projected costs, savings, fees or revenues resulting from the regulatory change.	Implementing and enforcing this regulatory proposal will not produce a cost to any localities.
Benefits the regulatory change is designed to produce.	None

Impact on Other Entities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a, 3, or 4) on which it was reported. Information provided on that form need not be repeated here.

Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.	The analysis has been reported in tables 1a, 3, and 4 on the ORM Economic Impact form.
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<p>Agency's best estimate of the number of such entities that will be affected. Include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that:</p> <ul style="list-style-type: none"> a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million. 	<p>The analysis has been reported in tables 1a, 3, and 4 on the ORM Economic Impact form.</p>
<p>All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to:</p> <ul style="list-style-type: none"> a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements. 	<p>The analysis has been reported in tables 1a, 3, and 4 on the ORM Economic Impact form.</p>
<p>Benefits the regulatory change is designed to produce.</p>	<p>The analysis has been reported in tables 1a, 3, and 4 on the ORM Economic Impact form.</p>

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

If this analysis has been reported on the ORM Economic Impact form, indicate the tables on which it was reported. Information provided on that form need not be repeated here.

There are no viable alternatives to the proposal considered. Regulatory action is necessary to make corrections to the existing regulations, provide clarification to regulatory language, and add additional regulatory sections required by changes to the Code of Virginia.

Regulatory Flexibility Analysis

Consistent with § 2.2-4007.1 B of the Code of Virginia, describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the regulatory change.

No alternative regulatory methods are available to the agency. These changes are being made to comply with the Code of Virginia and make non-substantive changes for the purpose of clarity and readability; they do not address compliance and reduce reporting requirements, and the regulations do not impact small businesses.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below.

Consistent with § 2.2-4011 of the Code of Virginia, if an objection to the use of the fast-track process is received within the 30-day public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the agency shall: 1) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register and 2) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

If you are objecting to the use of the fast-track process as the means of promulgating this regulation, please clearly indicate your objection in your comment. Please describe the nature of, and reason for, your objection to using this process.

The Virginia Department of Health is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal and any alternative approaches, (ii) the potential impacts of the regulation, and (iii) the agency's regulatory flexibility analysis stated in this background document.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: <https://townhall.virginia.gov>. Comments may also be submitted by mail, email or fax to

Yolanda Aponte, Office of Vital Records,
P. O. Box 1000
Richmond, VA 23218,
Phone: (804) 482-7939,
Fax: (804) 662-6256,
Email: yolanda.aponte@vdh.virginia.gov.

In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

If an existing VAC Chapter(s) is being amended or repealed, use Table 1 to describe the changes between existing VAC Chapter(s) and the proposed regulation. If existing VAC Chapter(s) or sections are being repealed and replaced, ensure Table 1 clearly shows both the current number and the new number for each repealed section and the replacement section.

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
15VAC5-550-5		<p>“In addition to the words and terms defined in § 32.1-249 of the Code of Virginia, the following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:</p> <p>...</p> <p>"Primary evidence" means valid first-hand documentation established before the registrant's 18th birthday, such as school admission records, physician's records, immunization records, passport, federal census abstracts, baptismal records and insurance applications.</p> <p>"Registrant" means the person whose personal information is registered and filed in the systems of vital records.</p> <p>"Secondary evidence" means valid documentation established after the registrant's eighteenth birthday such as marriage records, child's birth certificate, school records, social security records, driver's records, work permit and employment records. Such evidence must be at least five years old."</p>	<p>CHANGE: The definitions for “primary evidence,” “registrant,” and “secondary evidence” are being updated. A definition for “registrar” is being added.</p> <p>INTENT: The intent is to increase the clarity of those definitions being amended. The intent of adding a definition for “registrar” is to be able to identify tasks that can be performed by the State Registrar or any other in the Commonwealth.</p> <p>RATIONALE: The rationale is that clearer regulations are better for the public and for agency staff administering them. The definition for “secondary evidence” also contained a substantive requirement, which should not be included in a “Definitions” section.</p> <p>LIKELY IMPACT: The likely impact is that the regulations will be more readable.</p>
12VAC5-550-20		<p>This section identified the purpose of the regulations.</p>	<p>CHANGE: The section is being repealed</p> <p>INTENT: The intent is to repeal non-regulatory provisions, which are unnecessary.</p> <p>RATIONALE: The rationale is that the provisions are not regulatory in nature pursuant to the definition of a regulation in § 2.2-4001. The Registrar of Regulations, pursuant to 1VAC7-10-40 (C) has the authority to omit purpose statements from publication.</p> <p>LIKELY IMPACT: The regulations will be shorter and not contain unnecessary language.</p>
12VAC5-550-30		<p>This section identifies the “administration” of the chapter.</p>	<p>CHANGE: The section is being repealed</p> <p>INTENT: The intent is to repeal non-regulatory provisions, which are unnecessary.</p>

			<p>RATIONALE: The rationale is that the provisions are not regulatory in nature pursuant to the definition of a regulation in § 2.2-4001. By nature of being promulgated by the Board of Health under its basic laws, the administration of the chapter is already set forth in the Code of Virginia. The Registrar of Regulations, pursuant to 1VAC7-10-40 (C) has the authority to non-regulatory provisions from publication.</p> <p>LIKELY IMPACT: The regulations will be shorter and not contain unnecessary language.</p>
12VAC5-550-50		This section indicates that the Administrative Process Act (APA) applies to the regulation.	<p>CHANGE: The section is being repealed</p> <p>INTENT: The intent is to repeal non-regulatory provisions, which are unnecessary.</p> <p>RATIONALE: The rationale is that the provisions are not regulatory in nature pursuant to the definition of a regulation in § 2.2-4001. The APA applies without including a statement to that effect in the regulation. The Registrar of Regulations, pursuant to 1VAC7-10-40 (C) has the authority to non-regulatory and unnecessary provisions from publication.</p> <p>LIKELY IMPACT: The regulations will be shorter and not contain unnecessary language.</p>
12VAC5-550-60		“The board reserves the right to authorize any procedure for the enforcement of this chapter that is not inconsistent with the provisions set forth herein and the provisions of Chapter 7 of Title 32.1 of the Code of Virginia.”	<p>CHANGE: The section is being repealed</p> <p>INTENT: The intent is non-regulatory provisions, which are unnecessary.</p> <p>RATIONALE: The rationale is that the provisions are not regulatory in nature pursuant to the definition of a regulation in § 2.2-4001. The section does not define or specify any specific power or procedure to be followed by a regulated entity or by the agency, and the Board’s powers are already set forth in the Code of Virginia. The Registrar of Regulations, pursuant to 1VAC7-10-40 (C) has the authority to non-regulatory and unnecessary provisions from publication.</p> <p>LIKELY IMPACT: The regulations will be shorter and not contain unnecessary language.</p>
12VAC5-550-125		This section describes the process by which a parent may receive a	<p>CHANGE: The change is to remove the requirement to pay a fee to receive a</p>

		<p>Certificate of Birth Resulting in Stillbirth.</p>	<p>Certificate pursuant to the section. Multiple changes in style and form are also made.</p> <p>INTENT: The intent is to provide stillbirth certificates free of charge. The requirements for the certificate have been re-organized for clarity and to make the section consistent with the Registrar of Regulations' <i>Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code</i> ("Style Requirements").</p> <p>RATIONALE: Chapter 171 (2022) removed the authority to charge a fee associated with obtaining a stillbirth certificate. Also, regulatory language should conform to the <i>Style Requirements</i> to ensure concise, clear, and consistent regulatory language.</p> <p>LIKELY IMPACT: The impact of the change is negligible, as there are very few stillbirth certificates produced each year, and the loss of revenue is minimal. In Virginia, there were approximately 2,800 stillbirths between 2018 and 2020 and these led to only 229 applications for certificates. For those wishing to obtain a certificate, though, they can do so free of charge. The language will also be more readable.</p>
<p>12VAC5-550-130</p>		<p>This section included the form to be used to register a marriage and the items to be included on the form.</p>	<p>CHANGE: The section will be updated to reference the process by which an officer issuing marriage license is to report those marriages to the State Registrar of Vital Records, including the form. It will also reference the form required to be used by members of the public to obtain a certified copy of a marriage certificate. The word "items" is also being stricken from the section title, as the section no longer lists the items in the form but makes reference to the form itself, instead.</p> <p>INTENT: The intent is make the regulations clearer and more reflective of the processes governed by the State Registrar and to reference the required forms to be used. In effect, because the forms no longer require race to be reported, it removes the current requirement which is unenforceable.</p> <p>RATIONALE: The rationale is that Chapters 209, 210, and 211 (2020), prompted by the order in a federal court case, <i>507 F. Supp. 3d 664 (E.D. Va. 2019)</i>, removed the reporting of race from marriage applications, licenses, and records.</p>

			<p>LIKELY IMPACT: The regulations will comply with the Code of Virginia.</p>
12VAC5-550-140		<p>This section included the form to be used to register a divorce or annulment and the items to be included on the form.</p>	<p>CHANGE: The section will be updated to reference the process by which a clerk of the court granting decrees of divorce and annulment to the State Registrar of Vital Records, including the form. It will also reference the form required to be used by members of the public to obtain a certified copy of a divorce or annulment certificate. The word “items” is also being stricken from the section title, as the section no longer lists the items in the form but makes reference to the form itself, instead.</p> <p>INTENT: The intent is make the regulations clearer and more reflective of the processes governed by the State Registrar and to reference the required forms to be used. In effect, because the forms no longer require race to be reported, it removes the current requirement which is unenforceable.</p> <p>RATIONALE: The rationale is that Chapters 209, 210, and 211 (2020), prompted by the order in a federal court case, <i>507 F. Supp. 3d 664 (E.D. Va. 2019)</i>, removed the reporting of race from divorce and annulment records.</p> <p>LIKELY IMPACT: The regulations will comply with the Code of Virginia.</p>
12VAC5-550-320		<p>This section describes the process by which a person may obtain a new birth certificate to reflect a change in sex.</p>	<p>CHANGE: The section still describes the process but updates the style and form of the language and makes reference to the specific form to be used, which itself contains the requisite information. The change adds in the process by which a person changing the sex on their birth certificate can also change their name.</p> <p>INTENT: The intent is clarify the process and form to change one’s sex as it appears on a birth certificate and confirm that process to the Code of Virginia. Also, regulatory language should conform to the <i>Style Requirements</i> to ensure concise, clear, and consistent regulatory language.</p> <p>RATIONALE: The rationale is that Chapters 465 and 466 (2020) amended the change of sex process in the Code of Virginia.</p> <p>LIKELY IMPACT: The regulations will comply with the Code of Virginia.</p>
12VAC5-550-440		<p>This section describes the process and requirements to correct or amend a vital record.</p>	<p>CHANGE: The subsections related to amending a birth certificate or marriage, divorce, or annulment record will be updated</p>

			<p>to make style and form changes. The death certificate amendment procedure will also be updated to allow for changes to be made administratively (i.e. without a court order) within 45 days instead of 30 and beyond 45 days in certain circumstances.</p> <p>INTENT: The intent of the style and form changes is to conform the section to the <i>Style Requirements</i>. The intent of the substantive change is to clarify the process by which a person may amend a death certificate, which includes an additional 15 days to request an administrative amendment.</p> <p>RATIONALE: The rationale is that the death certificate amendment process in the Code of Virginia was changed by Chapters 465 and 466 (2022). Also, regulatory language should conform to the <i>Style Requirements</i> to ensure concise, clear, and consistent regulatory language.</p> <p>LIKELY IMPACT: The regulations will comply with the Code of Virginia and members of the public who wish to amend a death certificate will utilize the new process and timelines. Additionally, the regulation will be clearer and more readable.</p>
<p>12VAC5-550-450</p>		<p>This section describes the evidence that a person is required to submit to request an amendment to a vital record.</p>	<p>CHANGE: The requirements related to amending birth and death certificates are separated. There are also minimal style changes made to the first paragraph of subsection A.</p> <p>INTENT: The intent is to clarify the difference between the evidence required to change a birth certificate vs. a death certificate. Also, regulatory language should conform to the <i>Style Requirements</i> to ensure concise, clear, and consistent regulatory language.</p> <p>RATIONALE: The rationale is that the process by which a death certificate can be amended, and subsequently the evidence needed were changed by Chapters 465 and 466 (2022). The current requirements do not distinguish between the two types of certificates, though the process for each is now different.</p> <p>LIKELY IMPACT: The regulations will comply with the Code of Virginia and members of the public who wish to amend a death certificate will utilize the new process</p>

<p>12VAC5-550-460</p>		<p>This section describes the manner by which the registrar makes requested and authorized amendments to vital records.</p>	<p>and timelines. Additionally, the regulation will be clearer and more readable.</p> <p>CHANGE: The changes are mostly non-substantive and in only style and form. Subsection A will be amended to remove the provision that a birth certificate on which a name is amended within seven years will not be considered to be amended and reduced to one year.</p> <p>INTENT: The intent is of the style changes is to conform the regulations to the <i>Style Requirements</i>. The change regarding the time in which a name may be changed without considering a birth certificate to be amended is intended to comply with § 32.1-269 (B) of the Code.</p> <p>RATIONALE: Regulatory language should conform to the <i>Style Requirements</i> to ensure concise, clear, and consistent regulatory language. Also, § 32.1-269 (B) requires the Board to “prescribe by regulation the conditions under which omissions or errors on certificates[...]may be corrected within one year after the date of the event without the certificate being marked amended.” The process will be updated to reflect that one year point instead of seven years.</p> <p>LIKELY IMPACT: The changes are for the most part to clarify the language, but also include a clarification of the timeline associated with the term “amendment” to now refer to changes made after one year from the date of the vital event. This change is needed to support the other changes to Regulations pertaining to vital records amendments which are necessary due to Chapters 116 and 117 of the 2022 Acts of Assembly.</p>
<p>12VAC5-550-520</p>		<p>A. The fee to be charged by the State Registrar or by the city or county registrar shall be \$10 for each full certification or short form certification of a vital record, or for a search of the files or records when no copy is made.</p> <p>B. When documents are amended or delayed birth registration is requested, the requester shall be charged an administrative fee of \$10.</p>	<p>CHANGE: The change is to update the fee for a certified copy from \$10 to \$12 unless otherwise directed in the Code. There are also style and form changes made to the section.</p> <p>INTENT: The intent is to conform the regulations to the Appropriation Act, which sets the fee at \$12 and to make reference to the special circumstances in which no fee is to be charged. The intent is also to conform the language to the <i>Style Requirements</i>.</p> <p>RATIONALE: Item 309 A, Chapter 4 of the 2004 Acts of Assembly, Special Session I initially updated the “standard vital records fee” to \$12. Item 290 A, Chapter 2 of the 2022 Acts of Assembly, Special Session I,</p>

			<p>includes that language. Also, regulatory language should conform to the <i>Style Requirements</i> to ensure concise, clear, and consistent regulatory language.</p> <p>LIKELY IMPACT: The regulations will conform to the Appropriation Act language.</p>
<p>FORMS (12VAC5-550)</p>		<p>The section listed 17 forms used by the State Registrar of Vital Records.</p>	<p>CHANGE: Forms only used by the Office of Vital Records, which include vital record templates, will be removed. The applications for a Birth Record, Marriage-Divorce Record, Death record, Stillbirth Certificate, form to change sex designation, and request to amend a birth certificate are all added. Additionally, the report of adoption, acknowledgement of paternity, and affidavit for correction of a record are all updated to reflect the most updated effective version of the Form.</p> <p>INTENT: The intent is to only list those forms that are used by the public and to ensure access to the most up to date versions of the forms.</p> <p>RATIONALE: The rationale is that forms listed in the section should include access to printable or downloadable versions of the form and vital record / certificate templates should not be publicly accessible. The forms that members of the public do need or are required to use should be listed and accessible.</p> <p>LIKELY IMPACT: The public will have access via the regulations in the VAC online to all relevant forms. Also, the section will be more concise with the removal of unnecessary references to other forms.</p>

1 **Project 7299 - Fast-Track**

2 **Department of Health**

3 **Amend Regulations following Periodic Review - Amendments to comply with the**
4 **Code of Virginia.**

5 **12VAC5-550-5. Definitions.**

6 In addition to the words and terms defined in § 32.1-249 of the Code of Virginia, the
7 following words and terms when used in this chapter shall have the following meanings
8 unless the context clearly indicates otherwise:

9 "Board" means the State Board of Health.

10 "Commissioner" means the State Health Commissioner.

11 "Department" means Virginia Department of Health.

12 "Immediate family" means a registrant mother, father (name must be shown on the
13 certification), sibling, current spouse and adult children.

14 "Informant" means person providing information to complete the filing of a vital record
15 in order to document a vital event.

16 "Midwife" means a registered nurse who has met the additional requirements of
17 education and examination for licensure as a nurse practitioner in the Commonwealth.

18 "Primary evidence" means valid first-hand documentation established before the
19 registrant's 18th birthday, ~~such as~~ including school admission records, physician's
20 records, immunization records, passport, federal census abstracts, baptismal records and
21 insurance applications.

22 "Registrant" means the person whose personal information is primarily registered on
23 a vital record and filed in the systems of vital records.

24 "Registrar" means the State Registrar of Vital Records or a county, city, or special
25 registrar to whom the State Registrar of Vital Records has delegated functions or duties.

26 "Secondary evidence" means valid documentation established after the registrant's
27 eighteenth birthday ~~such as~~ including marriage records, ~~child's a~~ birth certificate, school
28 records, social security records, driver's records, work permit and employment records.
29 ~~Such evidence must be at least five years old.~~

30 **Statutory Authority**

31 §§ 32.1-12 and 32.1-250 of the Code of Virginia.

32 **Historical Notes**

33 Derived from Virginia Register Volume 19, Issue 26, eff. October 8, 2003.

34 **12VAC5-550-20. Purpose of chapter. (Repealed.)**

35 ~~The board has promulgated this chapter to facilitate the vital record registration~~
36 ~~activities and health statistical services in a manner to ensure the uniform and efficient~~
37 ~~administration of the system. Required certificates, reports, and forms shall be prescribed,~~
38 ~~where feasible, to include data collected nationally for the benefit of all citizens. The~~
39 ~~protection of individual data from casual perusal is essential to the validity of the program~~
40 ~~as well as a desirable shield of sensitive personal information while providing health~~
41 ~~statistics for the protection of society as a whole.~~

42 **Statutory Authority**

43 § 32.1-273 of the Code of Virginia.

44 **Historical Notes**

45 Derived from VR355-29-100 § 1.2, eff. April 1, 1995.

46 **~~12VAC5-550-30. Administration of chapter. (Repealed.)~~**

47 ~~This chapter is administered by the board, the commissioner, and the State Registrar~~
48 ~~of Vital Records and Health Statistics.~~

49 ~~The State Registrar shall carry out the provisions of Chapter 7 (§ 32.1-249 et seq.) of~~
50 ~~Title 32.1 of the Code of Virginia and the regulations of the board.~~

51 **~~Statutory Authority~~**

52 ~~§§ 32.1-12 and 32.1-250 of the Code of Virginia.~~

53 **Historical Notes**

54 Derived from VR355-29-100 § 1.3, eff. April 1, 1995; amended, Virginia Register Volume
55 19, Issue 26, eff. October 8, 2003.

56 **~~12VAC5-550-50. Application of Administrative Process Act. (Repealed.)~~**

57 ~~Except where specifically provided otherwise by statute, the provisions of the Virginia~~
58 ~~Administrative Process Act, which is codified as Chapter 1.1:1 of Title 9 of the Code of~~
59 ~~Virginia, shall govern the adoption, amendment, modification, and revision, of this chapter,~~
60 ~~and the conduct of all proceedings hereunder.~~

61 **~~Statutory Authority~~**

62 ~~§ 32.1-273 of the Code of Virginia.~~

63 **Historical Notes**

64 Derived from VR355-29-100 § 1.6, eff. April 1, 1995.

65 **~~12VAC5-550-60. Powers and procedures of chapter not exclusive. (Repealed.)~~**

66 ~~The board reserves the right to authorize any procedure for the enforcement of this~~
67 ~~chapter that is not inconsistent with the provisions set forth herein and the provisions of~~
68 ~~Chapter 7 of Title 32.1 of the Code of Virginia.~~

69 **~~Statutory Authority~~**

70 ~~§ 32.1-273 of the Code of Virginia.~~

71 **Historical Notes**

72 Derived from VR355-29-100 § 1.7, eff. April 1, 1995.

73 **12VAC5-550-125. Certificate of birth resulting in a stillbirth.**

74 ~~In accordance with A. Pursuant to § 32.1-258.1 of the Code of Virginia, a certificate of~~
75 ~~birth resulting in a stillbirth shall be issued upon request from the parent the State Registrar~~
76 ~~shall, upon the request of either individual listed as the parent on a report of fetal death in~~
77 ~~Virginia, issue a Certificate of Birth Resulting in Stillbirth for a fetal death occurring after a~~
78 ~~gestational period of 20 weeks or more gestation and payment of the appropriate fee for~~
79 ~~a vital record. This .~~

80 B. The certificate shall contain the following information; name (optional); :

81 1. The registrant's name, if one is provided,

82 2. The mother's maiden name,

83 3. The father's name (if indicated), if indicated,

84 4. The date of event ~~the fetal death~~, and

85 5. The hospital of occurrence ~~or location the fetal death occurred~~.

86 ~~When C. If no report of spontaneous fetal death is available to establish the event,~~
87 ~~documentation from the following sources is acceptable: the parent may provide~~
88 ~~documentation from the following sources to establish that the fetal death occurred:~~

89 1. The licensed physician or licensed nurse midwife who provided care to the
90 mother, documentation from the

91 2. The medical record maintained at the hospital of occurrence, copy of the report
92 of spontaneous fetal death or documentation from where the fetal death occurred,
93 or

94 3. The funeral service director (if such services were provided); if funeral services
95 were provided.

96 **Statutory Authority**

97 §§ 32.1-12 and 32.1-250 , and 32.1-258.1 of the Code of Virginia.

98 **Historical Notes**

99 Derived from Virginia Register Volume 19, Issue 26, eff. October 8, 2003.

100 **12VAC5-550-130. Marriage return and certificate items.**

101 ~~The record of marriage to be used shall be the Marriage Return and Certificate,~~
102 ~~Commonwealth of Virginia, and shall contain the following items: city or county of the court~~
103 ~~of issuance; court clerk's number; for the groom: full name, age, date and place of birth,~~
104 ~~social security number or control number issued by the Department of Motor Vehicles,~~
105 ~~race, marital status if previously married, number of marriage, education, usual residence,~~
106 ~~the names of parents; for the bride: full name, maiden name, age, date and place of birth,~~
107 ~~social security number or control number issued by the Department of Motor Vehicles,~~
108 ~~race, marital status if previously married, number of marriage, education, usual residence,~~
109 ~~and names of parents; signature of clerk of court and date of license; date and place of~~
110 ~~marriage; whether civil or religious ceremony; certification and signature of officiant~~
111 ~~indicating title, address, and year and court of qualification; date received by clerk of court~~
112 ~~from officiant; and state file number.~~

113 A. An officer issuing marriage licenses shall, on or before the tenth day of each
114 calendar month, forward to the State Registrar a record of each marriage filed with him
115 during the preceding calendar month pursuant to § 32.1-267.

116 B. To request a certified copy of a certificate of marriage, an applicant shall submit to
117 the registrar a completed form VS6MD.

118 **Statutory Authority**

119 §§ 32.1-12 and 32.1-250 of the Code of Virginia.

120 **Historical Notes**

121 Derived from VR355-29-100 § 3.4, eff. April 1, 1995; amended, Virginia Register Volume
122 19, Issue 26, eff. October 8, 2003.

123 **12VAC5-550-140. Report of divorce or annulment items.**

124 ~~The report of divorce or annulment to be used shall be the Report of Divorce or~~
125 ~~Annulment, Commonwealth of Virginia, and shall contain the following items: city or county~~
126 ~~of court of issuance; for the husband: full name, date and place of birth, social security~~
127 ~~number or control number issued by the Department of Motor Vehicles, education, number~~
128 ~~of marriage, usual residence; for the wife: full maiden name, date and place of birth, social~~
129 ~~security number or control number issued by the Department of Motor Vehicles, education,~~
130 ~~number of the marriage, usual residence; date and place of marriage; identity of plaintiff~~
131 ~~and to whom divorce granted; number and custody of children under 18 in this family; date~~
132 ~~of separation; date of divorce; legal grounds or cause of divorce; signature of attorney or~~

133 ~~petitioner; certification and signature of clerk of court indicating type of decree; court file~~
134 ~~number; date final order entered; and state file number.~~

135 A. A clerk of court shall, on or before the tenth day of each calendar month, forward to
136 the State Registrar the report of each final decree of divorce and annulment granted during
137 the preceding calendar month pursuant to § 32.1-268.

138 B. To request a certified copy of a certificate of divorce or annulment, an applicant
139 shall submit to the registrar a completed form VS6MD.

140 **Statutory Authority**

141 §§ 32.1-12 and 32.1-250 of the Code of Virginia.

142 **Historical Notes**

143 Derived from VR355-29-100 § 3.5, eff. April 1, 1995; amended, Virginia Register Volume
144 19, Issue 26, eff. October 8, 2003.

145 **12VAC5-550-320. Change of sex.**

146 ~~Except as provided in subdivision 3 of 12VAC5-550-450, upon presentation of~~
147 ~~acceptable evidence (preoperative diagnosis, postoperative diagnosis and description of~~
148 ~~procedure) and a notarized affidavit from the physician performing the surgery, a new~~
149 ~~certificate of birth may be prepared by the State Registrar for a person born in this~~
150 ~~Commonwealth whose sex has been changed by surgical gender reassignment~~
151 ~~procedure. A certified copy of the court order changing the name of the registrant as well~~
152 ~~as designating the sex of the registrant must be in the possession of the State Registrar~~
153 ~~together with a request that a new certificate be prepared.~~

154 A. Upon request of a registrant or the registrant's legal representative, the State
155 Registrar shall issue a new certificate of birth to show a change of sex of the registrant.
156 The person requesting issuance of a new certificate of birth pursuant to this section shall
157 use the Changing Sex Designation, VS42 Form.

158 B. The State Registrar shall also issue, upon request of a registrant or the registrant's
159 legal representative requesting a change of sex pursuant to this section, a new certificate
160 of birth to show a new name if the registrant or the registrant's legal representative submits
161 a certified copy of a court order changing the registrant's name.

162 **Statutory Authority**

163 §§ 32.1-12 and 32.1-250 of the Code of Virginia.

164 **Historical Notes**

165 Derived from VR355-29-100 § 9.5, eff. April 1, 1995; amended, Virginia Register Volume
166 19, Issue 26, eff. October 8, 2003.

167 **Part XI**

168 **Correction and Amendment**

169 **12VAC5-550-440. Applications for correction.**

170 ~~A. After 30 days from the date of filing, no change or alteration in any birth or death~~
171 ~~certificate on file with the State Registrar or on file in any city or county of this~~
172 ~~Commonwealth shall be made except upon application to the State Registrar.~~

173 ~~1. To change or alter a birth certificate, such application shall be made by the~~
174 ~~reporting source, one of the parents, guardian, or legal representative of the child,~~
175 ~~or, if the person whose certificate is involved is 18 years of age or over, by the~~
176 ~~person himself.~~

177 ~~2. To change or alter a death certificate, such application shall be made by the~~
178 ~~surviving spouse or the next of kin of the deceased, attending funeral service~~
179 ~~licensee, or other reporting source, such as hospital medical records.~~

180 ~~3. Changes or alterations of the medical certification of cause of death may be~~
181 ~~requested only by the attending physician or by the medical examiner.~~

182 ~~B. Within 30 days from the date of filing, A. The State Registrar may enter missing~~
183 ~~data or corrected information may be entered on a birth or death certificate by the State~~
184 ~~Registrar or by the city or county registrar when the original record is in his possession. If~~
185 ~~the missing or corrected data is obtained at the initiative of the State Registrar within 30~~
186 ~~calendar days from the date of filing, the State Registrar shall not consider the record to~~
187 ~~be amended.~~

188 ~~B. The following persons may request an amendment to a birth certificate by filing an~~
189 ~~application with the State Registrar in the form of a written letter or the Birth Certificate~~
190 ~~Amendment Request, VS43 Form:~~

191 ~~1. If the registrant is under 18 years of age, the informant who filed the birth~~
192 ~~certificate, the registrant's parent, guardian, or legal representative, or~~

193 ~~2. If the registrant is 18 years of age or over or has been emancipated pursuant to~~
194 ~~Article 15 (§ 16.1-331 et seq.) of Chapter 11 of Title 16.1 of the Code of Virginia,~~
195 ~~the registrant or the registrant's legal representative.~~

196 ~~1. Applications for changes or alterations may be made by persons outlined in~~
197 ~~subdivision A 1 or A 2 of this section.~~

198 ~~2. Missing or corrected data may be obtained at the initiative of the city or county~~
199 ~~registrar by personal call, telephone, or query form from the reporting source~~
200 ~~responsible for filing the birth or death certificate. Data so obtained by the registrar~~
201 ~~shall not be deemed an amendment.~~

202 ~~C. The State Registrar shall, upon receipt of an application pursuant to subsection B~~
203 ~~of this section, advise the person whether the amendment can be made administratively,~~
204 ~~subject to the evidence requirements of this chapter or if the amendment requires a court~~
205 ~~order.~~

206 ~~C. Marriage and D. The registrar may amend a record of marriage, divorce, or~~
207 ~~annulment records on file with the State Registrar may be amended only by upon~~
208 ~~notification from the clerk of court in which the original record is filed. Such The notification~~
209 ~~to the State Registrar shall indicate what which items have been amended on the original~~
210 ~~record and shall indicate that the State Registrar's registrar's copy should shall be~~
211 ~~amended accordingly. Evidence The court in which the original record is filed shall~~
212 ~~determine the evidence required for amending a record of marriage and divorce, or~~
213 ~~annulment, records shall be determined by the court in which the original record is filed.~~

214 ~~E. A person may request the State Registrar to amend a death certificate by submitting~~
215 ~~an affidavit and supporting documentary evidence testifying to the corrected information~~
216 ~~to be amended. The State Registrar shall amend the death certificate to reflect the new~~
217 ~~information upon receipt of the affidavit and supporting documentary evidence.~~

218 ~~F. Pursuant to § 32.1-269.1, if more than 45 calendar days have elapsed since the~~
219 ~~filing of a death certificate, the surviving spouse or immediate family of the registrant,~~
220 ~~attending funeral service licensee, or other reporting source may file a petition, along with~~
221 ~~a sworn affidavit under oath that supports the request, with the circuit court of the county~~
222 ~~or city in which the registrant resided at the time of his death or the Circuit Court of the~~
223 ~~City of Richmond requesting an order to amend a death certificate other than correction~~
224 ~~of the following information by the State Registrar:~~

- 225 1. The spelling of the name of the registrant, registrant's parent or spouse, or the
226 informant;
227 2. The sex, age, race, date of birth, place of birth, citizenship, social security
228 number, education, occupation or kind of business, military status, or date of death
229 of the registrant;
230 3. The place of residence of the registrant, if located within Virginia; or
231 4. The name of the institution, county, city, town, street, or place where the death
232 occurred.

233 G. The State Registrar shall amend the death certificate upon receipt from the clerk of
234 the circuit court of the county or city in which the registrant resided at the time of his death
235 or the Circuit Court of the City of Richmond a certified copy of the court's order to amend
236 the death certificate in accordance with the order.

237 H. Only the provider who completed the registrant's medical certification pursuant to §
238 32.1-263 may request a change or amendment to the medical certification of cause of
239 death.

240 **Statutory Authority**

241 §§ 32.1-12 and 32.1-250 , and 32.1-269.1 of the Code of Virginia.

242 **Historical Notes**

243 Derived from VR355-29-100 § 11.1, eff. April 1, 1995; amended, Virginia Register Volume
244 19, Issue 26, eff. October 8, 2003.

245 **12VAC5-550-450. Evidence required for corrections or amendments.**

246 Every A. A person shall include a correction affidavit and documentary evidence
247 pursuant to this section with an application for a correction or amendment of to amend a
248 birth or death certificate shall be accompanied by appropriate documentary evidence as
249 follows: .

- 250 1. Except as provided in subdivisions 2 and 3 of this section, name changes, other
251 than minor corrections in spelling involving the given names or surname of a
252 registrant, or the given names or surnames of the parents or of a spouse as listed
253 on a certificate, shall require that a certified or attested copy of a court order
254 changing the name be obtained.
- 255 a. In cases where the mother's married surname is listed instead of her maiden
256 name, a correction can be made administratively with a correction affidavit and
257 copy of her birth record.
- 258 b. In cases where the given name shown on a birth certificate was not used or
259 known to the registrant and this fact can be proven by the registrant, the birth
260 certificate can be amended administratively with primary evidence showing the
261 name at birth and a correction affidavit.
- 262 2. Within one year of birth, the given names listed on a birth certificate may be
263 changed by the affidavit of:
- 264 a. Both parents;
- 265 b. The mother in the case of a child born out of wedlock;
- 266 c. The father in the case of the death or incapacity of the mother;
- 267 d. The mother in the case of the death or incapacity of the father; or
- 268 e. The guardian or agency having legal custody of the registrant.
- 269 3. In cases of hermaphroditism or pseudo-hermaphroditism, given names of a
270 registrant may be changed on a birth certificate by affidavit of the parents or

271 guardian as listed in subdivision 2 of this section, or by affidavit of the registrant if
272 18 years of age or older. Additionally, a statement from a physician must be
273 submitted which certified the birth record of the registrant contains an incorrect
274 designation of sex because of congenital hermaphroditism, pseudo-
275 hermaphroditism, or ambiguous genitalia which has since been medically clarified.

276 4. Except as otherwise provided in the Code of Virginia or this chapter, after one
277 year from the date of birth, any change of name shall be made only by court order,
278 and any second change of name within one year shall be made only by court order.

279 5. Within seven years after birth, given names may be added to a birth certificate
280 where such information has been left blank by use of an affidavit only prepared by
281 the parent, guardian, or legal representative of the child.

282 6. If the date of birth on a birth certificate is to be changed more than one year, a
283 certified copy of a court order changing the date of birth shall be submitted.
284 Evidence to be supplied to the court in support of such change should include a
285 federal census transcript from the Bureau of the Census.

286 7. If the date of birth on a birth certificate is to be changed to one year or less from
287 the date of birth, a federal census transcript from the Bureau of the Census shall
288 be required as documentary evidence.

289 8. If a federal census transcript cannot be obtained, an affidavit shall be obtained
290 which sets forth: the identity of the incorrect record, the incorrect data as it is listed,
291 the correct data as it should be listed, and the documentary evidence supporting
292 the facts. In addition to the affidavit, a document or certified or true copy of such
293 document must be obtained which was written before the registrants' eighth birth
294 date and will establish the identity of the certificate to be altered or corrected and
295 will support the true and correct facts. Any item of a vital record which has been
296 previously corrected may only be changed again by court order.

297 9. All documents, except the affidavit, shall be returned to the applicant after
298 review.

299 B. To amend a death certificate pursuant to 12VAC5-550-440, an applicant shall
300 submit to the State Registrar a certified copy of a court order obtained pursuant to § 32.1-
301 269.1 or a correction affidavit and primary or secondary documentary evidence testifying
302 to the amended information.

303 **Statutory Authority**

304 §§ 32.1-12 and 32.1-250 of the Code of Virginia.

305 **Historical Notes**

306 Derived from VR355-29-100 § 11.2, eff. April 1, 1995; amended, Virginia Register Volume
307 19, Issue 26, eff. October 8, 2003.

308 **12VAC5-550-460. Methods of correcting or altering certificates.**

309 A. A The registrar shall record a new name authorized by court order shall be recorded
310 by drawing a single line through the name appearing on the certificate record and inserting
311 the new name above it or to the side of it the new name. In addition, there shall be inserted
312 on the certificate the registrar shall insert on the record a statement that the name was
313 changed by court order and the date and place of such the court order. The The registrar
314 shall also insert the word "Amended" shall be written in the top margin of the certificate
315 record. Certificates on which given names are added within seven years after birth or on
316 which given names have been changed The registrar shall not consider a record as
317 amended if the registrant's name is amended within one year of the vital event that was

318 recorded, or if the name is amended at any time pursuant to subdivision 3 of 12VAC5-
319 550-450 shall not be considered as amended.

320 B. ~~In all other cases, corrections or alterations shall be made~~ The registrar shall record
321 amendments to other items by drawing a single line through the incorrect item, if listed,
322 and by inserting the correct or missing data immediately above it or to the side of it, or by
323 completing the blank item, ~~as the case may be.~~ In addition, ~~there shall be inserted on the~~
324 ~~certificate~~ the registrar shall insert a statement identifying the affidavit and documentary
325 evidence used as proof of the ~~correct facts~~ amended information and the date the
326 ~~correction~~ amendment was made. If the registrar receives the request to amend a record
327 three months have elapsed from after the date of filing, the registrar shall insert the word
328 "Amended" ~~shall be written~~ in the top margin of the certificate unless otherwise stated in
329 this chapter.

330 **Statutory Authority**

331 § 32.1-273 of the Code of Virginia.

332 **Historical Notes**

333 Derived from VR355-29-100 § 11.3, eff. April 1, 1995.

334 **12VAC5-550-520. Fees.**

335 A. ~~The fee to be charged by the State Registrar or by the city or county registrar shall~~
336 ~~be \$40 , except if otherwise directed in the Code of Virginia, charge a fee of \$12~~ for each
337 full certification or short form certification of a vital record, or for a search of the files or
338 records when no copy is made.

339 B. ~~When documents are amended or delayed birth registration is requested, the~~
340 ~~requester shall be charged an administrative fee of \$10. The registrar shall charge a fee~~
341 ~~of \$10 to amend a vital record or register a delayed birth registration.~~

342 **Statutory Authority**

343 §§ 32.1-12 and 32.1-250 of the Code of Virginia.

344 **Historical Notes**

345 Derived from VR355-29-100 § 13.2, eff. April 1, 1995; amended, Virginia Register Volume
346 19, Issue 26, eff. October 8, 2003.

347 FORMS (12VAC5-550)

348 ~~Certificate of Live Birth, VS1 (eff. 1/93).~~

349 ~~Certificate of Death, VS2 (eff. 1/89).~~

350 ~~Certificate of Death (Medical Examiner's Certificate), VS2A (eff. 1/89).~~

351 ~~Marriage Register, VS3 (eff. 1/90).~~

352 ~~Report of Divorce or Annulment, VS4 (eff. 1/90).~~

353 ~~Report of Spontaneous Fetal Death, VS5 (eff. 1/93).~~

354 ~~Report of Induced Termination of Pregnancy, VS5A (eff. 1/90).~~

355 ~~Application for Certification of a Vital Record, VS6 (eff. 7/02).~~

356 ~~Out-of-State Transit Permit, VS10 (eff. 7/85).~~

357 ~~Permit for Disinterment, Transit, and Reinterment, VS11 (eff. 7/85).~~
358 ~~Delayed Certificate of Birth, VS12 (eff. 4/85).~~
359 [Birth Record Application VS6B \(eff. 07/2020\)](#)
360 [Marriage-Divorce Record Application VS6MD \(eff. 02/2020\)](#)
361 [Death Record Application VS6D \(eff. 07/2022\).](#)
362 [Stillbirth Application VS6FD \(eff. 07/2022\).](#)
363 ~~Report of Adoption, VS21 (eff. 7/85).~~
364 [Report of Adoption, VS21 \(eff. 07/2012\).](#)
365 ~~Acknowledgement of Paternity, VS22 (eff. 9/93).~~
366 [Acknowledgement of Paternity, VS22 \(eff. 07/2004\).](#)
367 ~~Affidavit for Correction of a Record, VS32 (eff. 1/87).~~
368 [Affidavit for Correction of a Record, VS32 \(eff. 09/2005\).](#)
369 ~~Hospital Monthly Vital Statistics Report, VS33 (eff. 7/89).~~
370 ~~Funeral Director's Monthly Vital Statistics Report, VS33-A (eff. 3/90).~~
371 ~~Court Order Establishing Record of Birth, VS40 (eff. 10/88).~~
372 [Form for Changing Sex Designation, VS42 \(eff. 07/2020\).](#)
373 [Birth Certificate Amendment Request Form, VS43 \(eff. 07/2021\).](#)

Office of Regulatory Management
Economic Review Form

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC5 – 550
VAC Chapter title(s)	Certificate of birth resulting in a stillbirth, Marriage return and certificate items, Change of sex, Applications for correction, Evidence required for corrections or amendments.
Action title	Amend Regulations Following Statutory Changes
Date this document prepared	11/1/22

Cost Benefit Analysis

Table 1a must be completed for all actions. Tables 1b and 1c must be completed for actions (or portions thereof) where the agency is exercising discretion, including those where some of the changes are mandated by state or federal law or regulation. Tables 1b and 1c are not needed if **all** changes are mandated, and the agency is not exercising any discretion. In that case, enter a statement to that effect.

- (1) Direct Costs & Benefits: Identify all specific, direct economic impacts (costs and/or benefits), anticipated to result from the regulatory change. (A direct impact is one that affects entities regulated by the agency and which directly results from the regulatory change itself, without any intervening steps or effects. For example, the direct impact of a regulatory fee change is the change in costs for these regulated entities.) When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Keep in mind that this is the proposed change versus the status quo. One bullet has been provided, add additional bullets as needed.
- (2) Quantitative Factors:
 - (a) Enter estimated dollar value of total (overall) direct costs described above.
 - (b) Enter estimated dollar value of total (overall) direct benefits described above.
 - (c) Enter the present value of the direct costs based on the worksheet.
 - (d) Enter the present value of the direct benefits based on the worksheet.
- (3) Benefits-Costs Ratio: Calculate d divided by c OR enter it from the worksheet.
- (4) Net Benefit: Calculate d minus c OR enter it from the worksheet.
- (5) Indirect Costs & Benefits: Identify all specific, indirect economic impacts (costs and/or benefits), anticipated to result from the regulatory change. (An indirect impact is one that results from responses to the regulatory change, but which are not directly required by the regulation. Indirect impacts of a regulatory fee change on regulated entities could include a change in the prices they charge, changes in their operating procedures or employment levels, or decisions to enter or exit the regulated profession or market. Indirect impacts also include responses by other entities that have close economic ties to the regulated

entities, such as suppliers or partners.) If there are no indirect costs or benefits, include a specific statement to that effect.

- (6) Information Sources: Describe the sources of information used to determine the benefits and costs, including the source of the Quantitative Factors. If dollar amounts are not available, indicate why they are not.
- (7) Optional: Use this space to add any further information regarding the data provided in this table, including calculations, qualitative assessments, etc.

Table 1a: Costs and Benefits of the Proposed Changes (Primary Option)

<p>(1) Direct Costs & Benefits</p>	<ul style="list-style-type: none"> ● The regulatory action will amend <u>Definitions</u> (12VAC5-550-5). Minimal updates clarify language used in the Regulations to support a clearer understanding of the requirements and information included in 12VAC5-550. <p>Direct Costs: There are no direct costs associated with this change.</p> <p>Direct Benefits: Individuals will benefit inasmuch as the regulatory language will be more clear and easier to understand.</p> ● The regulatory action will repeal 12VAC5 – 550-20, 12VAC5 – 550-30, 12VAC5 – 550-50, 12VAC5 – 550-60 which are not regulatory in nature <p>Direct Costs: There are no direct costs associated with this change.</p> <p>Direct Benefits: The benefit of this change is to reduce the length of the regulation by removing unnecessary language.</p> ● The regulatory action will amend the <u>Certificate of birth resulting in a stillbirth regulation</u> (12VAC5-550-125) removing the requirement of a fee to be established for this certificate type. This action is required to conform to Chapter 171 of the 2022 Acts of Assembly. <p>Direct Costs: There are no direct costs to entities regulated by the agency as a result of this change.</p> <p>Direct Benefits: Individuals requesting a certificate of birth resulting in a stillbirth will no longer be charged a \$12 fee. From 2018 through 2020, the Office of Vital Records issued 229 of these certificates, equaling an average savings of \$916 per year if fees were not charged during that time period.</p> ● The regulatory action will amend the <u>Marriage return and certificate items</u> (12VAC5-550-130) and <u>Report of divorce or</u>
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annulment items (12VAC5-550-140) removing the item “race” on marriage and divorce certificates. This action is required to comply with Chapters 209, 210 and 211 of the 2020 Acts of Assembly.

Direct Costs: There are no direct costs associated with this change.

Direct Benefits: The direct benefits of this change are that the regulations will comply with the Code of Virginia.

- **The regulatory action will amend the Change of sex (12VAC5-550-320) to update the requirements for changing the sex on a birth certificate to conform to Chapter 466 of the 2020 Acts of Assembly.**

Direct Costs: There are no direct costs associated with this change.

Direct Benefits: Individuals seeking to change the sex on their birth certificate can now accomplish this through a simplified administrative process which does not require court costs. Legal fees can range widely so VDH does not have a way to calculate this potential benefit.

- **The regulatory action will amend the Applications for correction (12VAC5-550-440), Evidence required for corrections or amendments (12VAC5-550-450), and Methods of correcting or altering certificates (12VAC5-550-460) to allow information on a death certificate to be amended with supporting evidence for 45 days after the filing of the death certificate, and to clarify amendment forms and processes to create internal consistency within the Regulations. This action is required to conform to Chapter 117 of the 2022 Acts of Assembly. The change to Section 460 is to conform to § 32.1-269 (B) of the Code of Virginia.**

Direct Costs: There are no direct costs associated with this change.

Direct Benefits: Individuals seeking to amend a death certificate no longer need to pay court fees in order to obtain a court order to request an amendment to the decedent’s name, informant’s name, name of spouse, marital status, name of parents and place of residency when outside of the Commonwealth, if an amendment is made within 45 days of filing the death certificate. Legal fees can range widely so VDH does not have a way to calculate this potential benefit.

	<ul style="list-style-type: none"> <p>The regulatory action will amend the <u>Fees</u> (12VAC5-550-520) to document the fee charged for a vital record as established by Chapter 534 of the 2013 Acts of Assembly and the 2004 Budget Bill – HB5001 (Chapter 4).</p> <p>Direct Costs: Because the fee being reflected in the new regulation is being updated to simply reflect the fee that has been in effect since 2004, there is no additional new cost associated with this effort to align the Regulation to the Code.</p> <p>Direct Benefits: Individuals will benefit insomuch as the Regulatory language will be more clear and easier to understand when it is consistent with the Code.</p> <p>The regulatory action will amend the <u>Forms</u> (12VAC5-550-9998) to document and link to forms being explicitly referenced in these amendments, while removing those forms not referenced in the Regulations, and updating the effective dates.</p> <p>Direct Costs: There are no direct costs associated with this change.</p> <p>Direct Benefits: Forms will be easier to find.</p> <p>In addition to substantive changes mentioned above, a number of style and form changes are also being made to conform the language to the <i>Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code</i>. If these changes were promulgated in their own action, they would be exempt from the requirements of Article 2 of the Administrative Process Act, pursuant to § 2.2-4006 (A)(3).</p> <p>Direct Costs: There are no direct costs associated with this change.</p> <p>Direct Benefits: The language will conform to the <i>Form and Style Requirements</i> and be clearer and more readable.</p> 		
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(2) Quantitative Factors	Estimated Dollar Amount	Present Value	
Direct Costs	(a) \$0	(c) \$0	
Direct Benefits	(b) \$9,160 (over 10 years)	(d) \$8,048	
(3) Benefits-Costs Ratio	8,048/0	(4) Net Benefit	\$8,048

(5) Indirect Costs & Benefits	<p>Indirect Costs: There are no indirect costs associated with this regulatory action.</p> <p>Indirect Benefits: There are no indirect benefits associated with this regulatory action.</p>
(6) Information Sources	Report of the number of certificates of birth resulting in stillbirth issued from the Virginia Vital Events and Screening Tracking System (VVESTS) for years 2018 - 2020
(7) Optional	

Table 1b: Costs and Benefits under the Status Quo (No change to the regulation)

This table addresses current requirements and the implications of not making any changes. In other words, describe the costs and benefits of maintaining the current regulatory requirements as is.

(1) Direct Costs & Benefits	<p>The changes made in this action are required to conform to Chapters 116, 117 and 171 of the 2022 Acts of Assembly; Chapters 209, 210, 211, 465, and 466 of the 2020 Acts of Assembly; Item 290 (A), Chapter 2, 2022 Acts of Assembly, Special Session I; and § 32.1-269 (B). These changes are non-discretionary.</p> <p>The repeal of sections 20, 30, 50, and 60 is intended to conform the chapter to the definition of a “regulation” in § 2.2-4001 and reflect the intent of 1VAC7-10-40(C), which indicate that the provisions are non-regulatory in nature and should be omitted from the regulation.</p> <ul style="list-style-type: none"> • The “status quo” option would be to just leave the sections in the regulation. There are no direct cost or benefits associated with that option. <p>The style and form changes are to conform with the <i>Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code</i> and could be considered non-discretionary.</p> <ul style="list-style-type: none"> • The “status quo” option would be to leave the language in its current style and form, for which there are no associated direct costs or benefits. 	
(2) Quantitative Factors	Estimated Dollar Amount	Present Value
Direct Costs	(a)	(c)

Direct Benefits	(b)	(d)
(3) Benefits-Costs Ratio		(4) Net Benefit
(5) Indirect Costs & Benefits	There are no indirect costs or benefits associated with the “status quo” options listed above.	
(6) Information Sources		
(7) Optional		

Table 1c: Costs and Benefits under an Alternative Approach

This table addresses an alternative approach to accomplishing the objectives with different requirements. These alternative approaches may include the use of reasonably available alternatives in lieu of regulation, or information disclosure requirements or performance standards instead of regulatory mandates.

(1) Direct Costs & Benefits	<p>The changes made in this action are required to conform to Chapters 116, 117 and 171 of the 2022 Acts of Assembly; Chapters 209, 210, 211, 465, and 466 of the 2020 Acts of Assembly; Item 290 (A), Chapter 2, 2022 Acts of Assembly, Special Session I; and § 32.1-269 (B). These changes are non-discretionary and not subject to consideration of alternative approaches.</p> <p>The repeal of sections 20, 30, 50, and 60, along with the style and form changes, make no substantive changes to regulatory requirements associated with the chapter, are non-regulatory, and do not affect the rights or powers of any person or agency. As such, there are no viable alternative approaches to be considered.</p>	
(2) Quantitative Factors	Estimated Dollar Amount	Present Value
Direct Costs	(a)	(c)
Direct Benefits	(b)	(d)
(3) Benefits-Costs Ratio		(4) Net Benefit

(5) Indirect Costs & Benefits	
(6) Information Sources	
(7) Optional	

Impact on Local Partners

- (1) Describe the direct costs and benefits (as defined on page 1) for local partners in terms of real monetary costs and FTEs. Local partners include local or tribal governments, school divisions, or other local or regional authorities, boards, or commissions. If local partners are not affected, include a specific statement to that effect and a brief explanation of the rationale.
- (2) Quantitative Factors:
 - (a) Enter estimated dollar value of total (overall) direct costs described above.
 - (b) Enter estimated dollar value of total (overall) direct benefits described above.
- (3) Indirect Costs & Benefits: Describe any indirect benefits and costs (as defined on page 1) for local partners that are associated with all significant changes. If there are no indirect costs or benefits, include a specific statement to that effect.
- (4) Information Sources: describe the sources of information used to determine the benefits and costs, including the source of the Quantitative Factors. If dollar amounts are not available, indicate why they are not.
- (5) Assistance: Identify the amount and source of assistance provided for compliance in both funding and training or other technical implementation assistance.
- (6) Optional: Use this space to add any further information regarding the data provided in this table, including calculations, qualitative assessments, etc.

Note: If any of the above information was included in Table 1, use the same information here.

Table 2: Impact on Local Partners

(1) Direct Costs & Benefits	<ul style="list-style-type: none"> • Direct Costs: There are no direct costs to local partners associated with this regulatory action. • Direct Benefits: There are no direct benefits to local partners associated with this regulatory action.
(2) Quantitative Factors	Estimated Dollar Amount

Direct Costs	(a) \$0
Direct Benefits	(b) \$0
(3) Indirect Costs & Benefits	<ul style="list-style-type: none"> • Indirect Costs: There are no indirect costs to local partners associated with this regulatory action. • Indirect Benefits: There are no indirect benefits to local partners associated with this regulatory action.
(4) Information Sources	N/A
(5) Assistance	N/A
(6) Optional	N/A

Economic Impacts on Families

- (1) Describe the direct costs and benefits (as defined on page 1) to a typical family of three (average family size in Virginia according to the U. S. Census) arising from any proposed regulatory changes that would affect the costs of food, energy, housing, transportation, healthcare, and education. If families are not affected, include a specific statement to that effect and a brief explanation of the rationale.
- (2) Quantitative Factors:
 - (a) Enter estimated dollar value of direct costs.
 - (b) Enter estimated dollar value of direct benefits.
- (3) Indirect Costs & Benefits: Describe any indirect costs and benefits (as defined on page 1) to a typical family of three that are most likely to result from the proposed changes.
- (4) Information Sources: describe the sources of information used to determine the benefits and costs, including the source of the Quantitative Factors. If dollar amounts are not available, indicate why not.
- (5) Optional: Use this space to add any further information regarding the data provided in this table, including calculations, qualitative assessments, etc.

Note: If any of the above information was included in Table 1, use the same information here.

Table 3: Impact on Families

(1) Direct Costs & Benefits	<ul style="list-style-type: none"> • Direct Costs: There are no direct costs to families associated with this regulatory action. • Direct Benefits: As stated in Table 1a, families who experience a stillbirth within the Commonwealth and require a certificate of birth resulting in stillbirth will not be required to pay the \$12 fee for the certificate.
(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a) \$0
Direct Benefits	(b) \$916/year throughout the entire Commonwealth.
(3) Indirect Costs & Benefits	<ul style="list-style-type: none"> • Indirect Costs: There are no indirect costs to families associated with this regulatory action. • Indirect Benefits: There are no indirect benefits to families associated with this regulatory action.
(4) Information Sources	N/A
(5) Optional	N/A

Impacts on Small Businesses

- (1) Describe the direct costs and benefits (as defined on page 1) for small businesses. For purposes of this analysis, “small business” means the same as that term is defined in § 2.2-4007.1. If small businesses are not affected, include a specific statement to that effect and a brief explanation of the rationale.
- (2) Quantitative Factors:
 - (a) Enter estimated dollar value of direct costs.
 - (b) Enter estimated dollar value of direct benefits.
- (3) Indirect Costs & Benefits: Describe the indirect benefits and costs (as defined on page 1) for small businesses that are most likely to result from the proposed changes.
- (4) Alternatives: Add a qualitative discussion of any equally effective alternatives that would make the regulatory burden on small business more equitable compared to other affected business sectors, and how those alternatives were identified.

- (5) Information Sources: describe the sources of information used to determine the benefits and costs, including the source of the Quantitative Factors. If dollar amounts are not available, indicate why not.
- (6) Optional: Use this space to add any further information regarding the data provided in this table, including calculations, qualitative assessments, etc.

Note: If any of the above information was included in Table 1, use the same information here.

Table 4: Impact on Small Businesses

(1) Direct Costs & Benefits	<ul style="list-style-type: none"> • Direct Costs: There are no direct costs to small businesses associated with this regulatory action. • Direct Benefits: There are no direct benefits to small businesses associated with this regulatory action.
(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a)\$0
Direct Benefits	(b)\$0
(3) Indirect Costs & Benefits	<ul style="list-style-type: none"> • Indirect Costs: There are no indirect costs to small businesses associated with this regulatory action. • Indirect Benefits: There are no indirect benefits to small businesses associated with this regulatory action.
(4) Alternatives	The agency is not exercising any discretion with regard to the substantive provisions of this chapter and there are no direct or indirect costs to small businesses associated with this regulatory action. Alternatives are not available.
(5) Information Sources	N/A
(6) Optional	N/A

Changes to Number of Regulatory Requirements

For each individual VAC Chapter amended, repealed, or promulgated by this regulatory action, list (a) the initial requirement count, (b) the count of requirements that this regulatory package is adding, (c) the count of requirements that this regulatory package is reducing, (d) the net change in the number of requirements. This count should be based upon the text as written when this

stage was presented for executive branch review. Five rows have been provided, add or delete rows as needed.

Table 5: Total Number of Requirements

Chapter number	Number of Requirements			
	Initial Count	Additions	Subtractions	Net Change
20	1	0	1	-1
30	1	0	1	-1
50	1	0	1	-1
60	0	0	0	0
125	2	0	0	0
130	2	0	1	-1
140	2	0	0	0
320	0	3	0	3
440	7	0	0	0
450	8	2	1	1
460	7	7	7	0
520	2	1	1	0
9998	0	0	0	0



COMMONWEALTH of VIRGINIA

Colin M. Greene, MD, MPH
State Health Commissioner

Department of Health
P O BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

MEMORANDUM

DATE: November 7, 2022

TO: State Board of Health

FROM: Rebekah E. Allen, JD
Senior Policy Analyst, Office of Licensure and Certification

SUBJECT: Fast Track Action – Regulations for the Licensure of Hospitals in Virginia – Amend Regulation After Periodic Review

Enclosed for your review are proposed amendments to Regulations for the Licensure of Hospitals in Virginia (12VAC5-410-10 *et seq.*).

This fast-track action is being utilized to conform 12VAC5-410-10 *et seq.* to the Code of Virginia and to update out-of-date regulatory provisions. Changes include amendments to address mandates found in:

- Chapters 80 and 81 of the 2022 Acts of Assembly (minimum standards for any hospital that voluntarily installs a newborn safety device for the reception of children);
- Chapter 218 of the 2022 Acts of Assembly (requiring hospitals that makes minors' health records available to minors through a secure website to also make the health records available to the minor's parent or guardian through the same website);
- Chapters 678 and 679 of the 2022 Acts of Assembly (minimum standards for payment plans and providing information about charity care and financial assistance policies);
- Chapter 72 of the 2021 Acts of Assembly, Special Session I (prohibition on discriminating against health insurance enrollee on the basis of the enrollee being a litigant or potential litigant due to a motor vehicle accident);
- Chapter 220 of the 2021 Acts of Assembly, Special Session I (minimum requirements for designated support persons);
- Chapters 1080 and 1081 of the 2020 Acts of Assembly (prohibition on balance billing);
- Chapter 1088 of the 2020 Acts of Assembly (quarterly reporting of hospital employment of certified sexual assault nurse examiners); and
- Chapters 177 and 222 of the 2005 Acts of Assembly (design and construction guidelines for hospitals).

The changes also include minimum requirements for long-term care nursing units that are certified nursing facilities as required by Article 1 (§ 32.1-123 *et seq.*) of Chapter 5 of Title 32.1 of the Code of Virginia, updating breast milk storage requirements, removing unused terminology, improving terminology consistency, providing definitions for terms to match current clinical and industry practices, moving regulatory provisions to the appropriate part of 12VAC5-410-10 *et seq.*, and revising provisions related to the licensing process and oversight procedures.

The State Board of Health is requested to approve the Fast Track Action. Should the State Board of Health approve the Fast Track Action, the amendments will be submitted to the Office of the Attorney General to begin the Executive Branch review process, as specified by the Administrative Process Act. Following Executive Branch review and approval, the proposed regulatory text will be published in the Virginia Register of Regulations and on the Virginia Regulatory Town Hall website. A 30-day public comment period will begin. Fifteen days after the close of the public comment period, the regulation will become effective.



townhall.virginia.gov

Fast-Track Regulation Agency Background Document

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC5-410-10 <i>et seq.</i>
VAC Chapter title(s)	Regulations for the Licensure of Hospitals in Virginia
Action title	Amend Regulation After Periodic Review
Date this document prepared	November 29, 2022

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

This fast-track action is being utilized to conform 12VAC5-410-10 *et seq.* to the Code of Virginia and to update out-of-date regulatory provisions. Changes include amendments to address mandates found in:

- Chapters 80 and 81 of the 2022 Acts of Assembly (minimum standards for any hospital that voluntarily installs a newborn safety device for the reception of children);
- Chapter 218 of the 2022 Acts of Assembly (requiring hospitals that makes minors' health records available to minors through a secure website to also make the health records available to the minor's parent or guardian through the same website);
- Chapters 678 and 679 of the 2022 Acts of Assembly (minimum standards for payment plans and providing information about charity care and financial assistance policies);
- Chapter 72 of the 2021 Acts of Assembly, Special Session I (prohibition on discriminating against health insurance enrollee on the basis of the enrollee being a litigant or potential litigant due to a motor vehicle accident);

- Chapter 220 of the 2021 Acts of Assembly, Special Session I (minimum requirements for designated support persons);
- Chapters 1080 and 1081 of the 2020 Acts of Assembly (prohibition on balance billing);
- Chapter 1088 of the 2020 Acts of Assembly (quarterly reporting of hospital employment of certified sexual assault nurse examiners); and
- Chapters 177 and 222 of the 2005 Acts of Assembly (design and construction guidelines for hospitals).

The changes include including minimum requirements for long-term care nursing units that are certified nursing facilities required by Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia, updating breast milk storage requirements, removing unused terminology, improving terminology consistency, providing definitions for terms to match current clinical and industry practices, moving regulatory provisions to the appropriate part of 12VAC5-410-10 et seq., and revising provisions related to the licensing process and oversight procedures.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the “Definitions” section of the regulation.

“ACIP” means the Advisory Committee on Immunization Practices of the CDC.

“Board” means the State Board of Health.

“CDC” means the Centers for Disease Control and Prevention.

“Commissioner” means the State Health Commissioner.

“FGI” means The Facility Guidelines Institute.

“SANE” means sexual assault nurse examiner.

“VDH” means the Virginia Department of Health.

Statement of Final Agency Action

Provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) the name of the agency taking the action; and 3) the title of the regulation.

The Board approved the fast-track amendments for 12VAC5-410-10 et seq., Regulations for the Licensure of Hospitals in Virginia, on **DATE**.

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, “mandate” has the same meaning as defined in the ORM procedures, “a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part.”

Consistent with Virginia Code § 2.2-4012.1, also explain why this rulemaking is expected to be noncontroversial and therefore appropriate for the fast-track rulemaking process.

The Board is mandated by Va. Code § 2.2-4007.1(D) and Executive Order 14 (2020) to conduct a periodic review of its regulations. The impetus for this action is a recent periodic review that determined that this regulatory chapter needed to be amended. The rulemaking is expected to be noncontroversial because it is being utilized to conform the regulation to the statutes, legislative mandates, existing clinical and industry practices, and to accurately detail VDH’s licensing procedures and practices. Additionally, VDH’s subject matter experts believe that proposed changes would not jeopardize the protection of public health, safety, and welfare.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency’s overall regulatory authority.

Va. Code § 32.1-12 gives the Board the responsibility to make, adopt, promulgate, and enforce such regulations as may be necessary to carry out the provisions of Title 32.1 of the Code of Virginia. Va. Code § 32.1-127 requires the Board to adopt regulations that include minimum standards for (i) the construction and maintenance of hospitals and certified nursing facilities to ensure the environmental protection and the life safety of its patients, employees, and the public; (ii) the operation, staffing and equipping of hospitals and certified nursing facilities; (iii) qualifications and training of staff of hospitals and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; (iv) conditions under which a hospital may provide medical and nursing services to patients in their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility security of hospitals and certified nursing facilities. Subsection B of Va. Code § 32.1-127 further details the specific provisions to be included in the regulation.

Va. Code § 32.1-23.2 also requires VDH to designate the form and due date of reports required under Chapter 1088 (2020 Acts of Assembly). Va. Code § 32.1-127.001 requires the Board to promulgate regulations that shall include minimum standards for the design and construction of hospitals and certified nursing facilities consistent with the current edition of the FGI guidelines, per Chapter 177 and 222 of the 2005 Acts of Assembly. Chapters 80 and 81 of the 2022 Acts of Assembly created minimum standards for any hospital that voluntarily installs a newborn safety device for the reception of children. Chapters 678 and 679 of the 2022 Acts of Assembly created minimum standards for hospital payment plans and hospitals providing information about charity care and financial assistance policies. Chapter 72 of the 2021 Acts of Assembly, Special Session I prohibits hospital discrimination against health insurance enrollee on the basis of the enrollee being a litigant or potential litigant due to a motor vehicle accident. Chapter 220 of the 2021 Acts of Assembly, Special Session I created minimum requirements for designated support persons in hospitals. Chapters 1080 and 1081 of the 2020 Acts of Assembly prohibits balance billing by hospitals.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it is intended to solve.

The rationale or justification for the regulatory change is that the regulation should incorporate all legislative mandates, current clinical and industry practices, and current licensing processes and procedures. The

regulatory change is essential to protect the health, safety, or welfare of citizens because the regulation does not currently reference the most current clinical and industry practices, including for infection prevention and control, and does not address all mandated subjects affecting patient rights. The goals of the regulatory change are consistency with the Code of Virginia and reduced confusion for patients and for hospitals; the problems it is intended to solve are removing out-of-date material that impedes hospitals from utilizing current clinical standards and ensuring that hospitals and patients are equally aware of what their rights and obligations are.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

Section 10. Definitions

Adds definitions for "ACIP," "activities of daily living" or "ADL," "campus," "care provider," "CDC," "certified nursing facility," "certified sexual assault nurse examiner," "CMS," "emergency department," "general hospital accrediting organization," "hospital," "inspector," "operating room," "outpatient surgical hospital accrediting organization," "person with a disability," "support and assistance necessary due to the specifics of the person's disability," and "surgery." Revises definitions for "designated support person," "full-time," "general hospital," and "nursing home." Removes definitions for "special hospital." Renames "home health care department/service/program" to "home health services," renamed "nursing care unit" to "long-term care nursing unit," "outpatient hospital" to "outpatient surgical hospital," and "Office of Licensure and Certification" to "OLC."

Section 50. Classification

Removes the "special hospital" as a classification type.

Section 60. Separate license

Changes subsection A to use a consistent and defined term when discussing the location of hospitals and the need for separate licensure.

Section 100. Name

Removes the requirement to report a hospital name change within 30 calendar days as duplicative.

Section 130. Return of license.

Section is renamed to "Surrender of license; mid-term change of license." Clarifies what is a mid-term change to a license and clarifies a hospital's obligations and the process to obtain a changed license.

Section 140. Inspection procedure

Clarifies the inspection process and a hospital's obligations during and after the inspection.

Section 150. Plan of correction

Consolidates the plan of correction language found throughout the regulatory chapter to ensure the plan of correction requirements are consistent. Revisions include minimum elements of a plan of correction and the timeline for submission and completion of a plan of correction.

Section 160. Revocation of license

Section is renamed to "Disciplinary action." Matches statutory provisions about prohibited acts and disciplinary options available.

Part II. Organization and Operation of General and Special Hospitals

Part is renamed to "Organization and Operation of General Hospitals."

Section 215. Financial assistance in general hospitals

A new section. Describes minimum requirements for providing information about charity care and financial assistance and for payment plans.

Section 225. Newborn safety devices

A new section. Describes minimum requirements for operation of a newborn safety device if a hospital has elected to install a device.

Section 230. Patient care management

Replaces reference to 22-year-old document with a reference to analogous federal requirements for patient rights. Repeals designated support person requirements and discharge requirements for a patient receiving elective surgery who may need outpatient physical therapy.

Section 235. Persons with a disability; designated support persons in general hospitals

A new section. Describes minimum requirements for providing a person with a disability access to a designated support person.

Section 237. Discharge planning

Consolidates into a single section the discharge planning requirements for inpatient admissions and for patients receiving elective surgery who may need outpatient physical therapy.

Section 370. Medical records

Removes an incorrect statutory reference, amends storage and reproduction requirements, amends subsection to address fetal death reporting, and adds subsection to address parent or guardian electronic access to minor patient's medical records.

Section 380. Nursing service

Adds language about when hospitals' quarterly reports are due and what information is to be included in the reports. Corrected out-of-date regulatory references.

Section 442. Obstetric service design and equipment criteria

Updates design and construction standards to the most current edition of the FGI guidelines for hospitals.

Section 444. Newborn service medical direction; physician consultation and coverage; nursing direction, nurse staffing and coverage; policies and procedures

Updates the breast milk storage times to match current CDC recommendations.

Section 445. Newborn service design and equipment criteria

Updates design and construction standards to the most current edition of the FGI guidelines for hospitals.

Section 447. Combined obstetric and clean gynecological service; infection control

Updates documents incorporated by reference for isolation or segregation of mothers, newborns, and patients.

Section 465. Long-term care nursing services

A new section. Describes the minimum statutory standards for certified nursing facilities that are operated under a general hospital's license.

Section 650. General building and physical plan information

Updates design and construction standards to the most current edition of the FGI guidelines for hospitals and outpatient facilities.

Section 760. Long-term care nursing units

Updates design and construction standards to the most current edition of the FGI guidelines for hospitals.

Part IV Outpatient Surgical Hospitals: Organization, Operation, and Design Standards for Existing and New Facilities

Part is renamed to “Organization and Operation of Outpatient Surgical Hospitals.”

Section 1170. Policy and procedures manual

Replaces reference to 22-year-old document with a reference to analogous federal requirements for patient rights. Repeals designated support person requirements.

Section 1171. Persons with a disability; designated support person in outpatient surgical hospitals

A new section. Describes minimum requirements for providing a person with a disability access to a designated support person.

Section 1175. Discharge planning

This section is repealed.

Section 1178. Financial assistance in outpatient surgical hospitals

A new section. Describes minimum requirements for providing information about charity care and financial assistance and for payment plans.

Section 1190 Nursing staff

Adds language about when hospitals’ quarterly reports are due and what information is to be included in the reports.

Section 1260. Medical records

Removes an incorrect statutory reference and reference to VDH business unit, amends storage and reproduction requirements, and adds subsection to address parent or guardian electronic access to minor patient’s medical records.

Section 1350. Local and state codes and standards

Updates design and construction standards to the most current edition of the FGI guidelines for outpatient facilities.

DIBR

Lists all documents incorporated by reference in the regulatory changes.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

The primary advantages to the public are removal of language or requirements that were unclear, inconsistent, or outdated and addition of legislative mandates that had previously had not been incorporated into the regulations. The primary advantages to VDH or Commonwealth are clarity on the minimum requirements for hospitals and VDH in the administration of the hospital licensing program. There are no disadvantages to the public or the Commonwealth. Other pertinent matters of interest to the regulated community, government officials and the public would include the discovery during the periodic review that the hospital regulations failed to address or incorporate the minimum requirements for certified nursing facilities that are mandated by Article 1 (§ 32.1-123 *et seq.*) of Chapter 5 of Title 32.1 of the Code of Virginia. Eight general hospitals in the Commonwealth operate long-term care nursing units that are certified to participate in Medicare, Medicaid, or both; these units fall under the definition of “certified nursing facility” found in Va. Code § 32.1-123. The Board is addressing the omission in this regulatory change and is promulgating requirements for these long-term care nursing units that are in conformity with the statutory minimums. At this time, the Board is exercising its discretion to include only those statutory minimums.

Requirements More Restrictive than Federal

Identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements, or no requirements that exceed applicable federal requirements, include a specific statement to that effect.

VDH is not aware of any applicable federal requirements about:

- minimum standards for any hospital that voluntarily installs a newborn safety device for the reception of children, which is the subject of the mandates in Chapters 80 and 81 of the 2022 Acts of Assembly;
- requiring hospitals that makes minors' health records available to minors through a secure website to also make the health records available to the minor's parent or guardian through the same website, which is the subject of the mandate in Chapter 218 of the 2022 Acts of Assembly;
- minimum standards for payment plans and providing information about charity care and financial assistance policies, which is the subject of the mandates in Chapters 678 and 679 of the 2022 Acts of Assembly;
- discriminating against health insurance enrollee on the basis of the enrollee being a litigant or potential litigant due to a motor vehicle accident, which is the subject of the mandate in Chapter 72 of the 2021 Acts of Assembly, Special Session I;
- quarterly reporting of hospital employment of certified sexual assault nurse examiners, which is the subject of Chapter 1088 of the 2020 Acts of Assembly;
- storage of breast milk;
- isolation or segregation of mothers, newborns, and patients in obstetric and newborn services;
- licensing of hospitals or any processes or procedures related to licensing of hospitals;
- access to designated support persons by persons with disabilities

The regulatory change regarding the prohibition on balance billing derived from Chapters 1080 and 1081 of the 2020 Acts of Assembly do not exceed applicable federal requirements.

42 CFR § 483.80(d)(1) and (2) requires certified nursing facilities to offer influenza and pneumococcal vaccination to residents unless medically contradicted or the resident refuses vaccination. The legislative mandate in Chapter 762 of the 2004 Acts of Assembly is more specific than federal requirements about the clinical guidance informing vaccination, though the mandate does not exceed and is not more restrictive than applicable federal requirements.

The regulatory change regarding the design and construction guidelines for hospitals may be more restrictive than federal requirements, specifically 42 CFR §§ 482.41 and 483.90; however, Chapters 177 and 222 of the 2005 Acts of Assembly mandate the minimum requirements be consistent with the current edition of the applicable FGI guidelines so the Board does not have the discretion to be less restrictive.

The regulatory changes regarding training of certified nursing facility employees on mandated reporting, regarding the sex offender registry, information and notices about the family council, liability insurance, and visitation during public health emergencies related to COVID-19 may be more restrictive than federal requirements in 42 CFR Part 483 Subpart B; however, Va. Code § 32.-127 mandates the minimum requirements for certified nursing facilities so the Board does not have the discretion to be less restrictive.

Agencies, Localities, and Other Entities Particularly Affected

Consistent with § 2.2-4007.04 of the Code of Virginia, identify any other state agencies, localities, or other entities particularly affected by the regulatory change. Other entities could include local partners such as

tribal governments, school boards, community services boards, and similar regional organizations. "Particularly affected" are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

Other State Agencies Particularly Affected

Virginia Commonwealth University (VCU) Health Systems Authority will be required to comply with the regulatory changes.

Localities Particularly Affected

Lee County Hospital Authority and Chesapeake Hospital Authority will be required to comply with the regulatory changes.

Other Entities Particularly Affected

The 106 licensed general hospitals (including those operated by VCU Hospital Systems Authority, Lee County Hospital Authority, and Chesapeake Hospital Authority) and 67 outpatient surgical hospitals will be required to comply with the regulatory change.

Economic Impact

Consistent with § 2.2-4007.04 of the Code of Virginia, identify all specific economic impacts (costs and/or benefits), anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Keep in mind that this is the proposed change versus the status quo.

Impact on State Agencies

<p><i>For your agency:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources</p>	<p>There are no projected costs, savings, fees or revenues resulting from the regulatory change.</p>
<p><i>For other state agencies:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.</p>	<p>There are no known projected savings, fees, or revenues resulting from the regulatory change.</p> <p>VCU Health System Authority would have one-time costs associated with updating policies and procedures related to designated support persons, certified nursing facilities, parent or guardian electronic access to minor patient's records, discharge planning, financial assistance, and infection control and prevention. For its existing policies and procedures, VDH is estimating it would cost \$1,250 one-time to amend their policies on each topic to conform to the regulatory minimums. It may be the case that no</p>

	<p>amendments are needed if the policies and procedures meet or exceed the proposed regulatory minimums, in which case no cost is expected to be incurred. If VCU Hospital Systems Authority does not already have policies and procedures on these topics, VDH is estimating it would cost \$5,000 one-time to develop these policies and procedures per topic.</p> <p>There may be some ongoing recordkeeping and administrative costs because Chapter 1088 of the 2020 Acts of Assembly mandates that hospitals file quarterly reports with VDH about its SANE employment. VDH estimates these costs are not likely to exceed \$5,000 per year.</p> <p>There may be some ongoing recordkeeping and administrative costs associated with payment plans. VDH is unable to estimate at this time what the changes, if any, would be needed for VCU Hospital Systems Authority to implement the new requirements or what those changes may cost, as no information about this was reported in the Fiscal Impact Statement for Chapters 678 and 679 of the 2022 Acts of Assembly.</p>
<p><i>For all agencies:</i> Benefits the regulatory change is designed to produce.</p>	<p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of hospital patients by incorporating current clinical and industry practices as well as by requiring reasonable timely information from hospitals, access to information to ensure hospital compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>

Impact on Localities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a or 2) on which it was reported. Information provided on that form need not be repeated here.

<p>Projected costs, savings, fees or revenues resulting from the regulatory change.</p>	<p>There are no known projected savings, fees, or revenues resulting from the regulatory change.</p> <p>Lee County Hospital Authority and Chesapeake Hospital Authority would have one-time costs associated with updating policies and procedures related to designated support persons, certified nursing facilities, parent or guardian electronic access to minor patient’s records, discharge planning, financial assistance, and infection control and prevention. For their existing policies and procedures, VDH is estimating it would cost \$1,250 one-time to amend their policies on each topic to conform to the regulatory minimums. It may be the case that no amendments are needed</p>
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	<p>if the policies and procedures meet or exceed the proposed regulatory minimums, in which case no cost is expected to be incurred. If Lee County Hospital Authority and Chesapeake Hospital Authority do not already have policies and procedures on these topics, VDH is estimating it would cost \$5,000 one-time to develop these policies and procedures per topic.</p> <p>There may be some ongoing recordkeeping and administrative costs because Chapter 1088 of the 2020 Acts of Assembly mandates that hospitals file quarterly reports with VDH about its SANE employment. VDH estimates these costs are not likely to exceed \$5,000 per year.</p> <p>There may be some ongoing recordkeeping and administrative costs associated with payment plans. VDH is unable to estimate at this time what the changes, if any, would be needed for Lee County Hospital Authority and Chesapeake Hospital Authority to implement the new requirements or what those changes may cost.</p>
<p>Benefits the regulatory change is designed to produce.</p>	<p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of hospital patients by incorporating current clinical and industry practices as well as by requiring reasonable timely information from hospitals, access to information to ensure hospital compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>

Impact on Other Entities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a, 3, or 4) on which it was reported. Information provided on that form need not be repeated here.

<p>Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.</p>	<p>Licensed hospitals and applicants for hospital licensure.</p>
<p>Agency’s best estimate of the number of such entities that will be affected. Include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million.</p>	<p>The 106 licensed general hospitals (including those operated by VCU Hospital Systems Authority, Lee County Hospital Authority, and Chesapeake Hospital Authority) and 67 outpatient surgical hospitals will be required to comply with the regulatory change. Applicants for hospital licensure are infrequent and difficult to estimate.</p> <p>VDH estimates three of the outpatient surgical hospitals may meet the definition of “small business”</p>

<p>All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to:</p> <ul style="list-style-type: none"> a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements. 	<p>There are no known projected savings, fees, or revenues resulting from the regulatory change.</p> <p>Hospitals would have one-time costs associated with updating policies and procedures related to designated support persons, certified nursing facilities, parent or guardian electronic access to minor patient’s records, discharge planning, financial assistance, and infection control and prevention. For their existing policies and procedures, VDH is estimating it would cost \$1,250 one-time to amend their policies on each topic to conform to the regulatory minimums. It may be the case that no amendments are needed if the policies and procedures meet or exceed the proposed regulatory minimums, in which case no cost is expected to be incurred. If hospitals do not already have policies and procedures on these topics, VDH is estimating it would cost \$5,000 one-time to develop these policies and procedures per topic.</p> <p>There may be some ongoing recordkeeping and administrative costs because Chapter 1088 of the 2020 Acts of Assembly mandates that hospitals file quarterly reports with VDH about its SANE employment. VDH estimates these costs are not likely to exceed \$5,000 per year.</p> <p>There may be some ongoing recordkeeping and administrative costs associated with payment plans. VDH is unable to estimate at this time what the changes, if any, would be needed for hospitals to implement the new requirements or what those changes may cost.</p>
<p>Benefits the regulatory change is designed to produce.</p>	<p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of hospital patients by incorporating current clinical and industry practices as well as by requiring reasonable timely information from hospitals, access to information to ensure hospital compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

No alternative was considered because the General Assembly required the Board to adopt regulations governing the licensure of hospitals and amending the regulation is the least burdensome, least intrusive, and less costly method to accomplish the purpose of this action.

Regulatory Flexibility Analysis

Consistent with § 2.2-4007.1 B of the Code of Virginia, describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the regulatory change.

The Board is required to regulate the licensure of hospitals consistent with the provisions of Article 1 (§ 32.1-123 *et seq.*) of Chapter 5 of Title 32.1 of the Code of Virginia. Initiation of this regulatory action is the least burdensome method to conform the Regulations for the Licensure of Hospitals in Virginia (12VAC5-410-10 *et seq.*) to the statute.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below.

Consistent with § 2.2-4011 of the Code of Virginia, if an objection to the use of the fast-track process is received within the 30-day public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the agency shall: 1) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register and 2) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

If you are objecting to the use of the fast-track process as the means of promulgating this regulation, please clearly indicate your objection in your comment. Please also indicate the nature of, and reason for, your objection to using this process.

The Board is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal and any alternative approaches, (ii) the potential impacts of the regulation, and (iii) the agency's regulatory flexibility analysis stated in this background document.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: <https://townhall.virginia.gov>. Comments may also be submitted by mail, email or fax to Rebekah E. Allen, Senior Policy Analyst, Virginia Department of Health, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Henrico, VA 23233; email: regulatorycomment@vdh.virginia.gov; fax: (804) 527-4502. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
410-10	N/A	<p>12VAC5-410-10. Definitions.</p> <p>As used in this chapter, the following words and terms shall have the following meanings unless the context clearly indicates otherwise:</p> <p style="text-align: center;">* * *</p> <p>"Designated support person" means a person who is knowledgeable about the needs of a person with a disability, and who is designated, orally or in writing, by the individual with a disability, the individual's guardian, or the individual's care provider to provide support and assistance, including physical assistance, emotional support, assistance with communication or decision-making, or any other assistance necessary as a result of the person's disability, to the person with a disability at any time during which health care services are provided.</p> <p style="text-align: center;">* * *</p> <p>"Full-time" means a 37-1/2 to 40 hour work week.</p> <p>"General hospital" means institutions as defined by § 32.1-123 of the Code of Virginia with an organized medical staff; with permanent facilities that include inpatient beds; and with medical services, including physician services, dentist services and continuous nursing services, to provide diagnosis and treatment</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-10. Definitions.</p> <p>As used in this chapter, the following words and terms shall have the following meanings unless the context clearly indicates otherwise:</p> <p><u>"ACIP" means the Advisory Committee on Immunization Practices of the CDC.</u></p> <p><u>"Activity of daily living" or "ADL" has the same meaning as ascribed to the term in subsection A of § 32.1-137.08 of the Code of Virginia.</u></p> <p style="text-align: center;">* * *</p> <p><u>"Business day" means any day that is not a Saturday, Sunday, legal holiday, or day on which the OLC is closed. For the purposes of this chapter, any day on which the Governor authorizes the closing of the state government shall be considered a legal holiday.</u></p> <p><u>"Campus" means the physical area that is immediately adjacent to the hospital's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other physical areas determined on an individual case basis, by the OLC in accordance with 42 C.F.R. § 413.65, to be part of the hospital's campus.</u></p> <p><u>"Care provider" has the same meaning as ascribed to the term in subsection A of § 32.1-137.08 of the Code of Virginia.</u></p>

	<p>for patients who have a variety of medical and dental conditions that may require various types of care, such as medical, surgical, and maternity.</p> <p>"Home health care department/service/program" means a formally structured organizational unit of the hospital that is designed to provide health services to patients in their place of residence and meets Part II (12VAC5-381-150 et seq.) of the regulations adopted by the board for the licensure of home care organizations in Virginia.</p> <p style="text-align: center;">* * *</p> <p>"Nursing care unit" means an organized jurisdiction of nursing service in which nursing services are provided on a continuous basis.</p> <p style="text-align: center;">* * *</p> <p>"Office of Licensure and Certification" or "OLC" means the Office of Licensure and Certification of the Virginia Department of Health.</p> <p style="text-align: center;">* * *</p> <p>"Outpatient hospital" means institutions as defined by § 32.1-123 of the Code of Virginia that primarily provide facilities for the performance of surgical procedures on outpatients. Such patients may require treatment in a medical environment exceeding the normal capability found in a physician's office, but do not require inpatient hospitalization.</p> <p style="text-align: center;">* * *</p> <p>"Special hospital" means institutions as defined by § 32.1-123 of the Code of Virginia that provide care for a specialized group of patients or limit admissions to provide diagnosis and treatment for patients who have specific conditions (e.g.,</p>	<p><u>"CDC" means the Centers for Disease Control and Prevention.</u></p> <p><u>"Certified nursing facility" has the same meaning as ascribed to the term in § 32.1-123 of the Code of Virginia.</u></p> <p><u>"Certified sexual assault nurse examiner" means a nurse who is board certified by the International Association of Forensic Nurses as either a Sexual Assault Nurse Examiner-Pediatric (SANE-P) or a Sexual Assault Nurse Examiner-Adult/Adolescent (SANE-A).</u></p> <p style="text-align: center;">* * *</p> <p><u>"CMS" means the Centers for Medicare and Medicaid Services.</u></p> <p style="text-align: center;">* * *</p> <p>"Designated support person" or "DSP" means a person who is knowledgeable about the needs of a person with a disability, and who is designated, orally or in writing, by the individual with a disability, the individual's guardian, or the individual's care provider to provide support and assistance, including physical assistance, emotional support, assistance with communication or decision making, or any other assistance necessary as a result of the person's disability, to the person with a disability at any time during which health care services are provided has the same meaning as ascribed to the term in subsection A of § 32.1-137.08 of the Code of Virginia and is not a visitor.</p> <p style="text-align: center;">* * *</p> <p><u>"Emergency department" means a department of the hospital that provides emergency services and is located on, or within a 35-mile radius of, the campus of the hospital.</u></p> <p style="text-align: center;">* * *</p> <p>"Full time" means a 37 1/2 to 40 hour work week.</p> <p><u>"General hospital" means institutions a hospital as defined by § 32.1-123 of the Code of Virginia with an organized medical staff; with permanent facilities that include inpatient beds; and with medical services, including physician services, dentist services and continuous nursing services, to provide diagnosis and</u></p>
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		<p>tuberculosis, orthopedic, pediatric, maternity).</p>	<p>treatment for patients who have a variety of medical and dental conditions that may require various types of care, such as medical, surgical, and maternity.</p> <p><u>"General hospital accrediting organization"</u> means the Accreditation Commission for Health Care, the Center for Improvement in Healthcare Quality, DNV - Healthcare, The Joint Commission, or any accrediting organization that has been granted deeming authority for hospitals by CMS.</p> <p>"Home health care department/service/program" <u>"Home health services"</u> means a formally structured organizational unit of the hospital that is designed to provide health services to patients in their place of residence and meets Part II (12VAC5-381-150 et seq.) of the regulations adopted by the board for the licensure of home care organizations in Virginia.</p> <p><u>"Hospital"</u> has the same meaning ascribed to the term in § 32.1-123 of the Code of Virginia and includes general hospitals and outpatient surgical hospitals.</p> <p><u>"Inspector"</u> means an individual employed by or contracted by the Virginia Department of Health and designated by the commissioner to conduct inspections, investigations, or evaluations.</p> <p><u>"Long-term care nursing unit"</u> means an organized jurisdiction of nursing service in which nursing services are provided on a continuous basis.</p> <p style="text-align: center;">* * *</p> <p>"Nursing care unit" means an organized jurisdiction of nursing service in which nursing services are provided on a continuous basis.</p> <p>"Nursing home" means an institution or any identifiable component of any institution as defined by <u>has the same meaning as ascribed to the term in § 32.1-123 of the Code of Virginia with permanent facilities that include inpatient beds and whose primary function is the provision, on a continuing basis, of nursing and health related services for the treatment of patients who may require</u></p>
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			<p>various types of long term care, such as skilled care and intermediate care.</p> <p style="text-align: center;">* * *</p> <p>"Office of Licensure and Certification" or "OLC" means the Office of Licensure and Certification of the Virginia Department of Health.</p> <p><u>"Operating room" means a room in a hospital designated for the performance of surgery.</u></p> <p style="text-align: center;">* * *</p> <p>"Outpatient surgical hospital" means institutions a hospital as defined by § 32.1-123 of the Code of Virginia that primarily provide provides facilities for the performance of surgical procedures on outpatients. Such patients may require treatment in a medical environment exceeding the normal capability found in a physician's office, but do not require inpatient hospitalization.</p> <p><u>"Outpatient surgical hospital accrediting organization" means the Accreditation Commission for Ambulatory Health Care, the Accreditation Commission for Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, The Joint Commission, or any accrediting organization that has been granted deeming authority for ambulatory surgical centers by CMS.</u></p> <p style="text-align: center;">* * *</p> <p><u>"Person with a disability" has the same meaning as ascribed to the term in subsection A of § 32.1-137.08 of the Code of Virginia.</u></p> <p style="text-align: center;">* * *</p> <p>"Special hospital" means institutions as defined by § 32.1-123 of the Code of Virginia that provide care for a specialized group of patients or limit admissions to provide diagnosis and treatment for patients who have specific conditions (e.g., tuberculosis, orthopedic, pediatric, maternity).</p> <p style="text-align: center;">* * *</p> <p><u>"Support and assistance necessary due to the specifics of the person's disability" has the same meaning as</u></p>
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			<p><u>ascribed to the term in subsection A of § 32.1-137.08 of the Code of Virginia.</u></p> <p><u>"Surgery" has the same meaning as ascribed to the term in subsection A of § 54.1-2400.01:1 of the Code of Virginia.</u></p> <p>INTENT: The intent of the change is to create, remove, and update definitions for terms that have been cause for confusion.</p> <p>RATIONALE: The rationale for the change is that commonly used terms that may have multiple meanings depending on the speaker should be defined so that all audiences have a consistent understanding of the terms' intended meaning.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for hospitals, VDH, and the public.</p>
410-50	N/A	<p>12VAC5-410-50. Classification.</p> <p>Hospitals to be licensed shall be classified as general hospitals, special hospitals or outpatient hospitals defined by 12VAC5-410-10.</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-50. Classification.</p> <p>Hospitals to be licensed shall be classified as general hospitals, special hospitals or outpatient <u>surgical</u> hospitals defined by 12VAC5-410-10.</p> <p>INTENT: The intent of the change is to remove "special hospital" as a classification of hospital</p> <p>RATIONALE: The rationale for the change is that the Board has not utilized this hospital classification and has no regulatory provisions specific to special hospitals.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for hospitals.</p>
410-60	N/A	<p>12VAC5-410-60. Separate license.</p> <p>A. A separate license shall be required by hospitals maintained on separate premises even though they are operated under the same management. Separate license</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-60. Separate license.</p> <p>A. A separate license shall be required by hospitals maintained on separate premises <u>campuses</u> even though they are operated under the same</p>

		<p>is not required for separate buildings on the same grounds or within the same complex of buildings.</p> <p style="text-align: center;">* * *</p>	<p>management. Separate license is not required for separate buildings on the same grounds <u>campus</u> or within the same complex of buildings <u>or for an emergency department of a general hospital</u>.</p> <p style="text-align: center;">* * *</p> <p>INTENT: The intent of the change is to use consistent, defined terminology in regulation.</p> <p>RATIONALE: The rationale for the change is that a single defined term should be created and used instead of multiple undefined terms when discussing recurring subjects within the regulation.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for hospitals.</p>
410-100	N/A	<p>12VAC5-410-100. Name.</p> <p>Every hospital shall be designated by a permanent and appropriate name which shall appear on the application for license. Any change of name shall be reported to the OLC within 30 days.</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-100. Name.</p> <p>Every hospital shall be designated by a permanent and appropriate name which <u>that</u> shall appear on the application for license. Any change of name shall be reported to the OLC within 30 days.</p> <p>INTENT: The intent of the change is to remove conflicting or duplicative regulatory provisions.</p> <p>RATIONALE: The rationale for the change is that changes affecting a hospital license are already addressed in a separate regulatory section and should not be addressed here, too.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for hospitals about reporting name names.</p>
410-130	N/A	<p>12VAC5-410-130. Return of license.</p> <p>The OLC shall be notified in writing at least within 30 working days in advance of any proposed change in location or ownership of the facility. A license shall not be transferred from one owner to</p>	<p>CHANGE: The Board is proposing the following change:</p>

		<p>another or from one location to another. The license issued by the commissioner shall be returned to the OLC for correction or reissuance when any of the following changes occur during the licensing year:</p> <ol style="list-style-type: none"> 1. Revocation; 2. Change of location; 3. Change of ownership; 4. Change of name; 5. Change of bed capacity, except as provided in 12VAC5-410-110 C; or 6. Voluntary closure. 	<p>12VAC5-410-130. Return of license <u>Surrender of license; mid-term change of license.</u></p> <p><u>A. Upon revocation or suspension of a license, the hospital shall surrender its license to the OLC.</u></p> <p><u>B. The hospital shall notify the director of the OLC shall be notified in writing by submitting a mid-term change application at least within 30 working days no less than 30 calendar days in advance of any proposed change in location or ownership of the facility. A license shall not be transferred from one owner to another or from one location to another. The license issued by the commissioner shall be returned to the OLC for correction or reissuance when any of the following changes occur during the licensing year implementing any:</u></p> <ol style="list-style-type: none"> 1. Revocation; <u>2. 1. Change of location of the hospital, including change of location of any emergency department not located on the hospital's campus;</u> 3. 2. Change of ownership of the hospital; <u>3. Change of operator of the hospital;</u> <u>4. Change of name of the hospital;</u> <u>5. Change of bed capacity, except as provided in 12VAC5-410-110 C; which shall be accompanied by an approved Certificate of Public Need if the requested change is for an increase in bed capacity; or</u> <u>6. Change of services being provided, including any proposed addition or discontinuation, regardless of whether licensure is required for the service; or</u> 6. Voluntary closure <u>7. Closure of the hospital.</u> <p><u>C. The OLC shall:</u></p> <ol style="list-style-type: none"> <u>1. Consider the submission date of a mid-term change application to be the date it is postmarked or</u>
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			<p><u>the date it is received, whichever is earlier; and</u></p> <p><u>2. Notify in writing the licensee if the commissioner will issue a changed license.</u></p> <p><u>D. The commissioner's issuance of a changed license to the hospital shall satisfy the requirements of subdivision C 2 of this section.</u></p> <p><u>E. Upon receipt of the changed license, the licensee shall return its prior license issued by the commissioner to the OLC and destroy any copies of the prior license.</u></p> <p><u>F. A license may not be transferred or assigned. The commissioner may not issue a changed license in response to a change of operator of the hospital, but shall instead require the hospital to obtain a new license. If the hospital intends to implement a change of operator, it shall:</u></p> <p><u>1. File for a new license, in accordance with 12VAC5-410-70, no less than 30 calendar days in advance of any change of operator; and</u></p> <p><u>2. Upon receipt of the new license, surrender its prior license issued by the commissioner to the OLC and destroy any copies of the prior license.</u></p> <p><u>G. If the hospital is closing or will otherwise no longer be operational, it shall:</u></p> <p><u>1. Notify patients, legal representatives, and the OLC no fewer than seven calendar days prior to closing or ceasing operations where all clinical records are to be located following closure or cessation of operations; and</u></p> <p><u>2. Surrender its license to the OLC and destroy all copies of its license no more than five calendar days after the hospital closes or ceases operations.</u></p> <p><u>H. The OLC shall determine if any changes listed in subsection B affect the terms of the license or the continuing eligibility for a license. An inspector may</u></p>
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			<p><u>inspect the hospital during the process of evaluating a proposed change.</u></p> <p>INTENT: The intent of the change is to create a consistent list of what changes VDH needs to be aware of, when those changes are reportable, and what changes can result in a changed license versus a new license.</p> <p>RATIONALE: The rationale for the change is that transfer or assignment of licenses are prohibited by law, that certain license changes may require a new license, a new inspection (in the case of a change of location), or both, and that VDH needs to be aware of hospitals' active service lines for disaster preparedness planning and implementation.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for hospitals and VDH about when and what changes are reportable, and what changes warrant a new license.</p>
410-140	N/A	<p>12VAC5-410-140. Inspection procedure.</p> <p>A. The OLC may presume that a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and certified for participation in Title XVIII of the Social Security Act (Medicare) generally meets the requirements of Part II (12VAC5-410-170 et seq.) of this chapter provided the following conditions are met:</p> <ol style="list-style-type: none"> 1. The hospital provides to the OLC, upon request, a copy of the most current accreditation survey findings made by the Joint Commission on Accreditation of Healthcare Organizations; and 2. The hospital notifies the OLC within 10 days after receipt of any 	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-140. Inspection procedure.</p> <p><u>A. The OLC shall make periodic unannounced on-site inspections of a hospital as necessary but not less often than biennially. The OLC may make on-site inspections of applicants for licensure. Compliance with all standards shall be determined by the OLC.</u></p> <p><u>B. The hospital or applicant shall:</u></p> <ol style="list-style-type: none"> <u>1. Make available to the inspector any requested records;</u> <u>2. Permit an inspector to enter upon and into its property to inspect or investigate as the inspector reasonably deems necessary in order to determine the state of compliance with the provisions of this chapter and all laws administered by the board; and</u> <u>3. Allow the inspector access to interview the agents, employees, independent contractors,</u>

		<p>notice of revocation or denial of accreditation by the Joint Commission on Accreditation of Healthcare Organizations.</p> <p>B. The OLC may presume that a unit or part of a hospital licensed or certified by another state agency, or another section, bureau or division of the OLC meets the requirements of Part II of this chapter for that specific unit or part provided the following conditions are met:</p> <ol style="list-style-type: none"> 1. The hospital provides the OLC, upon request, a copy of the most current inspection report made by the other state agency; and 2. The hospital notifies the OLC within 10 days after receipt of any notice of revocation or suspension by the other state agency. <p>C. Notwithstanding any other provision of this chapter to the contrary, if the licensing agency finds, after inspection, violations pertaining to environmental health or life safety, the hospital shall receive a written licensing report of such findings. The hospital shall be required to submit a plan of correction in accordance with provisions of 12VAC5-410-150.</p>	<p><u>patients, legal representatives, patients' family members, and any person under the hospital's or applicant's control, direction, or supervision.</u></p> <p>C. After the on-site inspection, the inspector shall:</p> <ol style="list-style-type: none"> 1. <u>Discuss the findings of the inspection with the chief executive officer or his designee; and</u> 2. <u>Provide a written inspection report to the chief executive officer or his designee.</u> <p>D. <u>If the OLC cites one or more licensing violations in the written inspection report, the chief executive officer or his designee shall submit a plan of correction in accordance with 12VAC5-410-150.</u></p> <p>A. <u>E. The OLC may presume that a general hospital accredited deemed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) a general hospital accrediting organization and certified for participation in Title XVIII of the Social Security Act (Medicare) (42 U.S.C. § 301 et seq.) generally meets the requirements of Part II (12VAC5-410-170 et seq.) of this chapter provided the following conditions are met:</u></p> <ol style="list-style-type: none"> 1. The <u>general</u> hospital provides to the OLC, upon request, a copy of the most current accreditation survey findings made by the <u>Joint Commission on Accreditation of Healthcare Organizations general hospital accrediting organization</u>; and 2. The <u>general</u> hospital notifies the OLC within 10 days after receipt of any notice of revocation or denial of accreditation by the <u>Joint Commission on Accreditation of Healthcare Organizations general hospital accrediting organization.</u> <p>F. <u>The OLC may presume that an outpatient surgical hospital deemed by an outpatient surgical hospital accrediting organization and certified for participation</u></p>
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			<p>in Title XVIII of the Social Security Act (42 U.S.C. § 301 et seq.) generally meets the requirements of Part IV (12VAC5-410-1150 et seq.) of this chapter provided the following conditions are met:</p> <ol style="list-style-type: none"> 1. <u>The outpatient surgical hospital provides to the OLC, upon request, a copy of the most current accreditation survey findings made by the outpatient surgical hospital accrediting organization; and</u> 2. <u>The outpatient surgical hospital notifies the OLC within 10 days after receipt of any notice of revocation or denial of accreditation by the outpatient surgical hospital accrediting organization.</u> <p>B. G. The OLC may presume that a unit or part of a <u>general</u> hospital licensed or certified by another state agency, or another section, bureau or division of the OLC meets the requirements of Part II (12VAC5-410-170 et seq.) of this chapter for that specific unit or part provided the following conditions are met:</p> <ol style="list-style-type: none"> 1. The <u>general</u> hospital provides the OLC, upon request, a copy of the most current inspection report made by the other state agency; and 2. The <u>general</u> hospital notifies the OLC within 10 days after receipt of any notice of revocation or suspension by the other state agency. <p>H. The OLC may presume that a unit or part of an <u>outpatient surgical hospital licensed or certified by another state agency, or another section, bureau or division of the OLC meets the requirements of Part IV (12VAC5-410-1150 et seq.) of this chapter for that specific unit or part provided the following conditions are met:</u></p> <ol style="list-style-type: none"> 1. <u>The outpatient surgical hospital provides the OLC, upon request, a copy of the most current inspection report made by the other state agency; and</u>
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			<p><u>2. The outpatient surgical hospital notifies the OLC within 10 days after receipt of any notice of revocation or suspension by the other state agency.</u></p> <p>G. I. Notwithstanding any other provision of this chapter to the contrary, if the licensing agency <u>OLC</u> finds, after inspection, violations pertaining to environmental health or life safety, the hospital shall receive a written licensing report of such findings. The hospital shall be required to submit a plan of correction in accordance with provisions of 12VAC5-410-150.</p> <p>INTENT: The intent of the change is to more clearly specify what is expected of a hospital and VDH when an inspection occurs and to create a rebuttable compliance presumption for outpatient surgical hospitals.</p> <p>RATIONALE: The rationale for the change is hospitals are better able to anticipate what may be needed during inspection process if parameters are specified in regulation and that there is not rationale reason to exclude outpatient surgical hospitals from a rebuttable presumption of compliance.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for hospitals and more efficient inspection procedures for VDH if it can utilize similar rebuttable compliance presumptions for all hospital types on routine inspections.</p>
410-150	N/A	<p>12VAC5-410-150. Plan of correction.</p> <p>A. Upon receipt of a written licensing report each hospital shall prepare a plan for correcting any licensing violations cited at the time of inspection. The plan of correction shall be to the OLC within the specified time limit set forth in the licensing report. The plan of correction shall contain at least the following information:</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-150. Plan of correction.</p> <p>A. Upon receipt of a written licensing inspection report, <u>the chief executive officer or his designee</u> each hospital shall prepare a <u>written plan for correcting of correction addressing any each</u> violations violation cited at the time of inspection. The plan of correction shall be to the OLC within the specified time limit set forth in the licensing report. The plan</p>

		<p>1. The methods implemented to correct any violations of this chapter; and</p> <p>2. The date, on which such corrections are expected to be completed.</p> <p>B. The OLC shall notify the hospital, in writing, whenever any item in the plan of correction is determined to be unacceptable.</p>	<p>of correction shall contain at least the following information:</p> <p><u>B. The chief executive officer or his designee shall submit to the OLC a written plan of correction no more than 15 business days after receipt of the inspection report. The plan of correction shall contain for each licensing violation cited:</u></p> <p><u>1. The methods implemented to correct any violations of this chapter. A description of the corrective action or actions to be taken and the position title of the employees to implement the corrective action. If employees share the same position title, the chief executive officer or his designee shall assign the employees a unique identifier to distinguish them; and</u></p> <p><u>2. The expected correction date, on which such corrections are expected to be completed not to exceed 45 business days from the exit date of the inspection; and</u></p> <p><u>3. A description of the measures implemented to prevent a recurrence of each licensing violation.</u></p> <p><u>C. The chief executive officer or his designee shall ensure that the person responsible for the validity of the plan of correction signs, dates, and indicates their title on the plan of correction.</u></p> <p>B. D. <u>The OLC shall notify the hospital chief executive officer or his designee, in writing, whenever if the OLC determines any item in the plan of correction is determined to be unacceptable.</u></p> <p><u>E. The OLC may conduct an inspection to verify any portion of a plan of correction has been implemented.</u></p> <p><u>F. The chief executive officer or his designee shall ensure the plan of correction is implemented and monitored so that compliance is maintained.</u></p> <p><u>G. The commissioner may deny licensure or renewal of licensure if the chief executive officer or his designee</u></p>
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			<p><u>fails to submit an acceptable plan of correction or fails to implement an acceptable plan of correction.</u></p> <p><u>H. The OLC shall consider the submission date of a plan of correction to be the date it is postmarked or the date it is received, whichever is earlier.</u></p> <p>INTENT: The intent of the change is to standardize the plan of correction process to make it more similar to federal plan of correction processes.</p> <p>RATIONALE: The rationale for the change is that documentation of remedial action and completion of remedial action should be consistently applied to all hospitals.</p> <p>LIKELY IMPACT: The likely impact of the change is improved clarity about what should be in a plan of correction, when it is due, and when it should be completed.</p>
410-160	N/A	<p>12VAC5-410-160. Revocation of license.</p> <p>The commissioner may revoke or suspend the license to operate a hospital in accordance with § 32.1-135 of the Code of Virginia for the following reasons:</p> <ol style="list-style-type: none"> 1. Violation of any provision of these rules and regulations. Violations which in the judgment of the commissioner jeopardize the health or safety of patients shall be sufficient cause for immediate revocation or suspension; or 2. Willfully permitting, aiding, or abetting the commission of any illegal act in the hospital. 	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-160. Revocation of license <u>Disciplinary action.</u></p> <p>The commissioner may revoke or suspend the license to operate a hospital in accordance with § 32.1-135 of the Code of Virginia for the following reasons:</p> <ol style="list-style-type: none"> 1. Violation of any provision of these rules and regulations. Violations which in the judgment of the commissioner jeopardize the health or safety of patients shall be sufficient cause for immediate revocation or suspension; or 2. Willfully permitting, aiding, or abetting the commission of any illegal act in the hospital. <p><u>A. A hospital may not:</u></p> <ol style="list-style-type: none"> <u>1. Violate the provisions of this chapter or Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia;</u> <u>2. Permit, aid, or abet the commission of any illegal act in the hospital;</u>

			<p><u>3. Engage in a pattern of violations pursuant to § 38.2-3445.01 of the Code of Virginia;</u> <u>or</u></p> <p><u>4. Engage in a pattern of violations of subdivision B 13 of § 38.2-3407.15 of the Code of Virginia.</u></p> <p><u>B. The commissioner may:</u></p> <p><u>1. For each violation of subsection A of this section:</u></p> <p><u>a. Deny, revoke, or suspend the license to operate a hospital, in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia);</u></p> <p><u>b. Refer a hospital for criminal prosecution pursuant to subsection A of § 32.1-27 of the Code of Virginia; or</u></p> <p><u>c. Petition an appropriate court for an injunction, mandamus, or other appropriate remedy or imposition of a civil penalty against a hospital pursuant to subsection B or C of § 32.1-27 of the Code of Virginia;</u></p> <p><u>2. For each violation of subsection A of this section by or occurring in a long-term care nursing unit of a general hospital if that unit is a certified nursing facility:</u></p> <p><u>a. Restrict or prohibit new admissions to the long-term care nursing unit in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia);</u></p> <p><u>b. Petition an appropriate court for imposition of a civil monetary penalty against a hospital pursuant to subsection A of § 32.1-27.1 of the Code of Virginia; or</u></p> <p><u>c. Petition an appropriate court for appointment of a</u></p>
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			<p><u>receiver for the long-term care nursing unit pursuant to subsection B of § 32.1-27.1 of the Code of Virginia; and</u></p> <p><u>3. For each violation of subdivision A 3 of this section, levy a fine upon the hospital in an amount not to exceed \$1,000 per violation, in accordance with the Administrative Process Acts (§ 2.2-4000 et seq. of the Code of Virginia).</u></p> <p><u>C. Suspension of a license shall in all cases be for an indefinite time.</u></p> <p><u>D. For each violation of subsection A of this section and with the consent of the person who has violated subsection A of this section, the board may provide, in an order issued by the board, for the payment of civil charges for past violations in specific sums, which may not exceed the limits specified in § 32.1-27 of the Code of Virginia or if applicable, the limits specified in § 32.1-27.1 of the Code of Virginia.</u></p> <p><u>E. Upon receipt of a completed application and a nonrefundable service charge, the commissioner may issue a new license to a hospital that has had its license revoked if the commissioner determines that:</u></p> <ol style="list-style-type: none"> <u>1. The conditions upon which revocation was based have been corrected; and</u> <u>2. The applicant is in compliance with this chapter, Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia, and all other applicable state and federal law and regulations.</u> <p><u>F. Upon receipt of a completed application, the commissioner may partially or completely restore a suspended license to a hospital if the commissioner determines that:</u></p> <ol style="list-style-type: none"> <u>1. The conditions upon which suspension was based have been completely or partially corrected; and</u>
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			<p><u>2. The interests of the public will not be jeopardized by resumption of operation.</u></p> <p><u>G. The commissioner may not require an additional service charge for restoring a license pursuant to subsection F of this section.</u></p> <p><u>H. The hospital shall submit evidence relevant to subdivisions E 1, E 2, F 1, and F 2 of this subsection that is satisfactory to the commissioner or his designee. The commissioner or his designee may conduct an inspection prior to making a determination.</u></p> <p>INTENT: The intent of the change is to describe the grounds upon which the commissioner may take disciplinary action against a hospital, the options available to the commissioner for disciplinary action, and how a hospital may obtain a license after suspension or revocation.</p> <p>RATIONALE: The rationale for the change is that the regulation should conform to Chapter 72 of the 2021 Acts of Assembly, Special Session I, Chapters 1080 and 1081 of the 2020 Acts of Assembly, and to Va. Code §§ 32.1-27, 32.1-27.1, and 32.1-135.</p> <p>LIKELY IMPACT: The likely impact of the change is improved clarity for hospitals about what acts are not permitted and what consequences may follow if a prohibited act occurs.</p>
N/A	410-215	None	<p>CHANGE: The Board is proposing the following change:</p> <p style="text-align: center;">Part II</p> <p style="text-align: center;">Organization and Operation of General and Special Hospitals</p> <p><u>12VAC5-410-215. Financial assistance in general hospitals.</u></p> <p><u>A. As used in this section, "patient" and "uninsured patient" have the same meanings as ascribed to these terms in subsection A of § 32.1-137.010 of the Code of Virginia.</u></p>

			<p><u>B. A general hospital shall make reasonable efforts to screen every uninsured patient to determine whether the individual is eligible for medical assistance pursuant to the state plan for medical assistance or for financial assistance under the general hospital's financial assistance policy.</u></p> <p><u>C. A general hospital shall inform every uninsured patient who receives services at the general hospital and who is determined to be eligible for assistance under the general hospital's financial assistance policy of the option to enter into a payment plan with the general hospital.</u></p> <ol style="list-style-type: none"><u>1. A payment plan entered into pursuant to this subsection shall be provided to the patient in writing or electronically and shall provide for repayment of the cumulative amount owed to the general hospital.</u><u>2. The amount of monthly payments and the term of the payment plan shall be determined based upon the patient's ability to pay.</u><u>3. Any interest on amounts owed pursuant to the payment plan shall not exceed the maximum judgment rate of interest pursuant to § 6.2-302 of the Code of Virginia.</u><u>4. The general hospital may not charge any fees related to the payment plan.</u><u>5. The payment plan shall allow prepayment of amounts owed without penalty.</u> <p><u>D. A general hospital shall develop a process by which either an uninsured patient who agrees to a payment plan pursuant to subsection C of this section or the general hospital may request and shall be granted the opportunity to renegotiate the payment plan.</u></p> <ol style="list-style-type: none"><u>1. Renegotiation shall include opportunity for a new screening in accordance with subsection B of this section.</u>
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			<p><u>2. A general hospital may not charge any fees for renegotiation of a payment plan pursuant to this subsection.</u></p> <p><u>E. A general hospital shall provide written information about:</u></p> <p><u>1. Its charity care policies, including:</u></p> <ul style="list-style-type: none"><u>a. Policies related to free and discounted care;</u><u>b. Specific eligibility criteria for charity care; and</u><u>c. Procedures for applying for charity care;</u> <p><u>2. The availability of a payment plan for the payment of debt owed to the general hospital pursuant to subsection C of this section; and</u></p> <p><u>3. The renegotiation process described in subsection D of this section.</u></p> <p><u>F. To provide the information required by subsection E of this section, a general hospital shall:</u></p> <p><u>1. Post the information conspicuously in public areas of the general hospital, including admissions or registration areas, emergency departments, and associated waiting rooms;</u></p> <p><u>2. Make the information available to:</u></p> <ul style="list-style-type: none"><u>a. A patient at the time of admission or discharge, or at the time services are provided; and</u><u>b. Persons with limited English proficiency in accordance with the U.S. Department of Health and Human Services' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (August 8, 2003, 68 FR 47311), if the general</u>
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			<p><u>hospital is subject to the requirements of Title VI of the Civil Rights Act of 1964 (Pub. L. No. 88-352), as amended; and</u></p> <p><u>3. Include the information:</u></p> <p><u>a. With any billing statements sent to uninsured patients; and</u></p> <p><u>b. On any website maintained by the general hospital.</u></p> <p><u>G. Notwithstanding any other provision of law, a general hospital may not engage in any action described in § 501(r)(6) of the Internal Revenue Code, as it was in effect on January 1, 2020, to recover a debt for medical services against any patient unless the general hospital has made all reasonable efforts to determine whether the patient:</u></p> <p><u>1. Qualifies for medical assistance pursuant to the state plan for medical assistance; or</u></p> <p><u>2. Is eligible for financial assistance under the general hospital's financial assistance policy.</u></p> <p><u>H. Nothing in this section shall be construed to:</u></p> <p><u>1. Prohibit a general hospital, as part of its financial assistance policy, from requiring a patient to:</u></p> <p><u>a. Provide necessary information needed to determine eligibility for financial assistance under the general hospital's financial assistance policy, medical assistance pursuant to Title XVIII or XIX of the Social Security Act (42 U.S.C. § 301 et seq.), 10 U.S.C. § 1071 et seq., or other programs of insurance; or</u></p> <p><u>b. Undertake good faith efforts to apply for and enroll in the programs of insurance for which the patient may be eligible as a condition of</u></p>
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			<p><u>awarding _____ financial assistance:</u></p> <p><u>2. Require a general hospital to grant or continue to grant any financial assistance or payment plan pursuant to this section when:</u></p> <p><u>a. A patient has provided false, _____ inaccurate, _____ or incomplete _____ information required for determining eligibility for the general hospital's _____ financial assistance policy; or</u></p> <p><u>b. A patient has not undertaken good faith efforts to comply with any payment plan pursuant to this section; or</u></p> <p><u>3. Prohibit the coordination of benefits as required by state or federal law.</u></p> <p>INTENT: The intent of the change is to remove “special hospitals” from the name of this Part and to describe the minimum requirements for information disclosure about financial assistance, for payment plans, and for renegotiation of payment plans.</p> <p>RATIONALE: The rationale for the change is that the Board does not intend to use “special hospitals” as a classification of hospital and that the regulation should conform to Chapters 678 and 679 of the 2022 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for outpatient surgical hospitals about the minimum requirements for providing information about financial assistance and providing financial assistance to patients.</p>
N/A	410-225	None	<p>CHANGE: The Board is proposing the following change:</p>

			<p><u>12VAC5-410-225. Newborn safety devices.</u></p> <p><u>A general hospital that voluntarily installs a newborn safety device for the reception of children shall ensure that:</u></p> <ol style="list-style-type: none"><u>1. The device is located inside the hospital in an area that is conspicuous and visible to employees or personnel;</u><u>2. The device is staffed 24 hours a day by a health care provider;</u><u>3. The device is climate controlled and serves as a safe sleep environment for an infant;</u><u>4. The device is equipped with a dual alarm system that sounds 60 seconds after a child is placed in the device and automatically places a call to 911 if the alarm is not deactivated within 60 seconds from within the hospital;</u><u>5. The dual alarm system is visually checked at least two times per day and tested at least one time per week to ensure the alarm system is in working order;</u><u>6. The device automatically locks when a child is placed in the device; and</u><u>7. The device is identifiable by appropriate signage that shall include written and pictorial operational instructions.</u> <p>INTENT: The intent of the change is to describe the minimum standards a general hospital must meet if it choose to install a newborn safety device.</p> <p>RATIONALE: The rationale for the change is that the regulation should be consistent with Chapters 80 and 81 of the 2022 Acts of Assembly</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for general hospitals about the minimum requirements if they choose to install a newborn safety device.</p>
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<p>410-230</p>	<p>N/A</p>	<p>12VAC5-410-230. Patient care management.</p> <p style="text-align: center;">* * *</p> <p>C. Each hospital shall establish a protocol relating to the rights and responsibilities of patients based on Joint Commission on Accreditation of Healthcare Organizations' 2000 Hospital Accreditation Standards, January 2000. The protocol shall include a process reasonably designed to inform patients of their rights and responsibilities. Patients shall be given a copy of their rights and responsibilities upon admission.</p> <p style="text-align: center;">* * *</p> <p>G. If the Governor has declared a public health emergency related to the novel coronavirus (COVID-19), each hospital shall allow a person with a disability who requires assistance as a result of such disability to be accompanied by a designated support person at any time during which health care services are provided.</p> <p>1. In any case in which health care services are provided in an inpatient setting, and the duration of health care services in such inpatient setting is anticipated to last more than 24 hours, the person with a disability may designate more than one designated support person. However, no hospital shall be required to allow more than one designated support person to be present with a person with a disability at any time.</p> <p>2. A designated support person shall not be subject to any restrictions on visitation</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-230. Patient care management.</p> <p style="text-align: center;">* * *</p> <p>C. Each hospital shall establish a protocol relating to the rights and responsibilities of patients based on <u>42 C.F.R. § 482.13</u> Joint Commission on Accreditation of Healthcare Organizations' 2000 Hospital Accreditation Standards, January 2000. The protocol shall include a process reasonably designed to inform patients of their rights and responsibilities. Patients shall be given a copy of their rights and responsibilities upon admission.</p> <p style="text-align: center;">* * *</p> <p>G. If the Governor has declared a public health emergency related to the novel coronavirus (COVID-19), each hospital shall allow a person with a disability who requires assistance as a result of such disability to be accompanied by a designated support person at any time during which health care services are provided.</p> <p>1. In any case in which health care services are provided in an inpatient setting, and the duration of health care services in such inpatient setting is anticipated to last more than 24 hours, the person with a disability may designate more than one designated support person. However, no hospital shall be required to allow more than one designated support person to be present with a person with a disability at any time.</p> <p>2. A designated support person shall not be subject to any restrictions on visitation adopted by such hospital. However, such designated support person may be required to comply with all reasonable requirements of the hospital adopted to protect the health and safety of patients and staff of the hospital.</p>
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		<p>adopted by such hospital. However, such designated support person may be required to comply with all reasonable requirements of the hospital adopted to protect the health and safety of patients and staff of the hospital.</p> <p>3. Every hospital shall establish policies applicable to designated support persons and shall:</p> <ul style="list-style-type: none"> a. Make such policies available to the public on a website maintained by the hospital; and b. Provide such policies, in writing, to the patient at such time as health care services are provided. <p>H. Each hospital that is equipped to provide life-sustaining treatment shall develop a policy to determine the medical or ethical appropriateness of proposed medical care, which shall include:</p> <ul style="list-style-type: none"> 1. A process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; 2. Provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical 	<p>3. Every hospital shall establish policies applicable to designated support persons and shall:</p> <ul style="list-style-type: none"> a. Make such policies available to the public on a website maintained by the hospital; and b. Provide such policies, in writing, to the patient at such time as health care services are provided. <p>H. <u>G.</u> Each hospital that is equipped to provide life-sustaining treatment shall develop a policy to determine the medical or ethical appropriateness of proposed medical care, which shall include:</p> <ul style="list-style-type: none"> 1. A process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; 2. Provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the proposed health care of the patient; 3. Requirements for a written explanation of the decision of the interdisciplinary medical review committee, which shall be included in the patient's medical record; and 4. Provisions to ensure the patient, the patient's agent, or the person authorized to make the patient's medical decisions in accordance with § 54.1-2986 of the Code of Virginia is informed of the patient's right to obtain the patient's medical record and the right to obtain an independent medical opinion and afforded reasonable opportunity to
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	<p>inappropriate as documented in the patient's medical record.</p> <p>I. Each hospital shall establish a protocol requiring that, before a health care provider arranges for air medical transportation services for a patient who does not have an emergency medical condition as defined in 42 USC § 1395dd(e)(1), the hospital shall provide the patient or the patient's authorized representative with written or electronic notice that the patient (i) may have a choice of transportation by an air medical transportation provider or medically appropriate ground transportation by an emergency medical services provider and (ii) will be responsible for charges incurred for such transportation in the event that the provider is not a contracted network provider of the patient's health insurance carrier or such charges are not otherwise covered in full or in part by the patient's health insurance plan.</p> <p>J. Each hospital shall provide written information about the patient's ability to request an estimate of the payment amount for which the participant will be responsible pursuant to § 32.1-137.05 of the Code of Virginia. The written information shall be posted conspicuously in public areas of the hospital, including admissions or registration areas, and included on any website maintained by the hospital.</p> <p>K. Each hospital shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up treatment after discharge is informed that the patient:</p>	<p>scheduled to receive an elective surgical procedure for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up treatment after discharge is informed that the patient:</p> <ol style="list-style-type: none"> 1. Is expected to require outpatient physical therapy as a follow-up treatment; and 2. Will be required to select a physical therapy provider prior to being discharged from the hospital. <p>INTENT: The intent of the change is to use a more relevant basis for patient rights protocols and to create two new sections of regulation that separately address discharge planning and designated support persons.</p> <p>RATIONALE: The rationale for the change is that a document from 2000 is an out-of-date basis for patient rights, that all general hospitals in Virginia are already complying with 42 C.F.R. § 482.13 as a condition of participation in Medicare, and that discharge planning and designated support persons are topics requiring significantly more detail that, if both were to continue to be addressed in the present section of regulation, would make the section more difficult to read.</p> <p>LIKELY IMPACT: The likely impact of the change is improved readability of this regulatory section and improved ease in locating provisions addressing discharge planning and designated support persons.</p>
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		<p>1. Is expected to require outpatient physical therapy as a follow-up treatment; and</p> <p>2. Will be required to select a physical therapy provider prior to being discharged from the hospital.</p>	
<p>410-230(G)</p>	<p>410-235</p>	<p>See row above regarding changes proposed for 410-230.</p>	<p>CHANGE: The Board is proposing the following change:</p> <p><u>12VAC5-410-235. Persons with a disability; designated support person in general hospital.</u></p> <p>A. For the purposes of this section:</p> <p>1. <u>"Admission" means accepting a person for bed occupancy and care that is anticipated to span at least two midnights or for observation;</u></p> <p>2. <u>"General hospital" means a general hospital other than one that is certified as a long-term acute care hospital or specialty rehabilitation hospital.</u></p> <p>B. <u>A general hospital shall allow a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a DSP who will provide support and assistance necessary due to the specifics of the person's disability to the person with a disability during an admission.</u></p> <p>1. <u>In any case in which the duration of the admission lasts more than 24 hours, the person with a disability may designate more than one DSP.</u></p> <p>2. <u>No general hospital shall be required to allow more than one DSP to be present with a person with a disability at any time.</u></p> <p>C. A general hospital may:</p> <p>1. <u>Not subject a DSP to any restrictions on visitation;</u></p> <p>2. <u>Require a DSP to comply with all reasonable requirements of a general hospital adopted to</u></p>

			<p><u>protect the health and safety of the person with a disability; the DSP; the staff and other patients of, or visitors to, a general hospital; and the public; and</u></p> <p><u>3. Restrict a DSP's access to specified areas of and movement on the premises of a general hospital when such restrictions are determined by a general hospital to be reasonably necessary to protect the health and safety of the person with a disability; the DSP; the staff and other patients of, or visitors to, a general hospital; and the public.</u></p> <p><u>D. A general hospital may request that a person with a disability provide documentation indicating that he is a person with a disability.</u></p> <p><u>1. If the person with a disability fails, refuses, or is unable to provide documentation requested pursuant to subsection D of this section, a general hospital may perform an objective assessment of the person to determine whether he is a person with a disability.</u></p> <p><u>2. If a general hospital fails to perform an objective assessment pursuant to subdivision D 1 of this section, a general hospital may not prohibit a DSP from accompanying a person with a disability for the purpose of providing support and assistance necessary due to the specifics of the person's disability.</u></p> <p><u>E. A general hospital shall</u></p> <p><u>1. Establish protocols to inform patients, at the time of admission, of the right of a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a DSP for the purpose of providing support and assistance necessary due to the specifics of the person's disability;</u></p>
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			<p><u>2. Develop and make available to a patient or his guardian, authorized representative, or care provider upon request written information regarding the right of a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a DSP and any policies related to that right; and</u></p> <p><u>3. Make the written information described in subdivision E 2 of this section available to the public on its website.</u></p> <p><u>G. This section may not:</u></p> <p><u>1. Alter the obligation of a general hospital to provide patients with effective communication support or other required services, regardless of the presence of a DSP or other reasonable accommodation, consistent with applicable federal or state law or regulations; and</u></p> <p><u>2. Be interpreted to:</u></p> <p><u>a. Prevent a general hospital from complying, or interfere with the ability of a general hospital to comply, with or cause a general hospital to violate any federal or state law or regulation;</u></p> <p><u>b. Deem a DSP to be acting under the direction or control of a general hospital or as an agent of a general hospital; or</u></p> <p><u>c. Require a general hospital to allow a DSP to perform any action or provide any support or assistance necessary due to the specifics of the person's disability when a general hospital reasonably determines that the performance of the action or provision would be:</u></p> <p><u>(1) _____ Medically _____ or therapeutically contraindicated; or</u></p>
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			<p><u>(2) A threat to the health and safety of the person with a disability, the DSP, or the staff or other patients of, or visitors to, a general hospital.</u></p> <p>INTENT: The intent of the change is to describe the minimum requirements for access to designated support persons by persons with disabilities in general hospitals.</p> <p>RATIONALE: The rationale for the change is that the regulation should be in conformity with Chapter 220 of the 2021 Acts of Assembly, Special Session I.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for general hospitals about what the minimum requirements for designated support persons are outside of a Governor-declared public health emergency related to COVID-19.</p>
<p>410-230(K) and 410-1175</p>	<p>410-237</p>	<p>See row above regarding proposed changes to 410-230 and row below regarding proposed changes to 410-1175</p>	<p>CHANGE: The Board is proposing the following change:</p> <p><u>12VAC5-410-237. Discharge planning.</u></p> <p><u>A. A general hospital shall provide each patient admitted as an inpatient or his legal guardian the opportunity to designate:</u></p> <ol style="list-style-type: none"> <u>1. An individual who will care for or assist the patient in his residence following discharge from a general hospital; and</u> <u>2. To whom a general hospital shall provide information regarding the patient's discharge plan and any follow-up care, treatment, and services that the patient may require.</u> <p><u>B. Upon admission, a general hospital shall record in the patient's medical record:</u></p> <ol style="list-style-type: none"> <u>1. The name of the individual designated by the patient;</u> <u>2. The relationship between the patient and the person; and</u> <u>3. The person's telephone number and address.</u>

			<p><u>C. If the patient fails or refuses to designate an individual to receive information regarding his discharge plan and any follow-up care, treatment, and services, a general hospital shall record the patient's failure or refusal in the patient's medical record.</u></p> <p><u>D. A patient may change the designated individual at any time prior to the patient's release, and a general hospital shall record the changes, including the information referenced in subsection B of this section, in the patient's medical record within 24 hours of such a change.</u></p> <p><u>E. Prior to discharging a patient who has designated an individual pursuant to subsections A or D of this section, a general hospital shall:</u></p> <ol style="list-style-type: none"><u>1. Notify the designated individual of the patient's discharge.</u><u>2. Provide the designated individual with a copy of the patient's discharge plan and instructions and information regarding any follow-up care, treatment, or services that the designated individual will provide; and</u><u>3. Consult with the designated individual regarding the designated individual's ability to provide the care, treatment, or services.</u> <p><u>F. The discharge plan prescribed in subdivision E 2 of this section shall include:</u></p> <ol style="list-style-type: none"><u>1. The name and contact information of the designated individual;</u><u>2. A description of follow-up care, treatment, and services that the patient requires; and</u><u>3. Information, including contact information, about any health care, long-term care, or other community-based services and supports necessary for the implementation of the patient's discharge plan.</u>
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			<p><u>G. A general hospital shall include a copy of the discharge plan and any instructions or information provided to the designated individual in the patient's medical record.</u></p> <p><u>H. A general hospital shall provide each individual designated pursuant to subsection A or D of this section the opportunity for a demonstration of specific follow-up care tasks that the designated individual will provide to the patient in accordance with the patient's discharge plan prior to the patient's discharge, including opportunity for the designated individual to ask questions regarding the performance of follow-up care tasks in a culturally competent manner and in the designated individual's native language.</u></p> <p><u>I. A general hospital shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up treatment after discharge is informed that the patient:</u></p> <ol style="list-style-type: none"> <u>1. Is expected to require outpatient physical therapy as a follow-up treatment; and</u> <u>2. Will be required to select a physical therapy provider prior to being discharged from a general hospital.</u> <p>INTENT: The intent of the change is to have all of the inpatient discharge planning information located in the part of the regulatory chapter where inpatient services are addressed.</p> <p>RATIONALE: The rationale for the change is that the regulation should be in conformity with statutory/legislative mandates and that many of these requirements were incorrectly located in the part of the regulatory chapter for hospitals that do not provide inpatient services.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for general hospitals about inpatient discharge</p>
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			<p>requirements and where they are located in 12VAC5-410.</p>
<p>410-370</p>	<p>N/A</p>	<p>12VAC5-410-370. Medical records. * * *</p> <p>E. Provisions shall be made for the safe storage of medical records or accurate and legible reproductions thereof according to § 32.1-127.1:03 of the Code of Virginia and the Health Insurance Portability and Accountability Act, or HIPAA (42 USC § 1320d et seq.).</p> <p>F. All medical records either original or accurate reproductions shall be preserved for a minimum of five years following discharge of the patient.</p> <ol style="list-style-type: none"> 1. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years. 2. Birth and death information shall be retained for 10 years in accordance with § 32.1-274 of the Code of Virginia. 	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-370. Medical records. * * *</p> <p>E. Provisions shall be made for the safe storage of medical records or <u>and the accurate and legible reproductions thereof of medical records</u> according to § 32.1-127.1:03 of the Code of Virginia and the Health Insurance Portability and Accountability Act, or HIPAA (42 USC § 1320d et seq.) (Pub. L. No. 104-191).</p> <p>F. All medical records either original or accurate reproductions shall be preserved for a minimum of five years following discharge of the patient.</p> <ol style="list-style-type: none"> 1. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years. 2. Birth and death information shall be retained for 10 years in accordance with § 32.1-274 of the Code of Virginia. 3. <u>Record of abortions and proper information for the issuance of a fetal death certificate shall be furnished the Office of Vital Records, Virginia Department of Health, as required by law.</u> <p>G. <u>A general hospital that makes health records, as defined in § 32.1-127.1:03 of the Code of Virginia, of patients who are minors available to patients through a secure website shall make the health records available to the patient's parent or guardian through the secure website, unless the general hospital cannot make the health record available:</u></p> <ol style="list-style-type: none"> 1. <u>In a manner that prevents disclosure of information, the disclosure of which has been denied pursuant to subsection F of § 32.1-127.1:03 of the Code of Virginia; or</u>

			<p><u>2. Because the consent required in accordance with subsection E of § 54.1-2969 of the Code of Virginia has not been provided.</u></p> <p>INTENT: The intent of the change is to correct an erroneous statutory citation, to require that hospitals are capable of both safe storage and accurate reproduction of medical records, to update the regulatory text to match the style guidelines, to mirror fetal death reporting provisions for outpatient surgical hospitals, and to describe minimum standards for giving parent’s or guardian’s electronic access to their minor’s medical records.</p> <p>RATIONALE: The rationale for the change is that statutory references should be accurate, that fetal death reporting should not be different between general hospitals and outpatient surgical hospitals, that hospitals should not have the discretion to choose between whether to provide safe storage or accurate reproduction of medical records, that the style guidelines ensure more intelligible regulatory text, and that the regulation should be in conformity with Chapter 218 of the 2022 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for general hospitals regarding parental/guardian electronic access to a minor patient’s medical records.</p>
410-380	N/A	<p>12VAC5-410-380. Nursing service.</p> <p style="text-align: center;">* * *</p> <p>C. All nursing services shall be directly provided by an appropriately qualified registered nurse or licensed practical nurse, except for those nursing tasks that may be delegated by a registered nurse according to 18VAC90-20-420 through 18VAC90-20-460 of the regulation of the Virginia Board of Nursing with a plan developed and implemented by the hospital.</p> <p>D. Nursing personnel shall be assigned to patient care units</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-380. Nursing service.</p> <p style="text-align: center;">* * *</p> <p>C. All nursing services shall be directly provided by an appropriately qualified registered nurse or licensed practical nurse, except for those nursing tasks that may be delegated by a registered nurse according to 18VAC90-20-420 <u>18VAC90-19-240</u> through 18VAC90-20-460 <u>18VAC90-19-280</u> of the regulation of the Virginia Board of Nursing with a plan developed and implemented by the hospital.</p>

		<p>in a manner that minimizes the risk of cross infection and accidental contamination.</p>	<p>D. Nursing personnel shall be assigned to patient care units in a manner that minimizes the risk of cross infection and accidental contamination.</p> <p><u>E. Each hospital shall quarterly report to the department no later than 30 calendar days after January 1st, April 1st, July 1st, and October 1st:</u></p> <ol style="list-style-type: none"> <u>1. The total number of certified sexual assault nurse examiners employed by the hospital; and</u> <u>2. The location, including street address, and contact information for each location at which such certified sexual assault nurse examiner provides services.</u> <p><u>Each hospital shall report the information required by this subsection to the Office of Family Health Services, Virginia Department of Health.</u></p> <p>INTENT: The intent of the change is to update regulatory references and to describe what hospitals should report, when they should report, and to whom they should report data regarding SANEs they employ.</p> <p>RATIONALE: The rationale for the change is that regulatory references should be accurate and the regulations should be in conformity with Chapter 1088 of the 2020 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for hospitals about their reporting responsibilities and what regulations apply to them and improved consistency in the data being reported.</p>
410-442	N/A	<p>12VAC5-410-442. Obstetric service design and equipment criteria.</p> <p>A. Renovation or construction of a hospital's obstetric unit shall be consistent with (i) section 2.2-2.9 of Part 2 of the 2018 Guidelines for Design and Construction of Hospitals of the Facility Guidelines Institute pursuant to § 32.1-127.001 of the Code of Virginia and (ii) the</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-442. Obstetric service design and equipment criteria.</p> <p>A. Renovation or construction of a hospital's obstetric unit shall be consistent with (i) section 2-2-2.9 <u>2.2-2.10</u> of Part 2 of the 2018 <u>2022 Edition</u> of the (The Facility Guidelines Institute) <u>(The Facility Guidelines Institute)</u> pursuant to § 32.1-127.001 of the Code of</p>

		<p>Virginia Uniform Statewide Building Code (13VAC5-63). * * *</p>	<p>Virginia and (ii) the Virginia Uniform Statewide Building Code (13VAC5-63). * * *</p> <p>INTENT: The intent of the change is to update the design and construction guidelines to the recently published 2022 edition.</p> <p>RATIONALE: The rationale for the change is that the regulation should be in conformity with the mandates in Chapters 177 and 222 of the 2005 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion about which edition of the FGI guidelines general hospitals should reference.</p>
410-444	N/A	<p>12VAC5-410-444. Newborn service medical direction; physician consultation and coverage; nursing direction, nurse staffing and coverage; policies and procedures. * * *</p> <p>B. The duties and responsibilities of the medical directors of all levels of newborn service shall include, but not be limited to the: * * *</p> <p>F. The nursing direction, staff and coverage required for the general level newborn service shall be as follows: * * *</p> <p>2. The nursing director's responsibilities shall include, but not be limited to: * * *</p> <p>H. The nursing direction, staff and coverage for the specialty level newborn service shall be the same as the lower level newborn service levels with the following exceptions:</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-444. Newborn service medical direction; physician consultation and coverage; nursing direction, nurse staffing and coverage; policies and procedures. * * *</p> <p>B. The duties and responsibilities of the medical directors of all levels of newborn service shall include, but not be limited to the: * * *</p> <p>F. The nursing direction, staff and coverage required for the general level newborn service shall be as follows: * * *</p> <p>2. The nursing director's responsibilities shall include, but not be limited to: * * *</p> <p>H. The nursing direction, staff and coverage for the specialty level newborn service shall be the same as the lower level newborn service levels with the following exceptions:</p> <p>1. ...The responsibilities of the nurse manager shall include, but not be limited to:</p>

	<p>1. ...The responsibilities of the nurse manager shall include, but not be limited to:</p> <p style="text-align: center;">* * *</p> <p>K. The policies and procedures for the general level nursery and all higher levels of newborn services shall include, but not be limited to:</p> <p style="text-align: center;">* * *</p> <p>3. ...The collaboration agreements shall include, but not be limited to:</p> <p style="text-align: center;">* * *</p> <p>17. The management of mothers who utilize breast milk with their newborns. Breast milk shall be collected in aseptic containers, dated, stored under refrigeration and consumed or disposed of within 24-48 hours of collection if the breast milk has not been frozen. This policy pertains to breast milk collected while in the hospital or at home for hospital use.</p> <p>18. Preparation and use of formula including, but not limited to:</p> <p style="text-align: center;">* * *</p> <p>L. The additional policies and procedures required for the intermediate level newborn service shall include, but not be limited to:</p> <p style="text-align: center;">* * *</p> <p>M. The additional policies and procedures required for the specialty level newborn service shall include, but not be limited to:</p> <p style="text-align: center;">* * *</p> <p>N. The additional policies and procedures required for the</p>	<p style="text-align: center;">* * *</p> <p>K. The policies and procedures for the general level nursery and all higher levels of newborn services shall include, but not be limited to:</p> <p style="text-align: center;">* * *</p> <p>3. ...The collaboration agreements shall include, but not be limited to:</p> <p style="text-align: center;">* * *</p> <p>17. The management of mothers who utilize breast milk with their newborns. Breast milk shall be collected in aseptic containers, dated, stored under refrigeration and consumed or disposed of within 24-48 <u>96</u> hours of collection if the breast milk has not been frozen. This policy pertains to breast milk collected while in the hospital or at home for hospital use.</p> <p>18. Preparation and use of formula including, but not limited to:</p> <p style="text-align: center;">* * *</p> <p>L. The additional policies and procedures required for the intermediate level newborn service shall include, but not be limited to:</p> <p style="text-align: center;">* * *</p> <p>M. The additional policies and procedures required for the specialty level newborn service shall include, but not be limited to:</p> <p style="text-align: center;">* * *</p> <p>N. The additional policies and procedures required for the subspecialty level newborn service shall include, but not be limited to:</p> <p style="text-align: center;">* * *</p> <p>INTENT: The intent of the change is to update breast milk storage requirements to match current recommendations from the CDC and to update the regulatory text to match the style guidelines.</p> <p>RATIONALE: The rationale for the change is that regulation should reference</p>
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		<p>subspecialty level newborn service shall include, but not be limited to:</p> <p style="text-align: center;">* * *</p>	<p>current clinical practices as recommended by subject matter experts and that the style guidelines ensure more intelligible regulatory text.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for general hospitals regarding breast milk storage.</p>
410-445	N/A	<p>12VAC5-410-445. Newborn service design and equipment criteria.</p> <p>A. Construction or renovation of a hospital's nursery shall be consistent with (i) section 2.2-2.10 of Part 2 of the 2018 Guidelines for Design and Construction of Hospitals of the Facility Guidelines Institute pursuant to § 32.1-127.001 of the Code of Virginia and (ii) the Virginia Uniform Statewide Building Code (13VAC5-63). Hospitals with higher-level nurseries shall comply with section 2.2-2.8 of Part 2 of the 2018 edition of the guidelines as applicable.</p> <p style="text-align: center;">* * *</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-445. Newborn service design and equipment criteria.</p> <p>A. Construction or renovation of a hospital's nursery shall be consistent with (i) section 2.2-2.10 <u>2.2-2.11</u> of Part 2 of the 2018 Guidelines for Design and Construction of Hospitals, <u>2022 Edition</u> of the <u>(The</u> Facility Guidelines Institute) pursuant to § 32.1-127.001 of the Code of Virginia and (ii) the Virginia Uniform Statewide Building Code (13VAC5-63). Hospitals with higher-level nurseries shall comply with section 2.2-2.8 <u>2.2-2.9</u> of Part 2 of the 2018 <u>2022</u> edition of the guidelines as applicable.</p> <p style="text-align: center;">* * *</p> <p>INTENT: The intent of the change is to update the design and construction guidelines to the recently published 2022 edition.</p> <p>RATIONALE: The rationale for the change is that the regulation should be in conformity with the mandates in Chapters 177 and 222 of the 2005 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion about which edition of the FGI guidelines general hospitals should reference.</p>
410-447	N/A	<p>12VAC5-410-447. Combined obstetric and clean gynecological service; infection control.</p> <p>A. A hospital may combine obstetric and clean gynecological services...The policies and procedures shall be</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-447. Combined obstetric and clean gynecological service; infection control.</p> <p>A. A hospital may combine obstetric and clean gynecological services...The</p>

	<p>approved by the medical and nursing staff of these services and adopted by the governing body and shall include, but not limited to the following requirements:</p> <p style="text-align: center;">* * *</p> <p>B. In addition to the infection control requirements specified in 12VAC5-410-490...The policies and procedures shall be adopted by the governing body and shall include, but not be limited to, the following:</p> <p style="text-align: center;">* * *</p> <p>2. Written criteria for the isolation or segregation of mothers and newborns, in accordance with Guidelines for Perinatal Care (American Academy of Pediatrics/American College of Obstetricians and Gynecologists) and Control of Communicable Diseases in Man (American Public Health Association) to include at least the following categories:</p> <p style="text-align: center;">* * *</p> <p>3. Written policies and procedures for the isolation of patients in accordance with Guidelines for Perinatal Care (AAP/ACOG) and Control of Communicable Diseases in Man (American Public Health Association) including, but not limited to, the following:</p> <p style="text-align: center;">* * *</p> <p>7. Techniques of patient care, including handwashing and the</p>	<p>policies and procedures shall be approved by the medical and nursing staff of these services and adopted by the governing body and shall include, but not limited to the following requirements:</p> <p style="text-align: center;">* * *</p> <p>B. In addition to the infection control requirements specified in 12VAC5-410-490...The policies and procedures shall be adopted by the governing body and shall include, but not be limited to, the following:</p> <p style="text-align: center;">* * *</p> <p>2. Written criteria for the isolation or segregation of mothers and newborns, in accordance with Guidelines for Perinatal Care, <u>8th Edition, 2017</u>, (American Academy of Pediatrics/American College of Obstetricians and Gynecologists) and Control of Communicable Diseases in Man <u>Manual, 21st Edition, 2022</u> (American Public Health Association) to include at least the following categories:</p> <p style="text-align: center;">* * *</p> <p>3. Written policies and procedures for the isolation of patients in accordance with Guidelines for Perinatal Care, <u>8th Edition, 2017</u> (<u>AAP/ACOG</u>) (<u>American Academy of Pediatrics/American College of Obstetricians and Gynecologists</u>) and Control of Communicable Diseases in Man <u>Manual, 21st Edition, 2022</u> (American Public Health Association) including, but not limited to, the following:</p> <p style="text-align: center;">* * *</p> <p>7. Techniques of patient care, including handwashing and the use of protective clothing such as gowns, masks, and gloves; and</p> <p>8. Infection control in the nursery, including but not limited to:</p> <p style="text-align: center;">* * *</p> <p>INTENT: The intent of the change to update the regulatory text to match the</p>
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		<p>use of protective clothing such as gowns, masks, and gloves; and * * *</p>	<p>style guidelines and to cite the current editions of the relevant clinical texts.</p> <p>RATIONALE: The rationale for the change is that the style guidelines ensure more intelligible regulatory text, that the regulation should be in conformity with the Virginia Code Commission's regulation on documents incorporated by reference, and that general hospitals should be relying on current clinical texts about infection prevention and control.</p> <p>LIKELY IMPACT: The likely impact of the change is general hospitals being able to utilize current clinical texts about infection prevention and control while remaining in compliance with the applicable regulations.</p>
N/A	410-465	None	<p>CHANGE: The Board is proposing the following change:</p> <p><u>12VAC5-410-465. Long-term care nursing services.</u></p> <p><u>A. The provisions of this section shall apply to a general hospital's long-term care nursing unit if that unit is a certified nursing facility. The general hospital shall be responsible for ensuring its long-term care nursing unit meets the requirements of this section.</u></p> <p><u>B. For the purposes of this section, "resident" means any person admitted to a general hospital's long-term care nursing unit.</u></p> <p><u>C. A long-term care nursing unit shall fully disclose to the applicant for admission the unit's admissions policies, including any preferences given.</u></p> <p><u>D. A long-term care nursing unit shall train, or arrange for training of, all employees who work in the long-term care unit and who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 of the Code of Virginia on such reporting procedures and the consequences for failing to make a required report.</u></p> <p><u>E. A long-term care nursing unit shall register with the Department of State Police to receive notice of the registration, reregistration, or verification of</u></p>

		<p><u>registration information of any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 of the Code of Virginia within the same or a contiguous zip code area in which the long-term care nursing unit is located, pursuant to § 9.1-914 of the Code of Virginia.</u></p> <p><u>F. If a long-term care nursing unit anticipates a potential resident will have a length of stay greater than three days or in fact stays longer than three days, the long-term care nursing unit shall ascertain, prior to admission, whether the potential resident is required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 of the Code of Virginia.</u></p> <p><u>G. Upon the request of the unit's family council, a long-term care nursing unit shall send notices and information about the family council mutually developed by the family council and the administration of the unit, and provided to the unit for such purpose, to the listed responsible party or a contact person of the resident's choice up to six times per year.</u></p> <ol style="list-style-type: none"> <u>1. Such notices may be included together with a monthly billing statement or other regular communication.</u> <u>2. Notices and information shall also be posted in a designated location within the unit.</u> <u>3. No family member of a resident or other resident representative shall be restricted from participating in meetings in the unit with the families or resident representatives of other residents in the unit.</u> <p><u>H. A general hospital shall maintain for its long-term care unit liability insurance coverage in a minimum amount of \$1 million, and professional liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15 of the Code of Virginia, to compensate residents or individuals for</u></p>
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			<p><u>injuries and losses resulting from the negligent or criminal acts of the unit.</u></p> <p><u>I. During a public health emergency related to COVID-19, a long-term care unit shall establish a protocol to allow each resident to receive visits, consistent with guidance from the CDC and as directed by CMS and the board, which shall include:</u></p> <p><u>1.Provisions describing:</u></p> <p><u>a. The conditions, including conditions related to the presence of COVID-19 in the long-term care nursing unit and community, under which in-person visits will be allowed and under which in-person visits will not be allowed and visits will be required to be virtual;</u></p> <p><u>b. The requirements with which in-person visitors will be required to comply to protect the health and safety of the residents and staff of the long-term care nursing unit;</u></p> <p><u>c. The types of technology, including interactive audio or video technology, and the staff support necessary to ensure visits are provided as required by this subsection; and</u></p> <p><u>d. The steps the long-term care unit will take in the event of a technology failure, service interruption, or documented emergency that prevents visits from occurring as required by this subsection;</u></p> <p><u>2. A statement of the frequency with which visits, including virtual and in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each resident;</u></p> <p><u>3. A provision authorizing a resident or the resident's</u></p>
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			<p><u>personal representative to waive or limit visitation, provided that such waiver or limitation is included in the resident's health record; and</u></p> <p><u>4. A requirement that the general hospital publish on its website or communicate to each resident or the resident's authorized representative, in writing or via electronic means, the long-term care unit's plan for providing visits to residents as required by this subsection.</u></p> <p><u>J. Unless the vaccination is medically contraindicated or the resident declines the offer of vaccination, a general hospital shall provide, or arrange for, the administration to the residents of an annual influenza vaccination and a pneumococcal vaccination in accordance with the following recommendations of ACIP:</u></p> <ol style="list-style-type: none"> <u>1. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2022–23 Influenza Season, MMWR 71 (1), 2022, CDC;</u> <u>2. Use of 15-Valent Pneumococcal Conjugate Vaccine and 20-Valent Pneumococcal Conjugate Vaccine Among U.S. Adults: Updated Recommendations of ACIP — United States, MMWR 71 (4), 2022, CDC;</u> <u>3. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Adults Aged >65 Years: Updated Recommendations of ACIP, MMWR 68 (46), 2019, CDC;</u> <u>4. Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of ACIP, MMWR 64 (15), 2015, CDC;</u>
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410-650	N/A	<p>12VAC5-410-650. General building and physical plant information.</p> <p>A. All construction of new buildings and additions, renovations, alterations or repairs of existing buildings for occupancy as a hospital shall conform to state and local codes, zoning ordinances, and the Virginia Uniform Statewide Building Code (13VAC5-63).</p> <p>In addition, hospitals shall be designed and constructed consistent with Part 1 and Part 2 of the 2018 Guidelines for Design and Construction of Hospitals of the Facility Guidelines Institute pursuant to § 32.1-127.001 of the Code of Virginia.</p> <p>B. Architectural drawings and specifications for all new construction or for additions, alterations, or renovations to any existing building shall be dated, stamped with professional seal, and signed by the architect. The architect shall certify that the drawings and specifications were prepared to conform to the Virginia Uniform Statewide Building Code (13VAC5-63) and be consistent with Part 1 and Part 2 of the 2018 Guidelines for Design and Construction of Hospitals of the Facility Guidelines Institute.</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-650. General building and physical plant information.</p> <p>A. All construction of new buildings and additions, renovations, <u>or</u> alterations or repairs of existing buildings for occupancy as a hospital shall conform to state and local codes, zoning ordinances, and the Virginia Uniform Statewide Building Code (13VAC5-63).</p> <p>In addition, hospitals shall be designed and constructed consistent with Part 1 and Part 2 of the 2018 Guidelines for Design and Construction of Hospitals, <u>2022 Edition of the (The Facility Guidelines Institute), as amended by the November 2022 Errata for Guidelines for Design and Construction of Hospitals, 2022 Edition (The Facility Guidelines Institute), and if applicable, Chapter 2.8 of Part 2 of the Guidelines for Design and Construction of Outpatient Facilities, 2022 Edition (The Facility Guidelines Institute), as amended by the November 2022 Errata for Guidelines for Design and Construction of Outpatient Facilities, 2022 Edition (The Facility Guidelines Institute) pursuant to § 32.1-127.001 of the Code of Virginia.</u></p> <p>B. Architectural drawings and specifications for all new construction or for additions, alterations, or renovations to any existing building shall be dated, stamped with professional seal, and signed by the architect. The architect shall certify that the drawings and specifications were prepared to conform to the Virginia Uniform Statewide Building Code (13VAC5-63) and be consistent with Part 1 and Part 2 of the 2018</p>

			<p>Guidelines for Design and Construction of Hospitals, 2022 Edition of the (The Facility Guidelines Institute), as amended by the November 2022 Errata for Guidelines for Design and Construction of Hospitals, 2022 Edition (The Facility Guidelines Institute), and if applicable, Chapter 2.8 of the Guidelines for Design and Construction of Outpatient Facilities, 2022 Edition (The Facility Guidelines Institute), as amended by the November 2022 Errata for Guidelines for Design and Construction of Outpatient Facilities, 2022 Edition (The Facility Guidelines Institute).</p> <p>INTENT: The intent of the change is to update the design and construction guidelines to the recently published 2022 editions, including the move of provisions related to freestanding emergency departments from the hospital guidelines to the outpatient facility guidelines.</p> <p>RATIONALE: The rationale for the change is that the regulation should be in conformity with the mandates in Chapters 177 and 222 of the 2005 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion about which editions of the FGI guidelines general hospitals should reference.</p>
410-760	N/A	<p>12VAC5-410-760. Long-term care nursing units.</p> <p>Construction and renovation of long-term care nursing units, including intermediate and skilled nursing care nursing units, shall be designed and constructed consistent with section 2-2-2.13 of Part 2 of the 2018 Guidelines for Design and Construction of Hospitals of the Facility Guidelines Institute pursuant to § 32.1-127.001 of the Code of Virginia.</p> <p>...The architect shall certify that the drawings and specifications were prepared to conform to the Virginia Uniform Statewide Building Code</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-760. Long-term care nursing units.</p> <p>Construction and renovation of long-term care nursing units, including intermediate and skilled nursing care nursing units, shall be designed and constructed consistent with section 2-2-2.13 <u>2-2-2.15</u> of Part 2 of the 2018 Guidelines for Design and Construction of Hospitals, 2022 Edition of the (The Facility Guidelines Institute) pursuant to § 32.1-127.001 of the Code of Virginia.</p> <p>...The architect shall certify that the drawings and specifications were prepared to conform to the Virginia Uniform Statewide Building Code</p>

		<p>(13VAC5-63) and be consistent with section 2-2-2.13 of Part 2 of the 2018 Guidelines for Design and Construction of Hospitals of the Facility Guidelines Institute</p>	<p>(13VAC5-63) and be consistent with section 2-2-2.13 <u>2.2-2.15</u> of Part 2 of the 2018 Guidelines for Design and Construction of Hospitals, <u>2022 Edition</u> of the (The Facility Guidelines Institute).</p> <p>INTENT: The intent of the change is to update the design and construction guidelines to the recently published 2022 edition.</p> <p>RATIONALE: The rationale for the change is that the regulation should be in conformity with the mandates in Chapters 177 and 222 of the 2005 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion about which edition of the FGI guidelines general hospitals should reference.</p>
<p>410-1170</p>	<p>N/A</p>	<p>Part IV</p> <p>Outpatient Surgical Hospitals: Organization, Operation, and Design Standards for Existing and New Facilities</p> <p>12VAC5-410-1170. Policy and procedures manual.</p> <p style="text-align: center;">* * *</p> <p>B. A copy of approved policies and procedures and revisions thereto shall be made available to the OLC upon request.</p> <p>C. Each outpatient surgical hospital shall establish a protocol relating to the rights and responsibilities of patients based on Joint Commission on Accreditation of Healthcare Organizations' Standards for Ambulatory Care (2000 Hospital Accreditation Standards, January 2000). The protocol shall include a process reasonably designed to inform patients of their rights and responsibilities. Patients shall be given a copy of their rights and responsibilities upon admission.</p>	<p>CHANGE: The Board is proposing the following change:</p> <p style="text-align: center;">Part IV</p> <p><u>Organization and Operation of Outpatient Surgical Hospitals: Organization, Operation, and Design Standards for Existing and New Facilities</u></p> <p>12VAC5-410-1170. Policy and procedures manual.</p> <p style="text-align: center;">* * *</p> <p>B. <u>An outpatient surgical hospital shall provide</u> A <u>a</u> copy of approved policies and procedures and <u>any subsequent revisions thereto shall be made available</u> to the OLC upon request.</p> <p>C. Each outpatient surgical hospital shall establish a protocol relating to the rights and responsibilities of patients based on <u>42 C.F.R. § 416.50</u> Joint Commission on Accreditation of Healthcare Organizations' Standards for Ambulatory Care (2000 Hospital Accreditation Standards, January 2000). The protocol shall include a process reasonably designed to inform patients of their rights and responsibilities. Patients shall be given a copy of their rights and responsibilities upon admission.</p>

	<p>D. If the Governor has declared a public health emergency related to the novel coronavirus (COVID-19), each outpatient surgical hospital shall allow a person with a disability who requires assistance as a result of such disability to be accompanied by a designated support person at any time during which health care services are provided.</p> <p>1. A designated support person shall not be subject to any restrictions on visitation adopted by such outpatient surgical hospital. However, such designated support person may be required to comply with all reasonable requirements of the outpatient surgical hospital adopted to protect the health and safety of patients and staff of the outpatient surgical hospital.</p> <p>2. Every outpatient surgical hospital shall establish policies applicable to designated support persons and shall:</p> <p>a. Make such policies available to the public on a website maintained by the outpatient surgical hospital; and</p> <p>b. Provide such policies, in writing, to the patient at such time as health care services are provided.</p> <p>E. Each outpatient surgical hospital shall obtain a criminal history record check pursuant to</p>	<p>D. If the Governor has declared a public health emergency related to the novel coronavirus (COVID-19), each outpatient surgical hospital shall allow a person with a disability who requires assistance as a result of such disability to be accompanied by a designated support person at any time during which health care services are provided.</p> <p>1. A designated support person shall not be subject to any restrictions on visitation adopted by such outpatient surgical hospital. However, such designated support person may be required to comply with all reasonable requirements of the outpatient surgical hospital adopted to protect the health and safety of patients and staff of the outpatient surgical hospital.</p> <p>2. Every outpatient surgical hospital shall establish policies applicable to designated support persons and shall:</p> <p>a. Make such policies available to the public on a website maintained by the outpatient surgical hospital; and</p> <p>b. Provide such policies, in writing, to the patient at such time as health care services are provided.</p> <p>E. D. Each outpatient surgical hospital shall obtain a criminal history record check pursuant to § 32.1-126.02 of the Code of Virginia on any compensated employee not licensed by the Board of Pharmacy whose job duties provide access to controlled substances within the outpatient surgical hospital pharmacy.</p> <p>INTENT: The intent of the change is to update the Part's name to match Part II and not be confused with Part V, to use a more relevant basis for patient rights protocols, and to create a new section of regulation that separately addresses designated support persons.</p>
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		<p>§ 32.1-126.02 of the Code of Virginia on any compensated employee not licensed by the Board of Pharmacy whose job duties provide access to controlled substances within the outpatient surgical hospital pharmacy.</p>	<p>RATIONALE: The rationale for the change is that the current Part name gives the incorrect impression it addresses design and construction standards when it does not, that a document from 2000 is an out-of-date basis for patient rights, that over 95% of outpatient surgical hospitals in Virginia are already complying with 42 C.F.R. § 416.50 as a condition for coverage participation in Medicare, and that designated support persons is a topics requiring significantly more detail that, if it were to continue to be addressed in the present section of regulation, would make the section more difficult to read.</p> <p>LIKELY IMPACT: The likely impact of the change is improved readability of this regulatory section and improved ease in locating provisions addressing designated support persons and design and constructions for outpatient surgical hospitals.</p>
<p>410-1170(D)</p>	<p>410-1171</p>	<p>See row above about proposed changes to 410-1170</p>	<p>CHANGE: The Board is proposing the following change:</p> <p><u>12VAC5-410-1171. Persons with a disability; designated support person in outpatient surgical hospital.</u></p> <p><u>A. For the purposes of this section, "admission" means accepting a person for observation.</u></p> <p><u>B. An outpatient surgical hospital shall allow a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a DSP who will provide support and assistance necessary due to the specifics of the person's disability to the person with a disability during an admission.</u></p> <p><u>1. In any case in which the duration of the admission lasts more than 24 hours, the person with a disability may designate more than one DSP.</u></p> <p><u>2. No outpatient surgical hospital shall be required to allow more than one DSP to be present with a person with a disability at any time.</u></p>

			<p><u>C. An outpatient surgical hospital may:</u></p> <ol style="list-style-type: none"><u>1. Not subject a DSP to any restrictions on visitation;</u><u>2. Require a DSP to comply with all reasonable requirements of an outpatient surgical hospital adopted to protect the health and safety of the person with a disability; the DSP; the staff and other patients of, or visitors to, an outpatient surgical hospital; and the public; and</u><u>3. Restrict a DSP's access to specified areas of and movement on the premises of an outpatient surgical hospital when such restrictions are determined by an outpatient surgical hospital to be reasonably necessary to protect the health and safety of the person with a disability; the DSP; the staff and other patients of, or visitors to, an outpatient surgical hospital; and the public.</u> <p><u>D. An outpatient surgical hospital may request that a person with a disability provide documentation indicating that he is a person with a disability.</u></p> <ol style="list-style-type: none"><u>1. If the person with a disability fails, refuses, or is unable to provide documentation requested pursuant to subsection D of this section, an outpatient surgical hospital may perform an objective assessment of the person to determine whether he is a person with a disability.</u><u>2. If an outpatient surgical hospital fails to perform an objective assessment pursuant to subdivision D 1 of this section, an outpatient surgical hospital may not prohibit a DSP from accompanying a person with a disability for the purpose of providing support and assistance necessary due to the specifics of the person's disability.</u> <p><u>E. An outpatient surgical hospital shall</u></p>
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			<p><u>1. Establish protocols to inform patients, at the time of admission, of the right of a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a DSP for the purpose of providing support and assistance necessary due to the specifics of the person's disability;</u></p> <p><u>2. Develop and make available to a patient or his guardian, authorized representative, or care provider upon request written information regarding the right of a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a DSP and any policies related to that right; and</u></p> <p><u>3. Make the written information described in subdivision E 2 of this section available to the public on its website.</u></p> <p><u>G. This section may not:</u></p> <p><u>1. Alter the obligation of an outpatient surgical hospital to provide patients with effective communication support or other required services, regardless of the presence of a DSP or other reasonable accommodation, consistent with applicable federal or state law or regulations; and</u></p> <p><u>2. Be interpreted to:</u></p> <p><u>a. Prevent an outpatient surgical hospital from complying, or interfere with the ability of an outpatient surgical hospital to comply, with or cause an outpatient surgical hospital to violate any federal or state law or regulation;</u></p> <p><u>b. Deem a DSP to be acting under the direction or control of an outpatient surgical hospital or as an agent of an</u></p>
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			<p><u>outpatient surgical hospital;</u> <u>or</u> <u>c. Require an outpatient surgical hospital to allow a DSP to perform any action or provide any support or assistance necessary due to the specifics of the person's disability when an outpatient surgical hospital reasonably determines that the performance of the action or provision would be:</u> <u>(1) Medically or therapeutically contraindicated; or</u> <u>(2) Would pose a threat to the health and safety of the person with a disability, the DSP, or the staff or other patients of, or visitors to, an outpatient surgical hospital.</u></p> <p>INTENT: The intent of the change is to describe the minimum requirements for access to designated support persons by persons with disabilities in outpatient surgical hospitals.</p> <p>RATIONALE: The rationale for the change is that the regulation should be in conformity with Chapter 220 of the 2021 Acts of Assembly, Special Session I.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for outpatient surgical hospitals about what the minimum requirements for designated support persons are outside of a Governor-declared public health emergency related to COVID-19.</p>
410-1175	N/A	<p>12VAC5-410-1175. Discharge planning.</p> <p>A. Every hospital shall provide each patient admitted as an inpatient or his legal guardian the opportunity to designate an individual who will care for or assist the patient in his residence following discharge from the hospital and to whom the hospital</p>	<p>CHANGE: The Board is proposing to repeal this section.</p> <p>INTENT: The intent of the change is to remove provisions about discharge planning in an inpatient setting from the provisions about outpatient surgical hospitals.</p> <p>RATIONALE: The rationale for the change is that these discharge planning</p>

	<p>shall provide information regarding the patient's discharge plan and any follow-up care, treatment, and services that the patient may require.</p> <p>B. Every hospital upon admission shall record in the patient's medical record:</p> <ol style="list-style-type: none"> 1. The name of the individual designated by the patient; 2. The relationship between the patient and the person; and 3. The person's telephone number and address. <p>C. If the patient fails or refuses to designate an individual to receive information regarding his discharge plan and any follow-up care, treatment, and services, the hospital shall record the patient's failure or refusal in the patient's medical record.</p> <p>D. A patient may change the designated individual at any time prior to the patient's release, and the hospital shall record the changes, including the information referenced in subsection B of this section, in the patient's medical record within 24 hours of such a change.</p> <p>E. Prior to discharging a patient who has designated an individual pursuant to subsection A or D of this section, the hospital shall (i) notify the designated individual of the patient's discharge, (ii) provide the designated individual with a copy of the patient's discharge plan and instructions and information regarding any follow-up care, treatment, or services that the designated individual will provide, and (iii) consult with the designated individual regarding the designated individual's ability to provide the care, treatment, or</p>	<p>provisions were inadvertently placed in the wrong Part of this regulation and should be moved to the Part for general hospitals.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for hospitals and improved ease of locating the discharge planning requirements.</p>
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		<p>services. Such discharge plan shall include:</p> <ol style="list-style-type: none"> 1. The name and contact information of the designated individual; 2. A description of follow-up care, treatment, and services that the patient requires; and 3. Information, including contact information, about any health care, long-term care, or other community-based services and supports necessary for the implementation of the patient's discharge plan. <p>A copy of the discharge plan and any instructions or information provided to the designated individual shall be included in the patient's medical record.</p> <p>F. The hospital shall provide each individual designated pursuant to subsection A or D of this section the opportunity for a demonstration of specific follow-up care tasks that the designated individual will provide to the patient in accordance with the patient's discharge plan prior to the patient's discharge, including opportunity for the designated individual to ask questions regarding the performance of follow-up care tasks. Such opportunity shall be provided in a culturally competent manner and in the designated individual's native language.</p>	
N/A	410-1178	None	<p>CHANGE: The Board is proposing the following change:</p> <p><u>12VAC5-410-1178. Financial assistance in outpatient surgical hospitals.</u></p> <p><u>A. As used in this section, "patient" and "uninsured patient" have the same meanings as ascribed to these terms in</u></p>

			<p><u>subsection A of § 32.1-137.010 of the Code of Virginia.</u></p> <p><u>B. An outpatient surgical hospital shall make reasonable efforts to screen every uninsured patient to determine whether the individual is eligible for medical assistance pursuant to the state plan for medical assistance or for financial assistance under the outpatient surgical hospital's financial assistance policy.</u></p> <p><u>C. An outpatient surgical hospital shall inform every uninsured patient who receives services at the outpatient surgical hospital and who is determined to be eligible for assistance under the outpatient surgical hospital's financial assistance policy of the option to enter into a payment plan with the outpatient surgical hospital.</u></p> <ol style="list-style-type: none"> <u>1. A payment plan entered into pursuant to this subsection shall be provided to the patient in writing or electronically and shall provide for repayment of the cumulative amount owed to the outpatient surgical hospital.</u> <u>2. The amount of monthly payments and the term of the payment plan shall be determined based upon the patient's ability to pay.</u> <u>3. Any interest on amounts owed pursuant to the payment plan shall not exceed the maximum judgment rate of interest pursuant to § 6.2-302 of the Code of Virginia.</u> <u>4. The outpatient surgical hospital may not charge any fees related to the payment plan.</u> <u>5. The payment plan shall allow prepayment of amounts owed without penalty.</u> <p><u>D. An outpatient surgical hospital shall develop a process by which either an uninsured patient who agrees to a payment plan pursuant to subsection C of this section or the outpatient surgical hospital may request and shall be granted the opportunity to renegotiate the payment plan.</u></p>
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			<p><u>1. Renegotiation shall include opportunity for a new screening in accordance with subsection B of this section.</u></p> <p><u>2. An outpatient surgical hospital may not charge any fees for renegotiation of a payment plan pursuant to this subsection.</u></p> <p><u>E. An outpatient surgical hospital shall provide written information about:</u></p> <p><u>1. Its charity care policies, including:</u></p> <ul style="list-style-type: none"><u>a. Policies related to free and discounted care;</u><u>b. Specific eligibility criteria for charity care; and</u><u>c. Procedures for applying for charity care;</u> <p><u>2. The availability of a payment plan for the payment of debt owed to the outpatient surgical hospital pursuant to subsection C of this section; and</u></p> <p><u>3. The renegotiation process described in subsection D of this section.</u></p> <p><u>F. To provide the information required by subsection F of this section, an outpatient hospital shall:</u></p> <p><u>1. Post the information conspicuously in public areas of the outpatient surgical hospital, including admissions or registration areas and associated waiting rooms;</u></p> <p><u>2. Make the information available to:</u></p> <ul style="list-style-type: none"><u>a. A patient at the time of admission or discharge, or at the time services are provided; and</u><u>b. Persons with limited English proficiency in accordance with the U.S. Department of Health and Human Services' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin</u>
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			<p><u>Discrimination Affecting Limited English Proficient Persons (August 8, 2003, 68 FR 47311), if the outpatient surgical hospital is subject to the requirements of Title VI of the Civil Rights Act of 1964 (Pub. L. No. 88-352), as amended; and</u></p> <p><u>3. Include the information:</u></p> <p><u>a. With any billing statements sent to uninsured patients; and</u></p> <p><u>b. On any website maintained by the outpatient surgical hospital.</u></p> <p><u>G. Notwithstanding any other provision of law, an outpatient surgical hospital may not engage in any action described in § 501(r)(6) of the Internal Revenue Code, as it was in effect on January 1, 2020, to recover a debt for medical services against any patient unless the outpatient surgical hospital has made all reasonable efforts to determine whether the patient:</u></p> <p><u>1. Qualifies for medical assistance pursuant to the state plan for medical assistance; or</u></p> <p><u>2. Is eligible for financial assistance under the outpatient surgical hospital's financial assistance policy.</u></p> <p><u>H. Nothing in this section shall be construed to:</u></p> <p><u>1. Prohibit an outpatient surgical hospital, as part of its financial assistance policy, from requiring a patient to:</u></p> <p><u>a. Provide necessary information needed to determine eligibility for financial assistance under the outpatient surgical hospital's financial assistance policy, medical assistance pursuant to Title XVIII or XIX of the Social Security Act (42 U.S.C. § 301 et seq.) or 10 U.S.C. § 1071</u></p>
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			<p><u>et seq., or other programs of insurance; or</u></p> <p><u>b. Undertake good faith efforts to apply for and enroll in the programs of insurance for which the patient may be eligible as a condition of awarding financial assistance;</u></p> <p><u>2. Require an outpatient surgical hospital to grant or continue to grant any financial assistance or payment plan pursuant to this section when:</u></p> <p><u>a. A patient has provided false, inaccurate, or incomplete information required for determining eligibility for the outpatient surgical hospital's financial assistance policy; or</u></p> <p><u>b. A patient has not undertaken good faith efforts to comply with any payment plan pursuant to this section;</u></p> <p><u>or</u></p> <p><u>3. Prohibit the coordination of benefits as required by state or federal law.</u></p> <p>INTENT: The intent of the change is to describe the minimum requirements for information disclosure about financial assistance, for payment plans, and for renegotiation of payment plans.</p> <p>RATIONALE: The rationale for the change is that the regulation should conform to Chapters 678 and 679 of the 2022 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for outpatient surgical hospitals about the minimum requirements for providing information about financial assistance and providing financial assistance to patients.</p>
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<p>410-1190</p>	<p>N/A</p>	<p>12VAC5-410-1190. Nursing staff.</p> <p>The total number of nursing personnel will vary depending upon the number and types of patients to be admitted and the types of operative procedures to be performed or the services programmed.</p> <p style="text-align: center;">* * *</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-1190. Nursing staff.</p> <p><u>A.</u> The total number of nursing personnel will vary depending upon the number and types of patients to be admitted and the types of operative procedures to be performed or the services programmed.</p> <p style="text-align: center;">* * *</p> <p><u>B.</u> Each outpatient surgical hospital shall quarterly report to the department no later than 30 calendar days after January 1st, April 1st, July 1st, and October 1st:</p> <ol style="list-style-type: none"> <u>1. The total number of certified sexual assault nurse examiners employed by the outpatient surgical hospital; and</u> <u>2. The location, including street address, and contact information for each location at which such certified sexual assault nurse examiner provides services.</u> <p><u>Each outpatient surgical hospital shall report the information required by this subsection to the Office of Family Health Services, Virginia Department of Health.</u></p> <p>INTENT: The intent of the change is to describe what hospitals should report, when they should report, and to whom they should report data regarding SANEs they employ.</p> <p>RATIONALE: The rationale for the change is that the regulation should be in conformity with Chapter 1088 of the 2020 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for hospitals about their reporting responsibilities and improved consistency about the data being reported.</p>
<p>410-1260</p>	<p>N/A</p>	<p>12VAC5-410-1260. Medical records.</p> <p>A. Medical records. An accurate and complete clinical record or chart shall be maintained on each patient. The</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-1260. Medical records.</p> <p>A. Medical records. An accurate and complete clinical record or chart shall be</p>

	<p>record or chart shall contain sufficient information to satisfy the diagnosis or need for the medical or surgical service. It shall include, when applicable, but not be limited to the following:</p> <p style="text-align: center;">* * *</p> <p>4. Confirmation of pregnancy, if applicable;</p> <p style="text-align: center;">* * *</p> <p>13. Patient instructions, preoperative and postoperative;</p> <p style="text-align: center;">* * *</p> <p>B. Provisions shall be made for the safe storage of medical records or accurate and legible reproductions thereof according to § 32.1-127.1:03 of the Code of Virginia and the Health Insurance Portability and Accountability Act, or HIPAA (42 USC § 1320d et seq.).</p> <p>C. All medical records, either original or accurate reproductions, shall be preserved for a minimum of five years following discharge of the patient.</p> <p style="text-align: center;">* * *</p> <p>3. Record of abortions and proper information for the issuance of a fetal death certificate shall be furnished the Division of Vital Records, Virginia Department of Health, within 10 days after the abortion.</p>	<p>maintained on each patient. The record or chart shall contain sufficient information to satisfy the diagnosis or need for the medical or surgical service. It shall include, when applicable, but not be limited to the following:</p> <p style="text-align: center;">* * *</p> <p>4. Confirmation of pregnancy, if applicable;</p> <p style="text-align: center;">* * *</p> <p>13. Patient instructions, preoperative and postoperative; <u>and</u></p> <p style="text-align: center;">* * *</p> <p>B. Provisions shall be made for the safe storage of medical records or <u>and the</u> accurate and legible reproductions thereof of medical records according to § 32.1-127.1:03 of the Code of Virginia and the Health Insurance Portability and Accountability Act, or HIPAA (42 USC § 1320d et seq.) (Pub. L. No. 104-191).</p> <p>C. All medical records, either original or accurate reproductions, shall be preserved for a minimum of five years following discharge of the patient.</p> <p style="text-align: center;">* * *</p> <p>3. Record of abortions and proper information for the issuance of a fetal death certificate shall be furnished <u>to the Division Office of Vital Records, Virginia Department of Health, within 10 days after the abortion as required by law.</u></p> <p>D. <u>An outpatient surgical hospital that makes health records, as defined in § 32.1-127.1:03 of the Code of Virginia, of patients who are minors available to patients through a secure website shall make the health records available to the patient's parent or guardian through the secure website, unless the hospital cannot make the health record available:</u></p> <p style="padding-left: 40px;"><u>1. In a manner that prevents disclosure of information, the disclosure of which has been denied pursuant to subsection F of § 32.1-127.1:03 of the Code of Virginia; or</u></p>
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			<p><u>2. Because the consent required in accordance with subsection E of § 54.1-2969 of the Code of Virginia has not been provided.</u></p> <p>INTENT: The intent of the change is to correct an erroneous statutory citation, to update the name of a business unit within VDH, to require that hospitals are capable of both safe storage and accurate reproduction of medical records, to update the regulatory text to match the style guidelines, and to describe minimum standards for giving parent’s or guardian’s electronic access to their minor’s medical records.</p> <p>RATIONALE: The rationale for the change is that statutory references should be accurate, that VDH business units should be referred to by their current names, that hospitals should not have the discretion to choose between whether to provide safe storage or accurate reproduction of medical records, that the style guidelines ensure more intelligible regulatory text, and that the regulation should be in conformity with Chapter 218 of the 2022 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for general hospitals regarding parental/guardian electronic access to a minor patient’s medical records.</p>
410-1350	N/A	<p>12VAC5-410-1350. Local and state codes and standards.</p> <p>A. All construction of new buildings and additions, alterations, or repairs to existing buildings for occupancy as a "free-standing" outpatient hospital shall conform to state and local codes, zoning ordinances, and the Virginia Uniform Statewide Building Code (13VAC5-63).</p> <p>In addition, hospitals shall be designed and constructed consistent with Part 1 and sections 2.1 and 2.7 of Part 2 of the 2018 Guidelines for Design and Construction of Outpatient</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-410-1350. Local and state codes and standards.</p> <p>A. All construction of new buildings and additions, <u>renovations, or alterations;</u> or repairs to existing buildings for occupancy as a "free-standing" outpatient hospital shall conform to state and local codes, zoning ordinances, and the Virginia Uniform Statewide Building Code (13VAC5-63).</p> <p>In addition, hospitals shall be designed and constructed consistent with Part 1 and sections <u>Chapters</u> 2.1 and 2.7 of Part 2 of the 2018 Guidelines for Design and Construction of Outpatient</p>

		<p>Facilities of the Facility Guidelines Institute pursuant to § 32.1-127.001 of the Code of Virginia.</p> <p>Architectural drawings and specifications for all new construction or for additions, alterations, or renovations to any existing building shall be dated, stamped with professional seal, and signed by the architect. The architect shall certify that the drawings and specifications were prepared to conform to the Virginia Uniform Statewide Building Code (13VAC5-63) and be consistent with Part 1 and sections 2.1 and 2.7 of Part 2 of the 2018 Guidelines for Design and Construction of Outpatient Facilities of the Facility Guidelines Institute.</p> <p>B. The use of an incinerator shall require permitting from the nearest regional office of the Department of Environmental Quality.</p> <p style="text-align: center;">* * *</p>	<p>Facilities, 2022 Edition of the (The Facility Guidelines Institute) pursuant to § 32.1-127.001 of the Code of Virginia, as amended by the November 2022 Errata for Guidelines for Design and Construction of Outpatient Facilities, 2022 Edition (The Facility Guidelines Institute).</p> <p>Architectural drawings and specifications for all new construction or for additions, alterations, or renovations to any existing building shall be dated, stamped with professional seal, and signed by the architect. The architect shall certify that the drawings and specifications were prepared to conform to the Virginia Uniform Statewide Building Code (13VAC5-63) and be consistent with Part 1 and sections Chapters 2.1 and 2.7 of Part 2 of the 2018 Guidelines for Design and Construction of Outpatient Facilities, 2022 Edition of the (The Facility Guidelines Institute), as amended by the November 2022 Errata for Guidelines for Design and Construction of Outpatient Facilities, 2022 Edition (The Facility Guidelines Institute).</p> <p style="text-align: center;">* * *</p> <p>INTENT: The intent of the change is to update the design and construction guidelines to the recently published 2022 edition.</p> <p>RATIONALE: The rationale for the change is that the regulation should be in conformity with the mandates in Chapters 177 and 222 of the 2005 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion about which edition of the FGI guidelines outpatient surgical hospitals should reference.</p>
DIBR		<p>Documents Incorporated by Reference (12VAC5-410)</p> <p>Guidelines for Design and Construction of Hospitals, 2018 Edition, Facility Guidelines Institute, Washington D.C., http://www.fgiguideines.org</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>Documents Incorporated by Reference (12VAC5-410)</p> <p><u>Control of Communicable Diseases Manual, American Public Health</u></p>

		<p>Guidelines for Design and Construction of Outpatient Facilities, 2018 Edition, Facility Guidelines Institute, Washington, D.C., https://fgiguideines.org</p>	<p><u>Association, 21st Edition, 2022, https://www.apha.org</u></p> <p><u>Errata for Guidelines for Design and Construction of Hospitals, The Facility Guidelines Institute, 2022 Edition, https://fgiguideines.org/guidelines/errata-addenda/ (eff. 11/2022).</u></p> <p><u>Errata for Guidelines for Design and Construction of Outpatient Facilities, The Facility Guidelines Institute, 2022 Edition, https://fgiguideines.org/guidelines/errata-addenda/ (eff. 11/2022).</u></p> <p><u>Guidelines for Design and Construction of Hospitals, 2018 Edition, The Facility Guidelines Institute, Washington D.C., 2022 Edition, http://www.fgiguideines.org https://fgiguideines.org.</u></p> <p><u>Guidelines for Design and Construction of Outpatient Facilities, 2018 Edition, The Facility Guidelines Institute, Washington, D.C., 2022 Edition, https://fgiguideines.org.</u></p> <p><u>Guidelines for Perinatal Care, American Academy of Pediatric/American College of Obstetricians and Gynecologists, 8th Edition, 2017, https://www.aap.org and https://www.acog.org.</u></p> <p><u>Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of ACIP, MMWR 64 (15), 2015, CDC.</u></p> <p><u>Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2022–23 Influenza Season, MMWR 71 (1), 2022, CDC.</u></p> <p><u>Prevention of Pneumococcal Disease Among Infants and Children — Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine: Recommendations of ACIP, MMWR 59 (RR-11), 2010, CDC.</u></p> <p><u>Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23), MMWR 59 (34), 2010, CDC.</u></p>
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			<p><u>Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Adults Aged >65 Years: Recommendations of ACIP, MMWR 63 (37), 2014, CDC.</u></p> <p><u>Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Adults Aged >65 Years: Updated Recommendations of ACIP, MMWR 68 (46), 2019, CDC.</u></p> <p><u>Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine for Adults with Immunocompromising Conditions: Recommendations of ACIP, MMWR 61 (40), 2012, CDC.</u></p> <p><u>Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Children Aged 6–18 Years with Immunocompromising Conditions: Recommendations of ACIP, MMWR 62 (25), 2013, CDC.</u></p> <p><u>Use of 15-Valent Pneumococcal Conjugate Vaccine and 20-Valent Pneumococcal Conjugate Vaccine Among U.S. Adults: Updated Recommendations of ACIP — United States, MMWR 71 (4), 2022, CDC.</u></p> <p>INTENT: The intent of these proposed changes is to ensure documents incorporated by reference are current and accurate.</p> <p>RATIONALE: The rationale behind these proposed changes is that hospitals should be held to current standards and guidelines.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is improved patient health and safety at hospitals.</p>
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1 **Project 6374 - Fast-Track**

2 **Department of Health**

3 **Amend Regulation After Periodic Review**

4 **12VAC5-410-10. Definitions.**

5 As used in this chapter, the following words and terms shall have the following meanings
6 unless the context clearly indicates otherwise:

7 "ACIP" means the Advisory Committee on Immunization Practices of the CDC.

8 "Activity of daily living" or "ADL" has the same meaning as ascribed to the term in subsection
9 A of § 32.1-137.08 of the Code of Virginia.

10 "Board" means the State Board of Health.

11 "Business day" means any day that is not a Saturday, Sunday, legal holiday, or day on which
12 the OLC is closed. For the purposes of this chapter, any day on which the Governor authorizes
13 the closing of the state government shall be considered a legal holiday.

14 "Campus" means the physical area that is immediately adjacent to the hospital's main
15 buildings, other areas and structures that are not strictly contiguous to the main buildings but are
16 located within 250 yards of the main buildings, and any other physical areas determined on an
17 individual case basis, by the OLC in accordance with 42 C.F.R. § 413.65, to be part of the
18 hospital's campus.

19 "Care provider" has the same meaning as ascribed to the term in subsection A of § 32.1-
20 137.08 of the Code of Virginia.

21 "CDC" means the Centers for Disease Control and Prevention.

22 "Certified nursing facility" has the same meaning as ascribed to the term in § 32.1-123 of the
23 Code of Virginia.

24 "Certified sexual assault nurse examiner" means a nurse who is board certified by the
25 International Association of Forensic Nurses as either a Sexual Assault Nurse Examiner-Pediatric
26 (SANE-P) or a Sexual Assault Nurse Examiner-Adult/Adolescent (SANE-A).

27 "Chief executive officer" means a job descriptive term used to identify the individual appointed
28 by the governing body to act in its behalf in the overall management of the hospital. Job titles may
29 include administrator, superintendent, director, executive director, president, vice-president, and
30 executive vice-president.

31 "CMS" means the Centers for Medicare and Medicaid Services.

32 "Commissioner" means the State Health Commissioner.

33 "Consultant" means one who provides services or advice upon request.

34 "Department" means an organized section of the hospital.

35 "Designated support person" or "DSP" means a person who is knowledgeable about the
36 needs of a person with a disability, and who is designated, orally or in writing, by the individual
37 with a disability, the individual's guardian, or the individual's care provider to provide support and
38 assistance, including physical assistance, emotional support, assistance with communication or
39 decision-making, or any other assistance necessary as a result of the person's disability, to the
40 person with a disability at any time during which health care services are provided has the same
41 meaning as ascribed to the term in subsection A of § 32.1-137.08 of the Code of Virginia and is
42 not a visitor.

43 "Direction" means authoritative policy or procedural guidance for the accomplishment of a
44 function or activity.

45 "Emergency department" means a department of the hospital that provides emergency
46 services and is located on, or within a 35-mile radius of, the campus of the hospital.

47 "Facilities" means building(s), equipment, and supplies necessary for implementation of
48 services by personnel.

49 ~~"Full time" means a 37 1/2 to 40 hour work week.~~

50 ~~"General hospital" means institutions a hospital as defined by § 32.1-123 of the Code of~~
51 ~~Virginia with an organized medical staff; with permanent facilities that include inpatient beds; and~~
52 ~~with medical services, including physician services, dentist services and continuous nursing~~
53 ~~services, to provide diagnosis and treatment for patients who have a variety of medical and dental~~
54 ~~conditions that may require various types of care, such as medical, surgical, and maternity.~~

55 "General hospital accrediting organization" means the Accreditation Commission for Health
56 Care, the Center for Improvement in Healthcare Quality, DNV - Healthcare, The Joint
57 Commission, or any accrediting organization that has been granted deeming authority for
58 hospitals by CMS.

59 ~~"Home health care department/service/program" "Home health services" means a formally~~
60 ~~structured organizational unit of the hospital that is designed to provide health services to patients~~
61 ~~in their place of residence and meets Part II (12VAC5-381-150 et seq.) of the regulations adopted~~
62 ~~by the board for the licensure of home care organizations in Virginia.~~

63 "Hospital" has the same meaning ascribed to the term in § 32.1-123 of the Code of Virginia
64 and includes general hospitals and outpatient surgical hospitals.

65 "Inspector" means an individual employed by or contracted by the Virginia Department of
66 Health and designated by the commissioner to conduct inspections, investigations, or evaluations.

67 "Long-term care nursing unit" means an organized jurisdiction of nursing service in which
68 nursing services are provided on a continuous basis.

69 "Medical" means pertaining to or dealing with the healing art and the science of medicine.

70 ~~"Nursing care unit" means an organized jurisdiction of nursing service in which nursing~~
71 ~~services are provided on a continuous basis.~~

72 ~~"Nursing home" means an institution or any identifiable component of any institution as~~
73 ~~defined by has the same meaning as ascribed to the term in § 32.1-123 of the Code of Virginia~~
74 ~~with permanent facilities that include inpatient beds and whose primary function is the provision,~~
75 ~~on a continuing basis, of nursing and health related services for the treatment of patients who~~
76 ~~may require various types of long term care, such as skilled care and intermediate care.~~

77 "Nursing services" means patient care services pertaining to the curative, palliative,
78 restorative, or preventive aspects of nursing that are prepared or supervised by a registered
79 nurse.

80 ~~"Office of Licensure and Certification" or "OLC" means the Office of Licensure and~~
81 ~~Certification of the Virginia Department of Health.~~

82 "Operating room" means a room in a hospital designated for the performance of surgery.

83 "Organized" means administratively and functionally structured.

84 "Organized medical staff" means a formal organization of physicians and dentists with the
85 delegated responsibility and authority to maintain proper standards of medical care and to plan
86 for continued betterment of that care.

87 ~~"Outpatient surgical hospital" means institutions a hospital as defined by § 32.1-123 of the~~
88 ~~Code of Virginia that primarily provide provides facilities for the performance of surgical~~
89 ~~procedures on outpatients. Such patients may require treatment in a medical environment~~
90 ~~exceeding the normal capability found in a physician's office, but do not require inpatient~~
91 ~~hospitalization.~~

92 "Outpatient surgical hospital accrediting organization" means the Accreditation Commission
93 for Ambulatory Health Care, the Accreditation Commission for Health Care, the American
94 Association for Accreditation of Ambulatory Surgery Facilities, The Joint Commission, or any
95 accrediting organization that has been granted deeming authority for ambulatory surgical centers
96 by CMS.

97 "Ownership/person" means any individual, partnership, association, trust, corporation,
98 municipality, county, governmental agency, or any other legal or commercial entity that owns or
99 controls the physical facilities and/or manages or operates a hospital.

100 "Person with a disability" has the same meaning as ascribed to the term in subsection A of §
101 32.1-137.08 of the Code of Virginia.

102 "Rural hospital" means any general hospital in a county classified by the federal Office of
103 Management and Budget (OMB) as rural, any hospital designated as a critical access hospital,
104 any general hospital that is eligible to receive funds under the federal Small Rural Hospital
105 Improvement Grant Program, or any general hospital that notifies the commissioner of its desire
106 to retain its rural status when that hospital is in a county reclassified by the OMB as a metropolitan
107 statistical area as of June 6, 2003.

108 "Service" means a functional division of the hospital. Also used to indicate the delivery of care.

109 ~~"Special hospital" means institutions as defined by § 32.1-123 of the Code of Virginia that~~
110 ~~provide care for a specialized group of patients or limit admissions to provide diagnosis and~~
111 ~~treatment for patients who have specific conditions (e.g., tuberculosis, orthopedic, pediatric,~~
112 ~~maternity).~~

113 "Special care unit" means an appropriately equipped area of the hospital where there is a
114 concentration of physicians, nurses, and others who have special skills and experience to provide
115 optimal medical care for patients assigned to the unit.

116 "Staff privileges" means authority to render medical care in the granting institution within well-
117 defined limits, based on the individual's professional license and the individual's experience,
118 competence, ability, and judgment.

119 "Support and assistance necessary due to the specifics of the person's disability" has the
120 same meaning as ascribed to the term in subsection A of § 32.1-137.08 of the Code of Virginia.

121 "Surgery" has the same meaning as ascribed to the term in subsection A of § 54.1-2400.01:1
122 of the Code of Virginia.

123 "Unit" means a functional division or facility of the hospital.

124 **Statutory Authority**

125 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

126 **Historical Notes**

127 Derived from VR355-33-500 § 1.1, eff. July 28, 1993; amended, Virginia Register Volume 11,
128 Issue 8, eff. April 1, 1995; Volume 11, Issue 16, eff. June 1, 1995; Volume 21, Issue 12, eff. May
129 9, 2005; Volume 23, Issue 10, eff. March 1, 2007; Volume 29, Issue 19, eff. June 20, 2013;
130 Volume 37, Issue 14, eff. March 31, 2021.

131 **12VAC5-410-50. Classification.**

132 Hospitals to be licensed shall be classified as general hospitals, ~~special hospitals~~ or outpatient
133 surgical hospitals defined by 12VAC5-410-10.

134 **Statutory Authority**

135 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

136 **Historical Notes**

137 Derived from VR355-33-500 § 1.5, eff. July 28, 1993; amended, Virginia Register Volume 11,
138 Issue 8, eff. April 1, 1995.

139 **12VAC5-410-60. Separate license.**

140 A. A separate license shall be required by hospitals maintained on separate ~~premises~~
141 campuses even though they are operated under the same management. Separate license is not
142 required for separate buildings on the same ~~grounds~~ campus or within the same complex of
143 buildings or for an emergency department of a general hospital.

144 B. Hospitals which have separate organized sections, units, or buildings to provide services
145 of a classification covered by provisions of other state statutes or regulations may be required to
146 have an additional applicable license for that type or classification of service (e.g., psychiatric,
147 nursing home, home health services, and outpatient surgery).

148 **Statutory Authority**

149 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

150 **Historical Notes**

151 Derived from VR355-33-500 § 1.6, eff. July 28, 1993; amended, Virginia Register Volume 11,
152 Issue 8, eff. April 1, 1995; Volume 29, Issue 19, eff. June 20, 2013.

153 **12VAC5-410-100. Name.**

154 Every hospital shall be designated by a permanent and appropriate name ~~which that~~ shall
155 appear on the application for license. ~~Any change of name shall be reported to the OLC within 30~~
156 ~~days.~~

157 **Statutory Authority**

158 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

159 **Historical Notes**

160 Derived from VR355-33-500 § 1.10, eff. July 28, 1993; amended, Virginia Register Volume 11,
161 Issue 8, eff. April 1, 1995; Volume 23, Issue 10, eff. March 1, 2007.

162 **12VAC5-410-130. ~~Return of license~~ Surrender of license; mid-term change of license.**

163 A. Upon revocation or suspension of a license, the hospital shall surrender its license to the
164 OLC.

165 B. ~~The hospital shall notify the director of the OLC shall be notified in writing by submitting a~~
166 mid-term change application at least within 30 working days no less than 30 calendar days in
167 advance of any proposed change in location or ownership of the facility. A license shall not be
168 transferred from one owner to another or from one location to another. The license issued by the
169 commissioner shall be returned to the OLC for correction or reissuance when any of the following
170 changes occur during the licensing year implementing any:

171 1. Revocation;

172 2. 1. Change of location of the hospital, including change of location of any emergency
173 department not located on the hospital's campus;

174 3. 2. Change of ownership of the hospital;

175 3. Change of operator of the hospital;

176 4. Change of name of the hospital;

177 5. Change of bed capacity, except as provided in 12VAC5-410-110 C; which shall be
178 accompanied by an approved Certificate of Public Need if the requested change is for an
179 increase in bed capacity; or

180 6. Change of services being provided, including any proposed addition or discontinuation,
181 regardless of whether licensure is required for the service; or

182 ~~6. Voluntary closure~~ 7. Closure of the hospital.

183 C. The OLC shall:

184 1. Consider the submission date of a mid-term change application to be the date it is
185 postmarked or the date it is received, whichever is earlier; and

186 2. Notify in writing the licensee if the commissioner will issue a changed license.

187 D. The commissioner's issuance of a changed license to the hospital shall satisfy the
188 requirements of subdivision C 2 of this section.

189 E. Upon receipt of the changed license, the licensee shall return its prior license issued by the
190 commissioner to the OLC and destroy any copies of the prior license.

191 F. A license may not be transferred or assigned. The commissioner may not issue a changed
192 license in response to a change of operator of the hospital, but shall instead require the hospital
193 to obtain a new license. If the hospital intends to implement a change of operator, it shall:

194 1. File for a new license, in accordance with 12VAC5-410-70, no less than 30 calendar
195 days in advance of any change of operator; and

196 2. Upon receipt of the new license, surrender its prior license issued by the commissioner
197 to the OLC and destroy any copies of the prior license.

198 G. If the hospital is closing or will otherwise no longer be operational, it shall:

199 1. Notify patients, legal representatives, and the OLC no fewer than seven calendar days
200 prior to closing or ceasing operations where all clinical records are to be located following
201 closure or cessation of operations; and

202 2. Surrender its license to the OLC and destroy all copies of its license no more than five
203 calendar days after the hospital closes or ceases operations.

204 H. The OLC shall determine if any changes listed in subsection B affect the terms of the
205 license or the continuing eligibility for a license. An inspector may inspect the hospital during the
206 process of evaluating a proposed change.

207 **Statutory Authority**

208 §§ 32.1-12, and 32.1-127, and 32.1-132 of the Code of Virginia.

209 **Historical Notes**

210 Derived from VR355-33-500 § 1.13, eff. July 28, 1993; amended, Virginia Register Volume 11,
211 Issue 8, eff. April 1, 1995; Volume 11, Issue 16, eff. June 1, 1995; Volume 23, Issue 10, eff. March
212 1, 2007; Volume 35, Issue 24, eff. August 23, 2019.

213 **12VAC5-410-140. Inspection procedure.**

214 A. The OLC shall make periodic unannounced on-site inspections of a hospital as necessary
215 but not less often than biennially. The OLC may make on-site inspections of applicants for
216 licensure. Compliance with all standards shall be determined by the OLC.

217 B. The hospital or applicant shall:

218 1. Make available to the inspector any requested records;

219 2. Permit an inspector to enter upon and into its property to inspect or investigate as the
220 inspector reasonably deems necessary in order to determine the state of compliance with
221 the provisions of this chapter and all laws administered by the board; and

222 3. Allow the inspector access to interview the agents, employees, independent
223 contractors, patients, legal representatives, patients' family members, and any person
224 under the hospital's or applicant's control, direction, or supervision.

225 C. After the on-site inspection, the inspector shall:

226 1. Discuss the findings of the inspection with the chief executive officer or his designee;
227 and

228 2. Provide a written inspection report to the chief executive officer or his designee.

229 D. If the OLC cites one or more licensing violations in the written inspection report, the chief
230 executive officer or his designee shall submit a plan of correction in accordance with 12VAC5-
231 410-150.

232 A. ~~E.~~ The OLC may presume that a general hospital accredited deemed by the ~~Joint~~
233 ~~Commission on Accreditation of Healthcare Organizations (JCAHO)~~ a general hospital
234 accrediting organization and certified for participation in Title XVIII of the Social Security Act
235 (Medicare) (42 U.S.C. § 301 et seq.) generally meets the requirements of Part II (12VAC5-410-
236 170 et seq.) of this chapter provided the following conditions are met:

237 1. The general hospital provides to the OLC, upon request, a copy of the most current
238 accreditation survey findings made by the ~~Joint Commission on Accreditation of~~
239 ~~Healthcare Organizations~~ general hospital accrediting organization; and

240 2. The general hospital notifies the OLC within 10 days after receipt of any notice of
241 revocation or denial of accreditation by the ~~Joint Commission on Accreditation of~~
242 ~~Healthcare Organizations~~ general hospital accrediting organization.

243 F. The OLC may presume that an outpatient surgical hospital deemed by an outpatient
244 surgical hospital accrediting organization and certified for participation in Title XVIII of the Social
245 Security Act (42 U.S.C. § 301 et seq.) generally meets the requirements of Part IV (12VAC5-410-
246 1150 et seq.) of this chapter provided the following conditions are met:

247 1. The outpatient surgical hospital provides to the OLC, upon request, a copy of the most
248 current accreditation survey findings made by the outpatient surgical hospital accrediting
249 organization; and

250 2. The outpatient surgical hospital notifies the OLC within 10 days after receipt of any
251 notice of revocation or denial of accreditation by the outpatient surgical hospital accrediting
252 organization.

253 B. ~~G.~~ The OLC may presume that a unit or part of a general hospital licensed or certified by
254 another state agency, or another section, bureau or division of the OLC meets the requirements
255 of Part II (12VAC5-410-170 et seq.) of this chapter for that specific unit or part provided the
256 following conditions are met:

257 1. The general hospital provides the OLC, upon request, a copy of the most current
258 inspection report made by the other state agency; and

259 2. The general hospital notifies the OLC within 10 days after receipt of any notice of
260 revocation or suspension by the other state agency.

261 H. The OLC may presume that a unit or part of an outpatient surgical hospital licensed or
262 certified by another state agency, or another section, bureau or division of the OLC meets the
263 requirements of Part IV (12VAC5-410-1150 et seq.) of this chapter for that specific unit or part
264 provided the following conditions are met:

265 1. The outpatient surgical hospital provides the OLC, upon request, a copy of the most
266 current inspection report made by the other state agency; and

267 2. The outpatient surgical hospital notifies the OLC within 10 days after receipt of any
268 notice of revocation or suspension by the other state agency.

269 ~~C. I.~~ Notwithstanding any other provision of this chapter to the contrary, if the ~~licensing agency~~
270 OLC finds, after inspection, violations pertaining to environmental health or life safety, the hospital
271 shall receive a written licensing report of such findings. The hospital shall be required to submit a
272 plan of correction in accordance with provisions of 12VAC5-410-150.

273 **Statutory Authority**

274 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

275 **Historical Notes**

276 Derived from VR355-33-500 § 1.14, eff. July 28, 1993; amended, Virginia Register Volume 11,
277 Issue 8, eff. April 1, 1995; Volume 11, Issue 16, eff. June 1, 1995; Volume 23, Issue 10, eff. March
278 1, 2007.

279 **12VAC5-410-150. Plan of correction.**

280 A. Upon receipt of a written licensing inspection report, the chief executive officer or his
281 designee each hospital shall prepare a written plan for correcting of correction addressing any
282 each licensing violations violation cited at the time of inspection. The plan of correction shall be
283 to the OLC within the specified time limit set forth in the licensing report. The plan of correction
284 shall contain at least the following information:

285 B. The chief executive officer or his designee shall submit to the OLC a written plan of
286 correction no more than 15 business days after receipt of the inspection report. The plan of
287 correction shall contain for each licensing violation cited:

288 1. The methods implemented to correct any violations of this chapter A description of the
289 corrective action or actions to be taken and the position title of the employees to implement
290 the corrective action. If employees share the same position title, the chief executive officer
291 or his designee shall assign the employees a unique identifier to distinguish them; and

292 2. The expected correction date, on which such corrections are expected to be completed
293 not to exceed 45 business days from the exit date of the inspection; and

294 3. A description of the measures implemented to prevent a recurrence of each licensing
295 violation.

296 C. The chief executive officer or his designee shall ensure that the person responsible for the
297 validity of the plan of correction signs, dates, and indicates their title on the plan of correction.

298 ~~B.~~ D. The OLC shall notify the hospital chief executive officer or his designee, in writing,
299 whenever if the OLC determines any item in the plan of correction is determined to be
300 unacceptable.

301 E. The OLC may conduct an inspection to verify any portion of a plan of correction has been
302 implemented.

303 F. The chief executive officer or his designee shall ensure the plan of correction is
304 implemented and monitored so that compliance is maintained.

305 G. The commissioner may deny licensure or renewal of licensure if the chief executive officer
306 or his designee fails to submit an acceptable plan of correction or fails to implement an acceptable
307 plan of correction.

308 H. The OLC shall consider the submission date of a plan of correction to be the date it is
309 postmarked or the date it is received, whichever is earlier.

310 **Statutory Authority**

311 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

312 **Historical Notes**

313 Derived from VR355-33-500 § 1.15, eff. July 28, 1993; amended, Virginia Register Volume 11,
314 Issue 8, eff. April 1, 1995; Volume 11, Issue 16, eff. June 1, 1995; Volume 23, Issue 10, eff. March
315 1, 2007.

316 **12VAC5-410-160. Revocation of license Disciplinary action.**

317 ~~The commissioner may revoke or suspend the license to operate a hospital in accordance~~
318 ~~with § 32.1-135 of the Code of Virginia for the following reasons:~~

- 319 ~~1. Violation of any provision of these rules and regulations. Violations which in the~~
320 ~~judgment of the commissioner jeopardize the health or safety of patients shall be sufficient~~
321 ~~cause for immediate revocation or suspension; or~~
322 ~~2. Willfully permitting, aiding, or abetting the commission of any illegal act in the hospital.~~
- 323 A. A hospital may not:
- 324 1. Violate the provisions of this chapter or Article 1 (§ 32.1-123 et seq.) of Chapter 5 of
325 Title 32.1 of the Code of Virginia;
- 326 2. Permit, aid, or abet the commission of any illegal act in the hospital;
- 327 3. Engage in a pattern of violations pursuant to § 38.2-3445.01 of the Code of Virginia; or
- 328 4. Engage in a pattern of violations of subdivision B 13 of § 38.2-3407.15 of the Code of
329 Virginia.
- 330 B. The commissioner may:
- 331 1. For each violation of subsection A of this section:
- 332 a. Deny, revoke, or suspend the license to operate a hospital, in accordance with the
333 Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia);
- 334 b. Refer a hospital for criminal prosecution pursuant to subsection A of § 32.1-27 of
335 the Code of Virginia; or
- 336 c. Petition an appropriate court for an injunction, mandamus, or other appropriate
337 remedy or imposition of a civil penalty against a hospital pursuant to subsection B or
338 C of § 32.1-27 of the Code of Virginia;
- 339 2. For each violation of subsection A of this section by or occurring in a long-term care
340 nursing unit of a general hospital if that unit is a certified nursing facility:
- 341 a. Restrict or prohibit new admissions to the long-term care nursing unit in accordance
342 with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia);
- 343 b. Petition an appropriate court for imposition of a civil monetary penalty against a
344 hospital pursuant to subsection A of § 32.1-27.1 of the Code of Virginia; or
- 345 c. Petition an appropriate court for appointment of a receiver for the long-term care
346 nursing unit pursuant to subsection B of § 32.1-27.1 of the Code of Virginia; and
- 347 3. For each violation of subdivision A 3 of this section, levy a fine upon the hospital in an
348 amount not to exceed \$1,000 per violation, in accordance with the Administrative Process
349 Acts (§ 2.2-4000 et seq. of the Code of Virginia).
- 350 C. Suspension of a license shall in all cases be for an indefinite time.
- 351 D. For each violation of subsection A of this section and with the consent of the person who
352 has violated subsection A of this section, the board may provide, in an order issued by the board,
353 for the payment of civil charges for past violations in specific sums, which may not exceed the
354 limits specified in § 32.1-27 of the Code of Virginia or if applicable, the limits specified in § 32.1-
355 27.1 of the Code of Virginia.
- 356 E. Upon receipt of a completed application and a nonrefundable service charge, the
357 commissioner may issue a new license to a hospital that has had its license revoked if the
358 commissioner determines that:
- 359 1. The conditions upon which revocation was based have been corrected; and
- 360 2. The applicant is in compliance with this chapter, Article 1 (§ 32.1-123 et seq.) of Chapter
361 5 of Title 32.1 of the Code of Virginia, and all other applicable state and federal law and
362 regulations.
- 363 F. Upon receipt of a completed application, the commissioner may partially or completely
364 restore a suspended license to a hospital if the commissioner determines that:

365 1. The conditions upon which suspension was based have been completely or partially
366 corrected; and

367 2. The interests of the public will not be jeopardized by resumption of operation.

368 G. The commissioner may not require an additional service charge for restoring a license
369 pursuant to subsection F of this section.

370 H. The hospital shall submit evidence relevant to subdivisions E 1, E 2, F 1, and F 2 of this
371 subsection that is satisfactory to the commissioner or his designee. The commissioner or his
372 designee may conduct an inspection prior to making a determination.

373 **Statutory Authority**

374 §§ 32.1-12, 32.1-27, 32.1-27.1, and 32.1-127, 32.1-135, 32.1-137.07, and 38.2-3407.15 of the
375 Code of Virginia.

376 **Historical Notes**

377 Derived from VR355-33-500 § 1.16, eff. July 28, 1993; amended, Virginia Register Volume 11,
378 Issue 8, eff. April 1, 1995.

379 **Part II**

380 **Organization and Operation of General and ~~Special~~ Hospitals**

381 **12VAC5-410-215. Financial assistance in general hospitals.**

382 A. As used in this section, "patient" and "uninsured patient" have the same meanings as
383 ascribed to these terms in subsection A of § 32.1-137.010 of the Code of Virginia.

384 B. A general hospital shall make reasonable efforts to screen every uninsured patient to
385 determine whether the individual is eligible for medical assistance pursuant to the state plan for
386 medical assistance or for financial assistance under the general hospital's financial assistance
387 policy.

388 C. A general hospital shall inform every uninsured patient who receives services at the general
389 hospital and who is determined to be eligible for assistance under the general hospital's financial
390 assistance policy of the option to enter into a payment plan with the general hospital.

391 1. A payment plan entered into pursuant to this subsection shall be provided to the patient
392 in writing or electronically and shall provide for repayment of the cumulative amount owed
393 to the general hospital.

394 2. The amount of monthly payments and the term of the payment plan shall be determined
395 based upon the patient's ability to pay.

396 3. Any interest on amounts owed pursuant to the payment plan shall not exceed the
397 maximum judgment rate of interest pursuant to § 6.2-302 of the Code of Virginia.

398 4. The general hospital may not charge any fees related to the payment plan.

399 5. The payment plan shall allow prepayment of amounts owed without penalty.

400 D. A general hospital shall develop a process by which either an uninsured patient who agrees
401 to a payment plan pursuant to subsection C of this section or the general hospital may request
402 and shall be granted the opportunity to renegotiate the payment plan.

403 1. Renegotiation shall include opportunity for a new screening in accordance with
404 subsection B of this section.

405 2. A general hospital may not charge any fees for renegotiation of a payment plan pursuant
406 to this subsection.

407 E. A general hospital shall provide written information about:

408 1. Its charity care policies, including:

- 409 a. Policies related to free and discounted care;
410 b. Specific eligibility criteria for charity care; and
411 c. Procedures for applying for charity care;
412 2. The availability of a payment plan for the payment of debt owed to the general hospital
413 pursuant to subsection C of this section; and
414 3. The renegotiation process described in subsection D of this section.
415 F. To provide the information required by subsection E of this section, a general hospital shall:
416 1. Post the information conspicuously in public areas of the general hospital, including
417 admissions or registration areas, emergency departments, and associated waiting rooms;
418 2. Make the information available to:
419 a. A patient at the time of admission or discharge, or at the time services are provided;
420 and
421 b. Persons with limited English proficiency in accordance with the U.S. Department of
422 Health and Human Services' Guidance to Federal Financial Assistance Recipients
423 Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited
424 English Proficient Persons (August 8, 2003, 68 FR 47311), if the general hospital is
425 subject to the requirements of Title VI of the Civil Rights Act of 1964 (Pub. L. No. 88-
426 352), as amended; and
427 3. Include the information:
428 a. With any billing statements sent to uninsured patients; and
429 b. On any website maintained by the general hospital.
430 G. Notwithstanding any other provision of law, a general hospital may not engage in any action
431 described in § 501(r)(6) of the Internal Revenue Code, as it was in effect on January 1, 2020, to
432 recover a debt for medical services against any patient unless the general hospital has made all
433 reasonable efforts to determine whether the patient:
434 1. Qualifies for medical assistance pursuant to the state plan for medical assistance; or
435 2. Is eligible for financial assistance under the general hospital's financial assistance
436 policy.
437 H. Nothing in this section shall be construed to:
438 1. Prohibit a general hospital, as part of its financial assistance policy, from requiring a
439 patient to:
440 a. Provide necessary information needed to determine eligibility for financial
441 assistance under the general hospital's financial assistance policy, medical assistance
442 pursuant to Title XVIII or XIX of the Social Security Act (42 U.S.C. § 301 et seq.), 10
443 U.S.C. § 1071 et seq., or other programs of insurance; or
444 b. Undertake good faith efforts to apply for and enroll in the programs of insurance for
445 which the patient may be eligible as a condition of awarding financial assistance;
446 2. Require a general hospital to grant or continue to grant any financial assistance or
447 payment plan pursuant to this section when:
448 a. A patient has provided false, inaccurate, or incomplete information required for
449 determining eligibility for the general hospital's financial assistance policy; or
450 b. A patient has not undertaken good faith efforts to comply with any payment plan
451 pursuant to this section; or
452 3. Prohibit the coordination of benefits as required by state or federal law.

453 **Statutory Authority**

454 §§ 32.1-12, 32.1-127, 32.1-137.01, and 32.1-137.010 of the Code of Virginia.

455 **12VAC5-410-225. Newborn safety devices.**

456 A general hospital that voluntarily installs a newborn safety device for the reception of children
457 shall ensure that:

458 1. The device is located inside the hospital in an area that is conspicuous and visible to
459 employees or personnel;

460 2. The device is staffed 24 hours a day by a health care provider;

461 3. The device is climate controlled and serves as a safe sleep environment for an infant;

462 4. The device is equipped with a dual alarm system that sounds 60 seconds after a child
463 is placed in the device and automatically places a call to 911 if the alarm is not deactivated
464 within 60 seconds from within the hospital;

465 5. The dual alarm system is visually checked at least two times per day and tested at least
466 one time per week to ensure the alarm system is in working order;

467 6. The device automatically locks when a child is placed in the device; and

468 7. The device is identifiable by appropriate signage that shall include written and pictorial
469 operational instructions.

470 **Statutory Authority**

471 §§ 8.01-226.5:2, 32.-12, and 32.1-127 of the Code of Virginia.

472 **12VAC5-410-230. Patient care management.**

473 A. All patients shall be under the care of a member of the medical staff.

474 B. Each hospital shall have a plan that includes effective mechanisms for the periodic review
475 and revision of patient care policies and procedures.

476 C. Each hospital shall establish a protocol relating to the rights and responsibilities of patients
477 based on 42 C.F.R. § 482.13 Joint Commission on Accreditation of Healthcare Organizations'
478 2000 Hospital Accreditation Standards, January 2000. The protocol shall include a process
479 reasonably designed to inform patients of their rights and responsibilities. Patients shall be given
480 a copy of their rights and responsibilities upon admission.

481 D. No medication or treatment shall be given except on the signed order of a person lawfully
482 authorized by state statutes.

483 1. Hospital personnel, as designated in medical staff bylaws, rules and regulations, or
484 hospital policies and procedures, may accept emergency telephone and other verbal
485 orders for medication or treatment for hospital patients from physicians and other persons
486 lawfully authorized by state statute to give patient orders.

487 2. As specified in the hospital's medical staff bylaws, rules and regulations, or hospital
488 policies and procedures, emergency telephone and other verbal orders shall be signed
489 within a reasonable period of time not to exceed 72 hours, by the person giving the order,
490 or, when such person is not available, cosigned by another physician or other person
491 authorized to give the order.

492 E. Each hospital shall have a reliable method for identification of each patient, including
493 newborn infants.

494 F. Each hospital shall include in its visitation policy a provision allowing each adult patient to
495 receive visits from any individual from whom the patient desires to receive visits, subject to other
496 restrictions contained in the visitation policy including the patient's medical condition and the
497 number of visitors permitted in the patient's room simultaneously.

498 ~~G. If the Governor has declared a public health emergency related to the novel coronavirus~~
499 ~~(COVID-19), each hospital shall allow a person with a disability who requires assistance as a~~

500 ~~result of such disability to be accompanied by a designated support person at any time during~~
501 ~~which health care services are provided.~~

502 ~~1. In any case in which health care services are provided in an inpatient setting, and the~~
503 ~~duration of health care services in such inpatient setting is anticipated to last more than~~
504 ~~24 hours, the person with a disability may designate more than one designated support~~
505 ~~person. However, no hospital shall be required to allow more than one designated support~~
506 ~~person to be present with a person with a disability at any time.~~

507 ~~2. A designated support person shall not be subject to any restrictions on visitation~~
508 ~~adopted by such hospital. However, such designated support person may be required to~~
509 ~~comply with all reasonable requirements of the hospital adopted to protect the health and~~
510 ~~safety of patients and staff of the hospital.~~

511 ~~3. Every hospital shall establish policies applicable to designated support persons and~~
512 ~~shall:~~

513 ~~a. Make such policies available to the public on a website maintained by the hospital;~~
514 ~~and~~

515 ~~b. Provide such policies, in writing, to the patient at such time as health care services~~
516 ~~are provided.~~

517 ~~H. G. Each hospital that is equipped to provide life-sustaining treatment shall develop a policy~~
518 ~~to determine the medical or ethical appropriateness of proposed medical care, which shall include:~~

519 ~~1. A process for obtaining a second opinion regarding the medical and ethical~~
520 ~~appropriateness of proposed medical care in cases in which a physician has determined~~
521 ~~proposed care to be medically or ethically inappropriate;~~

522 ~~2. Provisions for review of the determination that proposed medical care is medically or~~
523 ~~ethically inappropriate by an interdisciplinary medical review committee and a~~
524 ~~determination by the interdisciplinary medical review committee regarding the medical and~~
525 ~~ethical appropriateness of the proposed health care of the patient;~~

526 ~~3. Requirements for a written explanation of the decision of the interdisciplinary medical~~
527 ~~review committee, which shall be included in the patient's medical record; and~~

528 ~~4. Provisions to ensure the patient, the patient's agent, or the person authorized to make~~
529 ~~the patient's medical decisions in accordance with § 54.1-2986 of the Code of Virginia is~~
530 ~~informed of the patient's right to obtain the patient's medical record and the right to obtain~~
531 ~~an independent medical opinion and afforded reasonable opportunity to participate in the~~
532 ~~medical review committee meeting.~~

533 ~~The policy shall not prevent the patient, the patient's agent, or the person authorized to make~~
534 ~~the patient's medical decisions from obtaining legal counsel to represent the patient or from~~
535 ~~seeking other legal remedies, including court review, provided that the patient, the patient's agent,~~
536 ~~person authorized to make the patient's medical decisions, or legal counsel provide written notice~~
537 ~~to the chief executive officer of the hospital within 14 days of the date of the physician's~~
538 ~~determination that proposed medical treatment is medically or ethically inappropriate as~~
539 ~~documented in the patient's medical record.~~

540 ~~I. H. Each hospital shall establish a protocol requiring that, before a health care provider~~
541 ~~arranges for air medical transportation services for a patient who does not have an emergency~~
542 ~~medical condition as defined in 42 USC § 1395dd(e)(1), the hospital shall provide the patient or~~
543 ~~the patient's authorized representative with written or electronic notice that the patient (i) may~~
544 ~~have a choice of transportation by an air medical transportation provider or medically appropriate~~
545 ~~ground transportation by an emergency medical services provider and (ii) will be responsible for~~
546 ~~charges incurred for such transportation in the event that the provider is not a contracted network~~

547 provider of the patient's health insurance carrier or such charges are not otherwise covered in full
548 or in part by the patient's health insurance plan.

549 ~~J. I.~~ Each hospital shall provide written information about the patient's ability to request an
550 estimate of the payment amount for which the participant will be responsible pursuant to § 32.1-
551 137.05 of the Code of Virginia. The written information shall be posted conspicuously in public
552 areas of the hospital, including admissions or registration areas, and included on any website
553 maintained by the hospital.

554 ~~K. Each hospital shall establish protocols to ensure that any patient scheduled to receive an~~
555 ~~elective surgical procedure for which the patient can reasonably be expected to require outpatient~~
556 ~~physical therapy as a follow-up treatment after discharge is informed that the patient:~~

- 557 ~~1. Is expected to require outpatient physical therapy as a follow-up treatment; and~~
558 ~~2. Will be required to select a physical therapy provider prior to being discharged from the~~
559 ~~hospital.~~

560 **Statutory Authority**

561 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

562 **Historical Notes**

563 Derived from VR355-33-500 § 2.7, eff. July 28, 1993; amended, Virginia Register Volume 11,
564 Issue 8, eff. April 1, 1995; Volume 19, Issue 1, eff. November 1, 2002; Errata, 19:3 VA.R. 549
565 October 21, 2002; amended, Virginia Register Volume 24, Issue 11, eff. March 5, 2008; Volume
566 35, Issue 4, eff. November 14, 2018; Volume 35, Issue 21, eff. July 10, 2019; Volume 35, Issue
567 24, eff. August 23, 2019; Volume 36, Issue 23, eff. August 6, 2020; Volume 37, Issue 14, eff.
568 March 31, 2021.

569 **12VAC5-410-235. Persons with a disability; designated support person in general** 570 **hospitals.**

571 A. For the purposes of this section:

572 1. "Admission" means accepting a person for bed occupancy and care that is anticipated
573 to span at least two midnights or for observation;

574 2. "General hospital" means a general hospital other than one that is certified as a long-
575 term acute care hospital or specialty rehabilitation hospital.

576 B. A general hospital shall allow a person with a disability who requires support and assistance
577 necessary due to the specifics of the person's disability to be accompanied by a DSP who will
578 provide support and assistance necessary due to the specifics of the person's disability to the
579 person with a disability during an admission.

580 1. In any case in which the duration of the admission lasts more than 24 hours, the person
581 with a disability may designate more than one DSP.

582 2. No general hospital shall be required to allow more than one DSP to be present with a
583 person with a disability at any time.

584 C. A general hospital may:

585 1. Not subject a DSP to any restrictions on visitation;

586 2. Require a DSP to comply with all reasonable requirements of a general hospital adopted
587 to protect the health and safety of the person with a disability; the DSP; the staff and other
588 patients of, or visitors to, a general hospital; and the public; and

589 3. Restrict a DSP's access to specified areas of and movement on the premises of a
590 general hospital when such restrictions are determined by a general hospital to be
591 reasonably necessary to protect the health and safety of the person with a disability; the
592 DSP; the staff and other patients of, or visitors to, a general hospital; and the public.

593 D. A general hospital may request that a person with a disability provide documentation
594 indicating that he is a person with a disability.

595 1. If the person with a disability fails, refuses, or is unable to provide documentation
596 requested pursuant to subsection D of this section, a general hospital may perform an
597 objective assessment of the person to determine whether he is a person with a disability.

598 2. If a general hospital fails to perform an objective assessment pursuant to subdivision D
599 1 of this section, a general hospital may not prohibit a DSP from accompanying a person
600 with a disability for the purpose of providing support and assistance necessary due to the
601 specifics of the person's disability.

602 E. A general hospital shall

603 1. Establish protocols to inform patients, at the time of admission, of the right of a person
604 with a disability who requires support and assistance necessary due to the specifics of the
605 person's disability to be accompanied by a DSP for the purpose of providing support and
606 assistance necessary due to the specifics of the person's disability;

607 2. Develop and make available to a patient or his guardian, authorized representative, or
608 care provider upon request written information regarding the right of a person with a
609 disability who requires support and assistance necessary due to the specifics of the
610 person's disability to be accompanied by a DSP and any policies related to that right; and

611 3. Make the written information described in subdivision E 2 of this section available to the
612 public on its website.

613 G. This section may not:

614 1. Alter the obligation of a general hospital to provide patients with effective
615 communication support or other required services, regardless of the presence of a DSP
616 or other reasonable accommodation, consistent with applicable federal or state law or
617 regulations; and

618 2. Be interpreted to:

619 a. Prevent a general hospital from complying, or interfere with the ability of a general
620 hospital to comply, with or cause a general hospital to violate any federal or state law
621 or regulation;

622 b. Deem a DSP to be acting under the direction or control of a general hospital or as
623 an agent of a general hospital; or

624 c. Require a general hospital to allow a DSP to perform any action or provide any
625 support or assistance necessary due to the specifics of the person's disability when a
626 general hospital reasonably determines that the performance of the action or provision
627 would be:

628 (1) Medically or therapeutically contraindicated; or

629 (2) A threat to the health and safety of the person with a disability, the DSP, or the staff
630 or other patients of, or visitors to, a general hospital.

631 **Statutory Authority**

632 §§ 32.1-12, 32.1-127, and 32.1-137.08 of the Code of Virginia.

633 **12VAC5-410-237. Discharge planning.**

634 A. A general hospital shall provide each patient admitted as an inpatient or his legal guardian
635 the opportunity to designate:

636 1. An individual who will care for or assist the patient in his residence following discharge
637 from a general hospital; and

638 2. To whom a general hospital shall provide information regarding the patient's discharge
639 plan and any follow-up care, treatment, and services that the patient may require.

640 B. Upon admission, a general hospital shall record in the patient's medical record:

- 641 1. The name of the individual designated by the patient;
- 642 2. The relationship between the patient and the person; and
- 643 3. The person's telephone number and address.

644 C. If the patient fails or refuses to designate an individual to receive information regarding his
645 discharge plan and any follow-up care, treatment, and services, a general hospital shall record
646 the patient's failure or refusal in the patient's medical record.

647 D. A patient may change the designated individual at any time prior to the patient's release,
648 and a general hospital shall record the changes, including the information referenced in
649 subsection B of this section, in the patient's medical record within 24 hours of such a change.

650 E. Prior to discharging a patient who has designated an individual pursuant to subsections A
651 or D of this section, a general hospital shall:

- 652 1. Notify the designated individual of the patient's discharge,
- 653 2. Provide the designated individual with a copy of the patient's discharge plan and
654 instructions and information regarding any follow-up care, treatment, or services that the
655 designated individual will provide; and
- 656 3. Consult with the designated individual regarding the designated individual's ability to
657 provide the care, treatment, or services.

658 F. The discharge plan prescribed in subdivision E 2 of this section shall include:

- 659 1. The name and contact information of the designated individual;
- 660 2. A description of follow-up care, treatment, and services that the patient requires; and
- 661 3. Information, including contact information, about any health care, long-term care, or
662 other community-based services and supports necessary for the implementation of the
663 patient's discharge plan.

664 G. A general hospital shall include a copy of the discharge plan and any instructions or
665 information provided to the designated individual in the patient's medical record.

666 H. A general hospital shall provide each individual designated pursuant to subsection A or D
667 of this section the opportunity for a demonstration of specific follow-up care tasks that the
668 designated individual will provide to the patient in accordance with the patient's discharge plan
669 prior to the patient's discharge, including opportunity for the designated individual to ask questions
670 regarding the performance of follow-up care tasks in a culturally competent manner and in the
671 designated individual's native language.

672 I. A general hospital shall establish protocols to ensure that any patient scheduled to receive
673 an elective surgical procedure for which the patient can reasonably be expected to require
674 outpatient physical therapy as a follow-up treatment after discharge is informed that the patient:

- 675 1. Is expected to require outpatient physical therapy as a follow-up treatment; and
- 676 2. Will be required to select a physical therapy provider prior to being discharged from a
677 general hospital.

678 **Statutory Authority**

679 §§ 32.1-12, 32.1-127, and 32.1-137.03 of the Code of Virginia.

680 **12VAC5-410-370. Medical records.**

681 A. The medical record department shall be staffed and equipped to facilitate the accurate
682 processing, checking, indexing, filing and retrieval of all medical records.

683 B. A medical record shall be established and maintained for every person treated on an
684 inpatient, outpatient (ambulatory) or emergency basis, in any unit of the hospital. The record shall
685 be available to all other units.

686 A separate medical record shall be maintained for each newborn infant. Entered on the chart
687 of the newborn shall be notes of gestational history, including any pathology and information
688 regarding complications of delivery and mother's medication during labor and delivery.

689 C. Written policies and procedures shall be established regarding content and completion of
690 medical records.

691 D. Entries in the medical record shall be made by the responsible person in accordance with
692 hospital policies and procedures.

693 E. Provisions shall be made for the safe storage of medical records ~~or~~ and the accurate and
694 legible reproductions ~~thereof~~ of medical records according to § 32.1-127.1:03 of the Code of
695 Virginia and the Health Insurance Portability and Accountability Act, ~~or HIPAA (42 USC § 1320d~~
696 ~~et seq.)~~ (Pub. L. No. 104-191).

697 F. All medical records either original or accurate reproductions shall be preserved for a
698 minimum of five years following discharge of the patient.

699 1. Records of minors shall be kept for at least five years after such minor has reached the
700 age of 18 years.

701 2. Birth and death information shall be retained for 10 years in accordance with § 32.1-
702 274 of the Code of Virginia.

703 3. Record of abortions and proper information for the issuance of a fetal death certificate
704 shall be furnished to the Office of Vital Records, Virginia Department of Health, as required
705 by law.

706 G. A general hospital that makes health records, as defined in § 32.1-127.1:03 of the Code of
707 Virginia, of patients who are minors available to patients through a secure website shall make the
708 health records available to the patient's parent or guardian through the secure website, unless
709 the general hospital cannot make the health record available:

710 1. In a manner that prevents disclosure of information, the disclosure of which has been
711 denied pursuant to subsection F of § 32.1-127.1:03 of the Code of Virginia; or

712 2. Because the consent required in accordance with subsection E of § 54.1-2969 of the
713 Code of Virginia has not been provided.

714 **Statutory Authority**

715 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

716 **Historical Notes**

717 Derived from VR355-33-500 § 2.21, eff. July 28, 1993; amended, Virginia Register Volume 11,
718 Issue 8, eff. April 1, 1995; Volume 22, Issue 8, eff. January 25, 2006.

719 **12VAC5-410-380. Nursing service.**

720 A. Each hospital shall have an organized nursing department. A registered nurse qualified on
721 the basis of education, experience and clinical ability shall be responsible for the direction of
722 nursing care provided the patients.

723 B. The number and type of nursing personnel on all shifts shall be based upon the needs of
724 the patients and the capabilities of the nursing staff assigned to the patient care unit. All registered
725 nurses and licensed practical nurses shall hold a current license issued by the Virginia Board of
726 Nursing or a current multistate licensure privilege to practice nursing in Virginia.

727 C. All nursing services shall be directly provided by an appropriately qualified registered nurse
728 or licensed practical nurse, except for those nursing tasks that may be delegated by a registered

729 nurse according to ~~18VAC90-20-420~~ 18VAC90-19-240 through ~~18VAC90-20-460~~ 18VAC90-19-
730 280 of the regulation of the Virginia Board of Nursing with a plan developed and implemented by
731 the hospital.

732 D. Nursing personnel shall be assigned to patient care units in a manner that minimizes the
733 risk of cross infection and accidental contamination.

734 E. Each hospital shall quarterly report to the department no later than 30 calendar days after
735 January 1st, April 1st, July 1st, and October 1st:

736 1. The total number of certified sexual assault nurse examiners employed by the hospital;
737 and

738 2. The location, including street address, and contact information for each location at
739 which such certified sexual assault nurse examiner provides services.

740 Each hospital shall report the information required by this subsection to the Office of Family
741 Health Services, Virginia Department of Health.

742 **Statutory Authority**

743 §§ 32.1-12, 32.1-23.2, and 32.1-127 of the Code of Virginia.

744 **Historical Notes**

745 Derived from VR355-33-500 § 2.22, eff. July 28, 1993; amended, Virginia Register Volume 11,
746 Issue 8, eff. April 1, 1995; Volume 11, Issue 16, eff. June 1, 1995; Volume 22, Issue 8, eff. January
747 25, 2006.

748 **12VAC5-410-442. Obstetric service design and equipment criteria.**

749 A. Renovation or construction of a hospital's obstetric unit shall be consistent with (i) section
750 ~~2.2-2.9~~ 2.2-2.10 of Part 2 of the ~~2018~~ Guidelines for Design and Construction of Hospitals, 2022
751 Edition of the (The Facility Guidelines Institute) pursuant to § 32.1-127.001 of the Code of Virginia
752 and (ii) the Virginia Uniform Statewide Building Code (13VAC5-63).

753 B. Delivery rooms labor, deliver, and recover (LDR) rooms; labor delivery, recovery, and
754 postpartum (LDRP) rooms; and nurseries shall be equipped to provide emergency resuscitation
755 for mothers and infants.

756 C. Equipment and supplies shall be assigned for exclusive use in the obstetric and newborn
757 units.

758 D. The same equipment and supplies required for the labor room and delivery room shall be
759 available for use in the LDR/LDRP rooms during periods of labor, delivery, and recovery.

760 E. Sterilizing equipment shall be available in the obstetric unit or in a central sterilizing
761 department. Flash sterilizing equipment or sterile supplies and instruments shall be provided in
762 the obstetric unit.

763 F. Daily monitoring is required of the stock of necessary equipment in the LDR rooms and
764 LDRP rooms and nursery.

765 G. The hospital shall provide the following equipment in the labor, delivery and recovery rooms
766 and, except where noted, in the LDR/LDRP rooms:

767 1. Labor rooms.

768 a. A labor or birthing bed with adjustable side rails.

769 b. Adjustable lighting adequate for the examination of patients.

770 c. An emergency signal and intercommunication system.

771 d. A sphygmomanometer, stethoscope and fetoscope or doppler.

772 e. Fetal monitoring equipment with internal and external attachments.

773 f. Mechanical infusion equipment.

- 774 g. Wall-mounted oxygen and suction outlets.
- 775 h. Storage equipment.
- 776 i. Sterile equipment for emergency delivery to include at least one clamp and suction
- 777 bulb.
- 778 j. Neonatal resuscitation cart.
- 779 2. Delivery rooms.
 - 780 a. A delivery room table that allows variation in positions for delivery. This equipment
 - 781 is not required for the LDR/LDRP rooms.
 - 782 b. Adequate lighting for vaginal deliveries or cesarean deliveries.
 - 783 c. Sterile instruments, equipment, and supplies to include sterile uterine packs for
 - 784 vaginal deliveries or cesarean deliveries, episiotomies or laceration repairs,
 - 785 postpartum sterilizations and cesarean hysterectomies.
 - 786 d. Continuous in-wall oxygen source and suction outlets for both mother and infant.
 - 787 e. Equipment for inhalation and regional anesthesia. This equipment is not required
 - 788 for LDR/LDRP rooms.
 - 789 f. A heated, temperature-controlled infant examination and resuscitation unit.
 - 790 g. An emergency call system.
 - 791 h. Plastic pharyngeal airways, adult and newborn sizes.
 - 792 i. Laryngoscope and endotracheal tubes, adult and newborn sizes.
 - 793 j. A self-inflating bag with manometer and adult and newborn masks that can deliver
 - 794 100% oxygen.
 - 795 k. Separate cardiopulmonary crash carts for mothers and infants.
 - 796 l. Sphygmomanometer.
 - 797 m. Cardiac monitor. This equipment is not required for the LDR/LDRP rooms.
 - 798 n. Gavage tubes.
 - 799 o. Umbilical vessel catheterization trays. This equipment is not required for LDR/LDRP
 - 800 rooms.
 - 801 p. Equipment that provides a source of continuous suction for aspiration of the pharynx
 - 802 and stomach.
 - 803 q. Stethoscope.
 - 804 r. Fetoscope.
 - 805 s. Intravenous solutions and equipment.
 - 806 t. Wall clock with a second hand.
 - 807 u. Heated bassinets equipped with oxygen and transport incubator.
 - 808 v. Neonatal resuscitation cart.
- 809 3. Recovery rooms.
 - 810 a. Beds with side rails.
 - 811 b. Adequate lighting.
 - 812 c. Bedside stands, overbed tables, or fixed shelving.
 - 813 d. An emergency call signal.
 - 814 e. Equipment necessary for a complete physical examination.
 - 815 f. Accessible oxygen and suction equipment.

816 **Statutory Authority**

817 §§ 32.1-12, 32.1-127, and 32.1-127.001 of the Code of Virginia.

818 **Historical Notes**

819 Former 12VAC5-41-440 C 5 and 6 derived from VR 355-33-500 § 2.28, eff. July 28, 1993;
820 amended, Virginia Register Volume 11, Issue 8, eff. April 1, 1995; Volume 11, Issue 16, eff. June
821 1, 1995; Volume 11, Issue 21, eff. August 10, 1995; amended and adopted as 12VAC5-410-442,
822 Virginia Register 21, Issue 6, eff. February 14, 2005; Volume 22, Issue 8, eff. January 25, 2006;
823 Volume 23, Issue 10, eff. March 1, 2007; Volume 37, Issue 19, eff. June 9, 2021.

824 **12VAC5-410-444. Newborn service medical direction; physician consultation and**
825 **coverage; nursing direction, nurse staffing and coverage; policies and procedures.**

826 A. The governing body shall appoint a physician as medical director of the organized newborn
827 service who meets the qualifications specified in the medical staff bylaws. In addition, the medical
828 director must meet the qualifications specified for the medical direction of the highest level of
829 newborn service provided by the hospital.

830 1. If a hospital offers only general level newborn services, the medical director shall be a
831 physician qualified to provide normal newborn care, including the ability to immediately
832 resuscitate and stabilize a sick newborn for transfer to a higher level of service.

833 2. If a hospital offers intermediate level newborn services, the medical director shall be a
834 board-certified or board-eligible pediatrician with training and experience in the care of
835 preterm neonates, including stabilization and ventilation management.

836 3. If a hospital offers specialty level newborn services, the medical director shall be a
837 board-certified or board-eligible neonatologist.

838 4. If a hospital offers subspecialty level newborn services, the medical director shall be a
839 board-certified or board-eligible neonatologist.

840 B. The duties and responsibilities of the medical directors of all levels of newborn service shall
841 include, ~~but not be limited to the:~~

842 1. General supervision of the quality of care provided patients admitted to the service;

843 2. Establishment of criteria for admission to the service;

844 3. Adherence of the service to standards of professional practices, policies and
845 procedures, the medical protocol, and the hospital's collaboration agreements adopted by
846 the medical staff and governing body applicable to the service;

847 4. Development of recommendations to the medical staff on standards of professional
848 practice and staff privileges applicable to the service;

849 5. Identification of clinical conditions and medical and surgical procedures that require
850 physician consultation;

851 6. Conducting conferences, at least quarterly, to review routine and emergency surgical
852 procedures, complications and infant and maternal mortality and morbidity. Infant mortality
853 and morbidity shall be discussed with the obstetric service staff; and

854 7. Active participation in the service's quality assurance program.

855 C. The hospital shall provide the following physician consultation and coverage in the general
856 level newborn nursery service and all higher level nursery services unless unique requirements
857 are specifically imposed for the higher level nursery services:

858 1. A physician with pediatric privileges capable of arriving on-site within 30 minutes of
859 notification shall be on the 24-hour on-call duty roster;

860 2. A physician or nurse skilled in neonatal cardiopulmonary resuscitation (CPR) shall be
861 available in the hospital at all times.

- 862 3. A current roster of physicians, with a delineation of their newborn, pediatric, medical
863 and surgical privileges shall be posted at each nurses' station in the newborn service unit.
- 864 4. A copy of the 24-hour on-call duty schedule, including a list of on-call consulting
865 physicians, shall be posted at each nurses' station in the newborn service unit.
- 866 5. If the medical director is not a board-certified or board-eligible pediatrician, the hospital
867 shall have a written agreement with one or more board-certified or board-eligible
868 pediatricians to be available to provide consultation on a 24-hour basis. Consultation may
869 be by telephone.
- 870 6. If a hospital does not have a neonatologist on staff available on a 24-hour basis, it shall
871 have a written agreement with another hospital to provide consultation, at least by
872 telephone, on a 24-hour basis, by a board-certified or board-eligible neonatologist. The
873 consultant shall be available to advise on the development of a protocol for the care and
874 transport of sick newborns.
- 875 D. The physician consultation and coverage for the intermediate level newborn nursery
876 service shall be the same as the general level newborn service with the following exceptions:
- 877 1. Subdivision C 1 of this section shall not apply.
- 878 2. Physician coverage shall be provided on a 24-hour on-call basis by a board-certified or
879 board-eligible pediatrician or pediatricians capable of arriving on-site within 30 minutes of
880 notification.
- 881 E. The physician consultation and coverage for the specialty level and the subspecialty level
882 newborn services shall be the same as for the lower level newborn services with the following
883 exceptions:
- 884 1. Subdivision C 1 of this section shall not apply.
- 885 2. In-house physician consultation and coverage shall be provided 24 hours a day by a:
- 886 a. Board-certified or board-eligible neonatologist;
- 887 b. Board-certified or board-eligible pediatrician;
- 888 c. Second year or higher level pediatric resident; or
- 889 d. Neonatal nurse practitioner.
- 890 3. Whenever in-house coverage is provided as stated in subdivision 2 b, c, or d of this
891 subsection, a board-certified or board-eligible neonatologist shall be on-call and available
892 to be on-site within 20 minutes of request.
- 893 F. The nursing direction, staff and coverage required for the general level newborn service
894 shall be as follows:
- 895 1. The neonatal nursing program shall be under the direction of a registered nurse.
- 896 2. The nursing director's responsibilities shall include, ~~but not be limited to:~~
- 897 a. Directing neonatal nursing services;
- 898 b. Guiding the development and implementation of neonatal nursing policies and
899 procedures;
- 900 c. Collaborating with the medical staff; and
- 901 d. Consulting with referral hospitals with which a hospital has transfer agreements
902 applicable to the service or services.
- 903 3. Each occupied unit of the newborn service shall be under the direct supervision of a
904 registered nurse 24 hours a day. The registered nurse shall have documented
905 competence in neonatal nursing appropriate to the level of service provided.

- 906 4. If a general level newborn nursery is organized as a separate nursing unit, staffing shall
907 be based on a formula of a minimum of one nursing personnel to every eight newborns.
908 Staffing shall include at least one registered nurse for the unit for each duty shift to provide
909 direct supervision for nursing care.
- 910 5. If the postpartum and general level newborn units are organized as combined rooming-
911 in or modified rooming-in units, staffing shall be based on a formula of one nursing
912 personnel for every four mother-baby units. The rooming-in units shall always be staffed
913 with no less than two nursing personnel assigned to each shift. One of the two nursing
914 personnel shall be a registered nurse to provide direct supervision of nursing care.
- 915 6. When infants are present in the nursery, at least one nursing personnel trained in the
916 care of newborn infants, with duties restricted to the care of the infants, shall be assigned
917 to the nursery at all times. This nursing personnel is in addition to the registered nurse
918 who is required to provide supervision.
- 919 7. To ensure adequate nursing staff for the nursery for normal newborns, duty schedules
920 shall be developed and actual shift staffing shall occur according to the following minimum
921 nurse to patient ratios:
- 922 a. 1:4 Recently born infants and those needing close observation.
 - 923 b. 1:8 Newborns needing only routine care.
 - 924 c. 1:4 Mother-newborn routine care.
- 925 8. Student nurses, licensed practical nurses and nursing aides who assist in the nursing
926 care of newborn infants shall be under the direct supervision of a registered nurse.
- 927 9. At least one nurse on each shift who is skilled in neonatal cardiopulmonary resuscitation
928 must be immediately available to the nursery.
- 929 10. All nursing personnel assigned to the newborn service shall have orientation to the
930 nursery, including orientation to patient care appropriate for the service level provided.
- 931 G. The nursing direction, staff and coverage required of the intermediate level newborn
932 service shall be the same as required of the general level newborn service with the following
933 exceptions:
- 934 1. To ensure adequate nursing staff for the nursery, duty schedules shall be developed
935 and actual shift staffing shall occur according to a ratio of at least one nurse to four
936 neonates.
 - 937 2. All registered nurses assigned to the newborn service shall be trained in neonatal
938 cardiopulmonary resuscitation (CPR).
- 939 H. The nursing direction, staff and coverage for the specialty level newborn service shall be
940 the same as the lower level newborn service levels with the following exceptions:
- 941 1. The newborn nursery service shall have a nurse manager. The nurse manager shall be
942 a registered nurse with advanced training and experience in the nursing management of
943 high-risk neonates and their families. The responsibilities of the nurse manager shall
944 include, ~~but not be limited to:~~
 - 945 a. Daily management of the nursery;
 - 946 b. Supervision and evaluation of nursing personnel assigned to the nursery;
 - 947 c. Assuring nursing coverage 24 hours a day; and
 - 948 d. Implementing nursing policies and procedures at the service level. - 949 2. All registered nurses shall have advanced training and experience in the management
950 of neonatal patients, including specialized care technology and ventilator care for

951 neonates. Only registered nurses with this advanced training and experience shall be
952 assigned to care for neonates on ventilators.

953 3. To ensure adequate nursing staff for the nursery, duty schedules shall be developed
954 and actual shift staffing shall occur according to a ratio of at least one nurse to three
955 patients for neonates requiring specialty level care. For those neonates who have been
956 assessed as no longer needing specialty level care, nurse to patient ratios shall be
957 according to the neonate's appropriate level of service.

958 I. The nursing direction, staff and coverage for the subspecialty level newborn service shall
959 be the same as all lower levels of newborn services with the following exceptions:

960 1. A neonatal clinical nurse specialist shall be assigned to the nursery, duties and
961 responsibilities shall include staff consultation, collaboration, and teaching.

962 2. All registered nurses shall have advanced training and experience, beyond what is
963 required of nurses in the lower level nurseries, in the management of high-risk neonates,
964 including the care of unstable neonates with multisystem problems.

965 3. To ensure adequate nursing staff for the nursery, duty schedules shall be developed
966 and actual shift staffing shall occur according to the following minimum nurse to patient
967 ratios for neonates requiring subspecialty level care:

968 a. 1:2 Neonates requiring subspecialty level care; and

969 b. 1:1 Neonates requiring multisystem support.

970 For those neonates who have been assessed as no longer needing subspecialty level
971 care, nurse to patient ratios shall be according to the neonate's appropriate level of
972 service.

973 4. All nursing patient care shall be provided by registered nurses assigned to the
974 subspecialty level nursery.

975 J. The governing body shall adopt written policies and procedures approved by the medical
976 and nursing staff of the service, for the medical care of newborns.

977 K. The policies and procedures for the general level nursery and all higher levels of newborn
978 services shall include, ~~but not be limited to:~~

979 1. Medical criteria for the identification of high-risk neonatal patients.

980 2. Protocols for the management of all neonatal medical conditions that are routinely
981 managed by the service as well as protocols for the stabilization and transfer of neonates
982 that require a higher level of newborn service. These protocols shall be maintained in the
983 nursery in addition to the telephone numbers of each nursery and the names of each
984 referral newborn service medical director.

985 3. Written collaboration agreements with hospitals with higher levels of newborn services.
986 A hospital may enter into more than one collaboration agreement. The collaboration
987 agreements shall specifically identify those medical conditions that require consultation
988 and may necessitate a neonatal transfer as well as the interim treatment required prior to
989 transfer. Nothing in the regulation shall require a birth hospital to enter into a collaboration
990 agreement with a referral hospital that disagrees with the medical, consultation and
991 transfer protocols adopted by the birth hospital. All neonatal transfers shall conform with
992 Section 1867 of the Social Security Act, its amendments in force to date and implementing
993 regulations. At the time of any transfer, the medical treatment at the referral hospital shall
994 outweigh the risks to the neonate from affecting the transfer. The collaboration
995 agreements shall include, ~~but not be limited to:~~

996 a. Criteria for neonatal transfer to the referral nursery;

997 b. Procedures for neonatal transport;

- 998 c. Back transfer criteria which provides for the return of the neonate to the referring
999 hospital when medically appropriate;
- 1000 d. Annual review by both parties of all cases of neonatal transfer;
- 1001 e. Annual review by both parties of the collaboration agreements; and
- 1002 f. Annual evaluation by both parties of the collaboration agreement and modification
1003 of the agreement, as necessary, as indicated by the evaluation results.
- 1004 4. Establishment and maintenance of an ongoing, documented quality assurance program
1005 by the service that utilizes a multidisciplinary team of health practitioners and
1006 administrators for review and is integrated with the hospital's overall quality assurance
1007 program.
- 1008 a. The quality assurance program shall include:
- 1009 (1) Problem identification;
- 1010 (2) Action plans;
- 1011 (3) Evaluation; and
- 1012 (4) Follow-up.
- 1013 b. The quality assurance program shall include an annual review of the following:
- 1014 (1) Neonatal transfer cases;
- 1015 (2) Management of in-house neonatal cases; and
- 1016 (3) Staff in-house inservice programs.
- 1017 c. Outcome statistics, including morbidity, mortality, and the appropriateness of
1018 neonatal transfers, shall be compiled in a standardized manner and reviewed quarterly
1019 by a multidisciplinary committee.
- 1020 5. Immediate resuscitation and stabilization of the sick neonate in accordance with current
1021 cardiopulmonary resuscitation (CPR) standards of the American Heart Association and
1022 the American Academy of Pediatrics.
- 1023 6. Care of newborns after delivery to include the following:
- 1024 a. Care of eyes, skin and umbilical cord and the provision of a single parenteral dose
1025 of Vitamin K-1, water soluble, as a prophylaxis against hemorrhagic disorder;
- 1026 b. Maintenance of the newborn's airway, respiration, and body temperature; and
- 1027 c. Assessment of the newborn and recording of the one-minute and five-minute Apgar
1028 scores.
- 1029 7. Performance of prophylaxis against ophthalmia neonatorum by the administration of a
1030 1.0% solution of silver nitrate aqueous solution, erythromycin, or tetracycline ointment or
1031 solution. This process is to be performed within one hour of delivery with documentation
1032 entered in the newborn's medical record. The process may be performed in the nursery.
- 1033 8. Clamping or tying of the umbilical cord and, when indicated, collecting a sample of cord
1034 blood.
- 1035 9. Performance of Rh type and Coombs' test for every newborn born to a Rh negative
1036 mother and performing major blood grouping and Coombs' tests when indicated for every
1037 newborn born to an O blood group mother or a mother with a family history of blood
1038 incompatibility. If such qualitative tests are performed, the results shall be documented in
1039 the newborn's medical record.
- 1040 10. Identification and treatment of hyperbilirubinemia and hypoglycemia.

- 1041 11. Identification of each newborn, prior to leaving the delivery room, with two identification
1042 bands fastened on the newborn and one identification band fastened on the mother. The
1043 newborn's medical record shall accompany the infant from the delivery room.
- 1044 12. Newborn transport, within the hospital, of all newborns who are either premature or
1045 compromised by using a heated bassinet equipped with oxygen, a transport incubator or
1046 other similar equipment.
- 1047 13. Registered nurse or physician assessment of a newborn within one hour after delivery
1048 and documentation of the assessment in the newborn's medical record. Assessment in
1049 the delivery area is permitted if the hospital permits a newborn and its mother to remain
1050 together during the immediate post-delivery period.
- 1051 14. Delineation of how infants are to be monitored during stays with their mothers and
1052 under what circumstances infants must be taken to the nursery immediately after delivery
1053 and not allowed to remain with their mothers.
- 1054 15. Physician examination of the newborn consistent with guidelines of the American
1055 Academy of Pediatrics. A high-risk newborn shall be examined upon admission to the
1056 nursery.
- 1057 16. Ensuring that every bassinet and incubator in the nursery bears the identification of
1058 the newborn's last name, sex, date and time of birth, the mother's last name, and the
1059 attending physician's name.
- 1060 17. The management of mothers who utilize breast milk with their newborns. Breast milk
1061 shall be collected in aseptic containers, dated, stored under refrigeration and consumed
1062 or disposed of within ~~24-48~~ 96 hours of collection if the breast milk has not been frozen.
1063 This policy pertains to breast milk collected while in the hospital or at home for hospital
1064 use.
- 1065 18. Preparation and use of formula including, ~~but not limited to:~~
1066 a. The distribution of feeding units immediately after assembly;
1067 b. The use of prepared formula only within the time period designated on the package;
1068 and
1069 c. The use of presterilized formula only, except in the case of facility-defined
1070 emergencies.
- 1071 19. Screening newborns for risk factors associated with hearing impairment as required in
1072 §§ 32.1-64.1 and 32.1-64.2 of the Code of Virginia and in accordance with the regulations
1073 of the Board of Health governing the Virginia Hearing Impairment Identification and
1074 Monitoring System (12VAC5-80).
- 1075 20. Screening and treatment of genetic, metabolic, and other diseases identifiable in the
1076 newborn period as specified in § 32.1-65 of the Code of Virginia and in accordance with
1077 the Regulations Governing the Newborn Screening and Treatment Program (12VAC5-
1078 70).
- 1079 21. Reporting to the Department of Health all required reportable congenital defects.
- 1080 22. Visitor contact with the newborn, including newborns delivered by cesarean section,
1081 and premature, sick, congenitally malformed, and dying newborns.
- 1082 23. Completion of birth certificates.
- 1083 24. Discharge planning appropriate for the needs of the patient for at-risk infants.
- 1084 L. The additional policies and procedures required for the intermediate level newborn service
1085 shall include, ~~but not be limited to:~~

- 1086 1. Insertion and maintenance of peripheral intravenous lines and use of pediatric infusion
1087 pumps that are accurate to plus or minus one milliliter an hour;
- 1088 2. Insertion and maintenance of umbilical arterial lines and the use of pediatric infusion
1089 pumps accurate to plus or minus one milliliter an hour;
- 1090 3. Use of heated, humidified, and blended supplemental oxygen by hood with a recording
1091 of oxygen levels every hour using a calibrated constant oxygen analyzer. The policy shall
1092 address consultation with a higher level nursery identified in the collaboration agreement
1093 when oxygen levels exceed 40% and remain at 40% or greater for a period of four hours
1094 or more;
- 1095 4. Administration of nasogastric or orogastric feedings;
- 1096 5. Use of saturation monitor (pulse oximeter or equivalent) for any newborn requiring
1097 supplemental oxygen;
- 1098 6. Use of assisted ventilation in preparation for transport;
- 1099 7. Initiation of PgE1 prior to transport; and
- 1100 8. Administration of blood components and a policy for provision of partial and total
1101 exchange transfusions.

1102 M. The additional policies and procedures required for the specialty level newborn service
1103 shall include, ~~but not be limited to:~~

- 1104 1. Provision of ongoing assisted ventilation;
- 1105 2. Administration of surfactant;
- 1106 3. Preparation and administration of total parenteral nutrition (TPN);
- 1107 4. Initiation and maintenance of pressor medications;
- 1108 5. Provision for developmental follow up;
- 1109 6. Insertion and maintenance of central umbilical arterial catheters or peripheral arterial
1110 lines with constant pressure monitoring;
- 1111 7. Placement of chest tubes with water seal on an emergency basis;
- 1112 8. Use of heated, humidified, and blended supplemental oxygen by hood with a recording
1113 of oxygen levels every hour using a calibrated constant oxygen analyzer;
- 1114 9. Administration and maintenance of CPAP including the requirement for in-house
1115 physician coverage;
- 1116 10. Daily availability of appropriate drug peak and trough assays on one milliliter or less
1117 of blood;
- 1118 11. Cardioversion capability specific for newborns; and
- 1119 12. Provision for ophthalmology consult and requirements regarding the examination of
1120 high-risk newborns.

1121 N. The additional policies and procedures required for the subspecialty level newborn service
1122 shall include, ~~but not be limited to:~~

- 1123 1. Provision for returning patients to the operating room within 30 minutes, if indicated;
- 1124 2. Provision for echocardiography evaluation;
- 1125 3. Provision for patient treatment on an extracorporeal membrane oxygenator (ECMO) or
1126 a written collaboration agreement with a hospital with this capability;
- 1127 4. Provision for maintenance of central venous pressure monitoring; and
- 1128 5. Provision for the maintenance of neonates on prostaglandin E1 (PgE1).

1129 **Statutory Authority**

1130 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

1131 **Historical Notes**

1132 Former 12VAC5-41-440 D 3 to 6 derived from VR 355-33-500 § 2.28, eff. July 28, 1993; amended,
1133 Virginia Register Volume 11, Issue 8, eff. April 1, 1995; Volume 11, Issue 16, eff. June 1, 1995;
1134 Volume 11, Issue 21, eff. August 10, 1995; amended and adopted as 12VAC5-410-444, Virginia
1135 Register 21, Issue 6, eff. February 14, 2005; Errata, 21:8 VA.R. 1016 December 27, 2004;
1136 amended, Virginia Register Volume 22, Issue 8, eff. January 25, 2006; Errata, 22:9 VA.R. 1437
1137 January 9, 2006.

1138 **12VAC5-410-445. Newborn service design and equipment criteria.**

1139 A. Construction or renovation of a hospital's nursery shall be consistent with (i) section ~~2.2-~~
1140 ~~2.10~~ 2.2-2.11 of Part 2 of the ~~2018~~ Guidelines for Design and Construction of Hospitals, 2022
1141 Edition of the (The Facility Guidelines Institute) pursuant to § 32.1-127.001 of the Code of Virginia
1142 and (ii) the Virginia Uniform Statewide Building Code (13VAC5-63). Hospitals with higher-level
1143 nurseries shall comply with section ~~2.2-2.8~~ 2.2-2.9 of Part 2 of the ~~2018~~ 2022 edition of the
1144 guidelines as applicable.

1145 B. The hospital shall provide the following equipment in the general level nursery and all higher
1146 level nurseries, unless additional equipment requirements are imposed for the higher level
1147 nurseries:

- 1148 1. Resuscitation equipment as specified for the delivery room in 12VAC5-410-442 G 2
- 1149 shall be available in the nursery at all times;
- 1150 2. Equipment for the delivery of 100% oxygen concentration, properly heated, blended,
- 1151 and humidified, with the ability to measure oxygen delivery in fractional inspired
- 1152 concentration (FI_{O2}). The oxygen analyzer shall be calibrated every eight hours and
- 1153 serviced according to the manufacturer's recommendations by a member of the hospital's
- 1154 respiratory therapy department or other responsible personnel trained to perform the task;
- 1155 3. Saturation monitor (pulse oximeter or equivalent);
- 1156 4. Equipment for monitoring blood glucose;
- 1157 5. Infant scales;
- 1158 6. Intravenous therapy equipment;
- 1159 7. Equipment and supplies for the insertion of umbilical arterial and venous catheters;
- 1160 8. Open bassinets, self-contained incubators, open radiant heat infant care system or any
- 1161 combination thereof appropriate to the service level;
- 1162 9. Equipment for stabilization of a sick infant prior to transfer that includes a radiant heat
- 1163 source capable of maintaining an infant's body temperature at 99°F;
- 1164 10. Equipment for insertion of a thoracotomy tube; and
- 1165 11. Equipment for proper administration and maintenance of phototherapy.

1166 C. The additional equipment required for the intermediate level newborn service and for any
1167 higher service level is:

- 1168 1. Pediatric infusion pumps accurate to plus or minus 1 milliliter (ml) per hour;
- 1169 2. On-site supply of PgE1;
- 1170 3. Equipment for 24-hour cardiorespiratory monitoring for neonatal use available for every
- 1171 incubator or radiant warmer;
- 1172 4. Saturation monitor (pulse oximeter or equivalent) available for every infant given
- 1173 supplemental oxygen;
- 1174 5. Portable x-ray machine; and

1175 6. If a mechanical ventilator is selected to provide assisted ventilation prior to transport, it
1176 shall be approved for the use of neonates.

1177 D. The additional equipment required for the specialty level newborn service and a higher
1178 newborn service is as follows:

1179 1. Equipment for 24-hour cardiorespiratory monitoring with central blood pressure
1180 capability for each neonate with an arterial line;

1181 2. Equipment necessary for ongoing assisted ventilation approved for neonatal use with
1182 online capabilities for monitoring airway pressure and ventilation performance;

1183 3. Equipment and supplies necessary for insertion and maintenance of chest tube for
1184 drainage;

1185 4. On-site supply of surfactant;

1186 5. Computed axial tomography equipment (CAT) or magnetic resonance imaging
1187 equipment (MRI);

1188 6. Equipment necessary for initiation and maintenance of continuous positive airway
1189 pressure (CPAP) with ability to constantly measure delineated pressures and including
1190 alarm for abnormal pressure (i.e., vent with PAP mode); and

1191 7. Cardioversion unit with appropriate neonatal paddles and ability to deliver appropriate
1192 small watt discharges.

1193 E. The hospital shall document that it has the appropriate equipment necessary for any of the
1194 neonatal surgical and special procedures it provides that are specified in its medical protocol and
1195 that are required for the specialty level newborn service.

1196 F. The additional equipment requirements for the subspecialty level newborn service are:

1197 1. Equipment for emergency gastrointestinal, genitourinary, central nervous system, and
1198 sonographic studies available 24 hours a day;

1199 2. Pediatric cardiac catheterization equipment;

1200 3. Portable echocardiography equipment; and

1201 4. Computed axial tomography equipment (CAT) and magnetic resonance imaging
1202 equipment (MRI).

1203 G. The hospital shall document that it has the appropriate equipment necessary for any of the
1204 neonatal surgical and special procedures it provides that are specified in the medical protocol and
1205 are required for the subspecialty level newborn service.

1206 **Statutory Authority**

1207 §§ 32.1-12, 32.1-127, and 32.1-127.001 of the Code of Virginia.

1208 **Historical Notes**

1209 Former 12VAC5-41-440 D 7 and 8 derived from VR 355-33-500 § 2.28, eff. July 28, 1993;
1210 amended, Virginia Register Volume 11, Issue 8, eff. April 1, 1995; Volume 11, Issue 16, eff. June
1211 1, 1995; Volume 11, Issue 21, eff. August 10, 1995; amended and adopted as 12VAC5-410-445,
1212 Virginia Register 21, Issue 6, eff. February 14, 2005; amended, Virginia Register Volume 22,
1213 Issue 8, eff. January 25, 2006; Volume 23, Issue 10, eff. March 1, 2007; Volume 26, Issue 22, eff.
1214 August 4, 2010; Volume 37, Issue 19, eff. June 9, 2021.

1215 **12VAC5-410-447. Combined obstetric and clean gynecological service; infection control.**

1216 A. A hospital may combine obstetric and clean gynecological services. The hospital shall
1217 define clean gynecological cases in written hospital policy. A combined obstetric and clean
1218 gynecologic service shall be organized under written policies and procedures. The policies and
1219 procedures shall be approved by the medical and nursing staff of these services and adopted by
1220 the governing body and shall include, ~~but not limited to~~ the following requirements:

- 1221 1. Cesarean section and obstetrically related surgery, other than vaginal delivery, shall be
1222 carried out in designated operating or delivery rooms. Vaginal deliveries may be
1223 performed in designated delivery or operating rooms that are used solely for obstetric or
1224 clean gynecologic procedures.
- 1225 2. Clean gynecological cases may be admitted to the postpartum nursing unit of the
1226 obstetric service according to procedures determined by the obstetrics and gynecologic
1227 staff and the hospital's infection control committee.
- 1228 3. Only members of the medical staff with approved privileges shall admit and care for
1229 patients in the combined service area. These admissions shall be subject to the medical
1230 staff bylaws.
- 1231 4. Hospitals with a combined service shall limit admission to the service to those patients
1232 allowed by policies adopted by the obstetric and gynecological medical staff and the
1233 hospital's infection control committee.
- 1234 5. Unoccupied beds shall be reserved daily in a combined service ready for use by
1235 obstetric patients.
- 1236 6. Patients admitted to the combined service may be taken to radiology or other hospital
1237 departments for diagnostic procedures, before or after surgery, if it is not evident that these
1238 procedures may be hazardous to the patients or to other patients on the combined service.
- 1239 7. Patients may receive postpartum or immediate postoperative care in the general
1240 recovery room prior to being returned to the combined service area if the following
1241 conditions prevail:
- 1242 a. The recovery room or intensive care unit is a separate unit adjacent to or part of the
1243 general surgical operating suite or delivery suite; and
- 1244 b. The recovery room is under the direct supervision of the chairman of the
1245 anesthesiology department of the hospital.
- 1246 In separate obstetric recovery rooms, supervision shall be provided by the obstetrician in
1247 charge or by physicians approved by the medical staff of the combined service.
- 1248 8. Nursing care of all patients shall be supervised by a registered nurse.
- 1249 9. Nursing care of both obstetrical and gynecological patients may be given by the same
1250 nursing personnel.
- 1251 10. Visitor regulations applicable to visitors of obstetric patients shall also apply to visitors
1252 of other patients admitted to the combined service.
- 1253 B. In addition to the infection control requirements specified in 12VAC5-410-490, the hospital's
1254 infection control committee, in cooperation with the obstetric and newborn medical and nursing
1255 staff, shall establish written policies and procedures for infection control within the obstetric and
1256 newborn services. The policies and procedures shall be adopted by the governing body and shall
1257 include, ~~but not be limited to, the following:~~
- 1258 1. The establishment of criteria for determining infection-related maternal and newborn
1259 morbidity;
- 1260 2. Written criteria for the isolation or segregation of mothers and newborns, in accordance
1261 with Guidelines for Perinatal Care, 8th Edition, 2017, (American Academy of
1262 Pediatrics/American College of Obstetricians and Gynecologists) and Control of
1263 Communicable Diseases in Man Manual, 21st Edition, 2022 (American Public Health
1264 Association) to include ~~at least the following categories:~~
- 1265 a. Birth prior to admission to the facility;
- 1266 b. Birth within the facility but prior to admission to the labor and delivery area;

- 1267 c. Readmission to the service after transfer or discharge;
1268 d. Presence of infection;
1269 e. Elevated temperature; and
1270 f. Presence of rash, diarrhea, or discharging skin lesions;
- 1271 3. Written policies and procedures for the isolation of patients in accordance with
1272 Guidelines for Perinatal Care, 8th Edition, 2017 (AAP/ACOG) (American Academy of
1273 Pediatrics/American College of Obstetricians and Gynecologists) and Control of
1274 Communicable Diseases in Man Manual, 21st Edition, 2022 (American Public Health
1275 Association) including, but not limited to, the following:
- 1276 a. Ensuring that a physician orders and documents in the patient's medical record the
1277 placement of a mother or newborn in isolation;
- 1278 b. Ensuring that at least one labor room is available for use by a patient requiring
1279 isolation;
- 1280 c. Provisions for the isolation of a mother and newborn together (rooming-in) or
1281 separately; and
- 1282 d. Policies and procedures for assigning nursing personnel to care for patients in
1283 isolation;
- 1284 4. Control of traffic, including personnel and visitors. Policies and procedures shall be
1285 established in the event that personnel from other services must work in the obstetric and
1286 newborn services or personnel from the obstetric and newborn services must work on
1287 other services. Appropriate clothing changes and handwashing shall be required of any
1288 individual prior to assuming temporary assignments or substitution from any other area or
1289 service in the hospital;
- 1290 5. Determination of the health status of personnel, and control of personnel with symptoms
1291 of communicable infectious disease;
- 1292 6. Review of cleaning procedures, agents, and schedules in use in the obstetric and
1293 newborn services. Incubators or bassinets shall be cleaned with detergent and disinfectant
1294 registered by the U.S. Environmental Protection Agency each time a newborn occupying
1295 it is discharged or at least every seven days;
- 1296 7. Techniques of patient care, including handwashing and the use of protective clothing
1297 such as gowns, masks, and gloves; and
- 1298 8. Infection control in the nursery, including ~~but not limited to:~~
- 1299 a. Closing of the nursery immediately in the event of an epidemic, as determined by
1300 the infection control director in consultation with the medical director and the
1301 Department of Health;
- 1302 b. Assigning a newborn to a clean incubator or bassinet at least every seven days;
- 1303 c. Using an impervious cover that completely covers the surface of the scale pan if
1304 newborns are weighed on a common scale, and changing the cover after each
1305 newborn is weighed;
- 1306 d. Gowning in isolation cases; and
- 1307 e. Requiring nursery personnel wear clean scrub attire in the nursery when they are
1308 handling infants. Appropriate cover garments shall be worn over scrub attire when
1309 personnel are holding infants. Personnel shall wash their hands after contact with each
1310 patient and upon entering or leaving the nursery.

1311 **Statutory Authority**

1312 § § 32.1-12 and 32.1-127 of the Code of Virginia.

1313 **Historical Notes**

1314 Former 12VAC5-41-440 E and F derived from VR 355-33-500 § 2.28, eff. July 28, 1993; amended,
1315 Virginia Register Volume 11, Issue 8, eff. April 1, 1995; Volume 11, Issue 16, eff. June 1, 1995;
1316 Volume 11, Issue 21, eff. August 10, 1995; amended and adopted as 12VAC5-410-447, Virginia
1317 Register Volume 21, Issue 6, eff. February 14, 2005.

1318 **12VAC5-410-465. Long-term care nursing services.**

1319 A. The provisions of this section shall apply to a general hospital's long-term care nursing unit
1320 if that unit is a certified nursing facility. The general hospital shall be responsible for ensuring its
1321 long-term care nursing unit meets the requirements of this section.

1322 B. For the purposes of this section, "resident" means any person admitted to a general
1323 hospital's long-term care nursing unit.

1324 C. A long-term care nursing unit shall fully disclose to the applicant for admission the unit's
1325 admissions policies, including any preferences given.

1326 D. A long-term care nursing unit shall train, or arrange for training of, all employees who work
1327 in the long-term care unit and who are mandated to report adult abuse, neglect, or exploitation
1328 pursuant to § 63.2-1606 of the Code of Virginia on such reporting procedures and the
1329 consequences for failing to make a required report.

1330 E. A long-term care nursing unit shall register with the Department of State Police to receive
1331 notice of the registration, reregistration, or verification of registration information of any person
1332 required to register with the Sex Offender and Crimes Against Minors Registry pursuant to
1333 Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 of the Code of Virginia within the same or a contiguous
1334 zip code area in which the long-term care nursing unit is located, pursuant to § 9.1-914 of the
1335 Code of Virginia.

1336 F. If a long-term care nursing unit anticipates a potential resident will have a length of stay
1337 greater than three days or in fact stays longer than three days, the long-term care nursing unit
1338 shall ascertain, prior to admission, whether the potential resident is required to register with the
1339 Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of
1340 Title 9.1 of the Code of Virginia.

1341 G. Upon the request of the unit's family council, a long-term care nursing unit shall send
1342 notices and information about the family council mutually developed by the family council and the
1343 administration of the unit, and provided to the unit for such purpose, to the listed responsible party
1344 or a contact person of the resident's choice up to six times per year.

1345 1. Such notices may be included together with a monthly billing statement or other regular
1346 communication.

1347 2. Notices and information shall also be posted in a designated location within the unit.

1348 3. No family member of a resident or other resident representative shall be restricted from
1349 participating in meetings in the unit with the families or resident representatives of other
1350 residents in the unit.

1351 H. A general hospital shall maintain for its long-term care unit liability insurance coverage in a
1352 minimum amount of \$1 million, and professional liability coverage in an amount at least equal to
1353 the recovery limit set forth in § 8.01-581.15 of the Code of Virginia, to compensate residents or
1354 individuals for injuries and losses resulting from the negligent or criminal acts of the unit.

1355 I. During a public health emergency related to COVID-19, a long-term care unit shall establish
1356 a protocol to allow each resident to receive visits, consistent with guidance from the CDC and as
1357 directed by CMS and the board, which shall include:

1358 1.Provisions describing:

- 1359 a. The conditions, including conditions related to the presence of COVID-19 in the
1360 long-term care nursing unit and community, under which in-person visits will be
1361 allowed and under which in-person visits will not be allowed and visits will be required
1362 to be virtual;
- 1363 b. The requirements with which in-person visitors will be required to comply to protect
1364 the health and safety of the residents and staff of the long-term care nursing unit;
- 1365 c. The types of technology, including interactive audio or video technology, and the
1366 staff support necessary to ensure visits are provided as required by this subsection;
1367 and
- 1368 d. The steps the long-term care unit will take in the event of a technology failure,
1369 service interruption, or documented emergency that prevents visits from occurring as
1370 required by this subsection;
- 1371 2. A statement of the frequency with which visits, including virtual and in-person, where
1372 appropriate, will be allowed, which shall be at least once every 10 calendar days for each
1373 resident;
- 1374 3. A provision authorizing a resident or the resident's personal representative to waive or
1375 limit visitation, provided that such waiver or limitation is included in the resident's health
1376 record; and
- 1377 4. A requirement that the general hospital publish on its website or communicate to each
1378 resident or the resident's authorized representative, in writing or via electronic means, the
1379 long-term care unit's plan for providing visits to residents as required by this subsection.
- 1380 J. Unless the vaccination is medically contraindicated or the resident declines the offer of
1381 vaccination, a general hospital shall provide, or arrange for, the administration to the residents of
1382 an annual influenza vaccination and a pneumococcal vaccination in accordance with the following
1383 recommendations of ACIP:
- 1384 1. [Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the](#)
1385 [Advisory Committee on Immunization Practices — United States, 2022–23 Influenza](#)
1386 [Season, MMWR 71 \(1\), 2022, CDC;](#)
- 1387 2. [Use of 15-Valent Pneumococcal Conjugate Vaccine and 20-Valent Pneumococcal](#)
1388 [Conjugate Vaccine Among U.S. Adults: Updated Recommendations of ACIP — United](#)
1389 [States, MMWR 71 \(4\), 2022, CDC;](#)
- 1390 3. [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
1391 [Polysaccharide Vaccine Among Adults Aged >65 Years: Updated Recommendations of](#)
1392 [ACIP, MMWR 68 \(46\), 2019, CDC;](#)
- 1393 4. [Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of ACIP, MMWR](#)
1394 [64 \(15\), 2015, CDC;](#)
- 1395 5. [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
1396 [Polysaccharide Vaccine Among Adults Aged >65 Years: Recommendations of ACIP,](#)
1397 [MMWR 63 \(37\), 2014, CDC;](#)
- 1398 6. [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
1399 [Polysaccharide Vaccine Among Children Aged 6–18 Years with Immunocompromising](#)
1400 [Conditions: Recommendations of ACIP, MMWR 62 \(25\), 2013, CDC;](#)
- 1401 7. [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
1402 [Polysaccharide Vaccine for Adults with Immunocompromising Conditions:](#)
1403 [Recommendations of ACIP, MMWR 61 \(40\), 2012, CDC;](#)

1404 [8. Prevention of Pneumococcal Disease Among Infants and Children — Use of 13-Valent](#)
1405 [Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine:](#)
1406 [Recommendations of ACIP, MMWR 59 \(RR-11\), 2010, CDC; and](#)
1407 [9. Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among](#)
1408 [Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine \(PPSV23\), MMWR 59](#)
1409 [\(34\), 2010, CDC.](#)

1410 **Statutory Authority**

1411 §§ ~~32.1-12~~ and 32.1-127 of the Code of Virginia.

1412 **12VAC5-410-650. General building and physical plant information.**

1413 A. All construction of new buildings and additions, renovations, or alterations ~~or repairs~~ of
1414 existing buildings for occupancy as a hospital shall conform to state and local codes, zoning
1415 ordinances, and the Virginia Uniform Statewide Building Code (13VAC5-63).

1416 In addition, hospitals shall be designed and constructed consistent with Part 1 and Part 2 of
1417 the ~~2018~~ Guidelines for Design and Construction of Hospitals, 2022 Edition of the (The Facility
1418 Guidelines Institute), as amended by the [November 2022 Errata for Guidelines for Design and](#)
1419 [Construction of Hospitals, 2022 Edition \(The Facility Guidelines Institute\)](#), and if applicable,
1420 Chapter 2.8 of Part 2 of the Guidelines for Design and Construction of Outpatient Facilities, 2022
1421 Edition (The Facility Guidelines Institute), as amended by the [November 2022 Errata for](#)
1422 [Guidelines for Design and Construction of Outpatient Facilities, 2022 Edition \(The Facility](#)
1423 [Guidelines Institute\)](#) pursuant to § ~~32.1-127.001~~ of the Code of Virginia.

1424 B. Architectural drawings and specifications for all new construction or for additions,
1425 alterations, or renovations to any existing building shall be dated, stamped with professional seal,
1426 and signed by the architect. The architect shall certify that the drawings and specifications were
1427 prepared to conform to the Virginia Uniform Statewide Building Code (13VAC5-63) and be
1428 consistent with Part 1 and Part 2 of the ~~2018~~ Guidelines for Design and Construction of Hospitals,
1429 2022 Edition of the (The Facility Guidelines Institute), as amended by the [November 2022 Errata](#)
1430 [for Guidelines for Design and Construction of Hospitals, 2022 Edition \(The Facility Guidelines](#)
1431 [Institute\)](#), and if applicable, Chapter 2.8 of the Guidelines for Design and Construction of
1432 Outpatient Facilities, 2022 Edition (The Facility Guidelines Institute), as amended by the
1433 [November 2022 Errata for Guidelines for Design and Construction of Outpatient Facilities, 2022](#)
1434 [Edition \(The Facility Guidelines Institute\)](#).

1435 **Statutory Authority**

1436 §§ ~~32.-12,~~ 32.1-127, and 32.1-127.001 of the Code of Virginia.

1437 **Historical Notes**

1438 Derived from VR355-33-500 § 3.1, eff. July 28, 1993; amended, Virginia Register Volume 11,
1439 Issue 8, eff. April 1, 1995; Volume 22, Issue 8, eff. January 25, 2006; Volume 23, Issue 10, eff.
1440 March 1, 2007; Volume 26, Issue 22, eff. August 4, 2010; Volume 37, Issue 19, eff. June 9, 2021.

1441 **12VAC5-410-760. Long-term care nursing units.**

1442 Construction and renovation of long-term care nursing units, including intermediate and skilled
1443 nursing care nursing units, shall be designed and constructed consistent with section ~~2-2-2.13~~
1444 2.2-2.15 of Part 2 of the ~~2018~~ Guidelines for Design and Construction of Hospitals, 2022 Edition
1445 of the (The Facility Guidelines Institute) pursuant to § ~~32.1-127.001~~ of the Code of Virginia.

1446 Architectural drawings and specifications for all new construction or for additions, alterations,
1447 or renovations to any existing building shall be dated, stamped with professional seal, and signed
1448 by the architect. The architect shall certify that the drawings and specifications were prepared to
1449 conform to the Virginia Uniform Statewide Building Code (13VAC5-63) and be consistent with

1450 section ~~2.2-2.13~~ 2.2-2.15 of Part 2 of the ~~2018~~ Guidelines for Design and Construction of
1451 Hospitals, 2022 Edition of the (The Facility Guidelines Institute).

1452 **Statutory Authority**

1453 §§ 32.1-12, 32.1-127 , and 32.1-127.001 of the Code of Virginia.

1454 **Historical Notes**

1455 Derived from VR355-33-500 § 3.12, eff. July 28, 1993; amended, Virginia Register Volume 11,
1456 Issue 8, eff. April 1, 1995; Volume 22, Issue 8, eff. January 25, 2006; Volume 23, Issue 10, eff.
1457 March 1, 2007; Volume 37, Issue 19, eff. June 9, 2021.

1458 **Part IV**

1459 Organization and Operation of Outpatient Surgical Hospitals: Organization, Operation, and
1460 Design Standards for Existing and New Facilities

1461 **12VAC5-410-1170. Policy and procedures manual.**

1462 A. Each outpatient surgical hospital shall develop a policy and procedures manual that shall
1463 include provisions covering the following items:

- 1464 1. The types of emergency and elective procedures that may be performed in the facility.
1465 2. Types of anesthesia that may be used.
1466 3. Admissions and discharges, including:
1467 a. Criteria for evaluating the patient before admission and before discharge; and
1468 b. Protocols to ensure that any patient scheduled to receive an elective surgical
1469 procedure for which the patient can reasonably be expected to require outpatient
1470 physical therapy as a follow-up treatment after discharge is informed that the patient:
1471 (1) Is expected to require outpatient physical therapy as a follow-up treatment; and
1472 (2) Will be required to select a physical therapy provider prior to being discharged from
1473 the hospital.
1474 4. Written informed consent of patient prior to the initiation of any procedures.
1475 5. Procedures for housekeeping and infection control and prevention.
1476 6. Disaster preparedness.
1477 7. Facility security.

1478 B. An outpatient surgical hospital shall provide A a copy of approved policies and procedures
1479 and any subsequent revisions ~~thereto shall be made available~~ to the OLC upon request.

1480 C. Each outpatient surgical hospital shall establish a protocol relating to the rights and
1481 responsibilities of patients based on 42 C.F.R. § 416.50 ~~Joint Commission on Accreditation of~~
1482 ~~Healthcare Organizations' Standards for Ambulatory Care (2000 Hospital Accreditation~~
1483 ~~Standards, January 2000).~~ The protocol shall include a process reasonably designed to inform
1484 patients of their rights and responsibilities. Patients shall be given a copy of their rights and
1485 responsibilities upon admission.

1486 D. ~~If the Governor has declared a public health emergency related to the novel coronavirus~~
1487 ~~(COVID-19), each outpatient surgical hospital shall allow a person with a disability who requires~~
1488 ~~assistance as a result of such disability to be accompanied by a designated support person at~~
1489 ~~any time during which health care services are provided.~~

- 1490 1. ~~A designated support person shall not be subject to any restrictions on visitation~~
1491 ~~adopted by such outpatient surgical hospital. However, such designated support person~~
1492 ~~may be required to comply with all reasonable requirements of the outpatient surgical~~

1493 ~~hospital adopted to protect the health and safety of patients and staff of the outpatient~~
1494 ~~surgical hospital.~~

1495 ~~2. Every outpatient surgical hospital shall establish policies applicable to designated~~
1496 ~~support persons and shall:~~

1497 ~~a. Make such policies available to the public on a website maintained by the outpatient~~
1498 ~~surgical hospital; and~~

1499 ~~b. Provide such policies, in writing, to the patient at such time as health care services~~
1500 ~~are provided.~~

1501 ~~E. D.~~ Each outpatient surgical hospital shall obtain a criminal history record check pursuant
1502 to § 32.1-126.02 of the Code of Virginia on any compensated employee not licensed by the Board
1503 of Pharmacy whose job duties provide access to controlled substances within the outpatient
1504 surgical hospital pharmacy.

1505 **Statutory Authority**

1506 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

1507 **Historical Notes**

1508 Derived from VR355-33-500 § 4.3, eff. July 28, 1993; amended, Virginia Register Volume 11,
1509 Issue 8, eff. April 1, 1995; Volume 19, Issue 1, eff. November 1, 2002; Volume 23, Issue 10, eff.
1510 March 1, 2007; Volume 28, Issue 2, eff. November 1, 2011; Volume 36, Issue 23, eff. August 6,
1511 2020; Volume 37, Issue 14, eff. March 31, 2021.

1512 **12VAC5-410-1171. Persons with a disability; designated support person in outpatient**
1513 **surgical hospitals.**

1514 A. For the purposes of this section, "admission" means accepting a person for observation.

1515 B. An outpatient surgical hospital shall allow a person with a disability who requires support
1516 and assistance necessary due to the specifics of the person's disability to be accompanied by a
1517 DSP who will provide support and assistance necessary due to the specifics of the person's
1518 disability to the person with a disability during an admission.

1519 1. In any case in which the duration of the admission lasts more than 24 hours, the person
1520 with a disability may designate more than one DSP.

1521 2. No outpatient surgical hospital shall be required to allow more than one DSP to be
1522 present with a person with a disability at any time.

1523 C. An outpatient surgical hospital may:

1524 1. Not subject a DSP to any restrictions on visitation;

1525 2. Require a DSP to comply with all reasonable requirements of an outpatient surgical
1526 hospital adopted to protect the health and safety of the person with a disability; the DSP;
1527 the staff and other patients of, or visitors to, an outpatient surgical hospital; and the public;
1528 and

1529 3. Restrict a DSP's access to specified areas of and movement on the premises of an
1530 outpatient surgical hospital when such restrictions are determined by an outpatient
1531 surgical hospital to be reasonably necessary to protect the health and safety of the person
1532 with a disability; the DSP; the staff and other patients of, or visitors to, an outpatient
1533 surgical hospital; and the public.

1534 D. An outpatient surgical hospital may request that a person with a disability provide
1535 documentation indicating that he is a person with a disability.

1536 1. If the person with a disability fails, refuses, or is unable to provide documentation
1537 requested pursuant to subsection D of this section, an outpatient surgical hospital may

1538 perform an objective assessment of the person to determine whether he is a person with
1539 a disability.

1540 2. If an outpatient surgical hospital fails to perform an objective assessment pursuant to
1541 subdivision D 1 of this section, an outpatient surgical hospital may not prohibit a DSP from
1542 accompanying a person with a disability for the purpose of providing support and
1543 assistance necessary due to the specifics of the person's disability.

1544 E. An outpatient surgical hospital shall

1545 1. Establish protocols to inform patients, at the time of admission, of the right of a person
1546 with a disability who requires support and assistance necessary due to the specifics of the
1547 person's disability to be accompanied by a DSP for the purpose of providing support and
1548 assistance necessary due to the specifics of the person's disability;

1549 2. Develop and make available to a patient or his guardian, authorized representative, or
1550 care provider upon request written information regarding the right of a person with a
1551 disability who requires support and assistance necessary due to the specifics of the
1552 person's disability to be accompanied by a DSP and any policies related to that right; and

1553 3. Make the written information described in subdivision E 2 of this section available to the
1554 public on its website.

1555 G. This section may not:

1556 1. Alter the obligation of an outpatient surgical hospital to provide patients with effective
1557 communication support or other required services, regardless of the presence of a DSP
1558 or other reasonable accommodation, consistent with applicable federal or state law or
1559 regulations; and

1560 2. Be interpreted to:

1561 a. Prevent an outpatient surgical hospital from complying, or interfere with the ability
1562 of an outpatient surgical hospital to comply, with or cause an outpatient surgical
1563 hospital to violate any federal or state law or regulation;

1564 b. Deem a DSP to be acting under the direction or control of an outpatient surgical
1565 hospital or as an agent of an outpatient surgical hospital; or

1566 c. Require an outpatient surgical hospital to allow a DSP to perform any action or
1567 provide any support or assistance necessary due to the specifics of the person's
1568 disability when an outpatient surgical hospital reasonably determines that the
1569 performance of the action or provision would be:

1570 (1) Medically or therapeutically contraindicated; or

1571 (2) A threat to the health and safety of the person with a disability, the DSP, or the staff
1572 or other patients of, or visitors to, an outpatient surgical hospital.

1573 **Statutory Authority**

1574 § §32.1-12, 32.1-127, and 32.1-173.08 of the Code of Virginia.

1575 **12VAC5-410-1175. Discharge planning. (Repealed.)**

1576 ~~A. Every hospital shall provide each patient admitted as an inpatient or his legal guardian the~~
1577 ~~opportunity to designate an individual who will care for or assist the patient in his residence~~
1578 ~~following discharge from the hospital and to whom the hospital shall provide information regarding~~
1579 ~~the patient's discharge plan and any follow-up care, treatment, and services that the patient may~~
1580 ~~require.~~

1581 ~~B. Every hospital upon admission shall record in the patient's medical record:~~

1582 ~~1. The name of the individual designated by the patient;~~

1583 ~~2. The relationship between the patient and the person; and~~

1584 3. The person's telephone number and address.

1585 C. If the patient fails or refuses to designate an individual to receive information regarding his
1586 discharge plan and any follow-up care, treatment, and services, the hospital shall record the
1587 patient's failure or refusal in the patient's medical record.

1588 D. A patient may change the designated individual at any time prior to the patient's release,
1589 and the hospital shall record the changes, including the information referenced in subsection B of
1590 this section, in the patient's medical record within 24 hours of such a change.

1591 E. Prior to discharging a patient who has designated an individual pursuant to subsection A
1592 or D of this section, the hospital shall (i) notify the designated individual of the patient's discharge,
1593 (ii) provide the designated individual with a copy of the patient's discharge plan and instructions
1594 and information regarding any follow-up care, treatment, or services that the designated individual
1595 will provide, and (iii) consult with the designated individual regarding the designated individual's
1596 ability to provide the care, treatment, or services. Such discharge plan shall include:

- 1597 1. The name and contact information of the designated individual;
1598 2. A description of follow-up care, treatment, and services that the patient requires; and
1599 3. Information, including contact information, about any health care, long-term care, or
1600 other community-based services and supports necessary for the implementation of the
1601 patient's discharge plan.

1602 A copy of the discharge plan and any instructions or information provided to the designated
1603 individual shall be included in the patient's medical record.

1604 F. The hospital shall provide each individual designated pursuant to subsection A or D of this
1605 section the opportunity for a demonstration of specific follow-up care tasks that the designated
1606 individual will provide to the patient in accordance with the patient's discharge plan prior to the
1607 patient's discharge, including opportunity for the designated individual to ask questions regarding
1608 the performance of follow-up care tasks. Such opportunity shall be provided in a culturally
1609 competent manner and in the designated individual's native language.

1610 **Statutory Authority**

1611 § 32.1-127 of the Code of Virginia.

1612 **Historical Notes**

1613 Derived from Virginia Register Volume 32, Issue 14, eff. April 8, 2016.

1614 **12VAC5-410-1178. Financial assistance in outpatient surgical hospitals.**

1615 A. As used in this section, "patient" and "uninsured patient" have the same meanings as
1616 ascribed to these terms in subsection A of § 32.1-137.010 of the Code of Virginia.

1617 B. An outpatient surgical hospital shall make reasonable efforts to screen every uninsured
1618 patient to determine whether the individual is eligible for medical assistance pursuant to the state
1619 plan for medical assistance or for financial assistance under the outpatient surgical hospital's
1620 financial assistance policy.

1621 C. An outpatient surgical hospital shall inform every uninsured patient who receives services
1622 at the outpatient surgical hospital and who is determined to be eligible for assistance under the
1623 outpatient surgical hospital's financial assistance policy of the option to enter into a payment plan
1624 with the outpatient surgical hospital.

1625 1. A payment plan entered into pursuant to this subsection shall be provided to the patient
1626 in writing or electronically and shall provide for repayment of the cumulative amount owed
1627 to the outpatient surgical hospital.

1628 2. The amount of monthly payments and the term of the payment plan shall be determined
1629 based upon the patient's ability to pay.

1630 3. Any interest on amounts owed pursuant to the payment plan shall not exceed the
1631 maximum judgment rate of interest pursuant to § 6.2-302 of the Code of Virginia.

1632 4. The outpatient surgical hospital may not charge any fees related to the payment plan.

1633 5. The payment plan shall allow prepayment of amounts owed without penalty.

1634 D. An outpatient surgical hospital shall develop a process by which either an uninsured patient
1635 who agrees to a payment plan pursuant to subsection C of this section or the outpatient surgical
1636 hospital may request and shall be granted the opportunity to renegotiate the payment plan.

1637 1. Renegotiation shall include opportunity for a new screening in accordance with
1638 subsection B of this section.

1639 2. An outpatient surgical hospital may not charge any fees for renegotiation of a payment
1640 plan pursuant to this subsection.

1641 E. An outpatient surgical hospital shall provide written information about:

1642 1. Its charity care policies, including:

1643 a. Policies related to free and discounted care;

1644 b. Specific eligibility criteria for charity care; and

1645 c. Procedures for applying for charity care;

1646 2. The availability of a payment plan for the payment of debt owed to the outpatient surgical
1647 hospital pursuant to subsection C of this section; and

1648 3. The renegotiation process described in subsection D of this section.

1649 F. To provide the information required by subsection F of this section, an outpatient hospital
1650 shall:

1651 1. Post the information conspicuously in public areas of the outpatient surgical hospital,
1652 including admissions or registration areas and associated waiting rooms;

1653 2. Make the information available to:

1654 a. A patient at the time of admission or discharge, or at the time services are provided;
1655 and

1656 b. Persons with limited English proficiency in accordance with the U.S. Department of
1657 Health and Human Services' Guidance to Federal Financial Assistance Recipients
1658 Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited
1659 English Proficient Persons (August 8, 2003, 68 FR 47311), if the outpatient surgical
1660 hospital is subject to the requirements of Title VI of the Civil Rights Act of 1964 (Pub.
1661 L. No. 88-352), as amended; and

1662 3. Include the information:

1663 a. With any billing statements sent to uninsured patients; and

1664 b. On any website maintained by the outpatient surgical hospital.

1665 G. Notwithstanding any other provision of law, an outpatient surgical hospital may not engage
1666 in any action described in § 501(r)(6) of the Internal Revenue Code, as it was in effect on January
1667 1, 2020, to recover a debt for medical services against any patient unless the outpatient surgical
1668 hospital has made all reasonable efforts to determine whether the patient:

1669 1. Qualifies for medical assistance pursuant to the state plan for medical assistance; or

1670 2. Is eligible for financial assistance under the outpatient surgical hospital's financial
1671 assistance policy.

1672 H. Nothing in this section shall be construed to:

1673 1. Prohibit an outpatient surgical hospital, as part of its financial assistance policy, from
1674 requiring a patient to:

- 1675 a. Provide necessary information needed to determine eligibility for financial
1676 assistance under the outpatient surgical hospital's financial assistance policy, medical
1677 assistance pursuant to Title XVIII or XIX of the Social Security Act (42 U.S.C. § 301 et
1678 seq.) or 10 U.S.C. § 1071 et seq., or other programs of insurance; or
1679 b. Undertake good faith efforts to apply for and enroll in the programs of insurance for
1680 which the patient may be eligible as a condition of awarding financial assistance;
1681 2. Require an outpatient surgical hospital to grant or continue to grant any financial
1682 assistance or payment plan pursuant to this section when:
1683 a. A patient has provided false, inaccurate, or incomplete information required for
1684 determining eligibility for the outpatient surgical hospital's financial assistance policy;
1685 or
1686 b. A patient has not undertaken good faith efforts to comply with any payment plan
1687 pursuant to this section; or
1688 3. Prohibit the coordination of benefits as required by state or federal law.

1689 **Statutory Authority**

1690 §§ 32.1-12, 32.1-127, 32.1-137.01, and 32.1-137.010 of the Code of Virginia.

1691 **12VAC5-410-1190. Nursing staff.**

1692 A. The total number of nursing personnel will vary depending upon the number and types of
1693 patients to be admitted and the types of operative procedures to be performed or the services
1694 programmed.

- 1695 1. A registered nurse qualified on the basis of education, experience, and clinical ability
1696 shall be responsible for the direction of nursing care provided the patients.
1697 2. The number and type of nursing personnel, including registered nurses, licensed
1698 practical nurses, and supplementary staff, shall be based upon the needs of the patients
1699 and the types of services performed.
1700 3. At least one registered nurse shall be on duty at all times while the facility is in use.
1701 4. Job descriptions shall be developed for each level of nursing personnel and include
1702 functions, responsibilities, and qualifications.
1703 5. Evidence of current Virginia registration required by state statute shall be on file in the
1704 facility.

1705 B. Each outpatient surgical hospital shall quarterly report to the department no later 30
1706 calendar days after January 1st, April 1st, July 1st, and October 1st:

- 1707 1. The total number of certified sexual assault nurse examiners employed by the outpatient
1708 surgical hospital; and
1709 2. The location, including street address, and contact information for each location at
1710 which such certified sexual assault nurse examiner provides services.

1711 Each outpatient surgical hospital shall report the information required by this subsection to the
1712 Office of Family Health Services, Virginia Department of Health.

1713 **Statutory Authority**

1714 §§ 32.1-12, 32.1-23.2, and 32.1-127 of the Code of Virginia.

1715 **Historical Notes**

1716 Derived from VR355-33-500 § 4.5, eff. July 28, 1993; amended, Virginia Register Volume 11,
1717 Issue 8, eff. April 1, 1995.

1718 **12VAC5-410-1260. Medical records.**

1719 A. ~~Medical records.~~ An accurate and complete clinical record or chart shall be maintained on
1720 each patient. The record or chart shall contain sufficient information to satisfy the diagnosis or
1721 need for the medical or surgical service. It shall include, when applicable, ~~but not be limited to~~ the
1722 following:

- 1723 1. Patient identification;
- 1724 2. Admitting information, including patient history and physical examination;
- 1725 3. Signed consent;
- 1726 4. Confirmation of pregnancy, ~~if applicable~~;
- 1727 5. Physician orders;
- 1728 6. Laboratory tests, pathologist's report of tissue, and radiologist's report of x-rays;
- 1729 7. Anesthesia record;
- 1730 8. Operative record;
- 1731 9. Surgical medication and medical treatments;
- 1732 10. Recovery room notes;
- 1733 11. Physician and nurses' progress notes,
- 1734 12. Condition at time of discharge,
- 1735 13. Patient instructions, preoperative and postoperative; and
- 1736 14. Names of referral physicians or agencies.

1737 B. Provisions shall be made for the safe storage of medical records ~~or~~ and the accurate and
1738 legible reproductions ~~thereof of medical records~~ according to § 32.1-127.1:03 of the Code of
1739 Virginia and the Health Insurance Portability and Accountability Act, ~~or HIPAA (42 USC § 1320d~~
1740 ~~et seq.)~~ (Pub. L. No. 104-191).

1741 C. All medical records, either original or accurate reproductions, shall be preserved for a
1742 minimum of five years following discharge of the patient.

- 1743 1. Records of minors shall be kept for at least five years after such minor has reached the
1744 age of 18 years.
- 1745 2. Birth and death information shall be retained for 10 years in accordance with § 32.1-
1746 274 of the Code of Virginia.
- 1747 3. Record of abortions and proper information for the issuance of a fetal death certificate
1748 shall be furnished to the Division Office of Vital Records, Virginia Department of Health,
1749 ~~within 10 days after the abortion as required by law.~~

1750 D. An outpatient surgical hospital that makes health records, as defined in § 32.1-127.1:03 of
1751 the Code of Virginia, of patients who are minors available to patients through a secure website
1752 shall make the health records available to the patient's parent or guardian through the secure
1753 website, unless the hospital cannot make the health record available:

- 1754 1. In a manner that prevents disclosure of information, the disclosure of which has been
1755 denied pursuant to subsection F of § 32.1-127.1:03 of the Code of Virginia; or
- 1756 2. Because the consent required in accordance with subsection E of § 54.1-2969 of the
1757 Code of Virginia has not been provided.

1758 **Statutory Authority**

1759 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

1760 **Historical Notes**

1761 Derived from VR355-33-500 § 4.12, eff. July 28, 1993; amended, Virginia Register Volume 11,
1762 Issue 8, eff. April 1, 1995; Volume 22, Issue 8, eff. January 25, 2006.

1763 **12VAC5-410-1350. Local and state codes and standards.**

1764 A. All construction of new buildings and additions, renovations, or alterations, ~~or repairs~~ to
1765 existing buildings for occupancy as a "free-standing" outpatient hospital shall conform to state
1766 and local codes, zoning ordinances, and the Virginia Uniform Statewide Building Code (13VAC5-
1767 63).

1768 In addition, hospitals shall be designed and constructed consistent with Part 1 and ~~sections~~
1769 Chapters 2.1 and 2.7 of Part 2 of the 2018 Guidelines for Design and Construction of Outpatient
1770 Facilities, 2022 Edition of the (The Facility Guidelines Institute) pursuant to § 32.1-127.001 of the
1771 Code of Virginia, as amended by the [November 2022 Errata for the Guidelines for Design and](#)
1772 [Construction of Outpatient Facilities, 2022 Edition \(The Facility Guidelines Institute\).](#)

1773 Architectural drawings and specifications for all new construction or for additions, alterations,
1774 or renovations to any existing building shall be dated, stamped with professional seal, and signed
1775 by the architect. The architect shall certify that the drawings and specifications were prepared to
1776 conform to the Virginia Uniform Statewide Building Code (13VAC5-63) and be consistent with
1777 Part 1 and ~~sections~~ Chapters 2.1 and 2.7 of Part 2 of the 2018 Guidelines for Design and
1778 Construction of Outpatient Facilities, 2022 Edition of the (The Facility Guidelines Institute), as
1779 amended by the [November 2022 Errata for Guidelines for Design and Construction of Outpatient](#)
1780 [Facilities, 2022 Edition \(The Facility Guidelines Institute\).](#)

1781 B. The use of an incinerator shall require permitting from the nearest regional office of the
1782 Department of Environmental Quality.

1783 C. Water shall be obtained from an approved water supply system. Outpatient surgery centers
1784 shall be connected to sewage systems approved by the Department of Health or the Department
1785 of Environmental Quality.

1786 D. Each outpatient surgery center shall establish a monitoring program for the internal
1787 enforcement of all applicable fire and safety laws and regulations.

1788 E. All radiological machines shall be registered with the Office of Radiological Health of the
1789 Virginia Department of Health. Installation, calibration and testing of machines and storage
1790 facilities shall comply with 12VAC5-481, Virginia Radiation Protection Regulations.

1791 F. Pharmacy services shall comply with Chapter 33 (§ 54.1-3300 et seq.) of Title 54.1 of the
1792 Code of Virginia and 18VAC110-20, Regulations Governing the Practice of Pharmacy.

1793 **Statutory Authority**

1794 §§ 32.1-12, 32.1-127, and 32.1-127.001 of the Code of Virginia.

1795 **Historical Notes**

1796 Derived from VR355-33-500 § 5.4, eff. July 28, 1993; amended, Virginia Register Volume 11,
1797 Issue 8, eff. April 1, 1995; Volume 22, Issue 8, eff. January 25, 2006; Volume 23, Issue 10, eff.
1798 March 1, 2007; Volume 26, Issue 22, eff. August 4, 2010; Volume 37, Issue 19, eff. June 9, 2021.

1799 **Documents Incorporated by Reference (12VAC5-410)**

1800 Control of Communicable Diseases Manual, American Public Health Association, 21st
1801 Edition, 2022, <https://www.apha.org>.

1802 [Errata for Guidelines for Design and Construction of Hospitals, The Facility Guidelines](https://fgiguilines.org/guidelines/errata-addenda/)
1803 [Institute, 2022 Edition, <https://fgiguilines.org/guidelines/errata-addenda/> \(eff. 11/2022\).](https://fgiguilines.org/guidelines/errata-addenda/)

1804 [Errata for Guidelines for Design and Construction of Outpatient Facilities, The Facility](https://fgiguilines.org/guidelines/errata-addenda/)
1805 [Guidelines Institute, 2022 Edition, <https://fgiguilines.org/guidelines/errata-addenda/> \(eff.](https://fgiguilines.org/guidelines/errata-addenda/)
1806 [11/2022\).](https://fgiguilines.org/guidelines/errata-addenda/)

- 1807 Guidelines for Design and Construction of Hospitals, ~~2018 Edition~~, The Facility Guidelines
1808 Institute, Washington D.C. ~~2022 Edition~~, ~~<http://www.fgiguideines.org>~~ <https://fgiguideines.org>.
- 1809 Guidelines for Design and Construction of Outpatient Facilities, ~~2018 Edition~~, The Facility
1810 Guidelines Institute, Washington, D.C. ~~2022 Edition~~, <https://fgiguideines.org>.
- 1811 Guidelines for Perinatal Care, American Academy of Pediatric/American College of
1812 Obstetricians and Gynecologists, 8th Edition, 2017, <https://www.aap.org> and
1813 <https://www.acog.org>.
- 1814 [Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of ACIP, MMWR 64](#)
1815 [\(15\), 2015, CDC.](#)
- 1816 [Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the](#)
1817 [Advisory Committee on Immunization Practices — United States, 2022–23 Influenza Season,](#)
1818 [MMWR 71 \(1\), 2022, CDC.](#)
- 1819 [Prevention of Pneumococcal Disease Among Infants and Children — Use of 13-Valent](#)
1820 [Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine:](#)
1821 [Recommendations of ACIP, MMWR 59 \(RR-11\), 2010, CDC.](#)
- 1822 [Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults](#)
1823 [Using the 23-Valent Pneumococcal Polysaccharide Vaccine \(PPSV23\), MMWR 59 \(34\), 2010,](#)
1824 [CDC.](#)
- 1825 [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
1826 [Polysaccharide Vaccine Among Adults Aged >65 Years: Recommendations of ACIP, MMWR 63](#)
1827 [\(37\), 2014, CDC.](#)
- 1828 [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
1829 [Polysaccharide Vaccine Among Adults Aged >65 Years: Updated Recommendations of ACIP,](#)
1830 [MMWR 68 \(46\), 2019, CDC.](#)
- 1831 [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
1832 [Polysaccharide Vaccine for Adults with Immunocompromising Conditions: Recommendations of](#)
1833 [ACIP, MMWR 61 \(40\), 2012, CDC.](#)
- 1834 [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
1835 [Polysaccharide Vaccine Among Children Aged 6–18 Years with Immunocompromising](#)
1836 [Conditions: Recommendations of ACIP, MMWR 62 \(25\), 2013, CDC.](#)
- 1837 [Use of 15-Valent Pneumococcal Conjugate Vaccine and 20-Valent Pneumococcal Conjugate](#)
1838 [Vaccine Among U.S. Adults: Updated Recommendations of ACIP — United States, MMWR 71](#)
1839 [\(4\), 2022, CDC.](#)

Office of Regulatory Management
Economic Review Form

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC5-410-10 et seq.
VAC Chapter title(s)	Regulations for the Licensure of Hospitals in Virginia
Action title	Amend Regulation After Periodic Review
Date this document prepared	November 28, 2022

Cost Benefit Analysis

Table 1a: Costs and Benefits of the Proposed Changes (Primary Option)

<p>(1) Direct Costs & Benefits</p>	<ul style="list-style-type: none"> • Hospitals must report specified changes to the Virginia Department of Health (VDH) at least 30 calendar days prior to initiating the change. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Hospitals have to permit inspectors access to their facilities, records, and persons under their control for the purposes of inspection and have to submit plans of correction for cited deficiencies, and have to implement corrections within 45 business days. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Hospitals have to meet minimum requirements if they intended to operate a newborn safety device. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.
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	<ul style="list-style-type: none">• Hospitals have to base their patient rights on analogous federal requirements. Direct Costs: No more than \$1,250 one-time in total and potentially \$0 in total, as all but one licensed hospital already has to meet the analogous federal requirements. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Hospitals have to meet the minimum requirements for allowing a person with a disability access to a designated support person. Direct Costs: \$1,250 one-time per hospital to update existing policies and procedures about designated support persons. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • General hospitals have to meet minimum discharge planning standards. Direct Costs: \$1,250 one-time per general hospital to update existing policies and procedures about discharge planning. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Hospitals have to meet the minimum requirements for information disclosure about financial assistance and payment plans. Direct Costs: \$1,250 one-time per hospital to update existing policies and procedures about financial assistance and payment plans. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Hospitals have to quarterly report sexual assault nurse examiner (SANE) employment information on the first day of each calendar quarter to the Office of Family Health Services. Direct Costs: \$5,000 annually per general hospital to track and report this information. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.
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	<ul style="list-style-type: none">• Hospitals have to meet minimum requirements for parent or guardian electronic access to minor patient’s medical records. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.• General hospitals have to report fetal death information as required by law to the Office of Vital Records. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.• Hospital construction, renovation, or alterations have to comply with the applicable sections of the 2022 guidelines from The Facility Guidelines Institute. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.• General hospitals providing newborn service can store breast milk for up to 96 hours. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.• Updates to current clinical standards for infection prevention and control for general hospitals with obstetric and gynecological services Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.
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	<ul style="list-style-type: none"> General hospitals with long-term care nursing units that are certified nursing facilities have to meet minimum statutory requirements <p>Direct Costs: \$1,250 one-time per topic per general hospital to update existing policies and procedures about immunization, and visitation; \$5,000 one-time per topic per general hospital to create policies and procedures about mandated reporting, regarding the sex offender registry, and information and notices about the family council. Only eight hospitals have long-term care nursing units that are certified nursing facilities.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p>		
(2) Quantitative Factors	Estimated Dollar Amount	Present Value	
Direct Costs	(a) \$9,896,250	(c) \$8,846,234	
Direct Benefits	(b) \$0	(d) \$0	
(3) Benefits-Costs Ratio	0.00	(4) Net Benefit	-\$8,846,234
(5) Indirect Costs & Benefits	<p>VDH is not aware of any quantifiable benefits at this time.</p> <p>As a result of the mandate to comply with the 2022 edition of the applicable design and construction guidelines, VDH anticipates that there may be a quantifiable indirect cost equal to 1.4% increase in construction costs for a 160-bed general hospital, a 2.7% increase in construction costs for a 12-bed general hospital that is certified as a critical access hospital, a 0.7% – 1.3% increase in construction costs for a multi-specialty outpatient surgical hospital.</p> <p>VDH is not aware of any other quantifiable costs at this time.</p>		
(6) Information Sources	The Facility Guidelines Institute; Division of Acute Care Services, Office of Licensure and Certification.		
(7) Optional	VDH has numerous challenges and constraints that limit a cost benefit analysis, including limited data availability, limited statutory discretion, and insufficient analytical models.		

	<p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of hospital patients by incorporating current clinical and industry practices as well as by requiring reasonable timely information from hospitals, access to information to ensure hospital compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>
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Table 1b: Costs and Benefits under the Status Quo (No change to the regulation)

<p>(1) Direct Costs & Benefits</p>	<p>Nondiscretionary changes have been omitted from this analysis.</p> <ul style="list-style-type: none"> • Hospitals must report specified changes to the Virginia Department of Health (VDH) at least 30 business days prior to initiating the change. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Hospitals have to permit inspectors access to their facilities, records, and persons under their control for the purposes of inspection and have to submit plans of correction for cited deficiencies, and have to implement corrections within 45 business days. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Hospitals have to quarterly report sexual assault nurse examiner (SANE) employment information. Direct Costs: \$5,000 annually per general hospital to track and report this information. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • General hospitals providing newborn service can store breast milk for up to 48 hours.
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	<p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> Clinical standards for infection prevention and control for general hospitals with obstetric and gynecological services reference material from pre-1996 <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p>		
(2) Quantitative Factors	Estimated Dollar Amount	Present Value	
Direct Costs	(a) \$0	(c) \$0	
Direct Benefits	(b) \$0	(d) \$0	
(3) Benefits-Costs Ratio	0.00	(4) Net Benefit	\$0
(5) Indirect Costs & Benefits	<p>VDH is not aware of any quantifiable benefits at this time from the discretionary regulatory changes.</p> <p>VDH is not aware of any quantifiable costs at this time from the discretionary regulatory changes.</p>		
(6) Information Sources	Division of Acute Care Services, Office of Licensure and Certification		
(7) Optional	<p>VDH has numerous challenges and constraints that limit a cost benefit analysis, including limited data availability, limited statutory discretion, and insufficient analytical models.</p> <p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of hospital patients by incorporating current clinical and industry practices as well as by requiring reasonable timely information from hospitals, access to information to ensure hospital compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>		

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Table 1c: Costs and Benefits under an Alternative Approach

<p>(1) Direct Costs & Benefits</p>	<p>Nondiscretionary changes have been omitted from this analysis.</p> <ul style="list-style-type: none"> • Hospitals must report specified changes to the Virginia Department of Health (VDH) within an unspecified time frame at the hospital’s discretion prior to initiating the change. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> • Hospitals have to permit inspectors access to their facilities, records, and persons under their control for the purposes of inspection and have to submit plans of correction for cited deficiencies, and have to implement corrections within an unspecified time frame at the hospital’s discretion. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> • Hospitals have to quarterly report sexual assault nurse examiner (SANE) employment information on a day of their choosing within a quarter to any person at VDH. <p>Direct Costs: \$5,000 annually per general hospital to track and report this information.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> • General hospitals providing newborn service can store breast milk for a length of time to be determined by the hospital. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p>
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	<p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> • Infection prevention and control for general hospitals with obstetric and gynecological services do not reference any clinical standards <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p>	
(2) Quantitative Factors	Estimated Dollar Amount	Present Value
Direct Costs	(a) \$0	(c) \$0
Direct Benefits	(b) \$0	(d) \$0
(3) Benefits-Costs Ratio	0.00	(4) Net Benefit \$0.00
(5) Indirect Costs & Benefits	<p>VDH is not aware of any quantifiable benefits at this time from the discretionary regulatory changes.</p> <p>VDH is not aware of any quantifiable costs at this time from the discretionary regulatory changes.</p>	
(6) Information Sources	Division of Acute Care Services, Office of Licensure and Certification	
(7) Optional	<p>VDH has numerous challenges and constraints that limit a cost benefit analysis, including limited data availability, limited statutory discretion, and insufficient analytical models.</p> <p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of hospital patients by incorporating current clinical and industry practices as well as by requiring reasonable timely information from hospitals, access to information to ensure hospital compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>	

Impact on Local Partners

Table 2: Impact on Local Partners

<p>(1) Direct Costs & Benefits</p>	<ul style="list-style-type: none"> • Hospitals must report specified changes to the Virginia Department of Health (VDH) at least 30 calendar days prior to initiating the change. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Hospitals have to permit inspectors access to their facilities, records, and persons under their control for the purposes of inspection and have to submit plans of correction for cited deficiencies, and have to implement corrections within 45 business days. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Hospitals have to meet minimum requirements if they intended to operate a newborn safety device. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Hospitals have to base their patient rights on analogous federal requirements. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Hospitals have to meet the minimum requirements for allowing a person with a disability access to a designated support person. Direct Costs: \$1,250 one-time per hospital to update existing policies and procedures about designated support persons.
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	<p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none">• General hospitals have to meet minimum discharge planning standards. <p>Direct Costs: \$1,250 one-time per general hospital to update existing policies and procedures about discharge planning.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none">• Hospitals have to meet the minimum requirements for information disclosure about financial assistance and payment plans. <p>Direct Costs: \$1,250 one-time per hospital to update existing policies and procedures about financial assistance and payment plans.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none">• Hospitals have to quarterly report sexual assault nurse examiner (SANE) employment information. <p>Direct Costs: \$5,000 annually per general hospital to track and report this information.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none">• Hospitals have to meet minimum requirements for parent or guardian electronic access to minor patient's medical records. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none">• General hospitals have to report fetal death information as required by law to the Office of Vital Records. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p>
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	<p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none">• Hospital construction, renovation, or alterations have to comply with the applicable sections of the 2022 guidelines from The Facility Guidelines Institute. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none">• General hospitals providing newborn service can store breast milk for up to 96 hours. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none">• Updates to current clinical standards for infection prevention and control for general hospitals with obstetric and gynecological services <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none">• General hospitals with long-term care nursing units that are certified nursing facilities have to meet minimum statutory requirements <p>Direct Costs: \$1,250 one-time per topic per general hospital to update existing policies and procedures about immunization, and visitation; \$5,000 one-time per topic per general hospital to create policies and procedures about mandated reporting, regarding the sex offender registry, and information and notices about the family council. Only eight hospitals have long-term care nursing units that are certified nursing facilities.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p>
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(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a) \$112,500
Direct Benefits	(b) \$0
(3) Indirect Costs & Benefits	<p>VDH is not aware of any quantifiable benefits at this time.</p> <p>As a result of the mandate to comply with the 2022 edition of the applicable design and construction guidelines, VDH anticipates that there may be a quantifiable indirect cost equal to 1.4% increase in construction costs for a 160-bed general hospital, a 2.7% increase in construction costs for a 12-bed general hospital that is certified as a critical access hospital, a 0.7% – 1.3% increase in construction costs for a multi-specialty outpatient surgical hospital.</p> <p>VDH is not aware of any other quantifiable costs at this time.</p>
(4) Information Sources	The Facility Guidelines Institute; Division of Acute Care Services, Office of Licensure and Certification.
(5) Assistance	None
(6) Optional	<p>VDH has numerous challenges and constraints that limit a cost benefit analysis, including limited data availability, limited statutory discretion, and insufficient analytical models.</p> <p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of hospital patients by incorporating current clinical and industry practices as well as by requiring reasonable timely information from hospitals, access to information to ensure hospital compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>

Economic Impacts on Families

Table 3: Impact on Families

(1) Direct Costs & Benefits	Families will not be affected by direct costs or benefits of the regulatory change as they are not subject to the requirements contained in this regulatory chapter and thus will incur no direct cost or benefit
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(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a) \$0
Direct Benefits	(b) \$0
(3) Indirect Costs & Benefits	VDH is not aware of any quantifiable indirect costs or benefits for families. To the extent that the cost or benefit of regulatory changes may be passed on to families, VDH cannot quantify that cost or benefit at this time.
(4) Information Sources	Division of Acute Care Services, Office of Licensure and Certification.
(5) Optional	<p>VDH has numerous challenges and constraints that limit a cost benefit analysis, including limited data availability, limited statutory discretion, and insufficient analytical models.</p> <p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of hospital patients by incorporating current clinical and industry practices as well as by requiring reasonable timely information from hospitals, access to information to ensure hospital compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>

Impacts on Small Businesses

Table 4: Impact on Small Businesses

(1) Direct Costs & Benefits	<p>VDH is not aware of any general hospital that meets the definition of “small business” so regulatory changes that exclusively impact general hospitals have been omitted from this analysis.</p> <ul style="list-style-type: none"> Hospitals must report specified changes to the Virginia Department of Health (VDH) at least 30 calendar days prior to initiating the change. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> Hospitals have to permit inspectors access to their facilities, records, and persons under their control for the purposes of inspection and
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	<p>have to submit plans of correction for cited deficiencies, and have to implement corrections within 45 business days.</p> <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none">• Hospitals have to meet minimum requirements if they intended to operate a newborn safety device. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none">• Hospitals have to base their patient rights on analogous federal requirements. <p>Direct Costs: No more than \$1,250 one-time in total and potentially \$0 in total, as all but one licensed hospital already has to meet the analogous federal requirements.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none">• Hospitals have to meet the minimum requirements for allowing a person with a disability access to a designated support person. <p>Direct Costs: \$1,250 one-time per hospital to update existing policies and procedures about designated support persons.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none">• Hospitals have to meet the minimum requirements for information disclosure about financial assistance and payment plans. <p>Direct Costs: \$1,250 one-time per hospital to update existing policies and procedures about financial assistance and payment plans.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p>
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	<ul style="list-style-type: none"> Hospitals have to quarterly report sexual assault nurse examiner (SANE) employment information on the first day of each calendar quarter to the Office of Family Health Services. Direct Costs: \$5,000 annually per general hospital to track and report this information. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. Hospitals have to meet minimum requirements for parent or guardian electronic access to minor patient’s medical records. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. Hospital construction, renovation, or alterations have to comply with the applicable sections of the 2022 guidelines from The Facility Guidelines Institute. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.
(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a) \$173,750
Direct Benefits	(b) \$0
(3) Indirect Costs & Benefits	<p>VDH is not aware of any quantifiable benefits at this time.</p> <p>As a result of the mandate to comply with the 2022 edition of the applicable design and construction guidelines, VDH anticipates that there may be a quantifiable indirect cost equal to 1.4% increase in construction costs for a 160-bed general hospital, a 2.7% increase in construction costs for a 12-bed general hospital that is certified as a critical access hospital, a 0.7% – 1.3%</p>

	<p>increase in construction costs for a multi-specialty outpatient surgical hospital.</p> <p>VDH is not aware of any other quantifiable costs at this time.</p>
(4) Alternatives	Of the changes that are discretionary (see Tables 1b and 1c for identification of the discretionary changes), VDH could not identify an alternative that achieved the same purpose without compromising the health, safety, and welfare of patients or without compromising VDH’s ability to comply in a cost-efficient manner with statutory/legislative mandates placed on the agency.
(5) Information Sources	The Facility Guidelines Institute; Division of Acute Care Services, Office of Licensure and Certification.
(6) Optional	<p>VDH has numerous challenges and constraints that limit a cost benefit analysis, including limited data availability, limited statutory discretion, and insufficient analytical models.</p> <p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of hospital patients by incorporating current clinical and industry practices as well as by requiring reasonable timely information from hospitals, access to information to ensure hospital compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>

Changes to Number of Regulatory Requirements

Table 5: Total Number of Requirements

	Number of Requirements			
Chapter number	Initial Count	Additions	Subtractions	Net Change
410	3,841	86	24	62



COMMONWEALTH of VIRGINIA

Colin M. Greene, MD, MPH
State Health Commissioner

Department of Health
P O BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

MEMORANDUM

DATE: November 7, 2022

TO: State Board of Health

FROM: Rebekah E. Allen, JD
Senior Policy Analyst, Office of Licensure and Certification

SUBJECT: Fast Track Action – Regulations for the Licensure of Nursing Facilities – Amend Regulation to Incorporate Chapter 72 (2021 Acts of Assembly, Special Session I), Chapters 829, 1080, and 1081 (2020 Acts of Assembly), Chapters 10 and 11 (2020 Acts of Assembly, Special Session I), Chapters 177 and 222 (2005 Acts of Assembly) and Chapter 762 (2004 Acts of Assembly), Update Terms to Match Statutory Language, and Update Licensure Provisions

Enclosed for your review are proposed amendments to Regulations for the Licensure of Nursing Facilities (12VAC5-371-10 *et seq.*).

This fast-track action is being utilized to conform 12VAC5-371-10 *et seq.* to the Code of Virginia and to update out-of-date regulatory provisions. Changes include amendments to address mandates found in:

- Chapter 72 of the 2021 Acts of Assembly, Special Session I (prohibition on discriminating against health insurance enrollee on the basis of the enrollee being a litigant or potential litigant due to a motor vehicle accident);
- Chapters 10 and 11 of the 2020 Acts of Assembly, Special Session I (visitation during public health emergencies);
- Chapter 829 of the 2020 Acts of Assembly (obligations with regards to the Sex Offenders and Crimes Against Minors Registry);
- Chapters 1080 and 1081 of the 2020 Acts of Assembly (prohibition on balance billing);
- Chapter 1278 of the 2020 Acts of Assembly (replacing occurrences of THC-A oil and cannabidiol oil with cannabis oil);
- Chapters 177 and 222 of the 2005 Acts of Assembly (design and construction guidelines for hospitals); and
- Chapter 762 of the 2004 Acts of Assembly (immunization standards for influenza and pneumonia).

The changes include including removing unused terminology, improving terminology consistency, providing definitions for terms to match current clinical and industry practices, moving regulatory provisions to the appropriate part of 12VAC5-371-10 *et seq.*, and revising provisions related to the licensing process and oversight procedures.

The State Board of Health is requested to approve the Fast Track Action. Should the State Board of Health approve the Fast Track Action, the amendments will be submitted to the Office of the Attorney General to begin the Executive Branch review process, as specified by the Administrative Process Act. Following Executive Branch review and approval, the proposed regulatory text will be published in the Virginia Register of Regulations and on the Virginia Regulatory Town Hall website. A 30-day public comment period will begin. Fifteen days after the close of the public comment period, the regulation will become effective.



townhall.virginia.gov

Fast-Track Regulation Agency Background Document

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC5-371
VAC Chapter title(s)	Regulations for the Licensure of Nursing Facilities
Action title	Amend Regulation to Incorporate Chapter 72 (2021 Acts of Assembly, Special Session I), Chapters 829, 1080, and 1081 (2020 Acts of Assembly), Chapters 10 and 11 (2020 Acts of Assembly, Special Session I), Chapters 177 and 222 (2005 Acts of Assembly) and Chapter 762 (2004 Acts of Assembly), Update Terms to Match Statutory Language, and Update Licensure Provisions
Date this document prepared	October 26, 2022

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

This fast-track action is being utilized to conform 12VAC5-371-10 *et seq.* to the Code of Virginia and to update out-of-date regulatory provisions. Changes include amendments to address mandates found in:

- Chapter 72 of the 2021 Acts of Assembly, Special Session I (prohibition on discriminating against health insurance enrollee on the basis of the enrollee being a litigant or potential litigant due to a motor vehicle accident);
- Chapters 10 and 11 of the 2020 Acts of Assembly, Special Session I (visitation during public health emergencies);

- Chapter 829 of the 2020 Acts of Assembly (obligations with regards to the Sex Offenders and Crimes Against Minors Registry);
- Chapters 1080 and 1081 of the 2020 Acts of Assembly (prohibition on balance billing);
- Chapter 1278 of the 2020 Acts of Assembly (replacing occurrences of THC-A oil and cannabidiol oil with cannabis oil);
- Chapters 177 and 222 of the 2005 Acts of Assembly (design and construction guidelines for nursing facilities); and
- Chapter 762 of the 2004 Acts of Assembly (immunization standards for influenza and pneumonia).

The changes include including removing unused terminology, improving terminology consistency, providing definitions for terms to match current clinical and industry practices, moving regulatory provisions to the appropriate part of 12VAC5-371-10 *et seq.*, and revising provisions related to the licensing process and oversight procedures.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the “Definitions” section of the regulation.

“Board” means the Virginia Board of Health.

“FGI Guidelines” means the 2022 edition of *Guidelines for Design and Construction of Residential Health, Care, and Support Facilities*, as amended by the August 2022 Errata, published by The Facilities Guidelines Institute.

“Nursing facility” means any nursing home as defined in § 32.1-123 of the Code of Virginia.

“VDH” means the Virginia Department of Health.

Statement of Final Agency Action

Provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) the name of the agency taking the action; and 3) the title of the regulation.

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, “mandate” has the same meaning as defined in the ORM procedures, “a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part.”

Consistent with Virginia Code § 2.2-4012.1, also explain why this rulemaking is expected to be noncontroversial and therefore appropriate for the fast-track rulemaking process.

Chapter 72 (2021 Acts of Assembly, Special Session I) and Chapters 1080 and 1801 (2020 Acts of Assembly) placed prohibitions on balance billing and discrimination against current or potential motor vehicle accident litigants that apply to nursing facilities. Chapters 10 and 11 (2020 Acts of Assembly, Special Session I) required the Board to promulgate regulations about nursing facility visitation during public health emergencies. Chapter 829 (2020 Acts of Assembly) made nondiscretionary changes to nursing facilities’

obligations with regards to the Sex Offenders and Crimes Against Minors Registry. Chapter 1278 (2020 Acts of Assembly) replaced occurrences of “THC-A oil” and “cannabidiol oil” with “cannabis oil.” Chapters 177 and 222 (2005 Acts of Assembly) require the Board to promulgate regulations for the licensure of nursing facilities that include minimum standards for the design and construction of nursing facilities consistent with the current edition of design and construction guidelines issued by The Facilities Guidelines Institute (successor to the American Institute of Architects Academy of Architecture for Health). Chapter 762 (2004 Acts of Assembly) requires the Board to promulgate regulations for the licensure of nursing facilities to mandate that nursing facilities “provide or arrange for the administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal vaccination, in accordance with the most recent recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.”

The rulemaking is expected to be noncontroversial because it is being utilized to conform to the statutory mandates and language and because it is detailing longstanding agency licensing procedures. No new requirements are being developed. Additionally, the agency’s subject matter experts believe that proposed changes would not jeopardize the protection of public health, safety, and welfare. Further, the rulemaking does not alter the intent of the regulation or the requirements placed on nursing facilities.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency’s overall regulatory authority.

Va. Code § 32.1-12 gives the Board the authority to make, adopt, promulgate, and enforce such regulations as may be necessary to carry out the provisions of Title 32.1 of the Code of Virginia. Va. Code § 32.1-127 requires the Board to adopt regulations that include minimum standards for (i) the construction and maintenance of nursing facilities to ensure the environmental protection and the life safety of its residents, employees, and the public; and (ii) the vaccination of residents, unless medically contraindicated or declined by the resident.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it is intended to solve.

The rationale or justification for this regulatory change is that regulations should be clearly written, up to date, conform to the law, and should be the least burdensome means of protecting the health, safety, and welfare of citizens. The regulatory change is essential to protect the health, safety, and welfare of citizens because unclear regulations hamper licensees’ ability to comply and out of date regulations may reference standards and practices that are not consistent with current clinical practices. The goals of this regulatory change are to improve consistency across the sections of this regulatory text, bring the regulatory text into alignment with the statutes, and update references to current clinical guidelines.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the “Detail of Changes” section below.

Section 10 Definitions

Adds definitions for “ACIP,” “business day,” “CDC,” “CMS,” “inspector,” and “licensee.” Removes definitions for “THC-A oil” and renamed “cannabidiol oil” to “cannabis oil.”

Section 30 License

Adds language about the non-assignment and non-transferability of a licensee and moves language about nursing facilities’ posting licenses for the public from subsection G of 12VAC5-371-110.

Section 55 Plan of correction

Consolidates the plan of correction language found throughout the regulatory chapter to ensure the plan of correction requirements are consistent. Revisions include minimum elements of a plan of correction and the timeline for submission and completion of a plan of correction.

Section 60 On-site inspections

Section is renamed to “Inspection procedure.” Amends text to more closely align with the Register of Regulation’s style guide, adds language about frequency of inspections, and removes language about plans of correction.

Section 70 Complaint investigation

Amends text to more closely align with the Register of Regulation’s style guide, adds language about evaluating the need for an on-site complaint inspection, and removes language about plans of correction.

Section 90 Administrative sections

Section is renamed to “Disciplinary action.” Matches statutory provisions about prohibited acts and disciplinary options available.

Section 100 Surrender of license

Section is renamed to “Surrender of license; mid-term change of license.” Clarifies what is a mid-term change to a license and clarifies a nursing facility’s obligations and the process to obtain a changed license.

Section 110 Management and administration

Removes language about a nursing facility’s requirement to inform the OLC of changes impacting its license and to post its license for the public. Updates documents incorporated by reference to the most recent recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Section 150 Resident rights

Amends section to match statutory language about registration, reregistration, and verification with the Sex Offender and Crimes Against Minors Registry.

Section 180 Infection control

Amends section to add provisions about visitation during public health emergencies related to COVID-19.

Section 300 Pharmaceutical services

Replaces “THC-A oil” and “cannabidiol oil” with “cannabis oil.”

Section 410 Unique design solutions

Updates documents incorporated by reference to the most recent FGI guidelines.

DOCUMENTS INCORPORATED BY REFERENCE (12VAC5-371)

Updated to reflect the changes in the proposed text and to reference the most current edition of each relevant document.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

The primary advantages to the public are removal of language or requirements that were unclear, inconsistent, or outdated and addition of legislative mandates that had previously had not been incorporated into the regulations. The primary advantages to VDH or Commonwealth are clarity on the minimum requirements for nursing facilities and VDH in the administration of the nursing facility licensing program. There are no disadvantages to the public or the Commonwealth. There are no primary disadvantages to the agency or the Commonwealth. There is no other pertinent matters of interest to the regulated community, government officials and the public.

Requirements More Restrictive than Federal

Identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements, or no requirements that exceed applicable federal requirements, include a specific statement to that effect.

VDH is not aware of any applicable federal requirements about:

- discriminating against health insurance enrollees on the basis of the enrollee being a litigant or potential litigant due to a motor vehicle accident, which is the subject of the mandate in Chapter 72 of the 2021 Acts of Assembly, Special Session I;
- Terminology for cannabis oil; and
- licensing of nursing facilities or any processes or procedures related to licensing of nursing facilities.

The regulatory change regarding the prohibition on balance billing derived from Chapters 1080 and 1081 of the 2020 Acts of Assembly do not exceed applicable federal requirements.

42 CFR § 483.80(d)(1) and (2) requires certified nursing facilities to offer influenza and pneumococcal vaccination to residents unless medically contradicted or the resident refuses vaccination. The legislative mandate in Chapter 762 of the 2004 Acts of Assembly is more specific than federal requirements about the clinical guidance informing vaccination, though the mandate does not exceed and is not more restrictive than applicable federal requirements.

The regulatory change regarding the design and construction guidelines for nursing facilities may be more restrictive than federal requirements, specifically 42 CFR § 483.90; however, Chapters 177 and 222 of the 2005 Acts of Assembly mandate the minimum requirements be consistent with the current edition of the applicable FGI guidelines so the Board does not have the discretion to be less restrictive.

The regulatory changes regarding the Sex Offender and Crimes Against Minors Registry and visitation during public health emergencies related to COVID-19 may be more restrictive than federal requirements in 42 CFR Part 483 Subpart B; however, Chapter 829 of the 2020 Acts of Assembly and Chapters 10 and 11 of the 2020 Acts of Assembly, Special Session I mandates the minimum requirements for nursing facilities so the Board does not have the discretion to be less restrictive.

Agencies, Localities, and Other Entities Particularly Affected

Consistent with § 2.2-4007.04 of the Code of Virginia, identify any other state agencies, localities, or other entities particularly affected by the regulatory change. Other entities could include local partners such as tribal governments, school boards, community services boards, and similar regional organizations. "Particularly affected" are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

Other State Agencies Particularly Affected

The two licensed nursing facilities operated by the Department of Veterans Services will be particularly affected.

Localities Particularly Affected

The licensed nursing facility operated by the County of Bedford will be particularly affected.

Other Entities Particularly Affected

The 286 licensed nursing facilities (including those operated by the County of Bedford and the Department of Veterans Services) and applicants for nursing facility licensure will be particularly affected.

Economic Impact

Consistent with § 2.2-4007.04 of the Code of Virginia, identify all specific economic impacts (costs and/or benefits), anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Keep in mind that this is the proposed change versus the status quo.

Impact on State Agencies

<p><i>For your agency:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources</p>	<p>There are no projected costs, savings, fees, or revenues resulting from the regulatory change.</p>
<p><i>For other state agencies:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.</p>	<p>There are no known projected savings, fees, or revenues resulting from the regulatory change.</p> <p>The Department of Veterans Services would have one-time costs associated with updating policies and procedures related to visitation. For its existing policies and procedures, VDH is estimating it would cost \$1,250 one-time to amend their policies per facility to conform to the regulatory minimums.</p>
<p><i>For all agencies:</i> Benefits the regulatory change is designed to produce.</p>	<p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of residents by</p>

	<p>incorporating current clinical and industry practices as well as by requiring reasonable timely information from nursing facilities, access to information to ensure nursing facility compliance, remedial action within a reasonable and a consistently applied timeframe if noncompliance does occur.</p>
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Impact on Localities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a or 2) on which it was reported. Information provided on that form need not be repeated here.

<p>Projected costs, savings, fees or revenues resulting from the regulatory change.</p>	<p>There are no known projected savings, fees, or revenues resulting from the regulatory change.</p> <p>The County of Bedford would have one-time costs associated with updating policies and procedures related to visitation. For its existing policies and procedures, VDH is estimating it would cost \$1,250 one-time to amend their policies to conform to the regulatory minimums.</p>
<p>Benefits the regulatory change is designed to produce.</p>	<p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of residents by incorporating current clinical and industry practices as well as by requiring reasonable timely information from nursing facilities, access to information to ensure nursing facility compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>

Impact on Other Entities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a, 3, or 4) on which it was reported. Information provided on that form need not be repeated here.

<p>Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.</p>	<p>Licensed nursing facilities and applicants for nursing facility licensure.</p>
<p>Agency's best estimate of the number of such entities that will be affected. Include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that:</p> <ul style="list-style-type: none"> a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million. 	<p>The 286 licensed nursing facilities (including those operated by the Department of Veterans Services and the County of Bedford) will be required to comply with the regulatory change. Applicants for new nursing facility licensure are infrequent and difficult to estimate.</p> <p>VDH does not have sufficient information to determine which nursing facilities have fewer than 500 full-time employees.</p>

<p>All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to:</p> <ul style="list-style-type: none"> a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements. 	<p>There are no known projected savings, fees, or revenues resulting from the regulatory change.</p> <p>Licensed nursing facilities would have one-time costs associated with updating policies and procedures related to visitation. For its existing policies and procedures, VDH is estimating it would cost \$1,250 one-time to amend their policies per facility to conform to the regulatory minimums.</p>
<p>Benefits the regulatory change is designed to produce.</p>	<p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of residents by incorporating current clinical and industry practices as well as by requiring reasonable timely information from nursing facilities, access to information to ensure nursing facility compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

No alternative was considered because the General Assembly required the Board to adopt regulations governing the licensure of nursing facilities and amending the regulation is the least burdensome, least intrusive, and less costly method to accomplish the purpose of this action.

Regulatory Flexibility Analysis

Consistent with § 2.2-4007.1 B of the Code of Virginia, describe the agency’s analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the regulatory change.

The Board is required to regulate the licensure of nursing facilities consistent with the provisions of Article 1 (§ 32.1-123 *et seq.*) of Chapter 5 of Title 32.1 of the Code of Virginia. Initiation of this regulatory action is the least burdensome method to conform the Regulations for the Licensure of Nursing Facilities (12VAC5-371-10 *et seq.*) to the statute.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below.

Consistent with § 2.2-4011 of the Code of Virginia, if an objection to the use of the fast-track process is received within the 30-day public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the agency shall: 1) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register and 2) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

If you are objecting to the use of the fast-track process as the means of promulgating this regulation, please clearly indicate your objection in your comment. Please also indicate the nature of, and reason for, your objection to using this process.

The Board is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal and any alternative approaches, (ii) the potential impacts of the regulation, and (iii) the agency's regulatory flexibility analysis stated in this background document.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: <https://townhall.virginia.gov>. Comments may also be submitted by mail, email or fax to Rebekah E. Allen, Senior Policy Analyst, Virginia Department of Health, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Henrico, VA 23233; email: regulatorycomment@vdh.virginia.gov; fax: (804) 527-4502. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
371-10	N/A	<p>12VAC5-371-10. Definitions.</p> <p>The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:</p> <p style="text-align: center;">* * *</p> <p>"Cannabidiol oil" means the same as the term is defined in subsection A of §</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-371-10. Definitions.</p> <p>The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:</p> <p style="text-align: center;">* * *</p>

		<p>54.1-3408.3 of the Code of Virginia.</p> <p style="text-align: center;">* * *</p> <p>"THC-A oil" means the same as the term is defined in subsection A of § 54.1-3408.3 of the Code of Virginia.</p> <p style="text-align: center;">* * *</p>	<p><u>"ACIP" means the Advisory Committee on Immunization Practices of the CDC.</u></p> <p style="text-align: center;">* * *</p> <p><u>"Business day" means any day that is not a Saturday, Sunday, legal holiday, or day on which the OLC is closed. For the purposes of this chapter, any day on which the Governor authorizes the closing of the state government shall be considered a legal holiday.</u></p> <p><u>"Cannabidiol—oil" "Cannabis oil"</u> means the same as the term is defined in subsection A of § 54.1-3408.3 of the Code of Virginia.</p> <p><u>"CDC" means the Centers for Disease Control and Prevention.</u></p> <p style="text-align: center;">* * *</p> <p><u>"CMS" means the Centers for Medicare and Medicaid Services.</u></p> <p style="text-align: center;">* * *</p> <p><u>"Inspector" means an individual employed by or contracted by the department and designated by the commissioner to conduct inspections, investigations, or evaluations.</u></p> <p style="text-align: center;">* * *</p> <p><u>"Licensee" means a person that has received and maintains an active license under the provisions of Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia and this chapter.</u></p> <p style="text-align: center;">* * *</p> <p>"THC A oil" means the same as the term is defined in subsection A of § 54.1-3408.3 of the Code of Virginia.</p> <p style="text-align: center;">* * *</p> <p>INTENT: The intent of the change is to create, remove, and update definitions for terms that have been cause for confusion.</p> <p>RATIONALE: The rationale for the change is that commonly used terms that may have multiple meanings depending on the speaker should be defined so that all audiences have a consistent understanding of the terms' intended meaning.</p>
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			<p>LIKELY IMPACT: The likely impact of the change is reduced confusion for nursing facilities, VDH, and the public.</p>
<p>371-30</p>	<p>N/A</p>	<p>12VAC5-371-30. License. * * *</p> <p>B. A license to operate a nursing facility is issued to a person or organization. An organization may be a partnership, association, corporation, or public entity.</p> <p>C. Each license and renewal thereof shall be issued for one year. A nursing facility shall operate within the terms of its license, which include the:</p> <ol style="list-style-type: none"> 1. Name of the nursing facility; 2. Name of the operator; 3. Physical location of the nursing facility; 4. Maximum number of beds allowed; and 5. Date the license expires. <p>* * *</p> <p>F. The number of resident beds allowed in a nursing facility shall be determined by the department. Requests to increase beds must be made in writing and must include an approved Certificate of Public Need, except as provided in 12VAC5-371-40 G.</p> <p>G. Nursing facility units located in and operated by hospitals shall be licensed under Regulations for the Licensure of Hospitals in Virginia (12VAC5-410). Approval for such units shall be included on the annual license issued to each hospital.</p> <p>* * *</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-371-30. License. * * *</p> <p>B. A license to operate a nursing facility <u>is shall be</u> issued to a person or organization. An organization may be a partnership, association, corporation, or public entity.</p> <p>C. Each license <u>shall expire at midnight December 31 of the year issued and renewal thereof shall be issued for one year.</u> A nursing facility shall operate within the terms of its license, which include the:</p> <ol style="list-style-type: none"> 1. Name of the nursing facility; 2. Name of the operator; 3. Physical location of the nursing facility; 4. Maximum number of beds allowed, <u>except as provide in 12VAC5-371-40 G;</u> and 5. Date the license expires. <p>* * *</p> <p>F. The number of resident beds allowed in a nursing facility shall be determined by the department commissioner. Requests to increase beds must be made in writing and must include an approved Certificate of Public Need, except as provided in 12VAC5-371-40 G.</p> <p>G. <u>Nursing facility Long-term care nursing units</u> located in and operated by hospitals shall be licensed under Regulations for the Licensure of Hospitals in Virginia (12VAC5-410). Approval for such units shall be included on the annual license issued to each hospital.</p> <p>* * *</p> <p><u>I. The licensee shall at all times:</u></p> <ol style="list-style-type: none"> <u>1. Maintain an active and accurate license; and</u> <u>2. Post its current license in a place readily visible and</u>

			<p><u>accessible to the public at the nursing facility.</u></p> <p>INTENT: The intent of the change is to remove duplicative or confusing provisions, to group general licensing principles together, and to conform the regulation to the statutes.</p> <p>RATIONALE: The rationale for the change is that the duplicative material is addressed earlier in 12VAC5-371, that the topics within the regulation should be addressed in singular locations instead of multiple, and that the regulation should be consisted with the Code of Virginia.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for nursing facilities.</p>
N/A	371-55	None	<p>CHANGE: The Board is proposing the following change:</p> <p><u>12VAC5-371-55. Plan of correction.</u></p> <p><u>A. Upon receipt of a written inspection report, the administrator or his designee shall prepare a written plan of correction addressing each licensing violation cited at the time of inspection.</u></p> <p><u>B. The administrator or his designee shall submit to the OLC a written plan of correction no more than 15 business days after receipt of the inspection report. The plan of correction shall contain for each licensing violation cited:</u></p> <ol style="list-style-type: none"> <u>1. A description of the corrective action or actions to be taken and the position title of the employees to implement the corrective action. If employees share the same position title, the administrator or his designee shall assign the employees a unique identifier to distinguish them;</u> <u>2. The expected correction date, not to exceed 45 business days from the exit date of the inspection; and</u> <u>3. A description of the measures implemented to prevent a</u>

			<p><u>recurrence of each licensing violation.</u></p> <p><u>C. The administrator or his designee shall ensure that the person responsible for the validity of the plan of correction signs, dates, and indicates their title on the plan of correction.</u></p> <p><u>D. The OLC shall notify the administrator or his designee if the OLC determines any item in the plan of correction is unacceptable.</u></p> <p><u>E. The OLC may conduct an inspection to verify any portion of a plan of correction has been implemented.</u></p> <p><u>F. The administrator or his designee shall ensure the plan of correction is implemented and monitored so that compliance is maintained.</u></p> <p><u>G. The commissioner may deny licensure or renewal of licensure if the administrator or his designee fails to submit an acceptable plan of correction or fails to implement an acceptable plan of correction.</u></p> <p><u>H. The OLC shall consider the submission date of a plan of correction to be the date it is postmarked or the date it is received, whichever is earlier.</u></p> <p>INTENT: The intent of the change is to standardize the plan of correction process to make it more similar to federal plan of correction processes.</p> <p>RATIONALE: The rationale for the change is that documentation of remedial action and completion of remedial action should be consistently applied to all nursing facilities.</p> <p>LIKELY IMPACT: The likely impact of the change is improved clarity about what should be in a plan of correction, when it is due, and when it should be completed.</p>
371-60	N/A	<p>12VAC5-371-60. On-site inspections.</p> <p>A. The licensing representative shall make unannounced on-site inspections of the nursing facility. The licensee shall be</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-371-60. On-site inspections Inspection procedure.</p> <p>A. The licensing representative OLC shall make <u>periodic</u> unannounced on-site</p>

		<p>responsible for correcting any deficiencies found during any on-site inspection. Compliance with all standards will be determined by the OLC.</p> <p>B. The licensee shall make available to the licensing representative any necessary records.</p> <p>C. The licensee shall also allow the licensing representative to interview the agents, employees, residents, family members, and any person under its custody, control, direction or supervision.</p> <p>D. After the on-site inspection, the licensing representative shall discuss the findings of the inspection with the administrator or designee.</p> <p>E. As applicable, the administrator shall submit an acceptable plan for correcting any deficiencies found during an on-site inspection.</p> <p>F. The administrator will be notified whenever any item in the plan of correction is determined to be unacceptable.</p> <p>G. The administrator shall be responsible for assuring the plan of correction is implemented and monitored so that compliance is maintained.</p>	<p>inspections of the nursing facility <u>as necessary but not less often than biennially</u>. <u>The OLC may make on-site inspections of applicants for licensure.</u> The licensee shall be responsible for correcting any deficiencies found during any on-site inspection. Compliance with all standards will <u>shall</u> be determined by the OLC.</p> <p>B. The licensee <u>or applicant</u> shall:</p> <ol style="list-style-type: none"> <u>1. make Make available to the licensing representative inspector any necessary requested records;</u> <u>2. Permit an inspector to enter upon and into its property to inspect or investigate as the inspector reasonably deems necessary in order to determine the state of compliance with the provisions of this chapter and all laws administered by the board; and</u> <u>3. Allow the inspector access to interview the agents, employees, independent contractors, residents, legal representatives, resident's family members, and any person under the licensee's or applicant's control, direction, or supervision.</u> <p>C. The licensee shall also allow the licensing representative to interview the agents, employees, residents, family members, and any person under its custody, control, direction or supervision.</p> <p>D. C. <u>After the on-site inspection, the licensing representative inspector shall:</u></p> <ol style="list-style-type: none"> <u>1. Discuss the findings of the inspection with the administrator or his designee; and</u> <u>2. Provide a written inspection report to the administrator or his designee.</u> <p>E. As applicable, the administrator shall submit an acceptable plan for correcting any deficiencies found during an on-site inspection.</p>
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			<p>F. The administrator will be notified whenever any item in the plan of correction is determined to be unacceptable.</p> <p>G. The administrator shall be responsible for assuring the plan of correction is implemented and monitored so that compliance is maintained.</p> <p>D. If the OLC cites one or more licensing violations in the written inspection report, the administrator or his designee shall submit a plan of correction in accordance with 12VAC5-371-55.</p> <p>INTENT: The intent of the change is to more clearly specify what is expected of a hospital and VDH when an inspection occurs.</p> <p>RATIONALE: The rationale for the change is nursing facilities are better able to anticipate what may be needed during inspection process if parameters are specified in regulation.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for nursing facilities.</p>
371-70	N/A	<p>12VAC5-371-70. Complaint investigation.</p> <p>A. The OLC has the responsibility to investigate any complaints regarding alleged violations of the standards or statutes and complaints of the abuse or neglect of persons in care. The Department of Social Services and the State Ombudsman are notified of complaints received.</p> <p>B. Complaints may be received in written or oral form and may be anonymous.</p> <p>C. When the investigation is complete, the licensee and the complainant, if known, will be notified of the findings of the investigation.</p> <p>D. As applicable, the administrator shall submit an</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-371-70. Complaint investigation.</p> <p>A. The OLC has the responsibility to <u>shall investigate any complaints and shall determine if an investigation requires an on-site inspection. In making this determination, the OLC shall consider several factors, to include: regarding</u> alleged violations of the standards or statutes and complaints of the abuse or neglect of persons in care. The Department of Social Services and the State Ombudsman are notified of complaints received.</p> <ol style="list-style-type: none"> <u>1. If the complainant has first-hand knowledge of the alleged incident;</u> <u>2. The nursing facility's regulatory history, including the number and</u>

		<p>acceptable plan for correcting any deficiencies found during a complaint investigation.</p> <p>E. The administrator will be notified whenever any item in the plan of correction is determined to be unacceptable.</p> <p>F. The administrator shall be responsible for assuring the plan of correction is implemented and monitored so that compliance is maintained.</p>	<p><u>severity of substantiated prior complaints;</u></p> <p><u>3. If the OLC has recently inspected the nursing facility and if the alleged incident would have been reviewed during the prior inspection;</u></p> <p><u>4. The nature of the complaint, including degree of potential serious harm to residents; and</u></p> <p><u>5. If the complaint may be investigated pursuant to Title XVIII or Title XIX of the Social Security Act.</u></p> <p><u>B. The OLC may request records from the licensee to assist in making a determination pursuant to subsection A of this section. The licensee shall provide the requested records no more than seven calendar days after OLC makes a request pursuant to this subsection.</u></p> <p><u>B. C. The OLC may receive Complaints complaints may be received in written or oral form and may be receive anonymous complaints.</u></p> <p><u>C. D. When the investigation is complete, the OLC shall notify the licensee and the complainant, if known, will be notified in writing of the findings of the investigation.</u></p> <p><u>D. E. As applicable, For any licensing violation cited during a complaint investigation, the administrator or his designee shall submit an acceptable a plan of correction for correcting any deficiencies found during a complaint investigation in accordance with 12VAC5-371-55.</u></p> <p><u>E. The administrator will be notified whenever any item in the plan of correction is determined to be unacceptable.</u></p> <p><u>F. The administrator shall be responsible for assuring the plan of correction is implemented and monitored so that compliance is maintained.</u></p> <p>INTENT: The intent of the changes is to update the regulatory text to match the style guidelines, and to give VDH</p>
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			<p>flexibility in determining whether a complaint warrants an on-site inspection.</p> <p>RATIONALE: The rationale for the change is that the style guidelines ensure more intelligible regulatory text and that VDH should be maximize efficient and effective use of limited agency resources in responding to complaints.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is improved readability of the section and a more adaptive and efficient complaint process.</p>
371-90	N/A	<p>12VAC5-371-90. Administrative sanctions.</p> <p>A. Nothing in this part shall prohibit the department from exercising its responsibility and authority to enforce the regulation, including proceeding directly to imposition of administrative sanctions, when the quality of care or the quality of life has been severely compromised.</p> <p>B. The commissioner may impose such administrative sanctions or take such actions as are appropriate for violation of any of the standards or statutes or for abuse or neglect of persons in care. Such sanctions include:</p> <ol style="list-style-type: none"> 1. Restricting or prohibiting new admissions to any nursing facility; 2. Petitioning the court to impose a civil penalty or to appoint a receiver, or both; or 3. Revoking or suspending the license of a nursing facility. <p>C. The following reasons may be considered by the department for the imposition of administrative sanctions or</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-371-90. Administrative sanctions <u>Disciplinary action.</u></p> <p>A. Nothing in this part shall prohibit the department from exercising its responsibility and authority to enforce the regulation, including proceeding directly to imposition of administrative sanctions, when the quality of care or the quality of life has been severely compromised.</p> <p>B. The commissioner may impose such administrative sanctions or take such actions as are appropriate for violation of any of the standards or statutes or for abuse or neglect of persons in care. Such sanctions include:</p> <ol style="list-style-type: none"> 1. Restricting or prohibiting new admissions to any nursing facility; 2. Petitioning the court to impose a civil penalty or to appoint a receiver, or both; or 3. Revoking or suspending the license of a nursing facility. <p>C. The following reasons may be considered by the department for the imposition of administrative sanctions or the imposition of civil penalties:</p> <ol style="list-style-type: none"> 1. Failure to demonstrate or maintain compliance with applicable standards or for violations of the provisions of the Code of Virginia; 2. Permitting, aiding, or abetting the commission of any illegal act in the nursing facility; or

		<p>the imposition of civil penalties:</p> <ol style="list-style-type: none"> 1. Failure to demonstrate or maintain compliance with applicable standards or for violations of the provisions of the Code of Virginia; 2. Permitting, aiding, or abetting the commission of any illegal act in the nursing facility; or 3. Deviating significantly from the program or services for which a license was issued without obtaining prior written approval from the OLC, or failure to correct such deviations within a specified time. <p>D. Violations which in the judgment of the OLC jeopardize the health and safety of residents shall be sufficient cause for immediate imposition of this section.</p> <p>E. The licensee will receive a notice of the department's intent to impose sanctions. The notice shall describe the reasons for imposing the sanction.</p> <p>F. Upon receipt of the notice to impose a sanction, the licensee has the right and the opportunity to appeal according to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia). The procedures for filing an appeal shall be outlined in the notice.</p>	<p>3. Deviating significantly from the program or services for which a license was issued without obtaining prior written approval from the OLC, or failure to correct such deviations within a specified time.</p> <p>D. Violations which in the judgment of the OLC jeopardize the health and safety of residents shall be sufficient cause for immediate imposition of this section.</p> <p>E. The licensee will receive a notice of the department's intent to impose sanctions. The notice shall describe the reasons for imposing the sanction.</p> <p>F. Upon receipt of the notice to impose a sanction, the licensee has the right and the opportunity to appeal according to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia). The procedures for filing an appeal shall be outlined in the notice.</p> <p><u>A. The licensee may not:</u></p> <ol style="list-style-type: none"> <u>1. Violate the provisions of this chapter or Articles 1 (§ 32.1-123 et seq.) or 2 (§ 32.1-138 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia;</u> <u>2. Permit, aid, or abet the commission of any illegal act in the nursing facility; or</u> <u>3. Engage in a pattern of violations pursuant to § 38.2-3445.01 of the Code of Virginia.</u> <p><u>B. The commissioner may:</u></p> <ol style="list-style-type: none"> <u>1. For each violation of subsection A of this section:</u> <ol style="list-style-type: none"> <u>a. Deny, revoke, or suspend the license to operate the nursing facility in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia);</u> <u>b. Restrict or prohibit new admissions to the nursing facility in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia);</u>
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			<p><u>c. Refer the licensee for criminal prosecution pursuant to subsection A of § 32.1-27 of the Code of Virginia;</u></p> <p><u>d. Petition an appropriate court for an injunction, mandamus, or other appropriate remedy against the licensee pursuant to subsection B of § 32.1-27 of the Code of Virginia;</u></p> <p><u>e. Petition an appropriate court for imposition of a civil monetary penalty against the licensee pursuant to subsection C of § 32.1-27 of the Code of Virginia or subsection A of § 32.1-27.1 of the Code of Virginia; or</u></p> <p><u>f. Petition an appropriate court for appointment of a receiver pursuant to subsection B of § 32.1-27.1 of the Code of Virginia; and</u></p> <p><u>2. For each violation of subdivision A 3 of this section, levy a fine upon the licensee in an amount not to exceed \$1,000 per violation, in accordance with the Administrative Process Acts (§ 2.2-4000 et seq. of the Code of Virginia).</u></p> <p><u>C. Suspension of a license shall in all cases be for an indefinite time.</u></p> <p><u>D. For each violation of subsection A of this section and with the consent of the person who has violated subsection A of this section, the board may provide, in an order issued by the board, for the payment of civil charges for past violations in specific sums, which may not exceed the limits specified in §§ 32.1-27 or 32.1-27.1 of the Code of Virginia.</u></p> <p><u>E. Upon receipt of a completed application and a nonrefundable service charge, the commissioner may issue a new license to the licensee that has had its license revoked if the commissioner determines that:</u></p>
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			<p><u>1. The conditions upon which revocation was based have been corrected; and</u></p> <p><u>2. The applicant is in compliance with this chapter, Articles 1 (§ 32.1-123 et seq.) and 2 (§ 32.1-138 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia, and all other applicable state and federal law and regulations.</u></p> <p><u>F. Upon receipt of a completed application, the commissioner may partially or completely restore a suspended license to the licensee if the commissioner determines that:</u></p> <p><u>1. The conditions upon which suspension was based have been completely or partially corrected; and</u></p> <p><u>2. The interests of the public will not be jeopardized by resumption of operation.</u></p> <p><u>G. The commissioner may not require an additional fee for restoring a license pursuant to subsection F of this section.</u></p> <p><u>H. The licensee shall submit evidence relevant to subdivisions E 1, E 2, F 1, and F 2 of this section that is satisfactory to the commissioner or his designee. The commissioner or his designee may conduct an inspection prior to making a determination.</u></p> <p>INTENT: The intent of the change is to describe the grounds upon which the commissioner may take disciplinary action against a nursing facility, the options available to the commissioner for disciplinary action, and how a nursing facility may obtain a license after suspension or revocation.</p> <p>RATIONALE: The rationale for the change is that the regulation should conform to Chapter 72 of the 2021 Acts of Assembly, Special Session I, Chapters 1080 and 1081 of the 2020 Acts of Assembly, and to Va. Code §§ 32.1-27, 32.1-27.1, and 32.1-135.</p> <p>LIKELY IMPACT: The likely impact of the change is improved clarity for nursing facilities about what acts are not permitted</p>
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			<p>and what consequences may follow if a prohibited act occurs.</p>
<p>371-100</p>	<p>N/A</p>	<p>12VAC5-371-100. Surrender of a license.</p> <p>A. Upon revocation or suspension of a license, the licensee must surrender its license to a representative of the OLC.</p> <p>B. If a license is revoked, a new license may be issued by the commissioner after satisfactory evidence is submitted that the conditions upon which revocation was based have been corrected and after proper inspection has been made and compliance with this chapter and applicable state and federal law has been obtained.</p> <p>C. Suspension of a license shall in all cases be for an indefinite time. The commissioner may completely or partially restore a suspended license when he determines that the conditions upon which suspension was based have been completely or partially corrected and that the interests of the public will not be jeopardized by resumption of operation.</p> <p>D. Other circumstances under which a license must be surrendered include transfer of ownership and discontinuation of services. The licensee must notify the OLC, in writing, 30 days before discontinuing services.</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-371-100. Surrender of a license; mid-term change of license.</p> <p>A. Upon revocation or suspension of a license, the licensee must <u>shall</u> surrender its license to a representative of the OLC.</p> <p>B. If a license is revoked, a new license may be issued by the commissioner after satisfactory evidence is submitted that the conditions upon which revocation was based have been corrected and after proper inspection has been made and compliance with this chapter and applicable state and federal law has been obtained.</p> <p>C. Suspension of a license shall in all cases be for an indefinite time. The commissioner may completely or partially restore a suspended license when he determines that the conditions upon which suspension was based have been completely or partially corrected and that the interests of the public will not be jeopardized by resumption of operation.</p> <p>D. Other circumstances under which a license must be surrendered include transfer of ownership and discontinuation of services. The licensee must notify the OLC, in writing, 30 days before discontinuing services.</p> <p><u>B. A licensee shall notify the director of the OLC in writing by submitting a mid-term change application no less than 30 calendar days in advance of implementing any:</u></p> <ol style="list-style-type: none"> <u>1. Change of location of the nursing facility;</u> <u>2. Change of ownership of the nursing facility;</u> <u>3. Change of operator of the nursing facility;</u> <u>4. Change of name of the nursing facility;</u> <u>5. Change of bed capacity, except as provided in 12VAC5-</u>

			<p><u>371-40 G, which shall be accompanied by an approved Certificate of Public Need if the requested change is for an increase in bed capacity.;</u></p> <p><u>6. Change in management contract or lease agreement to operate the nursing facility;</u></p> <p><u>7. Change of services being provided, including any proposed addition or discontinuation, regardless of whether licensure is required for the service; or</u></p> <p><u>8. Closure of the nursing facility.</u></p> <p><u>C. The OLC shall:</u></p> <p><u>1. Consider the submission date of a mid-term change application to be the date it is postmarked or the date it is received, whichever is earlier; and</u></p> <p><u>2. Notify in writing the licensee if the commissioner will issue a changed license.</u></p> <p><u>D. The commissioner's issuance of changed license to the licensee shall satisfy the requirements of subdivision C 2 of this section.</u></p> <p><u>E Upon receipt of the changed license, the licensee shall surrender its prior license issued by the commissioner to the OLC and destroy any copies of the prior license.</u></p> <p><u>F. A license may not be transferred or assigned. The commissioner may not issue a changed license in response to a change of operator of the nursing facility, but shall instead require the nursing facility to obtain a new license.. If the nursing facility intends to implement a change of operator, it shall:</u></p> <p><u>1. File for a new license, in accordance with 12VAC5-371-40, no less than 30 calendar days in advance of any operator change; and</u></p> <p><u>2. Upon receipt of the new license, surrender its prior license issued by the commissioner to the OLC and destroy any copies of the prior license.</u></p>
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			<p><u>G. If the nursing facility is closing or will otherwise no longer be operational, it shall:</u></p> <p><u>1. Notify residents, legal representatives, and the OLC no fewer than seven calendar days prior to closing or ceasing operations where all clinical records are to be located following closure or cessation of operations; and</u></p> <p><u>2. Surrender its license to the OLC and destroy all copies of its license no more than five calendar days after the nursing facility closes or ceases operations.</u></p> <p><u>H. The OLC shall determine if any changes listed in subsection B affect the terms of the license or the continuing eligibility for a license. An inspector may inspect the nursing facility during the process of evaluating a proposed change.</u></p> <p>INTENT: The intent of the change is to create a consistent list of what changes VDH needs to be aware of, when those changes are reportable, and what changes can result in a changed license versus a new license.</p> <p>RATIONALE: The rationale for the change is that transfer or assignment of licenses are prohibited by law, that certain license changes may require a new license, a new inspection (in the case of a change of location), or both, and that VDH needs to be aware of nursing facilities' active service lines for disaster preparedness planning and implementation.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for nursing facilities and VDH about when and what changes are reportable, and what changes warrant a new license.</p>
371-110	N/A	<p>12VAC5-371-110. Management administration. and</p> <p style="text-align: center;">* * *</p>	<p>CHANGE: The Board is proposing the following change:</p>

	<p>D. The nursing facility shall submit, in a timely manner as determined by the OLC, and implement a written plan of action to correct any noncompliance with these regulations identified during an inspection. The plan shall include:</p> <ol style="list-style-type: none"> 1. Description of the corrective action or actions to be taken; 2. Date of completion for each action; and 3. Signature of the person responsible for the operation. <p>E. The nursing facility shall permit representatives from the OLC to conduct inspections to...</p> <p>F. A nursing facility shall give written notification 30 calendar days in advance of implementation of changes affecting the accuracy of the license. Changes affecting the accuracy of the license are:</p> <ol style="list-style-type: none"> 1. Address; 2. Operator; 3. Name of the nursing facility; 4. Any proposed change in management contract or lease agreement to operate the nursing facility; 5. Implementing any proposed addition, deletion, or change in nursing facility services whether or not licensure is required; 6. A change in ownership; or 7. Bed capacity. 	<p>12VAC5-371-110. Management and administration.</p> <p style="text-align: center;">* * *</p> <p>D. The nursing facility shall submit, in a timely manner as determined by the OLC, and implement a written plan of action to correct any noncompliance with these regulations identified during an inspection. The plan shall include:</p> <ol style="list-style-type: none"> 1. Description of the corrective action or actions to be taken; 2. Date of completion for each action; and 3. Signature of the person responsible for the operation. <p>E. D. The nursing facility shall permit representatives from the OLC to conduct inspections to...</p> <p>F. A nursing facility shall give written notification 30 calendar days in advance of implementation of changes affecting the accuracy of the license. Changes affecting the accuracy of the license are:</p> <ol style="list-style-type: none"> 1. Address; 2. Operator; 3. Name of the nursing facility; 4. Any proposed change in management contract or lease agreement to operate the nursing facility; 5. Implementing any proposed addition, deletion, or change in nursing facility services whether or not licensure is required; 6. A change in ownership; or 7. Bed capacity. <p>Notices shall be sent to the attention of the director of the OLC.</p> <p>G. The current license from the commissioner shall be posted in a place clearly visible to the general public.</p> <p>H. E. The nursing facility shall fully disclose...</p> <p>I. F. The nursing facility shall identify...</p> <p>J. G. Unless the vaccination is medically contraindicated or the resident declines the offer of vaccination, The the nursing facility shall provide, or arrange</p>
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		<p>Notices shall be sent to the attention of the director of the OLC.</p> <p>G. The current license from the commissioner shall be posted in a place clearly visible to the general public.</p> <p>H. The nursing facility shall fully disclose...</p> <p>I. The nursing facility shall identify...</p> <p>J. The nursing facility shall provide, or arrange for, the administration to its residents of an annual influenza vaccination and a pneumonia vaccination according to the "Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2020–21 Influenza Season" and "Guidelines for Preventing Health-Care-Associated Pneumonia" from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, unless the vaccination is medically contraindicated or the resident declines the vaccination offer.</p> <p>K. Upon request of the nursing facility's family council, the nursing facility shall...</p>	<p>for, the administration to its residents of an annual influenza vaccination and a pneumonia pneumococcal vaccination according in accordance with the following recommendations of ACIP: to the "Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2020–21 Influenza Season" and "Guidelines for Preventing Health-Care-Associated Pneumonia" from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, unless the vaccination is medically contraindicated or the resident declines the vaccination offer.</p> <ol style="list-style-type: none"> 1. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2022–23 Influenza Season, MMWR 71 (1), 2022, CDC; 2. Use of 15-Valent Pneumococcal Conjugate Vaccine and 20-Valent Pneumococcal Conjugate Vaccine Among U.S. Adults: Updated Recommendations of ACIP — United States, MMWR 71 (4), 2022, CDC; 3. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Adults Aged >65 Years: Updated Recommendations of ACIP, MMWR 68 (46), 2019, CDC; 4. Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of ACIP, MMWR 64 (15), 2015, CDC; 5. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Adults Aged >65 Years: Recommendations of
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			<p>ACIP, MMWR 63 (37), 2014, CDC;</p> <p>6. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Children Aged 6–18 Years with Immunocompromising Conditions: Recommendations of ACIP, MMWR 62 (25), 2013, CDC;</p> <p>7. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine for Adults with Immunocompromising Conditions: Recommendations of ACIP, MMWR 61 (40), 2012, CDC;</p> <p>8. Prevention of Pneumococcal Disease Among Infants and Children — Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine: Recommendations of ACIP, MMWR 59 (RR-11), 2010, CDC; and</p> <p>9. Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23), MMWR 59 (34), 2010, CDC.</p> <p>H. Upon request of the nursing facility's family council, the nursing facility shall...</p> <p>INTENT: The intent of the changes is to remove duplicative requirements and to update references to current immunization guidelines.</p> <p>RATIONALE: The rationale for the changes is that the duplicative material is addressed earlier in 12VAC5-371 and that the regulation should be consistent with Chapter 762 of the 2004 Acts of Assembly.</p>
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371-150	N/A	<p>12VAC5-371-150. Resident rights.</p> <p style="text-align: center;">* * *</p> <p>G. The nursing facility shall register with the Department of State Police to receive notice of the registration or reregistration of any sex offender within the same or a contiguous zip code area in which the nursing facility is located pursuant to § 9.1-914 of the Code of Virginia.</p> <p>H. Prior to admission, each nursing facility shall determine if a potential resident is a registered sex offender when the potential resident is anticipated to have a length of stay:</p> <ol style="list-style-type: none"> 1. Greater than three days; or 2. In fact stays longer than three days. <p style="text-align: center;">* * *</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-371-150. Resident rights.</p> <p style="text-align: center;">* * *</p> <p>G. The nursing facility shall register with the Department of State Police to receive notice of the registration, or reregistration, or verification of any sex offender <u>person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 of the Code of Virginia</u> within the same or a contiguous zip code area in which the nursing facility is located pursuant to § 9.1-914 of the Code of Virginia.</p> <p>H. Prior to admission, each nursing facility shall determine <u>ascertain</u> if a potential resident is a registered sex offender <u>required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§9.1-900 et seq.) of Title 9.1 of the Code of Virginia</u> when if <u>if</u> the potential resident is anticipated to have a length of stay:</p> <ol style="list-style-type: none"> 1. <u>Is anticipated by the nursing facility to have a length of stay Greater greater</u> than three days; or 2. In fact stays longer than three days. <p style="text-align: center;">* * *</p> <p>INTENT: The intent of the change is to describe the minimum requirements a nursing facility must meet in regards to the Sex Offender and Crimes Against Minors Registry.</p> <p>RATIONALE: The rationale for the change is that the regulation should be consistent with Chapter 829 of the 2020 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for nursing</p>

			<p>facilities about the minimum requirements regarding the Sex Offender and Crimes Against Minors Registry.</p>
<p>371-180</p>	<p>N/A</p>	<p>12VAC5-371-180. Infection control.</p> <p style="text-align: center;">* * *</p> <p>E. During a declared public health emergency related to a communicable disease of public health threat, the nursing facility shall establish a protocol to allow residents to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect consistent with guidance from the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services and subject to compliance with any executive order, order of public health, department guidance, or any other applicable federal or state guidance having the effect of limiting visitation.</p> <p style="text-align: center;">* * *</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-371-180. Infection control.</p> <p style="text-align: center;">* * *</p> <p>E. During a declared public health emergency related to a communicable disease of public health threat, the nursing facility shall establish a protocol to allow residents to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect consistent with guidance from the Centers for Disease Control and Prevention <u>CDC</u> and the Centers for Medicare and Medicaid Services <u>CMS</u> and subject to compliance with any executive order, order of public health, department guidance, or any other applicable federal or state guidance having the effect of limiting visitation.</p> <p style="text-align: center;">* * *</p> <p><u>F. During a public health emergency related to COVID-19, a nursing facility shall establish a protocol to allow each resident to receive visits, consistent with guidance from the CDC and as directed by CMS and the board, which shall include:</u></p> <p><u>1.Provisions describing:</u></p> <p style="padding-left: 20px;"><u>a. The conditions, including conditions related to the presence of COVID-19 in the nursing facility and community, under which in-person visits will be allowed and under which in-person visits will not be allowed and visits will be required to be virtual;</u></p> <p style="padding-left: 20px;"><u>b. The requirements with which in-person visitors will be required to comply to protect the health and safety of the residents and staff of the nursing facility;</u></p> <p style="padding-left: 20px;"><u>c. The types of technology, including interactive audio or</u></p>

			<p><u>video technology, and the staff support necessary to ensure visits are provided as required by this subsection; and</u></p> <p><u>d. The steps the nursing facility will take in the event of a technology failure, service interruption, or documented emergency that prevents visits from occurring as required by this subsection;</u></p> <p><u>2. A statement of the frequency with which visits, including virtual and in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each resident;</u></p> <p><u>3. A provision authorizing a resident or the resident's personal representative to waive or limit visitation, provided that such waiver or limitation is included in the resident's health record; and</u></p> <p><u>4. A requirement that the nursing facility publish on its website or communicate to each resident or the resident's authorized representative, in writing or via electronic means, the nursing facility's plan for providing visits to residents as required by this subsection.</u></p> <p>INTENT: The intent of the change is to describe the minimum requirements a nursing facility must meet in regards to visitation during certain public health emergencies.</p> <p>RATIONALE: The rationale for the change is that the regulation should be consistent with Chapters 10 and 11 of the 2020 Acts of Assembly, Special Session I.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for nursing facilities about the minimum requirements for visitation during a future public health emergency.</p>
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<p>371-300</p>	<p>N/A</p>	<p>12VAC5-371-300. Pharmaceutical services.</p> <p style="text-align: center;">* * *</p> <p>E. Excluding cannabidiol oil and THC-A oil, no drug or medication shall be administered to any resident without a valid verbal order or a written, dated and signed order from a physician, dentist, podiatrist, nurse practitioner, or physician assistant, licensed in Virginia.</p> <p>F. Nursing facility employees who are authorized to possess, distribute, or administer medications to residents may store, dispense, or administer cannabidiol oil or THC-A oil to a resident who has:</p> <p style="padding-left: 40px;">1. Been issued a valid written certification for the use of cannabidiol oil or THC-A oil in accordance with subsection B of § 54.1-3408.3 of the Code of Virginia; and</p> <p style="text-align: center;">* * *</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-371-300. Pharmaceutical services.</p> <p style="text-align: center;">* * *</p> <p>E. Excluding cannabidiol oil and THC-A <u>cannabis</u> oil, no drug or medication shall be administered to any resident without a valid verbal order or a written, dated and signed order from a physician, dentist, podiatrist, nurse practitioner, or physician assistant, licensed in Virginia.</p> <p>F. Nursing facility employees who are authorized to possess, distribute, or administer medications to residents may store, dispense, or administer cannabidiol oil or THC-A <u>cannabis</u> oil to a resident who has:</p> <p style="padding-left: 40px;">1. Been issued a valid written certification for the use of cannabidiol oil or THC-A <u>cannabis</u> oil in accordance with subsection B of § 54.1-3408.3 of the Code of Virginia; and</p> <p style="text-align: center;">* * *</p> <p>INTENT: The intent of the change is to match regulatory language to statutory language.</p> <p>RATIONALE: The rationale for the change is that the regulation should be consistent with Chapter 1278 of the 2020 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion for nursing facilities about the correct terminology for cannabis oil.</p>
<p>371-410</p>	<p>N/A</p>	<p>12VAC5-371-410. Architectural drawings and specifications.</p> <p>A. All construction of new buildings and <u>all</u> additions, renovations, <u>or</u> alterations, or repairs of existing buildings for occupancy as a nursing facility shall conform to state and local codes, zoning</p>	<p>CHANGE: The Board is proposing the following change:</p> <p>12VAC5-371-410. Architectural drawings and specifications.</p> <p>A. All construction of new buildings and <u>all</u> additions, renovations, <u>or</u> alterations, or repairs of existing buildings for occupancy as a nursing facility shall conform to state and local codes, zoning</p>

		<p>ordinances, and the Virginia Uniform Statewide Building Code (13VAC5-63).</p> <p>In addition, nursing facilities shall be designed and constructed consistent with Parts 1 and 2 and section Chapter <u>Chapter 3.1</u> of Part 3 of the 2018 <u>2022</u> Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, <u>2022 Edition of the (The Facility Guidelines Institute), as amended by the August 2022 Errata for Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, 2022 Edition (The Facilities Guidelines Institute) pursuant to § 32.1-127.001 of the Code of Virginia.</u></p> <p>B. ...The architect shall certify that the drawings and specifications were prepared to conform to the Virginia Uniform Statewide Building Code and be consistent with Parts 1 and 2 and section Chapter <u>Chapter 3.1</u> of Part 3 of the 2018 <u>2022</u> Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, <u>2022 edition of the (The Facility Guidelines Institute), as amended by the August 2022 Errata for Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, 2022 Edition (The Facilities Guidelines Institute).</u></p> <p style="text-align: center;">* * *</p>	<p>ordinances, and the Virginia Uniform Statewide Building Code (13VAC5-63).</p> <p>In addition, nursing facilities shall be designed and constructed consistent with Parts 1 and 2 and section Chapter <u>Chapter 3.1</u> of Part 3 of the 2018 <u>2022</u> Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, <u>2022 Edition of the (The Facility Guidelines Institute), as amended by the August 2022 Errata for Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, 2022 Edition (The Facilities Guidelines Institute) pursuant to § 32.1-127.001 of the Code of Virginia.</u></p> <p>B. ...The architect shall certify that the drawings and specifications were prepared to conform to the Virginia Uniform Statewide Building Code and be consistent with Parts 1 and 2 and section Chapter <u>Chapter 3.1</u> of Part 3 of the 2018 <u>2022</u> Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, <u>2022 edition of the (The Facility Guidelines Institute), as amended by the August 2022 Errata for Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, 2022 Edition (The Facilities Guidelines Institute).</u></p> <p style="text-align: center;">* * *</p> <p>INTENT: The intent of the change is to update the design and construction guidelines to the recently published 2022 edition.</p> <p>RATIONALE: The rationale for the change is that the regulation should be in conformity with the mandates in Chapters 177 and 222 of the 2005 Acts of Assembly.</p> <p>LIKELY IMPACT: The likely impact of the change is reduced confusion about which edition of the FGI guidelines nursing facilities should reference.</p>
371-DIBR	N/A	<p>Documents Incorporated by Reference (12VAC5-371)</p> <p>Guidelines for Design and Construction of Residential</p>	<p>CHANGE: The Board is proposing the following change:</p>

		<p>Health, Care, and Support Facilities, 2018 Edition, Facility Guidelines Institute http://www.fgiguideines.org.</p> <p>Guidelines for Preventing Health-Care-Associated Pneumonia, 2003, MMWR 53 (RR-3), Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention.</p> <p>Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2020–21 Influenza Season, 2020, MMWR 69 (RR-8), Centers for Disease Control and Prevention.</p>	<p>Documents Incorporated by Reference (12VAC5-371)</p> <p>Errata for Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, The Facilities Guidelines Institute, 2022 Edition, https://fgiguideines.org/guidelines/errata-addenda/ (eff. 8/2022).</p> <p>Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, The Facilities Guidelines Institute, 2018 2022 Edition, Facility Guidelines Institute http://www.fgiguideines.org.</p> <p>Guidelines for Preventing Health-Care-Associated Pneumonia, 2003, MMWR 53 (RR-3), Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention.</p> <p>Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2020–21 Influenza Season, 2020, MMWR 69 (RR-8), Centers for Disease Control and Prevention.</p> <p>Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of ACIP, MMWR 64 (15), 2015, CDC.</p> <p>Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2022–23 Influenza Season, MMWR 71 (1), 2022, CDC.</p> <p>Prevention of Pneumococcal Disease Among Infants and Children — Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine: Recommendations of ACIP, MMWR 59 (RR-11), 2010, CDC.</p> <p>Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23), MMWR 59 (34), 2010, CDC.</p>
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			<p><u>Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Adults Aged >65 Years: Recommendations of ACIP, MMWR 63 (37), 2014, CDC.</u></p> <p><u>Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Adults Aged >65 Years: Updated Recommendations of ACIP, MMWR 68 (46), 2019, CDC.</u></p> <p><u>Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine for Adults with Immunocompromising Conditions: Recommendations of ACIP, MMWR 61 (40), 2012, CDC.</u></p> <p><u>Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Children Aged 6–18 Years with Immunocompromising Conditions: Recommendations of ACIP, MMWR 62 (25), 2013, CDC.</u></p> <p><u>Use of 15-Valent Pneumococcal Conjugate Vaccine and 20-Valent Pneumococcal Conjugate Vaccine Among U.S. Adults: Updated Recommendations of ACIP — United States, MMWR 71 (4), 2022, CDC.</u></p> <p>INTENT: The intent of these proposed changes is to ensure documents incorporated by reference are current and accurate.</p> <p>RATIONALE: The rationale behind these proposed changes is that nursing facilities should be held to current standards and guidelines.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is improved resident health and safety at nursing facilities.</p>
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1 **Project 6021 - Fast-Track**

2 **Department of Health**

3 **Amend Regulation to Incorporate Chapter 72 (2021 Acts of Assembly, Special Session I),**
4 **Chapters 829, 1080, and 1081 (2020 Acts of Assembly), Chapters 10 and 11 (2020 Acts of**
5 **Assembly, Special Session I), Chapters 177 and 222 (2005 Acts of Assembly) and**
6 **Chapter 762 (2004 Acts of Assembly), Update Terms to Match Statutory Language, and**
7 **Update Licensure Provisions**

8 **12VAC5-371-10. Definitions.**

9 The following words and terms when used in this chapter shall have the following meanings
10 unless the context clearly indicates otherwise:

11 "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or
12 punishment with resulting physical harm, pain or mental anguish, or deprivation by an individual,
13 including caretaker, of goods or services that are necessary to attain or maintain physical,
14 mental, and psychosocial well-being. This includes verbal, sexual, physical, or mental abuse.

15 "ACIP" means the Advisory Committee on Immunization Practices of the CDC.

16 "Administrator" means the individual licensed by the Virginia Board of Long-Term Care
17 Administrators and who has the necessary authority and responsibility for management of the
18 nursing facility.

19 "Admission" means the process of acceptance into a nursing facility, including orientation,
20 rules and requirements, and assignment to appropriate staff. Admission does not include
21 readmission to the facility after a temporary absence.

22 "Advance directive" means (i) a witnessed written document, voluntarily executed by the
23 declarant in accordance with the requirements of § 54.1-2983 of the Code of Virginia, or (ii) a
24 witnessed oral statement, made by the declarant subsequent to the time he is diagnosed as
25 suffering from a terminal condition and in accordance with the provision of § 54.1-2983 of the
26 Code of Virginia.

27 "Assessment" means the process of evaluating a resident for the purpose of developing a
28 profile on which to base services. Assessment includes information gathering, both initially and
29 on an ongoing basis, designed to assist the multi-disciplinary staff in determining the resident's
30 need for care, and the collection and review of resident-specific data.

31 "Attending physician" means a physician currently licensed by the Virginia Board of
32 Medicine and identified by the resident, or legal representative, as having the primary
33 responsibility in determining the delivery of the resident's medical care.

34 "Barrier crime" means any offense set forth in clause (i) of the definition of barrier crime in §
35 19.2-392.02 of the Code of Virginia.

36 "Board" means the Board of Health.

37 "Business day" means any day that is not a Saturday, Sunday, legal holiday, or day on
38 which the OLC is closed. For the purposes of this chapter, any day on which the Governor
39 authorizes the closing of the state government shall be considered a legal holiday.

40 ~~"Cannabidiol oil"~~ "Cannabis oil" means the same as the term is defined in subsection A of §
41 54.1-3408.3 of the Code of Virginia.

42 "CDC" means the Centers for Disease Control and Prevention.

43 "Certified nurse aide" means the title that can only be used by individuals who have met the
44 requirements to be certified, as defined by the Virginia Board of Nursing, and who are listed in
45 the nurse aide registry.

46 "Chemical restraint" means a psychopharmacologic drug (a drug prescribed to control
47 mood, mental status, or behavior) that is used for discipline or convenience and not required to
48 treat medical symptoms or symptoms from mental illness or mental retardation that prohibit an
49 individual from reaching his highest level of functioning.

50 "Clinical record" means the documentation of health care services, whether physical or
51 mental, rendered by direct or indirect resident-provider interactions. An account compiled by
52 physicians and other health care professionals of a variety of resident health information, such
53 as assessments and care details, including testing results, medicines, and progress notes.

54 "CMS" means the Centers for Medicare and Medicaid Services.

55 "Commissioner" means the State Health Commissioner.

56 "Complaint" means any allegation received by the Department of Health other than an
57 incident reported by the facility staff. Such allegations include abuse, neglect, exploitation, or
58 violation of state or federal laws or regulations.

59 "Comprehensive plan of care" means a written action plan, based on assessment data, that
60 identifies a resident's clinical and psychosocial needs, the interventions to meet those needs,
61 treatment goals that are measurable and that documents the resident's progress toward
62 meeting the stated goals.

63 "Construction" means the building of a new nursing facility or the expansion, remodeling, or
64 alteration of an existing nursing facility and includes the initial and subsequent equipping of the
65 facility.

66 "Criminal record report" means either the criminal record clearance with respect to
67 convictions for barrier crimes or the criminal history record from the Central Criminal Records
68 Exchange of the Virginia Department of State Police.

69 "Department" means the Virginia Department of Health.

70 "Dignity" means staff, in their interactions with residents, carry out activities which assist a
71 resident in maintaining and enhancing the resident's self-esteem and self-worth.

72 "Discharge" means the process by which the resident's services, delivered by the nursing
73 facility, are terminated.

74 "Discharge summary" means the final written summary of the services delivered, goals
75 achieved and post-discharge plan or final disposition at the time of discharge from the nursing
76 facility. The discharge summary becomes a part of the clinical record.

77 "Drug" means (i) articles or substances recognized in the official United States "Drug"
78 Pharmacopoeia National Formulary or official Homeopathic Pharmacopoeia of the United
79 States, or any supplement to any of them; (ii) articles or substances intended for the use in the
80 diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animal; (iii)
81 articles or substances, other than food, intended to affect the structure or any function of the
82 body of man or other animal; and (iv) articles or substances intended for use as a component of
83 any article specified in clause (i), (ii), or (iii). This does not include devices or their components,
84 parts or accessories.

85 "Electronic monitoring" means an unmanned video recording system with or without audio
86 capability installed in the room of a resident.

87 "Emergency preparedness plan" means a component of a nursing facility's safety
88 management program designed to manage the consequences of natural disasters or other
89 emergencies that disrupt the nursing facility's ability to provide care.

90 "Employee" means a person who performs a specific job function for financial remuneration
91 on a full-time or part-time basis.

92 "Facility-managed" means an electronic monitoring system that is installed, controlled, and
93 maintained by the nursing facility with the knowledge of the resident or legal representative in
94 accordance with the facility's policies.

95 "Full-time" means a minimum of 35 hours or more worked per week in the nursing facility.

96 "Inspector" means an individual employed by or contracted by the department and
97 designated by the commissioner to conduct inspections, investigations, or evaluations.

98 "Intelligent personal assistant" means a combination of an electronic device and a
99 specialized software application designed to assist users with basic tasks using a combination
100 of natural language processing and artificial intelligence, including such combinations known as
101 digital assistants or virtual assistants.

102 "Legal representative" means a person legally responsible for representing or standing in
103 the place of the resident for the conduct of his affairs. This may include a guardian, conservator,
104 attorney-in-fact under durable power of attorney, trustee, or other person expressly named by a
105 court of competent jurisdiction or the resident as his agency in a legal document that specifies
106 the scope of the representative's authority to act. A legal representative may only represent or
107 stand in the place of a resident for the function for which he has legal authority to act.

108 "Licensee" means a person that has received and maintains an active license under the
109 provisions of Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia and
110 this chapter.

111 "Medication" means any substance, whether prescription or over-the-counter drug, that is
112 taken orally or injected, inserted, topically applied, or otherwise administered.

113 "Neglect" means a failure to provide timely and consistent services, treatment, or care to a
114 resident necessary to obtain or maintain the resident's health, safety, or comfort or a failure to
115 provide timely and consistent goods and services necessary to avoid physical harm, mental
116 anguish, or mental illness.

117 "Nursing facility" means any nursing home as defined in § 32.1-123 of the Code of Virginia.

118 "OLC" means the Office of Licensure and Certification of the Virginia Department of Health.

119 "Person" means any individual, corporation, partnership, association, trust, or other legal
120 entity, whether governmental or private, owning, managing, or operating a nursing facility.

121 "Physical restraint" means any manual method or physical or mechanical device, material,
122 or equipment attached or adjacent to the resident's body that the individual cannot remove
123 easily which restricts freedom of movement or normal access to one's own body.

124 "Policy" means a written statement that describes the principles and guides and governs the
125 activities, procedures and operations of the nursing facility.

126 "Procedures" means a series of activities designed to implement program goals or policy,
127 which may or may not be written, depending upon the specific requirements within this chapter.
128 For inspection purposes, there must be evidence that procedures are actually implemented.

129 "Progress note" means a written statement, signed and dated by the person delivering the
130 care, consisting of a pertinent, chronological report of the resident's care. A progress note is a
131 component of the clinical record.

132 "Qualified" means meeting current legal requirements of licensure, registration or
133 certification in Virginia; having appropriate training and experience commensurate with assigned
134 responsibilities; or, if referring to a professional, possessing an appropriate degree or having
135 documented equivalent education, training or experience.

136 "Quality assurance" means systematic activities performed to determine the extent to which
137 clinical practice meets specified standards and values with regard to such things as
138 appropriateness of service assignment and duration, appropriateness of facilities and resources

139 utilized, adequacy and clinical soundness of care given. Such activities should also assure
140 changes in practice that do not meet accepted standards. Examples of quality assurance
141 activities include the establishment of facility-wide goals for resident care, the assessment of the
142 procedures used to achieve the goals, and the proposal of solutions to problems in attaining
143 those goals.

144 "Readmission" means a planned return to the nursing facility following a temporary absence
145 for hospitalization, off-site visit or therapeutic leave, or a return stay or confinement following a
146 formal discharge terminating a previous admission.

147 "Resident" means the primary service recipient, admitted to the nursing facility, whether that
148 person is referred to as a client, consumer, patient, or other term.

149 "Resident-managed" means an electronic monitoring system that is installed, controlled, and
150 maintained by the resident with the knowledge of the nursing facility.

151 "Supervision" means the ongoing process of monitoring the skills, competencies and
152 performance of the individual supervised and providing regular, face-to-face guidance and
153 instruction.

154 "Sworn disclosure" means a written statement or affirmation disclosing any criminal
155 convictions or any pending criminal charges, whether within or outside the Commonwealth, by
156 an applicant for compensated employment with a nursing facility.

157 ~~"THC-A oil" means the same as the term is defined in subsection A of § 54.1-3408.3 of the~~
158 ~~Code of Virginia.~~

159 "Volunteer" means a person who, without financial remuneration, provides services to the
160 nursing facility.

161 **Statutory Authority**

162 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

163 **Historical Notes**

164 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia
165 Register Volume 23, Issue 10, eff. March 1, 2007; Volume 26, Issue 26, eff. September 30,
166 2010; Volume 35, Issue 5, eff. December 13, 2018; Volume 36, Issue 23, eff. August 6, 2020;
167 Volume 37, Issue 17, eff. May 27, 2021; Volume 38, Issue 4, eff. November 11, 2021.

168 **12VAC5-371-30. License.**

169 A. This chapter is not applicable to:

- 170 1. Those entities listed in § 32.1-124 of the Code of Virginia; and
- 171 2. Facilities established or operated for the practice of religious tenets pursuant to §
172 32.1-128 of the Code of Virginia, except that such facilities shall comply with the statutes
173 and regulations on environmental protection and life safety.

174 B. A license to operate a nursing facility is shall be issued to a person ~~or organization.~~ ~~An~~
175 ~~organization may be a partnership, association, corporation, or public entity.~~

176 C. Each license shall expire at midnight December 31 of the year issued ~~and renewal~~
177 ~~thereof shall be issued for one year.~~ A nursing facility shall operate within the terms of its
178 license, which include the:

- 179 1. Name of the nursing facility;
- 180 2. Name of the operator;
- 181 3. Physical location of the nursing facility;
- 182 4. Maximum number of beds allowed, except as provide in 12VAC5-371-40 G; and
- 183 5. Date the license expires.

184 D. A separate license shall be required for nursing facilities maintained on separate
185 premises, even though they are owned or are operated under the same management.

186 E. Every nursing facility shall be designated by a permanent and unique name.

187 F. The number of resident beds allowed in a nursing facility shall be determined by the
188 ~~department commissioner. Requests to increase beds must be made in writing and must~~
189 ~~include an approved Certificate of Public Need, except as provided in 12VAC5-371-40-G.~~

190 G. ~~Nursing facility~~ Long-term care nursing units located in and operated by hospitals shall be
191 licensed under Regulations for the Licensure of Hospitals in Virginia (12VAC5-410). Approval
192 for such units shall be included on the annual license issued to each hospital.

193 H. Any person establishing, conducting, maintaining, or operating a nursing facility without a
194 license shall be guilty of a Class 6 felony.

195 I. The licensee shall at all times:

196 1. Maintain an active and accurate license; and

197 2. Post its current license in a place readily visible and accessible to the public at the
198 nursing facility.

199 **Statutory Authority**

200 §§ 32.1-12 , 32.1-125 and 32.1-127 of the Code of Virginia.

201 **Historical Notes**

202 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia
203 Register Volume 23, Issue 10, eff. March 1, 2007; Volume 35, Issue 24, eff. August 23, 2019;
204 Volume 37, Issue 17, eff. May 27, 2021.

205 **12VAC5-371-55. Plan of correction.**

206 A. Upon receipt of a written inspection report, the administrator or his designee shall prepare
207 a written plan of correction addressing each licensing violation cited at the time of inspection.

208 B. The administrator or his designee shall submit to the OLC a written plan of correction no
209 more than 15 business days after receipt of the inspection report. The plan of correction shall
210 contain for each licensing violation cited:

211 1. A description of the corrective action or actions to be taken and the position title of the
212 employees to implement the corrective action. If employees share the same position
213 title, the administrator or his designee shall assign the employees a unique identifier to
214 distinguish them;

215 2. The expected correction date, not to exceed 45 business days from the exit date of
216 the inspection; and

217 3. A description of the measures implemented to prevent a recurrence of each licensing
218 violation.

219 C. The administrator or his designee shall ensure that the person responsible for the validity
220 of the plan of correction signs, dates, and indicates their title on the plan of correction.

221 D. The OLC shall notify the administrator or his designee if the OLC determines any item in
222 the plan of correction is unacceptable.

223 E. The OLC may conduct an inspection to verify any portion of a plan of correction has been
224 implemented.

225 F. The administrator or his designee shall ensure the plan of correction is implemented and
226 monitored so that compliance is maintained.

227 G. The commissioner may deny licensure or renewal of licensure if the administrator or his
228 designee fails to submit an acceptable plan of correction or fails to implement an acceptable
229 plan of correction.

230 H. The OLC shall consider the submission date of a plan of correction to be the date it is
231 postmarked or the date it is received, whichever is earlier.

232 **Statutory Authority**

233 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

234 **12VAC5-371-60. On-site inspections Inspection procedure.**

235 A. ~~The licensing representative~~ OLC shall make periodic unannounced on-site inspections
236 of the nursing facility as necessary but not less often than biennially. The OLC may make on-
237 site inspections of applicants for licensure. The licensee shall be responsible for correcting any
238 deficiencies found during any on-site inspection. Compliance with all standards will shall be
239 determined by the OLC.

240 B. The licensee or applicant shall:

241 1. make ~~Make~~ available to the licensing representative inspector any necessary
242 requested records;

243 2. Permit an inspector to enter upon and into its property to inspect or investigate as the
244 inspector reasonably deems necessary in order to determine the state of compliance
245 with the provisions of this chapter and all laws administered by the board; and

246 3. Allow the inspector access to interview the agents, employees, independent
247 contractors, residents, legal representatives, resident's family members, and any person
248 under the licensee's or applicant's control, direction, or supervision.

249 ~~C. The licensee shall also allow the licensing representative to interview the agents,~~
250 ~~employees, residents, family members, and any person under its custody, control, direction or~~
251 ~~supervision.~~

252 ~~D. C.~~ After the on-site inspection, the licensing representative inspector shall: ~~discuss the~~
253 findings of the inspection with the administrator or designee.

254 1. Discuss the findings of the inspection with the administrator or his designee; and

255 2. Provide a written inspection report to the administrator or his designee.

256 ~~E. As applicable, the administrator shall submit an acceptable plan for correcting any~~
257 ~~deficiencies found during an on-site inspection.~~

258 ~~F. The administrator will be notified whenever any item in the plan of correction is~~
259 ~~determined to be unacceptable.~~

260 ~~G. The administrator shall be responsible for assuring the plan of correction is implemented~~
261 ~~and monitored so that compliance is maintained.~~

262 D. If the OLC cites one or more licensing violations in the written inspection report, the
263 administrator or his designee shall submit a plan of correction in accordance with 12VAC5-371-
264 55.

265 **Statutory Authority**

266 §§ 32.1-12 , ~~32.1-25~~, and 32.1-127 of the Code of Virginia.

267 **Historical Notes**

268 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia
269 Register Volume 23, Issue 10, eff. March 1, 2007; Volume 37, Issue 17, eff. May 27, 2021.

270 **12VAC5-371-70. Complaint investigation.**

271 ~~A. The OLC has the responsibility to shall investigate any complaints and shall determine if~~
272 ~~an investigation requires an on-site inspection. In making this determination, the OLC shall~~
273 ~~consider several factors, to include: regarding alleged violations of the standards or statutes and~~
274 ~~complaints of the abuse or neglect of persons in care. The Department of Social Services and~~
275 ~~the State Ombudsman are notified of complaints received.~~

- 276 1. If the complainant has first-hand knowledge of the alleged incident;
- 277 2. The nursing facility's regulatory history, including the number and severity of
- 278 substantiated prior complaints;
- 279 3. If the OLC has recently inspected the nursing facility and if the alleged incident would
- 280 have been reviewed during the prior inspection;
- 281 4. The nature of the complaint, including degree of potential serious harm to residents;
- 282 and
- 283 5. If the complaint may be investigated pursuant to Title XVIII or Title XIX of the Social
- 284 Security Act.

285 B. The OLC may request records from the licensee to assist in making a determination
 286 pursuant to subsection A of this section. The licensee shall provide the requested records no
 287 more than seven calendar days after OLC makes a request pursuant to this subsection.

288 ~~B. C. The OLC may receive Complaints~~ complaints may be received in written or oral form
 289 and may ~~be receive~~ receive anonymous complaints.

290 ~~C. D.~~ D. When the investigation is complete, the OLC shall notify the licensee and the
 291 complainant, if known, ~~will be notified~~ in writing of the findings of the investigation.

292 ~~D. E.~~ E. ~~As applicable, For any licensing violation cited during a complaint investigation,~~ the
 293 administrator or his designee shall submit ~~an acceptable a~~ a plan of correction for ~~correcting any~~
 294 ~~deficiencies found during a complaint investigation in accordance with 12VAC5-371-55.~~

295 ~~E. The administrator will be notified whenever any item in the plan of correction is~~
 296 ~~determined to be unacceptable.~~

297 ~~F. The administrator shall be responsible for assuring the plan of correction is implemented~~
 298 ~~and monitored so that compliance is maintained.~~

299 **Statutory Authority**

300 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

301 **Historical Notes**

302 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia
 303 Register Volume 23, Issue 10, eff. March 1, 2007; Volume 37, Issue 17, eff. May 27,
 304 2021.

305 **12VAC5-371-90. Administrative sanctions Disciplinary action.**

306 ~~A. Nothing in this part shall prohibit the department from exercising its responsibility and~~
 307 ~~authority to enforce the regulation, including proceeding directly to imposition of administrative~~
 308 ~~sanctions, when the quality of care or the quality of life has been severely compromised.~~

309 ~~B. The commissioner may impose such administrative sanctions or take such actions as are~~
 310 ~~appropriate for violation of any of the standards or statutes or for abuse or neglect of persons in~~
 311 ~~care. Such sanctions include:~~

- 312 ~~1. Restricting or prohibiting new admissions to any nursing facility;~~
- 313 ~~2. Petitioning the court to impose a civil penalty or to appoint a receiver, or both; or~~
- 314 ~~3. Revoking or suspending the license of a nursing facility.~~

315 ~~C. The following reasons may be considered by the department for the imposition of~~
 316 ~~administrative sanctions or the imposition of civil penalties:~~

- 317 ~~1. Failure to demonstrate or maintain compliance with applicable standards or for~~
 318 ~~violations of the provisions of the Code of Virginia;~~
- 319 ~~2. Permitting, aiding, or abetting the commission of any illegal act in the nursing facility;~~
 320 ~~or~~

321 ~~3. Deviating significantly from the program or services for which a license was issued~~
322 ~~without obtaining prior written approval from the OLC, or failure to correct such~~
323 ~~deviations within a specified time.~~

324 ~~D. Violations which in the judgment of the OLC jeopardize the health and safety of residents~~
325 ~~shall be sufficient cause for immediate imposition of this section.~~

326 ~~E. The licensee will receive a notice of the department's intent to impose sanctions. The~~
327 ~~notice shall describe the reasons for imposing the sanction.~~

328 ~~F. Upon receipt of the notice to impose a sanction, the licensee has the right and the~~
329 ~~opportunity to appeal according to the Administrative Process Act (§ 2.2-4000 et seq. of the~~
330 ~~Code of Virginia). The procedures for filing an appeal shall be outlined in the notice.~~

331 A. The licensee may not:

332 1. Violate the provisions of this chapter or Articles 1 (§ 32.1-123 et seq.) or 2 (§ 32.1-138
333 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia;

334 2. Permit, aid, or abet the commission of any illegal act in the nursing facility; or

335 3. Engage in a pattern of violations pursuant to § 38.2-3445.01 of the Code of Virginia.

336 B. The commissioner may:

337 1. For each violation of subsection A of this section:

338 a. Deny, revoke, or suspend the license to operate the nursing facility in accordance
339 with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia);

340 b. Restrict or prohibit new admissions to the nursing facility in accordance with the
341 Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia);

342 c. Refer the licensee for criminal prosecution pursuant to subsection A of § 32.1-27
343 of the Code of Virginia;

344 d. Petition an appropriate court for an injunction, mandamus, or other appropriate
345 remedy against the licensee pursuant to subsection B of § 32.1-27 of the Code of
346 Virginia;

347 e. Petition an appropriate court for imposition of a civil monetary penalty against the
348 licensee pursuant to subsection C of § 32.1-27 of the Code of Virginia or subsection
349 A of § 32.1-27.1 of the Code of Virginia; or

350 f. Petition an appropriate court for appointment of a receiver pursuant to subsection
351 B of § 32.1-27.1 of the Code of Virginia; and

352 2. For each violation of subdivision A 3 of this section, levy a fine upon the licensee in an
353 amount not to exceed \$1,000 per violation, in accordance with the Administrative
354 Process Acts (§ 2.2-4000 et seq. of the Code of Virginia).

355 C. Suspension of a license shall in all cases be for an indefinite time.

356 D. For each violation of subsection A of this section and with the consent of the person who
357 has violated subsection A of this section, the board may provide, in an order issued by the
358 board, for the payment of civil charges for past violations in specific sums, which may not
359 exceed the limits specified in §§ 32.1-27 or 32.1-27.1 of the Code of Virginia.

360 E. Upon receipt of a completed application and a nonrefundable service charge, the
361 commissioner may issue a new license to the licensee that has had its license revoked if the
362 commissioner determines that:

363 1. The conditions upon which revocation was based have been corrected; and

364 2. The applicant is in compliance with this chapter, Articles 1 (§ 32.1-123 et seq.) and 2
365 (§ 32.1-138 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia, and all other
366 applicable state and federal law and regulations.

367 F. Upon receipt of a completed application, the commissioner may partially or completely
368 restore a suspended license to the licensee if the commissioner determines that:

369 1. The conditions upon which suspension was based have been completely or partially
370 corrected; and

371 2. The interests of the public will not be jeopardized by resumption of operation.

372 G. The commissioner may not require an additional fee for restoring a license pursuant to
373 subsection F of this section.

374 H. The licensee shall submit evidence relevant to subdivisions E 1, E 2, F 1, and F 2 of this
375 section that is satisfactory to the commissioner or his designee. The commissioner or his
376 designee may conduct an inspection prior to making a determination.

377 **Statutory Authority**

378 §§ 32.1-12, 32.1-27, 32.1-27.1, and 32.1-127 of the Code of Virginia.

379 **Historical Notes**

380 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia
381 Register Volume 23, Issue 10, eff. March 1, 2007.

382 **12VAC5-371-100. Surrender of a license; mid-term change of license.**

383 A. Upon revocation or suspension of a license, the licensee ~~must~~ shall surrender its license
384 to a ~~representative of~~ the OLC.

385 ~~B. If a license is revoked, a new license may be issued by the commissioner after~~
386 ~~satisfactory evidence is submitted that the conditions upon which revocation was based have~~
387 ~~been corrected and after proper inspection has been made and compliance with this chapter~~
388 ~~and applicable state and federal law has been obtained.~~

389 ~~C. Suspension of a license shall in all cases be for an indefinite time. The commissioner~~
390 ~~may completely or partially restore a suspended license when he determines that the conditions~~
391 ~~upon which suspension was based have been completely or partially corrected and that the~~
392 ~~interests of the public will not be jeopardized by resumption of operation.~~

393 ~~D. Other circumstances under which a license must be surrendered include transfer of~~
394 ~~ownership and discontinuation of services. The licensee must notify the OLC, in writing, 30 days~~
395 ~~before discontinuing services.~~

396 B. A licensee shall notify the director of the OLC in writing by submitting a mid-term change
397 application no less than 30 calendar days in advance of implementing any:

398 1. Change of location of the nursing facility;

399 2. Change of ownership of the nursing facility;

400 3. Change of operator of the nursing facility;

401 4. Change of name of the nursing facility;

402 5. Change of bed capacity, except as provided in 12VAC5-371-40 G, which shall be
403 accompanied by an approved Certificate of Public Need if the requested change is for an
404 increase in bed capacity;

405 6. Change in management contract or lease agreement to operate the nursing facility;

406 7. Change of services being provided, including any proposed addition or
407 discontinuation, regardless of whether licensure is required for the service; or

408 8. Closure of the nursing facility.

409 C. The OLC shall:

410 1. Consider the submission date of a mid-term change application to be the date it is
411 postmarked or the date it is received, whichever is earlier; and

412 2. Notify in writing the licensee if the commissioner will issue a changed license.

413 D. The commissioner's issuance of changed license to the licensee shall satisfy the
414 requirements of subdivision C 2 of this section.

415 E Upon receipt of the changed license, the licensee shall surrender its prior license issued
416 by the commissioner to the OLC and destroy any copies of the prior license.

417 F. A license may not be transferred or assigned. The commissioner may not issue a
418 changed license in response to a change of operator of the nursing facility, but shall instead
419 require the nursing facility to obtain a new license. If the nursing facility intends to implement a
420 change of operator, it shall:

421 1. File for a new license, in accordance with 12VAC5-371-40, no less than 30 calendar
422 days in advance of any operator change; and

423 2. Upon receipt of the new license, surrender its prior license issued by the
424 commissioner to the OLC and destroy any copies of the prior license.

425 G. If the nursing facility is closing or will otherwise no longer be operational, it shall:

426 1. Notify residents, legal representatives, and the OLC no fewer than seven calendar
427 days prior to closing or ceasing operations where all clinical records are to be located
428 following closure or cessation of operations; and

429 2. Surrender its license to the OLC and destroy all copies of its license no more than five
430 calendar days after the nursing facility closes or ceases operations.

431 H. The OLC shall determine if any changes listed in subsection B affect the terms of the
432 license or the continuing eligibility for a license. An inspector may inspect the nursing facility
433 during the process of evaluating a proposed change.

434 **Statutory Authority**

435 §§ 32.1-12 , 32.1-125, and 32.1-127 of the Code of Virginia.

436 **Historical Notes**

437 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia
438 Register Volume 23, Issue 10, eff. March 1, 2007.

439 **12VAC5-371-110. Management and administration.**

440 A. No person shall own, establish, conduct, maintain, manage, or operate any nursing
441 facility, as defined in § 32.1-123 of the Code of Virginia, without having obtained a license.

442 B. The nursing facility must comply with:

443 1. These regulations (12VAC5-371);

444 2. Other applicable federal, state, or local laws and regulations; and

445 3. Its own policies and procedures.

446 C. The nursing facility shall submit, or make available, reports and information necessary to
447 establish compliance with these regulations and applicable statutes.

448 ~~D. The nursing facility shall submit, in a timely manner as determined by the OLC, and~~
449 ~~implement a written plan of action to correct any noncompliance with these regulations identified~~
450 ~~during an inspection. The plan shall include:~~

451 ~~1. Description of the corrective action or actions to be taken;~~

452 ~~2. Date of completion for each action; and~~

453 ~~3. Signature of the person responsible for the operation.~~

454 ~~E. D.~~ D. The nursing facility shall permit representatives from the OLC to conduct inspections
455 to:

456 1. Verify application information;

- 457 2. Determine compliance with this chapter;
458 3. Review necessary records; and
459 4. Investigate complaints.

460 ~~F. A nursing facility shall give written notification 30 calendar days in advance of~~
461 ~~implementation of changes affecting the accuracy of the license. Changes affecting the~~
462 ~~accuracy of the license are:~~

- 463 1. ~~Address;~~
464 2. ~~Operator;~~
465 3. ~~Name of the nursing facility;~~
466 4. ~~Any proposed change in management contract or lease agreement to operate the~~
467 ~~nursing facility;~~
468 5. ~~Implementing any proposed addition, deletion, or change in nursing facility services~~
469 ~~whether or not licensure is required;~~
470 6. ~~A change in ownership; or~~
471 7. ~~Bed capacity.~~

472 ~~Notices shall be sent to the attention of the director of the OLC.~~

473 ~~G. The current license from the commissioner shall be posted in a place clearly visible to the~~
474 ~~general public.~~

475 ~~H. E.~~ The nursing facility shall fully disclose its admission policies, including any preferences
476 given, to applicants for admission.

477 ~~I. F.~~ The nursing facility shall identify its operating elements and programs, the internal
478 relationship among these elements and programs, and the management or leadership structure.

479 ~~J. G. Unless the vaccination is medically contraindicated or the resident declines the offer of~~
480 ~~vaccination, The the nursing facility shall provide, or arrange for, the administration to its~~
481 ~~residents of an annual influenza vaccination and a pneumonia pneumococcal vaccination~~
482 ~~according in accordance with the following recommendations of ACIP: to the "Prevention and~~
483 ~~Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on~~
484 ~~Immunization Practices — United States, 2020–21 Influenza Season" and "Guidelines for~~
485 ~~Preventing Health-Care-Associated Pneumonia" from the Advisory Committee on Immunization~~
486 ~~Practices of the Centers for Disease Control and Prevention, unless the vaccination is medically~~
487 ~~contraindicated or the resident declines the vaccination offer.~~

488 1. [Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of](#)
489 [the Advisory Committee on Immunization Practices — United States, 2022–23 Influenza](#)
490 [Season, MMWR 71 \(1\), 2022, CDC;](#)

491 2. [Use of 15-Valent Pneumococcal Conjugate Vaccine and 20-Valent Pneumococcal](#)
492 [Conjugate Vaccine Among U.S. Adults: Updated Recommendations of ACIP — United](#)
493 [States, MMWR 71 \(4\), 2022, CDC;](#)

494 3. [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
495 [Polysaccharide Vaccine Among Adults Aged >65 Years: Updated Recommendations of](#)
496 [ACIP, MMWR 68 \(46\), 2019, CDC;](#)

497 4. [Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of ACIP,](#)
498 [MMWR 64 \(15\), 2015, CDC;](#)

499 5. [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
500 [Polysaccharide Vaccine Among Adults Aged >65 Years: Recommendations of ACIP,](#)
501 [MMWR 63 \(37\), 2014, CDC;](#)

502 [6. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
503 [Polysaccharide Vaccine Among Children Aged 6–18 Years with Immunocompromising](#)
504 [Conditions: Recommendations of ACIP, MMWR 62 \(25\), 2013, CDC;](#)

505 [7. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
506 [Polysaccharide Vaccine for Adults with Immunocompromising Conditions:](#)
507 [Recommendations of ACIP, MMWR 61 \(40\), 2012, CDC;](#)

508 [8. Prevention of Pneumococcal Disease Among Infants and Children — Use of 13-](#)
509 [Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide](#)
510 [Vaccine: Recommendations of ACIP, MMWR 59 \(RR-11\), 2010, CDC;](#) and

511 [9. Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among](#)
512 [Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine \(PPSV23\), MMWR](#)
513 [59 \(34\), 2010, CDC.](#)

514 K. H. Upon request of the nursing facility's family council, the nursing facility shall send
515 notices and information about the family council mutually developed by the family council and
516 the administration of the nursing facility, and provided to the nursing facility for such purpose, to
517 the legal representative or a contact person of the resident's choice up to six times a year. Such
518 notices may be included together with a monthly billing statement or other regular
519 communication. Notices and information shall also be posted in a designated location within the
520 nursing facility.

521 **Statutory Authority**

522 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

523 **Historical Notes**

524 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia
525 Register Volume 20, Issue 26, eff. September 27, 2004; Volume 23, Issue 10, eff. March 1,
526 2007; Volume 27, Issue 24, eff. September 1, 2011; Volume 37, Issue 17, eff. May 27,
527 2021.

528 **12VAC5-371-150. Resident rights.**

529 A. The nursing facility shall develop and implement policies and procedures that ensure
530 resident's rights as defined in §§ 32.1-138 and 32.1-138.1 of the Code of Virginia.

531 B. The procedures shall:

- 532 1. Not restrict any right a resident has under law;
- 533 2. Provide staff training to implement resident's rights; and
- 534 3. Include grievance procedures.

535 C. The name and telephone number of the complaint coordinator of the OLC, the Adult
536 Protective Services toll-free telephone number, and the toll-free telephone number for the State
537 Ombudsman shall be conspicuously posted in a public place.

538 D. Copies of resident rights shall be given to residents upon admittance to the nursing
539 facility and made available to residents currently in residence, to legal representatives, next of
540 kin, or sponsoring agency or agencies, and to the public.

541 E. The nursing facility shall have a plan to review resident rights with each resident annually,
542 or with the legal representative at least annually, and have a plan to advise each staff member
543 at least annually.

544 F. The nursing facility shall certify, in writing, that it is in compliance with the provisions of §§
545 32.1-138 and 32.1-138.1 of the Code of Virginia, relative to resident rights, as a condition of
546 license issuance or renewal.

547 G. The nursing facility shall register with the Department of State Police to receive notice of
548 the registration, ~~or reregistration, or verification~~ of any ~~sex-offender~~ person required to register
549 with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et
550 seq.) of Title 9.1 of the Code of Virginia within the same or a contiguous zip code area in which
551 the nursing facility is located pursuant to § 9.1-914 of the Code of Virginia.

552 H. Prior to admission, each nursing facility shall ~~determine~~ ascertain if a potential resident is
553 ~~a registered sex-offender~~ required to register with the Sex Offender and Crimes Against Minors
554 Registry pursuant to Chapter 9 (§9.1-900 et seq.) of Title 9.1 of the Code of Virginia ~~when~~ if the
555 potential resident is ~~anticipated to have a length of stay:~~

556 1. Is anticipated by the nursing facility to have a length of stay ~~Greater~~ greater than three
557 days; or

558 2. In fact stays longer than three days.

559 I. The nursing facility shall not restrict the rights of a resident's family and legal
560 representative to meet in the nursing facility with the families and legal representatives of other
561 residents .

562 **Statutory Authority**

563 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

564 **Historical Notes**

565 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia
566 Register Volume 17, Issue 1, eff. October 27, 2000; Volume 23, Issue 10, eff. March 1, 2007;
567 Volume 24, Issue 11, eff. March 5, 2008; Volume 34, Issue 11, eff. February 21, 2018; Volume
568 37, Issue 17, eff. May 27, 2021.

569 **12VAC5-371-180. Infection control.**

570 A. The nursing facility shall establish and maintain an infection control program designed to
571 provide a safe, sanitary, and comfortable environment and to prevent the development and
572 transmission of disease and infection.

573 B. The infection control program shall encompass the entire physical plant and all services.

574 C. The infection control program addressing the surveillance, prevention and control of
575 infections in the nursing facility shall include:

576 1. Procedures to isolate the infecting organism;

577 2. Access to handwashing equipment for staff;

578 3. Training of staff in proper handwashing techniques, according to accepted
579 professional standards, to prevent cross contamination;

580 4. Implementation of universal precautions by direct resident care staff;

581 5. Prohibiting employees with communicable diseases or infections from direct contact
582 with residents or their food, if direct contact will transmit disease;

583 6. Monitoring staff performance of infection control practices;

584 7. Handling, storing, processing and transporting linens, supplies and equipment in a
585 manner that prevents the spread of infection;

586 8. Handling, storing, processing and transporting regulated medical waste in accordance
587 with applicable regulations;

588 9. Maintaining an effective pest control program; and

589 10. Staff education regarding infection risk-reduction behavior.

590 D. The nursing facility shall report promptly to its local health department diseases
591 designated as "reportable" according to 12VAC5-90-80 when such cases are admitted to or are

592 diagnosed in the nursing facility and shall report any outbreak of infectious disease as required
593 by 12VAC5-90. An outbreak is defined as an increase in incidence of any infectious disease
594 above the usual incidence at the nursing facility.

595 E. During a declared public health emergency related to a communicable disease of public
596 health threat, the nursing facility shall establish a protocol to allow residents to receive visits
597 from a rabbi, priest, minister, or clergy of any religious denomination or sect consistent with
598 guidance from the ~~Centers for Disease Control and Prevention~~ CDC and the ~~Centers for~~
599 ~~Medicare and Medicaid Services~~ CMS and subject to compliance with any executive order,
600 order of public health, department guidance, or any other applicable federal or state guidance
601 having the effect of limiting visitation.

602 1. Such protocol may restrict the frequency and duration of visits and may require visits
603 to be conducted virtually using interactive audio or video technology.

604 2. Any such protocol may require the person visiting a resident pursuant to this
605 subsection to comply with all reasonable requirements of the nursing facility adopted to
606 protect the health and safety of the person, residents, and staff of the nursing facility.

607 F. During a public health emergency related to COVID-19, a nursing facility shall establish a
608 protocol to allow each resident to receive visits, consistent with guidance from the CDC and as
609 directed by CMS and the board, which shall include:

610 1. Provisions describing:

611 a. The conditions, including conditions related to the presence of COVID-19 in the
612 nursing facility and community, under which in-person visits will be allowed and
613 under which in-person visits will not be allowed and visits will be required to be
614 virtual;

615 b. The requirements with which in-person visitors will be required to comply to
616 protect the health and safety of the residents and staff of the nursing facility;

617 c. The types of technology, including interactive audio or video technology, and the
618 staff support necessary to ensure visits are provided as required by this subsection;
619 and

620 d. The steps the nursing facility will take in the event of a technology failure, service
621 interruption, or documented emergency that prevents visits from occurring as
622 required by this subsection;

623 2. A statement of the frequency with which visits, including virtual and in-person, where
624 appropriate, will be allowed, which shall be at least once every 10 calendar days for
625 each resident;

626 3. A provision authorizing a resident or the resident's personal representative to waive or
627 limit visitation, provided that such waiver or limitation is included in the resident's health
628 record; and

629 4. A requirement that the nursing facility publish on its website or communicate to each
630 resident or the resident's authorized representative, in writing or via electronic means,
631 the nursing facility's plan for providing visits to residents as required by this subsection.

632 **Statutory Authority**

633 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

634 **Historical Notes**

635 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia
636 Register Volume 22, Issue 7, eff. January 11, 2006; Volume 37, Issue 17, eff. May 27, 2021;
637 Volume 38, Issue 4, eff. November 11, 2021.

638 **12VAC5-371-300. Pharmaceutical services.**

639 A. Provision shall be made for the procurement, storage, dispensing, and accounting of
640 drugs and other pharmacy products in compliance with 18VAC110-20. This may be by
641 arrangement with an off-site pharmacy, but must include provisions for 24-hour emergency
642 service.

643 B. Each nursing facility shall develop and implement policies and procedures for the
644 handling of drugs and biologicals, including procurement, storage, administration, self-
645 administration, and disposal of drugs.

646 C. Each nursing facility shall have a written agreement with a qualified pharmacist to provide
647 consultation on all aspects of the provision of pharmacy services in the nursing facility.

648 D. The consultant pharmacist shall make regularly scheduled visits, at least monthly, to the
649 nursing facility for a sufficient number of hours to carry out the function of the agreement.

650 E. Excluding ~~cannabidiol oil and THC-A~~ cannabis oil, no drug or medication shall be
651 administered to any resident without a valid verbal order or a written, dated and signed order
652 from a physician, dentist, podiatrist, nurse practitioner, or physician assistant, licensed in
653 Virginia.

654 F. Nursing facility employees who are authorized to possess, distribute, or administer
655 medications to residents may store, dispense, or administer ~~cannabidiol oil or THC-A~~ cannabis
656 oil to a resident who has:

657 1. Been issued a valid written certification for the use of ~~cannabidiol oil or THC-A~~
658 cannabis oil in accordance with subsection B of § 54.1-3408.3 of the Code of Virginia;
659 and

660 2. Registered with the Board of Pharmacy.

661 G. Verbal orders for drugs or medications shall only be given to a licensed nurse,
662 pharmacist, or physician.

663 H. Drugs and medications not limited as to time or number of doses when ordered shall be
664 automatically stopped, according to the written policies of the nursing facility, and the attending
665 physician shall be notified.

666 I. Each resident's medication regimen shall be reviewed by a pharmacist licensed by the
667 Virginia Board of Pharmacy. Any irregularities identified by the pharmacist shall be reported to
668 the physician and the director of nursing, and their response documented.

669 J. Medication orders shall be reviewed at least every 60 days by the attending physician,
670 nurse practitioner, or physician's assistant.

671 K. Prescription and nonprescription drugs and medications may be brought into the nursing
672 facility by a resident's family, friend, or other person provided:

673 1. The individual delivering the drugs and medications assures timely delivery, in
674 accordance with the nursing facility's written policies, so that the resident's prescribed
675 treatment plan is not disrupted;

676 2. Each drug or medication is in an individual container; and

677 3. Delivery is not allowed directly to an individual resident.

678 In addition, prescription medications shall be obtained and labeled as required by law.

679 **Statutory Authority**

680 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

681 **Historical Notes**

682 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia
683 Register Volume 22, Issue 7, eff. January 11, 2006; Volume 36, Issue 23, eff. August 6, 2020;
684 Volume 37, Issue 17, eff. May 27, 2021.

685 **12VAC5-371-410. Architectural drawings and specifications.**

686 A. All construction of new buildings and all additions, renovations, or alterations, ~~or repairs~~
687 of existing buildings for occupancy as a nursing facility shall conform to state and local codes,
688 zoning ordinances, and the Virginia Uniform Statewide Building Code (13VAC5-63).

689 In addition, nursing facilities shall be designed and constructed consistent with Parts 1 and 2
690 and ~~section~~ Chapter 3.1 of Part 3 of the ~~2018~~ Guidelines for Design and Construction of
691 Residential Health, Care, and Support Facilities, 2022 Edition of the (The Facility Guidelines
692 Institute), as amended by the August 2022 Errata for Guidelines for Design and Construction of
693 Residential Health, Care, and Support Facilities, 2022 Edition (The Facilities Guidelines
694 Institute) pursuant to ~~§ 32.1-127.001~~ of the Code of Virginia.

695 B. Architectural drawings and specifications for all new construction or for additions,
696 alterations or renovations to any existing building, shall be dated, stamped with professional
697 seal, and signed by the architect. The architect shall certify that the drawings and specifications
698 were prepared to conform to the Virginia Uniform Statewide Building Code and be consistent
699 with Parts 1 and 2 and ~~section~~ Chapter 3.1 of Part 3 of the ~~2018~~ Guidelines for Design and
700 Construction of Residential Health, Care, and Support Facilities, 2022 edition of the (The Facility
701 Guidelines Institute), as amended by the August 2022 Errata for Guidelines for Design and
702 Construction of Residential Health, Care, and Support Facilities, 2022 Edition (The Facilities
703 Guidelines Institute).

704 C. Additional approval may include a Certificate of Public Need.

705 D. Upon completion of the construction, the nursing facility shall maintain a complete set of
706 legible "as built" drawings showing all construction, fixed equipment, and mechanical and
707 electrical systems, as installed or built.

708 **Statutory Authority**

709 §§ ~~32.1-12~~, 32.1-127, and 32.1-127.001 of the Code of Virginia.

710 **Historical Notes**

711 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia
712 Register Volume 22, Issue 7, eff. January 11, 2006; Volume 23, Issue 10, eff. March 1, 2007;
713 Volume 26, Issue 22, eff. August 4, 2010; Volume 37, Issue 14, eff. March 31, 2021.

714 Documents Incorporated by Reference (12VAC5-371)

715 [Errata for Guidelines for Design and Construction of Residential Health, Care, and Support](https://fgiguilines.org/guidelines/errata-addenda/)
716 [Facilities, The Facilities Guidelines Institute, 2022 Edition,](https://fgiguilines.org/guidelines/errata-addenda/)
717 [https://fgiguilines.org/guidelines/errata-addenda/ \(eff. 8/2022\).](https://fgiguilines.org/guidelines/errata-addenda/)

718 [Guidelines for Design and Construction of Residential Health, Care, and Support Facilities,](http://www.fgiguilines.org)
719 [The Facilities Guidelines Institute, 2018 2022 Edition, Facility Guidelines Institute](http://www.fgiguilines.org)
720 [http://www.fgiguilines.org.](http://www.fgiguilines.org)

721 [Guidelines for Preventing Health-Care-Associated Pneumonia, 2003, MMWR 53 \(RR-3\),](#)
722 [Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention.](#)

723 [Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the](#)
724 [Advisory Committee on Immunization Practices — United States, 2020–21 Influenza Season,](#)
725 [2020, MMWR 69 \(RR-8\), Centers for Disease Control and Prevention.](#)

726 [Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of ACIP, MMWR 64](#)
727 [\(15\), 2015, CDC.](#)

728 [Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the](#)
729 [Advisory Committee on Immunization Practices — United States, 2022–23 Influenza Season,](#)
730 [MMWR 71 \(1\), 2022, CDC.](#)

731 [Prevention of Pneumococcal Disease Among Infants and Children — Use of 13-Valent](#)
732 [Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine:](#)
733 [Recommendations of ACIP, MMWR 59 \(RR-11\), 2010, CDC.](#)

734 [Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among](#)
735 [Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine \(PPSV23\), MMWR 59 \(34\),](#)
736 [2010, CDC.](#)

737 [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
738 [Polysaccharide Vaccine Among Adults Aged >65 Years: Recommendations of ACIP, MMWR 63](#)
739 [\(37\), 2014, CDC.](#)

740 [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
741 [Polysaccharide Vaccine Among Adults Aged >65 Years: Updated Recommendations of ACIP,](#)
742 [MMWR 68 \(46\), 2019, CDC.](#)

743 [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
744 [Polysaccharide Vaccine for Adults with Immunocompromising Conditions: Recommendations of](#)
745 [ACIP, MMWR 61 \(40\), 2012, CDC.](#)

746 [Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal](#)
747 [Polysaccharide Vaccine Among Children Aged 6–18 Years with Immunocompromising](#)
748 [Conditions: Recommendations of ACIP, MMWR 62 \(25\), 2013, CDC.](#)

749 [Use of 15-Valent Pneumococcal Conjugate Vaccine and 20-Valent Pneumococcal](#)
750 [Conjugate Vaccine Among U.S. Adults: Updated Recommendations of ACIP — United States,](#)
751 [MMWR 71 \(4\), 2022, CDC.](#)

Office of Regulatory Management
Economic Review Form

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC5-371-10 et seq.
VAC Chapter title(s)	Regulations for the Licensure of Nursing Facilities
Action title	Amend Regulation to Incorporate Chapter 72 (2021 Acts of Assembly, Special Session I), Chapters 829, 1080, and 1081 (2020 Acts of Assembly), Chapters 10 and 11 (2020 Acts of Assembly, Special Session I), Chapters 177 and 222 (2005 Acts of Assembly) and Chapter 762 (2004 Acts of Assembly), Update Terms to Match Statutory Language, and Update Licensure Provisions
Date this document prepared	November 29, 2022

Cost Benefit Analysis

Table 1a: Costs and Benefits of the Proposed Changes (Primary Option)

<p>(1) Direct Costs & Benefits</p>	<ul style="list-style-type: none"> Nursing facilities must report specified changes to the Virginia Department of Health (VDH) at least 30 calendar days prior to initiating the change. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. Nursing facilities have to permit inspectors access to their facilities, records, and persons under their control for the purposes of inspection and have to submit plans of correction for cited deficiencies, and have to implement corrections within 45 business days. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. Nursing facility construction, renovation, or alterations have to comply with the applicable sections of the 2022 guidelines from The Facility Guidelines Institute. Direct Costs: VDH is not aware of any quantifiable direct costs at time.
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	<p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> Nursing facilities must have a policy addressing registration, reregistration, and verification with the Sex Offender and Crimes Against Minors Registry that meets statutory minimums. <p>Direct Costs: \$1,250 one-time per topic per nursing facility to update existing policies and procedures about the Sex Offender and Crimes Against Minors Registry.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> Nursing facilities must utilize current clinical recommendations for influenza and pneumococcal vaccination. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> Nursing facilities must have a policy addressing visitation during public health emergencies related to COVID-19 that meets statutory minimums. <p>Direct Costs: \$1,250 one-time per topic per nursing facility to update existing policies and procedures about visitation.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p>
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(2) Quantitative Factors	Estimated Dollar Amount	Present Value
Direct Costs	(a) \$715,000	(c) \$715,000
Direct Benefits	(b) \$0	(d) \$0
(3) Benefits-Costs Ratio	0.00	(4) Net Benefit -\$715,000

<p>(5) Indirect Costs & Benefits</p>	<p>VDH is not aware of any quantifiable benefits at this time.</p> <p>As a result of the mandate to comply with the 2022 edition of the applicable design and construction guidelines, VDH anticipates that there may be a quantifiable indirect cost equal to 0.2% increase in construction costs for a 180-bed nursing facility that is multiple stories of non-combustible construction and a 0.4% increase in construction costs for a 180-bed nursing facility that is a single story of combustible construction.</p> <p>VDH is not aware of any other quantifiable costs at this time.</p>
<p>(6) Information Sources</p>	<p>The Facility Guidelines Institute; Division of Acute Care Services, Office of Licensure and Certification.</p>
<p>(7) Optional</p>	<p>VDH has numerous challenges and constraints that limit a cost benefit analysis, including limited data availability, limited statutory discretion, and insufficient analytical models.</p> <p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of nursing facility residents by incorporating current clinical and industry practices as well as by requiring reasonable timely information from nursing facilities, access to information to ensure nursing facility compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>

Table 1b: Costs and Benefits under the Status Quo (No change to the regulation)

<p>(1) Direct Costs & Benefits</p>	<p>Nondiscretionary changes have been omitted from this analysis.</p> <ul style="list-style-type: none"> • Nursing facilities must report specified changes to the Virginia Department of Health (VDH) at least 30 calendar days prior to initiating the change, excluding nursing facility closures. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> • Nursing facilities have to permit inspectors access to their facilities, records, and persons under their control for the purposes of inspection and have to submit plans of correction for cited deficiencies, and have to implement corrections within an unspecified time.
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	<p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p>	
(2) Quantitative Factors	Estimated Dollar Amount	Present Value
Direct Costs	(a) \$0	(c) \$0
Direct Benefits	(b) \$0	(d) \$0
(3) Benefits-Costs Ratio	0.00	(4) Net Benefit \$0
(5) Indirect Costs & Benefits	<p>VDH is not aware of any quantifiable benefits at this time from the discretionary regulatory changes.</p> <p>VDH is not aware of any quantifiable costs at this time from the discretionary regulatory changes.</p>	
(6) Information Sources	Division of Acute Care Services, Office of Licensure and Certification	
(7) Optional	<p>VDH has numerous challenges and constraints that limit a cost benefit analysis, including limited data availability, limited statutory discretion, and insufficient analytical models.</p> <p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of nursing facility residents by incorporating current clinical and industry practices as well as by requiring reasonable timely information from nursing facilities, access to information to ensure nursing facility compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>	

Table 1c: Costs and Benefits under an Alternative Approach

(1) Direct Costs & Benefits	<p>Nondiscretionary changes have been omitted from this analysis.</p> <ul style="list-style-type: none"> Nursing facilities must report specified changes to the Virginia Department of Health (VDH) within an unspecified time frame at the nursing facility’s discretion prior to initiating the change.
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	<p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> Nursing facilities have to permit inspectors access to their facilities, records, and persons under their control for the purposes of inspection and have to submit plans of correction for cited deficiencies, and have to implement corrections within 45 calendar days. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p>	
(2) Quantitative Factors	Estimated Dollar Amount	Present Value
Direct Costs	(a) \$0	(c) \$0
Direct Benefits	(b) \$0	(d) \$0
(3) Benefits-Costs Ratio	0.00	(4) Net Benefit \$0.00
(5) Indirect Costs & Benefits	<p>VDH is not aware of any quantifiable benefits at this time from the discretionary regulatory changes.</p> <p>VDH is not aware of any quantifiable costs at this time from the discretionary regulatory changes.</p>	
(6) Information Sources	Division of Acute Care Services, Office of Licensure and Certification	
(7) Optional	<p>VDH has numerous challenges and constraints that limit a cost benefit analysis, including limited data availability, limited statutory discretion, and insufficient analytical models.</p> <p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of nursing facility residents by incorporating current clinical and industry practices as well as by requiring reasonable timely information from nursing facilities, access to</p>	

	information to ensure nursing facility compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.
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Impact on Local Partners

Table 2: Impact on Local Partners

(1) Direct Costs & Benefits	<ul style="list-style-type: none"> • Nursing facilities must report specified changes to the Virginia Department of Health (VDH) at least 30 calendar days prior to initiating the change. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Nursing facilities have to permit inspectors access to their facilities, records, and persons under their control for the purposes of inspection and have to submit plans of correction for cited deficiencies, and have to implement corrections within 45 business days. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Nursing facility construction, renovation, or alterations have to comply with the applicable sections of the 2022 guidelines from The Facility Guidelines Institute. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Nursing facilities must have a policy addressing registration, reregistration, and verification with the Sex Offender and Crimes Against Minors Registry that meets statutory minimums. Direct Costs: \$1,250 one-time per topic per nursing facility to update existing policies and procedures about the Sex Offender and Crimes Against Minors Registry.
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	<p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> Nursing facilities must utilize current clinical recommendations for influenza and pneumococcal vaccination. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> Nursing facilities must have a policy addressing visitation during public health emergencies related to COVID-19 that meets statutory minimums. <p>Direct Costs: \$1,250 one-time per topic per nursing facility to update existing policies and procedures about visitation.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p>
(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a) \$2,500
Direct Benefits	(b) \$0
(3) Indirect Costs & Benefits	<p>VDH is not aware of any quantifiable benefits at this time.</p> <p>As a result of the mandate to comply with the 2022 edition of the applicable design and construction guidelines, VDH anticipates that there may be a quantifiable indirect cost equal to 0.2% increase in construction costs for a 180-bed nursing facility that is multiple stories of non-combustible construction and a 0.4% increase in construction costs for a 180-bed nursing facility that is a single story of combustible construction.</p> <p>VDH is not aware of any other quantifiable costs at this time.</p>
(4) Information Sources	The Facility Guidelines Institute; Division of Acute Care Services, Office of Licensure and Certification.

(5) Assistance	None
(6) Optional	<p>VDH has numerous challenges and constraints that limit a cost benefit analysis, including limited data availability, limited statutory discretion, and insufficient analytical models.</p> <p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of nursing facility residents by incorporating current clinical and industry practices as well as by requiring reasonable timely information from nursing facilities, access to information to ensure nursing facility compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>

Economic Impacts on Families

Table 3: Impact on Families

(1) Direct Costs & Benefits	Families will not be affected by direct costs or benefits of the regulatory change as they are not subject to the requirements contained in this regulatory chapter and thus will incur no direct cost or benefit.
(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a) \$0
Direct Benefits	(b) \$0
(3) Indirect Costs & Benefits	VDH is not aware of any quantifiable indirect costs or benefits for families. To the extent that the cost or benefit of regulatory changes may be passed on to families, VDH cannot quantify that cost or benefit at this time.
(4) Information Sources	Division of Acute Care Services, Office of Licensure and Certification.
(5) Optional	<p>VDH has numerous challenges and constraints that limit a cost benefit analysis, including limited data availability, limited statutory discretion, and insufficient analytical models.</p> <p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of nursing facility residents by incorporating current clinical and industry practices as well as by requiring reasonable timely information from nursing facilities, access to</p>

	information to ensure nursing facility compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.
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Impacts on Small Businesses

Table 4: Impact on Small Businesses

<p>(1) Direct Costs & Benefits</p>	<ul style="list-style-type: none"> • Nursing facilities must report specified changes to the Virginia Department of Health (VDH) at least 30 calendar days prior to initiating the change. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Nursing facilities have to permit inspectors access to their facilities, records, and persons under their control for the purposes of inspection and have to submit plans of correction for cited deficiencies, and have to implement corrections within 45 business days. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Nursing facility construction, renovation, or alterations have to comply with the applicable sections of the 2022 guidelines from The Facility Guidelines Institute. Direct Costs: VDH is not aware of any quantifiable direct costs at time. Direct Benefits: VDH is not aware of any quantifiable direct benefits at time. • Nursing facilities must have a policy addressing registration, reregistration, and verification with the Sex Offender and Crimes Against Minors Registry that meets statutory minimums. Direct Costs: \$1,250 one-time per topic per nursing facility to update existing policies and procedures about the Sex Offender and Crimes Against Minors Registry.
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	<p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> Nursing facilities must utilize current clinical recommendations for influenza and pneumococcal vaccination. <p>Direct Costs: VDH is not aware of any quantifiable direct costs at time.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p> <ul style="list-style-type: none"> Nursing facilities must have a policy addressing visitation during public health emergencies related to COVID-19 that meets statutory minimums. <p>Direct Costs: \$1,250 one-time per topic per nursing facility to update existing policies and procedures about visitation.</p> <p>Direct Benefits: VDH is not aware of any quantifiable direct benefits at time.</p>
(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a) \$2,500 per nursing facility (see Response to #6 in this Table)
Direct Benefits	(b) \$0
(3) Indirect Costs & Benefits	<p>VDH is not aware of any quantifiable benefits at this time.</p> <p>As a result of the mandate to comply with the 2022 edition of the applicable design and construction guidelines, VDH anticipates that there may be a quantifiable indirect cost equal to 0.2% increase in construction costs for a 180-bed nursing facility that is multiple stories of non-combustible construction and a 0.4% increase in construction costs for a 180-bed nursing facility that is a single story of combustible construction.</p> <p>VDH is not aware of any other quantifiable costs at this time.</p>
(4) Alternatives	Of the changes that are discretionary (see Tables 1b and 1c for identification of the discretionary changes), VDH could not identify an alternative that achieved the same purpose without compromising the health, safety, and

	welfare of patients or without compromising VDH’s ability to comply in a cost-efficient manner with statutory/legislative mandates placed on the agency.
(5) Information Sources	The Facility Guidelines Institute; Division of Acute Care Services, Office of Licensure and Certification.
(6) Optional	<p>VDH does not have any data to indicate whether a currently licensed nursing facility meets the definition of “small business” so there may be no direct costs or direct benefits for small businesses.</p> <p>VDH has numerous challenges and constraints that limit a cost benefit analysis, including limited data availability, limited statutory discretion, and insufficient analytical models.</p> <p>The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of nursing facility residents by incorporating current clinical and industry practices as well as by requiring reasonable timely information from nursing facilities, access to information to ensure nursing facility compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.</p>

Changes to Number of Regulatory Requirements

Table 5: Total Number of Requirements

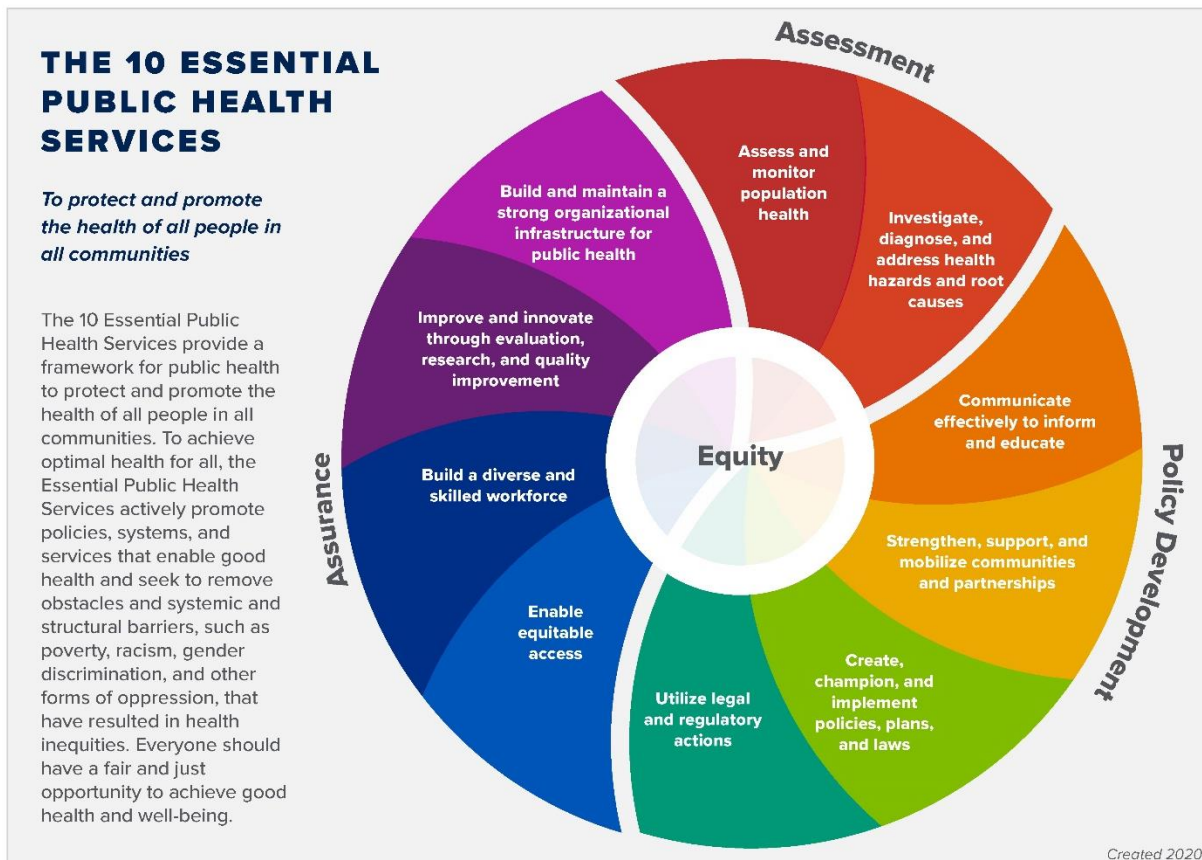
Chapter number	Number of Requirements			
	Initial Count	Additions	Subtractions	Net Change
371	1,357	31	15	16

ANNUAL REPORT OF THE BOARD OF HEALTH

INTRODUCTION

Pursuant to Virginia Code §32.1-14 the Virginia Department of Health (VDH) is submitting the following State Board of Health annual report summarizing health care issues affecting citizens of Virginia and the corresponding collaborative efforts to address health disparities.

Throughout 2022, the VDH continued leading the way for COVID-19 response while simultaneously providing services, programs, and interventions across the Commonwealth. VDH remains committed to ensure that every Virginian has a fair and equitable opportunity to achieve optimal health, and for Virginia to become the healthiest state in the nation. The COVID-19 pandemic underscored the importance of using data and partnering with communities to improve community health outcomes. Ensuring all Virginians have the opportunity for optimal health requires actions designed to understand and address the root causes of health disparities. VDH is focused on a team-of-teams approach to improve the health of all Virginians.



HIGHLIGHTED ACCOMPLISHMENTS

Response to Global Emerging Disease

During 2022, VDH continued to track COVID-19 and investigate outbreaks in higher risk settings. In May 2022, Monkeypox was identified in countries where it had not been detected in the past and began to spread globally. The Office of Epidemiology quickly developed and disseminated guidance for its clinical partners and the general public and established data systems and procedures to track and control the disease. Local health departments investigated cases, identified contacts of cases, and provided Monkeypox vaccine to targeted groups in order to prevent further transmission. In September 2022, the World Health Organization declared an outbreak of Ebola in Uganda, and VDH worked with Centers for Disease Control and Prevention (CDC) and other states to quickly re-establish its public health response to prevent transmission of Ebola in the United States. Beginning in early October, all travelers from Uganda were funneled through five US airports, including Dulles International. The Office of Epidemiology, the Office of Emergency Preparedness, and local health districts are worked closely with clinical partners to ensure preparedness; and VDH's regional epidemiology surge teams (established during the COVID-19 pandemic) conducted outreach to travelers from Uganda to provide public health guidance and monitoring.

Collaboration and Focus on Data to Foster Community Health Improvement

VDH launched several centers and programs that are focused on developing the capabilities of all programs and offices to drive measurable outcomes utilizing the Public Health 3.0 Framework.

- The Center for Community Health Improvement (CCHI) coordinates with and provides guidance and technical support to the VDH Central Office and local health districts to meet national public health accreditation requirements for (1) engaging with the public health system and the community in identifying and addressing health problems through collaborative processes; (2) conducting and disseminating assessments focused on population health status and public health issues facing the community; and (3) conducting comprehensive planning processes that result in population health improvement plans. The CCHI facilitates the collaborative State Health Assessment at least every five years.
- The Office of Family Health Services' Community Health Epidemiology Program (CHEP) provides strategic direction for community-engaged research and informatics activities supporting population health and equity, including metrics and dashboards, vulnerable population data systems, interoperability standards, and Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) monitoring. Since its inception in late August 2022, CHEP has worked to build relationships and work collaboratively with CCHI and local health districts to improve community health via evidence-based methods and appropriate data analyses regarding the distribution and determinants of population health.
- The Office of Information Management's Center of Public Health Informatics (CPHI) supports programs through the provision of expertise in the development, translation, visualization, and dissemination of public health data and informatics knowledge. CPHI improves population health outcomes by developing innovative ways to improve use and understanding of data to better inform and promote the health of all Virginians. The Community Health Informatics Team within the CPHI provides informatics, data and assessment support for the Community Health Assessments and Improvement Plans (CHAs/CHIPs); supports CCHI and Population Health with CARES portal data system's needs; standardizes key performance indicators; establishes data management best practices; and collects and maintains reliable, comparable and valid data that provides information on conditions of public health importance and on the health status of the population.

State Health Assessment

DRAFT – NOT APPROVED

In 2022, VDH facilitated Virginia’s State Health Assessment. The State Health Assessment (SHA) Data Highlights Report (Appendix A) provides an overview of health indicators and whether they have improved, remained stable, or worsened. These data show where community health efforts are working and where renewed attention is needed. The findings of the SHA will be analyzed, prioritized, and made actionable through the State Health Improvement Plan (SHIP) in 2023.

Virginia Community Health Improvement Data Portal

Partnering for a Healthy Virginia (PHV) was founded by VDH and the Virginia Hospital and Healthcare Association (VHHA) to impact population health efforts and activities. The goal of PHV is to ensure that every Virginian has a fair and equitable opportunity to achieve optimal health, making Virginia the healthiest state in the nation. Partnering for a Healthy Virginia is Virginia’s state-level population health improvement collaborative and continues to grow and expand partnerships, including stakeholders from local health districts, hospitals, community health coalitions, businesses, and foundations. In 2022, PHV continued its work towards population health improvement including the launch of the [Virginia Community Health Improvement Portal](#).

Community Health Assessment and Improvement Planning

For the first time in 2022 the Rappahannock Area Health District and Mary Washington Healthcare partnered to complete a joint CHA for the City of Fredericksburg and Caroline, King George, Spotsylvania, and Stafford Counties, as well as parts of Westmoreland, Orange, and Prince William Counties. Over 70 organizations and nearly 2,000 community members provided feedback during this collaborative assessment process. Using data from the assessment, mental health, affordable housing, and access to healthcare were identified as the top three priority issues to be addressed through a community health improvement plan (CHIP), which can be viewed in its entirety at www.vdh.virginia.gov/rappahannock/fy23-fy25_cha-chip. The plan outlines ways in which community organizations will come together to enhance collaboration around these issues, improve access to care, ensure equitable housing options, and develop a strategy to increase the healthcare workforce pathway.

The Rappahannock-Rapidan Health District is collaborating with five counties, two hospitals, two community foundations, and one community-based organization to complete a joint CHA. They pooled financial resources to contract with a facilitator to meet the varying needs of localities, hospitals, health departments, and community partners. Each organization selected key priority targets for improvement for the community health improvement process, and they will continue to collaborate implementing these strategies over the next CHIP cycle.

The Crater Health District has partnered with a private foundation that serves five of the eight health district localities to complete a community health needs assessment (CHNA) for its local health system. As a part of this partnership, Crater Health District has trained three staff to lead focus groups for the CHNA and is supporting the distribution of the community survey. The foundation will share all data collected and analyzed with the health district, which means this partnership will greatly expedite the CHA for Crater Health District.

The Fairfax Health District provides backbone support for the work of the Partnership for a Healthier Fairfax and the Fairfax Food Council, multi-sector community coalitions working to implement the goals, objectives and key actions of the Live Healthy Fairfax CHIP. Partnership for a Healthier Fairfax is engaged in implementation activities for year 4 of the CHIP and work is underway to complete a 2022 Community Health Assessment. The CHIP and local community health indicators are found on www.livehealthyfairfax.org. Current projects include promoting the “Real Food for Real Change” toolkit for middle school students, developing resources to help adults’ access behavioral care services, and developing a food rescue protocol for schools.



Partnership for a Healthier Fairfax Milestones

www.fairfaxcounty.gov/livehealthy

Fairfax - an engaged and empowered community working together to achieve optimal health and well-being for all who live, work and play here.

CURRENT PROJECTS:

- Identify food-growing initiatives with a Fairfax County searchable map
- Promote "Real Food for Real Change," toolkit for middle school youth
- Develop a food rescue protocol for schools
- Publish *Social Isolation and Loneliness: Impacts on Health and Approaches to Prevention for the Fairfax Community*
- Develop resources to help adults access behavioral health care services
- Launch *Healthy Together Fairfax* Event
- "Tell Me Your Story" Cultural Competency curriculum offered via the Northern Virginia Area Health Education Center at Mason (AHEC)
- Serve community needs during the Covid-19 pandemic

PROJECT HIGHLIGHTS:

- Develop and Launch CHIP 2.0 (2019-2023)
- Complete Community Health Assessment
- Establish Trauma-Informed Care Network
- Urban Agriculture in Zoning Modernization
- Develop Curriculum to Support the "Tell Me Your Story" Project
- Expand Food Insecurity Screening & Resources

2016-2017

PROJECT HIGHLIGHTS:

- Established Trauma Informed Community Network
- Completed Community Food Assessment
- Health in All Policies (HiAP) Objective Added to the Economic Success Plan of Fairfax County

PROJECTS LAUNCHED:

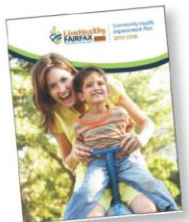
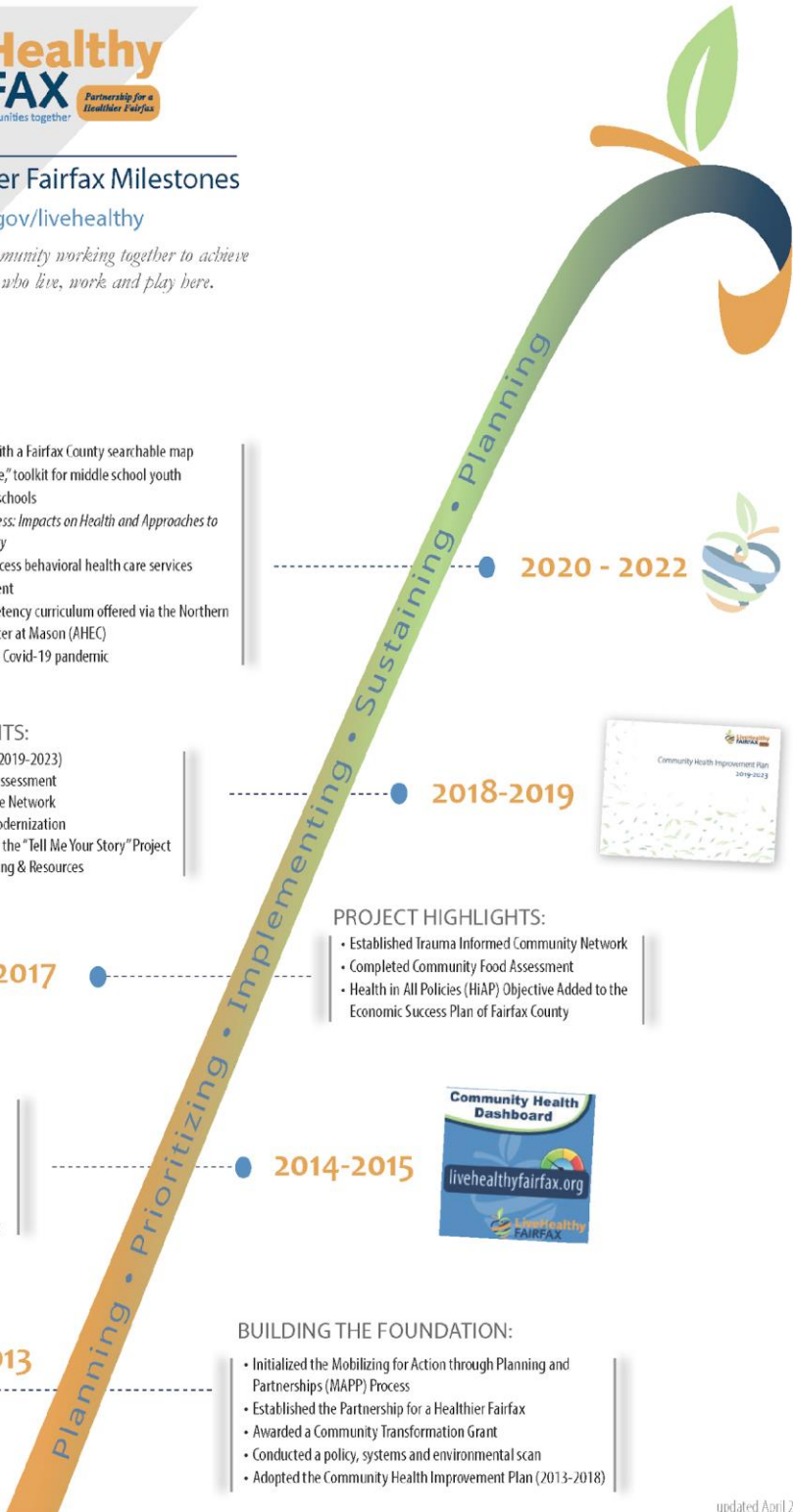
- Tobacco-Free Play Zones
- Community Health Dashboard
- Fairfax Food Council
- Healthy Community Design Summit
- Eat and Run Project
- Transit Center Health Impact Assessment

2014-2015

BUILDING THE FOUNDATION:

- Initialized the Mobilizing for Action through Planning and Partnerships (MAPP) Process
- Established the Partnership for a Healthier Fairfax
- Awarded a Community Transformation Grant
- Conducted a policy, systems and environmental scan
- Adopted the Community Health Improvement Plan (2013-2018)

2008-2013



updated April 2022

Office of Vital Records Improved Customer Service

The VDH Office of Vital Records (OVR) is the official repository of vital events (birth, death, spontaneous fetal death, marriage, divorce, and induced termination of pregnancy) occurring in the Commonwealth of Virginia. It is the responsibility of the various reporting sources (i.e. hospitals, clinics, courts, funeral homes) to file these vital events with OVR. With the exception of marriage and divorce records, these vital events are filed electronically via the Virginia Vital Event and Screening Tracking System (VVESTS). VVESTS is a web application used for the registration, collection, preservation, amendment and certification of vital records. In addition to collecting Virginia's vital events, OVR has reciprocity arrangements among the other states and US territories to receive vital records data pertaining to Virginia residents. Likewise, OVR exchanges data on vital events occurring in Virginia to non-residents with the proper states. In Virginia's vital records data, a distinction is made in the tables and analyses as to those events occurring in Virginia and to those occurring to residents of Virginia.

In April 2022 the fully online vital records application service was launched. This new service allows customers from around the world to request a copy of a vital record from a computer, phone or tablet. This new system decreases processing times and improves access to vital records for customers. In June 2022 the National Association for Public Health Statistics and Information Systems (NAPHSIS) awarded the OVR's Field Services Team the '2022 Team Excellence Award' for improving mortality and natality data quality in the state. OVR significantly improved customer satisfaction during the pandemic, with their rating on Google improving from 2.0 stars (out of 5.0) before the pandemic to 4.2 stars as of October 2022.

VDH's Office of Information Management's Vital Event Statistics Program analyzes Virginia vital event data, develops statistical reports, charts, tables and graphs and publishes the annual Virginia Health Statistics report online at: <https://apps.vdh.virginia.gov/HealthStats/stats.htm>.

School-Aged Dental Health Program

VDH's Division of Child and Family Health in the Office of Family Health Services has collaborated with the Virginia Health Catalyst and the Virginia Department of Education to create a School-Aged Dental Health Program. This program provides education, training, and resources to school nurses to increase the number of Virginia children receiving oral health services. This program focuses on preventative care by growing the number of school-based oral health programs. The school nurse training programs are designed to break down barriers to dental care by providing technical assistance. The first cohort (2021-2022 school year) consisted of twelve school nurses. The schools selected were in the underserved communities of Campbell County, Wythe County, Giles County, Pulaski County, Petersburg, Hopewell, Hampton Roads, Orange County and Eastern Shore.

Additionally, as of September 2022, Alexandria Health District's Neighborhood Health Team began to see patients enrolled at Mount Vernon Community School and William Ramsay Elementary School in Alexandria to provide dental care to 400 students during the 2022-2023 school year.

Pregnancy Loss Services Project

In 2022, VDH partnered with five organizations: Birth in Color RVA, Full Circle Grief Center, Kennedy's Angel Gowns, Sisters in Loss, and VCU, to create the Pregnancy Loss Services Project. VDH launched the project to support individuals and families who have experienced pregnancy loss. VDH's Pregnancy Loss Services Project aims to build community organizations' capacity by providing support and education services to individuals and groups (including families) who have experienced pregnancy loss. This program is supported by Title V funds and came about as a result of the Title V Maternal Child Health Needs Assessment. The program services include grief groups, community events, material support, education materials, and training for doulas.

State-Certified Doulas

Doulas positively impact maternal and infant health outcomes and the need for access to doula services was underscored during the Maternal Health Listening Sessions. The Board of Health finalized regulations guiding the State Doula Certification program in January 2022. VDH developed a process to allow doulas to apply for state certification. Interested doulas submit applications to the Virginia Certification Board. Doulas receiving state certification have the option of being listed in a public-facing database. Consumers can use the database to find a doula that meets their needs. State-certified doulas are eligible for Medicaid reimbursement and work with DMAS to become Medicaid providers. As of August 23, 2022, 37 doulas have received state certification. Of the 37, 22 have completed Medicaid enrollment, 21 have completed contracting with at least one MCO, and five are pending Medicaid enrollment.

The Rare Disease Council and Additional Newborn Screening Tests

This Virginia Newborn Screening and Birth Defects Surveillance Program includes the Newborn Bloodspot Screening (NBS) Program, Early Hearing Detection and Intervention (EHDI) program, the Critical Congenital Heart Disease (CCHD) Program, and the Birth Defects Surveillance (BDS) Program. The BDS program provided expertise and staff support to the new Virginia Rare Disease Council. The Rare Disease Council is a Governor appointed council with diverse representation to learn about the challenges of those affected by or living with family members of rare diseases and reports to the Governor and the General Assembly.

The NBS program implemented screening for two new disorders, Spinal Muscular Atrophy (SMA) and X-Linked Adrenoleukodystrophy (X-ALD), on March 16, 2022.

Maternal and Child Health Key Collaborations

VDH collaborated with Healthy Beginnings' learning cohort *Advancing Anti-Racism in Preterm Birth Prevention*, CityMatCH's Alignment for Action Learning Collaborative, and *Listening to the Living*, efforts aimed at bringing together firsthand knowledge of and access to Black maternal experiences and inspiring collective action to support better birth outcomes for Black women.

Stroke Care Partnerships

VDH and Virginia Hospital and Healthcare Association (VHHA) have identified key partners to improve the continuation of stroke care including EMS regional councils, Unite Us, Sheltering Arms Institute, Kwikpoint, Medical Society of Virginia, and the Virginia Pharmacists Association.

The Virginia Stroke Registry, developed by the VDH, and the ESO Data Exchange, a trauma registry, allow participating hospitals and EMS agencies in Virginia to access and use their own data to improve protocols and achieve better outcomes. Analysis of stroke outcomes across Virginia hospitals, as well as peer-reviewed research on stroke protocols, drove the development of a statewide Stroke Smart initiative in 2021. Stroke Smart aims to reduce pre-hospital delays of stroke by educating the public to recognize and activate 9-1-1 early. Clinical and community partners were critical for the implementation of new public health research-based protocols, training delivery, and successful dissemination of educational materials.

Substance Use Response

Harm reduction is a public health strategy to reduce negative health outcomes for persons who engage in behaviors that put them and others at risk for disease or injury. VDH has long-term experience implementing a public health approach to reduce the impact of drug-related injuries, including active monitoring and surveillance, primary prevention strategies, rescue initiatives, and comprehensive harm reduction (CHR) efforts. VDH works through its local health departments and partners with community based organizations to provide a set of public health strategies intended to reduce the negative impact of drug use, including infections, overdose, and death, among people who are unable or not ready to stop using drugs. Comprehensive Harm Reduction sites provide referral and linkage to other services such as substance use disorder treatment. Peer counselors play an important role in this program, working with participants over time to improve health outcomes. VDH is working to expand its network of [harm reduction partners](#) to more settings in order to reach those at greatest risk of encountering fentanyl and experiencing an overdose. Currently, there are eight authorized CHR sites in Virginia. Comprehensive Harm Reduction sites provide health education on the potential impact of fentanyl and how to identify it using test strips. These sites distribute both fentanyl test strips to identify when fentanyl is present and naloxone to reverse its impact in the event of an overdose. VDH Central Pharmacy Services supports sites with Fentanyl Test Strips (FTS) for distribution to community members and program participants, and designs protocol and processes for Local Health Districts in the distribution of these supplies. Through partnership with Virginia Broadcast Solutions, VDH continues to stand up public facing communication campaigns through a variety of media channels to message the overdose risks associated with drug use and link individuals to treatment.

The Mount Rogers Health District Population Health Team was a key partner in planning a fentanyl awareness day, held at Virginia High School in Bristol in the spring of 2022. In response to student overdoses, dozens of partners provided a day of programming for high school students, including an internationally known speaker, stories of local lived experience, and a resource fair focused on substance use prevention, mental health resources, and dispensing naloxone to students and staff. The event was so successful and well received by the students that other similar events are in the works locally.

StayWellNoVa

Since the summer of 2020, the Northern Virginia health districts of the City of Alexandria, and the counties of Arlington, Fairfax, Loudoun, and Prince William, have been collaborating on a public health information campaign, StayWellNoVa. The initiative began to boost childhood and flu immunizations, and then changed focus to promote COVID-19 vaccinations. Close collaboration with community partners to inform cultural competency, as well as engagement of trusted messengers and influencers, have served as the ‘special sauce’ to ensure that all promotions truly resonate with the intended audiences and deliver results. The initiative continues today with a new focus on monkeypox vaccination. This regional communications approach has innovated the way the local health districts target and connect with key public health audiences in Virginia’s most populous and diverse health districts.

The collage features several digital assets:

- NEW: Monkeypox:** A blue and green graphic with the text "> Unexplained Bumps or Rash? Learn more about the symptoms of monkeypox. START HERE" and an image of two men looking at a phone.
- Tik Tok & Snapchat:** A graphic with the text "Tell me you're broke without telling me you're broke" and an image of hands holding a wallet.
- Organic Social Media:** A graphic titled "Como Me Mantengo Saludable" (How I Stay Healthy) with a checklist: "Ejercicio matutino", "Manicure con amigas", "Recibir a mi familia para cena del domingo", and "Vacuna de refuerzo". It includes the text "Mi rutina de cuidado personal incluye tiempo para mí y mi familia. Estar al día con mi vacuna COVID-19 me ayuda a realizar las cosas que quiero hacer." and the website "MantenteSanoVA.com".
- Programmatic Video:** A video thumbnail with the text "don't let COVID define your future." and a photo of Dr. Florencia Segura, a pediatrician.
- Search Results:** A search result for "Book Your COVID-19 Vaccine | No Insurance Required | COVID Vaccines Work" from staywellnova.com, stating it is free for everyone in the U.S. and offers late-night and weekend appointments.
- StayWellNoVa.com:** A graphic describing it as a Northern Virginia public health information initiative from the City of Alexandria and surrounding counties.
- Spotify:** A graphic with the text "GET VACCINATED" and "StayWellNoVa.com" and a photo of a diverse group of people.
- Bottom Banner:** A purple and yellow banner with the text "> tú tienes el poder de protegerlos" (you have the power to protect them) and "Haz una cita" (Make an appointment) at mantentesanoVA.com.

Virginia Partners in Prayer and Prevention

Virginia Partners in Prayer and Prevention (Virginia P3) is a community health initiative that has developed meaningful partnerships across faith-based coalitions throughout the Commonwealth since its inception in 2016. These partnerships have increased collaboration between VDH and faith-based organizations and their members. Additionally, by working with these organizations on health and prevention, trust has been established and strengthened in VDH and public health among populations that have historical mistrust in the medical and public health systems, especially Black and African American communities. This year, Virginia P3 continued to develop partnerships with other organizations to deliver training, facilitate discussions, and disseminate resources across its faith-based coalitions. These partners include Department of Homeland Security for a faith-based safety active shooter training, Virginia Breast Cancer Foundation, American Association of Retired Persons, American Heart Association for Heart Health Matters, Walgreens for community collaborations, VDH Arthritis Coalition for Walk with Ease and the Chronic Disease Self-Management Program, and Alzheimer’s Association for Purple Power Virginia.

Telehealth-in-a-Box

VDH partnered with the Salem Veterans Affairs Health Care System to establish a new point of access at the Martinsville Health Department for telehealth services provided by the U.S. Veterans Health Administration. Services will be provided at the Martinsville Health Department, utilizing the “telehealth-in-a-box” model that the Salem Veterans Affairs Health Care System has utilized at several sites in their region. These are examples of the several partnerships with clinical providers and medical technology vendors, which allow VDH to better serve the public health needs of Virginia.

The Academic Advisory Council

The Academic Advisory Council is composed of the Chairs of all Council on Education for Public Health-accredited Master of Public Health programs in Virginia, and VDH staff. The Council represents the public health programs at

DRAFT – NOT APPROVED

Old Dominion University, Virginia Commonwealth University, Eastern Virginia Medical School, University of Virginia, Virginia Polytechnic Institute and State University, George Mason University, and Liberty University. During quarterly meetings the Council determines public health issues that can be better understood and addressed through collaboration with MPH program support. Community health initiatives and public health education are also incorporated into partnerships with several Historically Black Colleges and Universities in Virginia. These educational partnerships are invaluable resources to public health initiatives that serve student communities as well as the communities that these institutions are already working with directly.

Community Health Workers

Many health districts utilized the opportunity granted by COVID-19 funds to hire community health workers (CHWs). Rappahannock-Rapidan Health District has placed CHWs in each of their free clinics. The CHWs are working together, alongside the free clinic and the health district, to screen patients for social determinants of health and connect patients with resources. Mount Rogers Health District has partnered with the Institute for Public Health Innovation to hire a team of six CHWs. The CHWs were deployed in May and have been assisting with COVID-19 recovery and response efforts, in addition to training hundreds of people on how to use naloxone. Central Shenandoah Health District hired nine CHWs, who have supported 475 families since June 2021 (see graphic on page 9).

Central Shenandoah Health District

2021-2022 Community Health Improvement Efforts

The Population Health Program at the Central Shenandoah Health District launched Spring 2019. Since then, our team has grown into a robust community health improvement program focused on health equity and data driven interventions. Below are some program and district highlights from the past year.

Connection 2 Care CHW Program



- Onboarded and trained **9 Community Health Workers** (CHW)
- **475 families supported** since June 2021 through Unite Virginia
- Continue to distribute rapid COVID-19 test kits to food pantries, domestic violence shelters, clothing closets, and other social safety net providers

Community Engagement & Outreach



- **112 community events** attended by Population Health Staff since September 2021
- Actively participate in **8 local Community Coalitions**
- Established Weekly Wellness Newsletter with approximately **26,300 subscribers**

Substance Abuse Prevention Program



- Conducted **52 REVIVE! Training** events since March 2022
- **298 Individuals received REVIVE! Lay Rescue training** since March 2022 of individual Narcan met
- **305 boxes of Narcan distributed** since March 2022 approximate of
- Established Quarterly Substance Use Prevention newsletter to highlight community efforts across the district

COVID-19 Response



- CSHD hosted approximately **247 community-based COVID-19 vaccine clinics** since July 2021
- Approximately **138,000 total COVID-19 vaccines** dispensed by CSHD
- Approximately **29,360 COVID-19 tests** performed by CSHD staff in community testing settings

Funding Community Health Improvement Initiatives



- Provided **8 Community Based Organizations** (CBOs) with funding to address health disparities in the district
- CBOs include: Augusta Health Hospital, Rockbridge Area Health Center, Health Communities Health Centers, Highland County Medical Center, Valley Program for Aging Services, Community Foundation, Strength in Peers, and Rockbridge Area Transit Services



HIGHLIGHTS FROM STATE HEALTH ASSESSMENT

DEMOGRAPHICS

According to the U.S. Census Bureau 2021 population estimates, there are 8,642,274 residents in Virginia. Figure 1 displays the racial and ethnic make-up of Virginia residents. In 2021, the median household income in Virginia was \$76,398, higher than the US median income of \$67,340. As shown in Figure 2, the median annual household income was highest for Asian residents (\$121,000) and lowest for Black or African American residents (\$55,000).

Figure 1

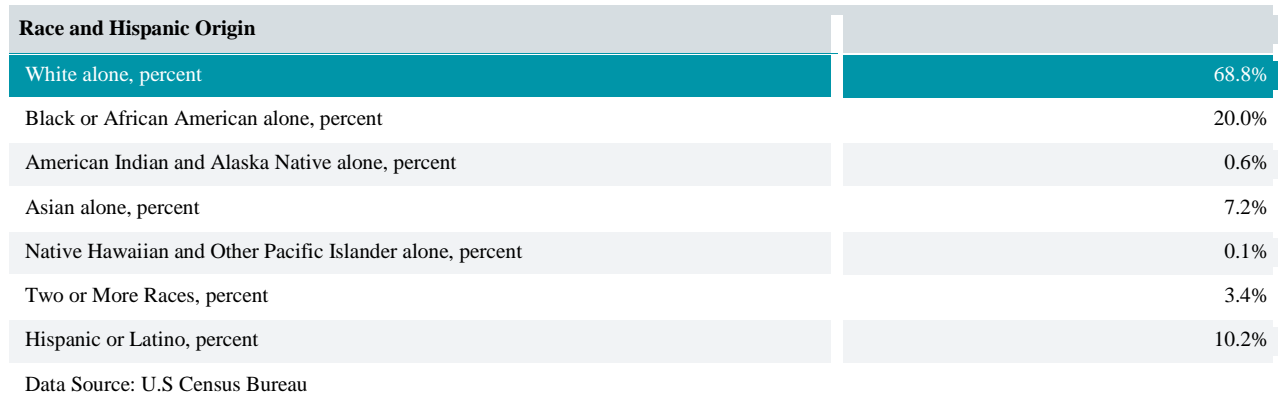
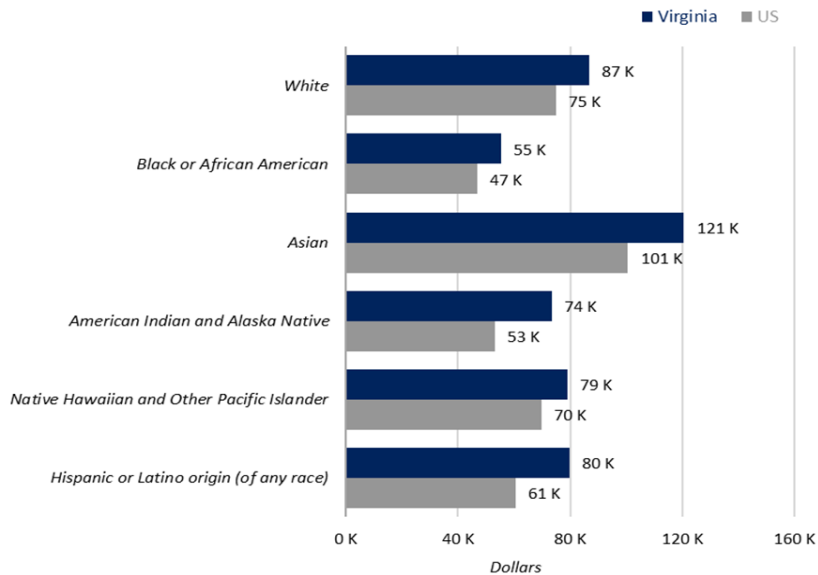


Figure 2

Median Household Income in the Past Year by Race/Ethnicity



Source: U.S. Census Bureau, 2021 American Community Survey 1-Year Estimates
 Note: Median Household Income (In 2021 Inflation-Adjusted Dollars)

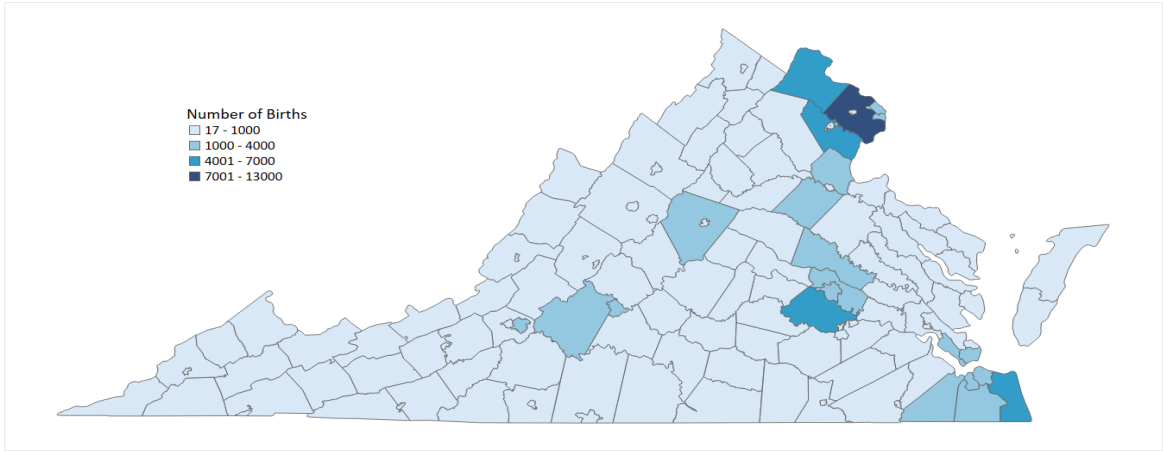


BIRTHS

In 2021, there were a total of 95,620 live births in Virginia Figure 3 shows the distribution of births by locality.

Figure 3

Total Births by Locality, 2021



Source: Virginia Department of Health, Office of Vital Records, Virginia Vital Events and Screening Tracking System.
Note: Residence refers to the Virginia city or county where the mother resided for a birth, where the patient resided for an induced termination of pregnancy or a natural fetal death, or where the deceased reside.

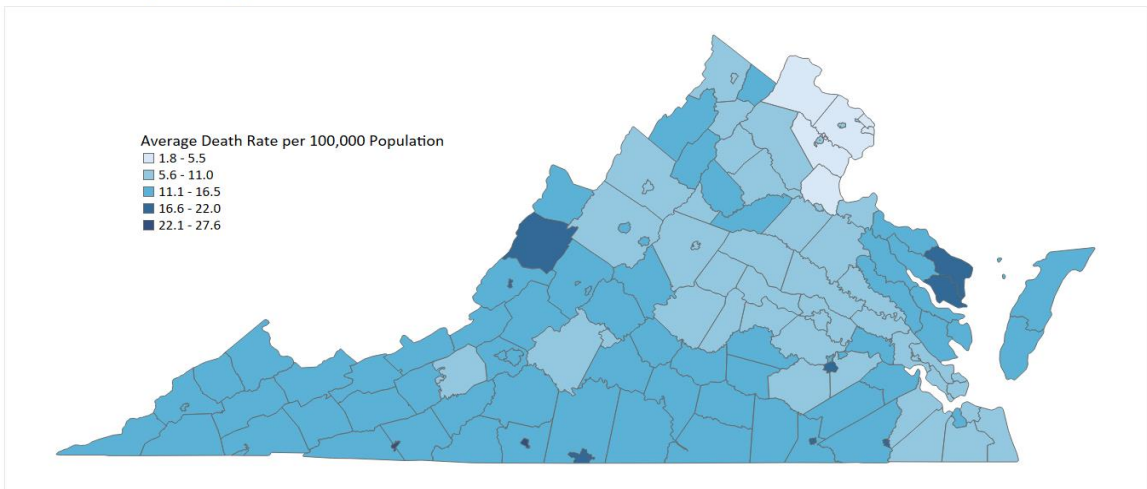


DEATHS

From 2018 to 2020 the overall death rate in Virginia was highest in Bath, Northumberland and Lancaster counties (Figure 4). 75.9% of deaths occurred in white residents (Figure 5). In 2021, the top three leading causes of deaths were heart disease, cancer, and COVID-19. Among adults 20-44 years old, the leading cause of death in Virginians was accidental poisoning and exposure to noxious substances (Figure 5).

Figure 4

Death Rate by Locality, 2018-2020

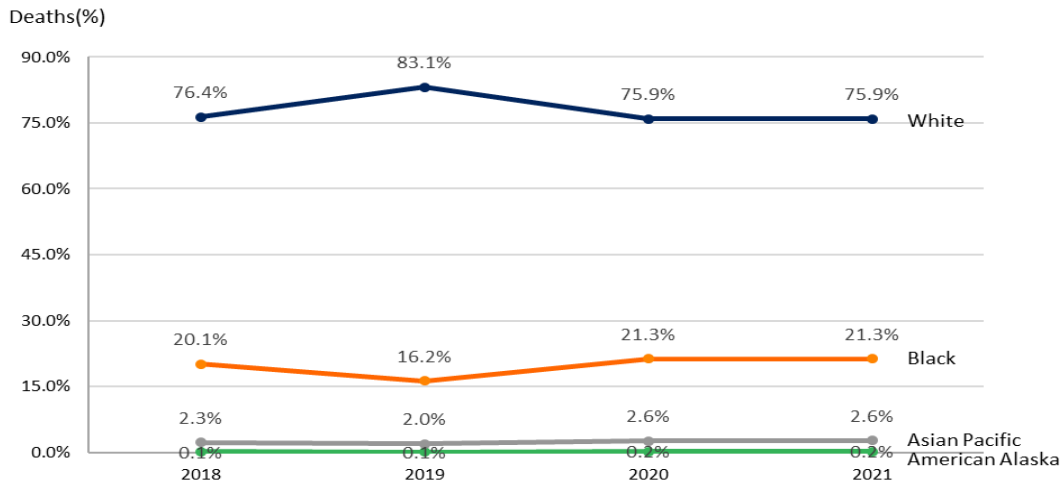


Source: Virginia Department of Health, Office of Vital Records, Virginia Vital Events and Screening Tracking System.
Note: Residence refers to the Virginia city or county where the mother resided for a birth, where the patient resided for an induced termination of pregnancy or a natural fetal death, or where the deceased reside.



Figure 5

Total Deaths by Race, 2018-2021 (Residence)



Source: Virginia Department of Health, Office of Vital Records, Virginia Vital Events and Screening Tracking System.

Note: Residence refers to the Virginia city or county where the mother resided for a birth, where the patient resided for an induced termination of pregnancy or a natural fetal death, or where the deceased reside.



Figure 6

	0-4	5-19	20-44	45-69	>70
Accidental Poisoning and Exposure to Noxious Substances	0.1%	1.5%	56.8%	39.9%	1.7%
Acute Myocardial Infarction	0.0%	0.0%	2.2%	34.3%	63.5%
All Other and Unspecified Malignant Neoplasms	0.4%	0.8%	3.6%	32.7%	62.5%
All Other Diseases	0.2%	0.3%	3.7%	21.0%	74.8%
All Other Forms of Heart Disease	0.2%	0.3%	4.6%	28.2%	66.7%
All Other Forms of Ischemic Heart Disease	0.0%	0.0%	0.6%	22.0%	77.4%
Alzheimers Disease	0.0%	0.0%	0.0%	3.7%	96.3%
Cerebrovascular Diseases	0.2%	0.1%	2.0%	19.0%	78.7%
COVID-19	0.1%	0.1%	4.3%	34.4%	61.1%
Diabetes Mellitus	0.0%	0.1%	4.1%	39.9%	55.9%
Heart Failure	0.1%	0.0%	1.0%	16.3%	82.6%
Other Chronic Lower Respiratory Diseases	0.0%	0.0%	0.2%	24.9%	74.9%
Other Diseases of Respiratory System	1.1%	0.2%	1.8%	27.8%	69.2%
Renal Failure	0.0%	0.0%	1.7%	27.1%	71.1%
Trachea, Bronchus, and Lung	0.0%	0.0%	0.7%	39.7%	59.6%

Source: Virginia Department of Health, Office of Vital Records, Virginia Vital Events and Screening Tracking System.

Note: Residence refers to the Virginia city or county where the mother resided for a birth, where the patient resided for an induced termination of pregnancy or a natural fetal death, or where the deceased reside.



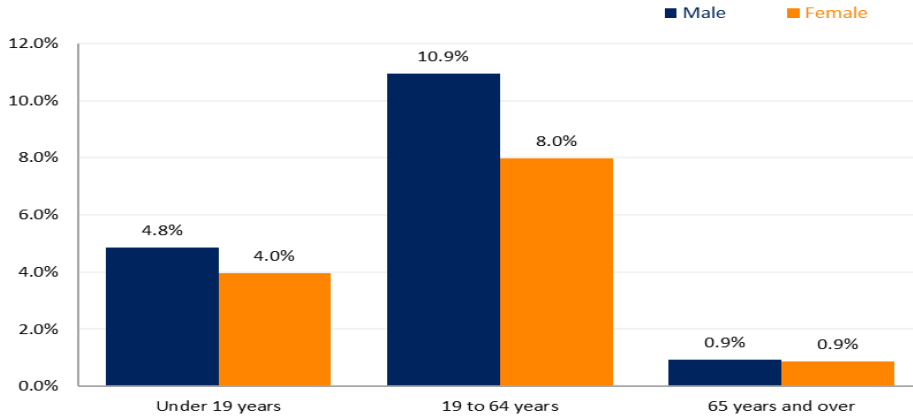
HEALTH INSURANCE

Since January 1, 2019, more adults living in Virginia have access to quality, low-cost health comprehensive health insurance through Virginia Medicaid. Covered adults include individuals ages 19-64 with income at or below 138% of the federal poverty level. In 2021, 10.9% of female adults 19 to 64 years old were uninsured, compared to 8% of males (Figure 7). As Figure 8 shows, 28.1% of Hispanic/Latino Virginians 19 to 64 years old were uninsured in

2021, compared to 6.7% of White Virginians and 9.1% of African American Virginians. Figure 9 shows that 28.4% of uninsured Virginians 26 to 64 years old had less than a high school education.

Figure 7

Percent Uninsured by Sex and Age, Virginia

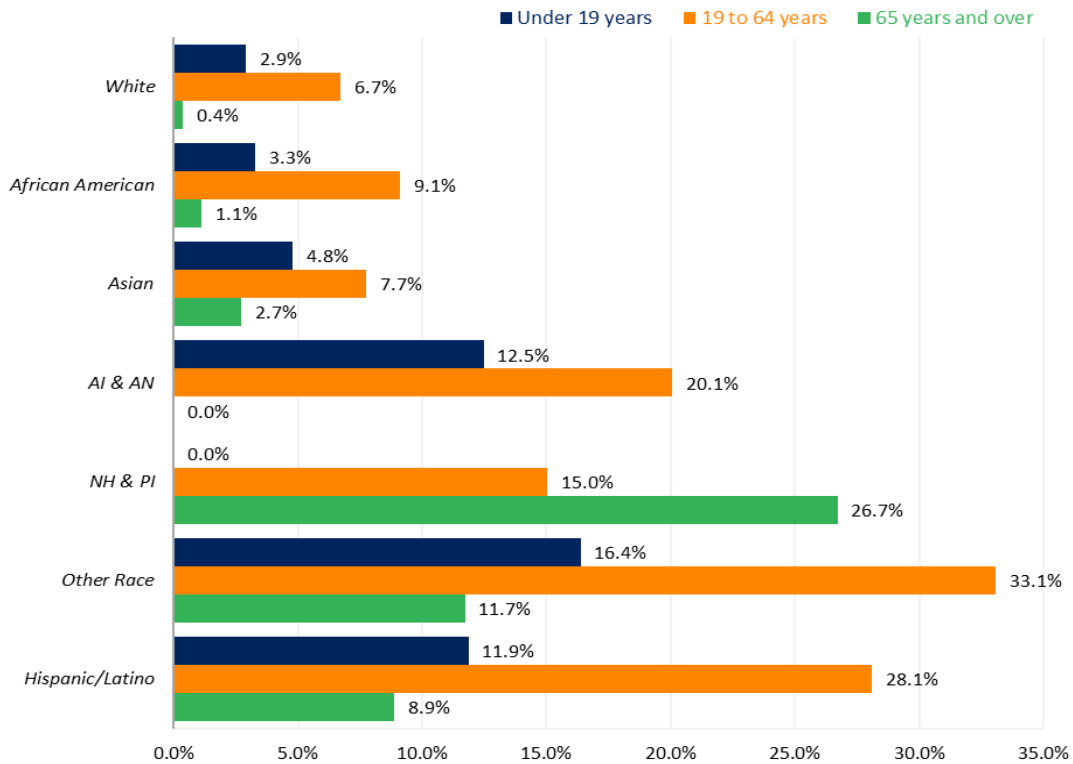


Source: U.S. Census Bureau, 2021 American Community Survey 1-Year Estimates



Figure 8

Percent Uninsured by Age and Race/Ethnicity, Virginia

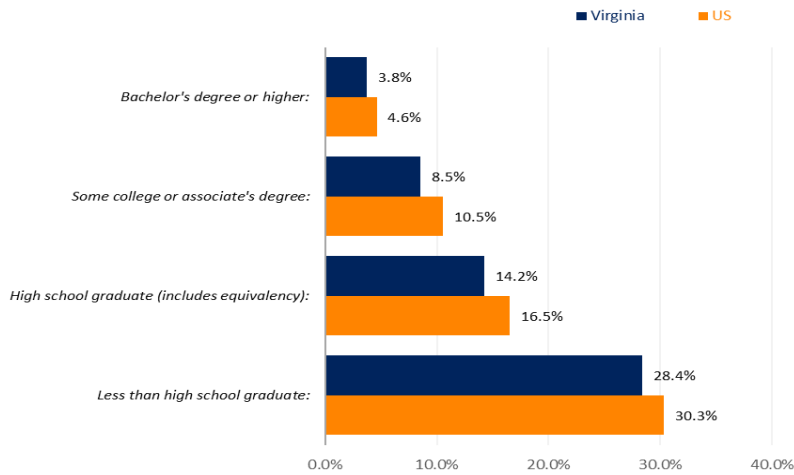


Source: U.S. Census Bureau, 2021 American Community Survey 1-Year Estimates



Figure 9

Percent Uninsured by Educational Attainment, Age 26-64 Years

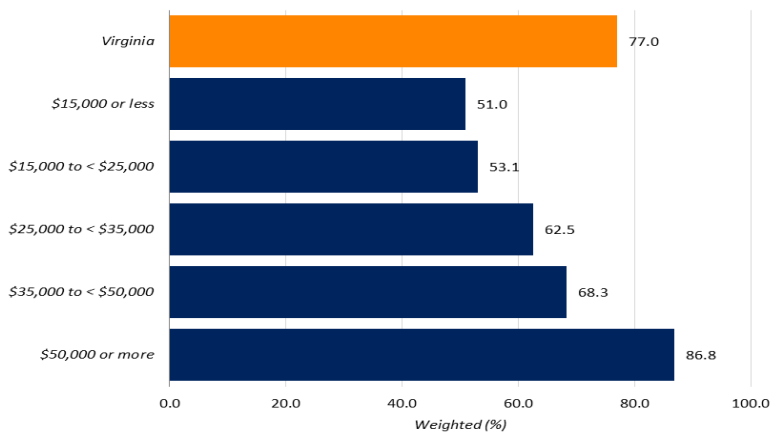


Source: U.S. Census Bureau, 2021 American Community Survey 1-Year Estimates



Figure 10

Dental Insurance Coverage Among Adults 18+ by Income, 2021



Source: Virginia Department of Health, Division of Policy and Evaluation, Behavioral Risk Factor Surveillance Survey, 2021.
 Note: Weighted counts and weighted percents are weighted to population characteristics.



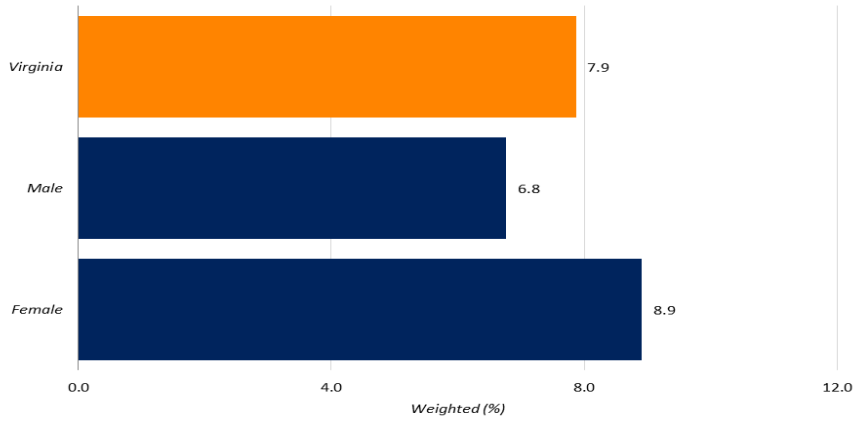
HEALTH CARE AFFORDABILITY

Even when Virginia residents have health insurance coverage, people with limited funds or lack of transportation options still may not be able to get the care they need. Delays in seeking medical care for injuries, illness or chronic conditions can have significant impact on the individual, the economy, and the healthcare system. These delays are mostly attributed to cost. According to the Kaiser Family Foundation, dental services are the most common type of care that people report delaying or skipping.

Lower income families spend a greater share of their income on health care costs than those families with higher incomes. In 2021, 7.9% of adults reported that they could not afford to see a doctor (Figure 11). The group with the highest percentage of adults who could not afford to see a doctor were in households earning \$15,000 to less than \$25,000 (Figure 12). The racial/ethnic group with the highest percentage of adults who could not afford to see a doctor were those that identified as Hispanic (Figure 13). By education level, Virginians with less than a high school education were the largest group that could not afford to see a doctor in 2021 (Figure 14).

Figure 11

Could Not Afford To See Doctor Among Adults 18+ by Sex, 2021

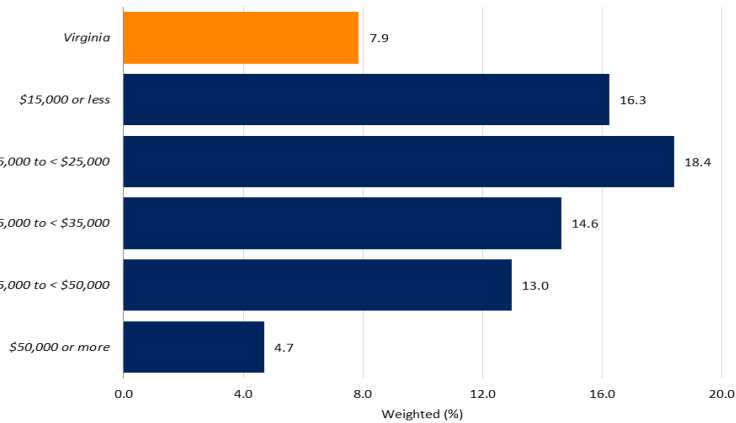


Source: Virginia Department of Health, Division of Policy and Evaluation, Behavioral Risk Factor Surveillance Survey, 2021.
 Note: Weighted counts and weighted percents are weighted to population characteristics.



Figure 12

Could Not Afford To See Doctor Among Adults 18+ by Income, 2021

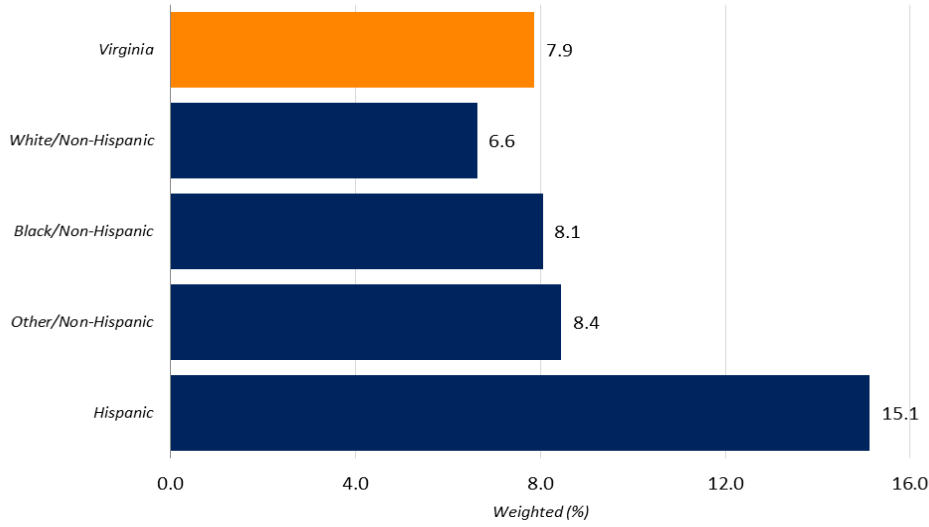


Source: Virginia Department of Health, Division of Policy and Evaluation, Behavioral Risk Factor Surveillance Survey, 2021.
 Note: Weighted counts and weighted percents are weighted to population characteristics.



Figure 13

Could Not Afford To See Doctor Among Adults 18+ by Race, 2021

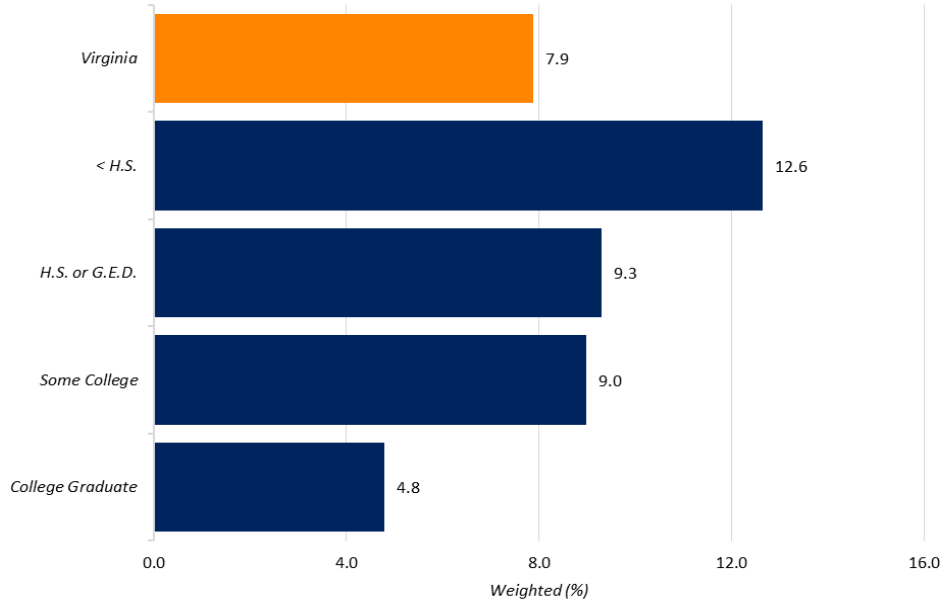


Source: Virginia Department of Health, Division of Policy and Evaluation, Behavioral Risk Factor Surveillance Survey, 2021.
Note: Weighted counts and weighted percents are weighted to population characteristics.



Figure 14

Could Not Afford To See Doctor Among Adults 18+ by Education Level, 2021



Source: Virginia Department of Health, Division of Policy and Evaluation, Behavioral Risk Factor Surveillance Survey, 2021.
Note: Weighted counts and weighted percents are weighted to population characteristics.



HEALTH OPPORTUNITY

Virginians who live in communities with higher income are able to access resources that contribute to their health more easily than Virginians who live in communities with lower income. The Social Vulnerability Index (Figure 14) measures the relative vulnerability of each US Census tract (subdivisions of counties). The tracts are ranked across 15 social factors (unemployment, minority status, disability, etc.) that are further grouped into four themes. Each tract is rated on each of the four themes as well as overall. Virginia’s variance in its SVI scores illustrates the wide array of needs and experiences of Virginians across our state.

A locality’s rurality also impacts the distribution of hospitals, clinics, and other healthcare services. Figure 15 from the Virginia Rural Health Plan shows the distribution of primary care shortage areas and illustrates the overlap between rurality and in gaps in healthcare access and health equity.

The Health Opportunity Index (Figure 18) is a multivariate tool that is used to identify and understand the effect of social determinants of health on health outcomes. The index uses 29 indicators to measure neighborhood health for residents. Some of these indicators include school poverty, access to healthy food, access to green space, home ownership rate, as well as other related indicators. Each indicator has an individual weight that correlates to the indicators ability to impact health. The indicators are all measured on different scales.

Figure 14

SOCIAL VULNERABILITY INDEX

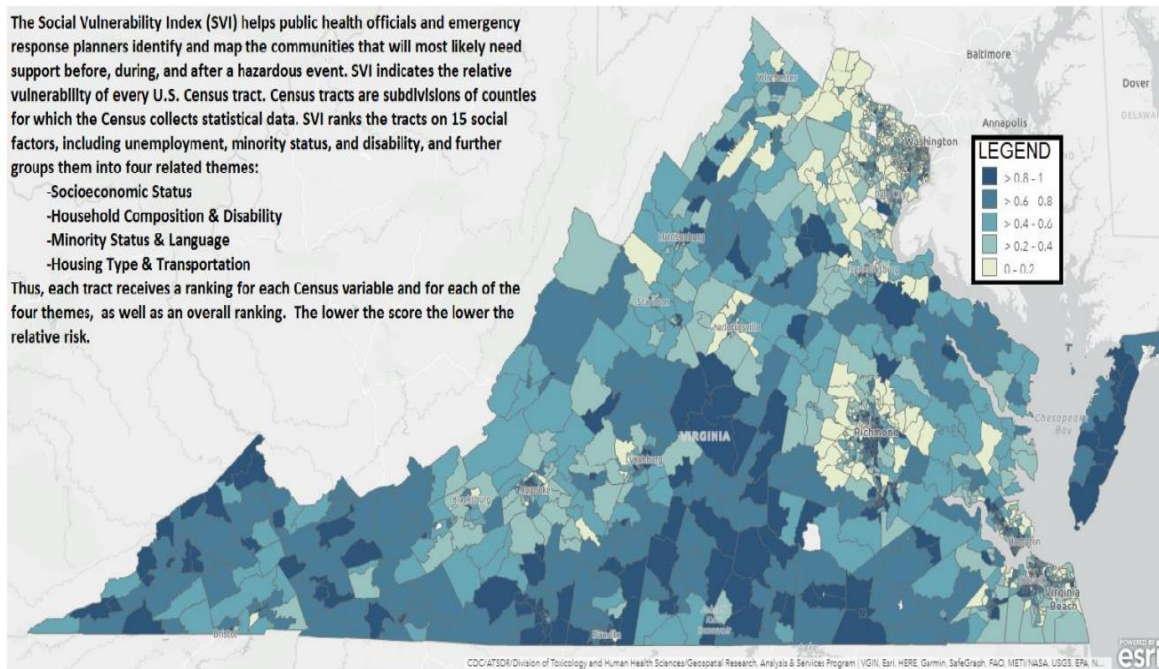


Figure 2.0
Data Source: CDC/ATSDR Social Vulnerability Index

Figure 15

Virginia Primary Care Professional * Shortage Areas (HPSAs) **

Updated as of 08/26/2022

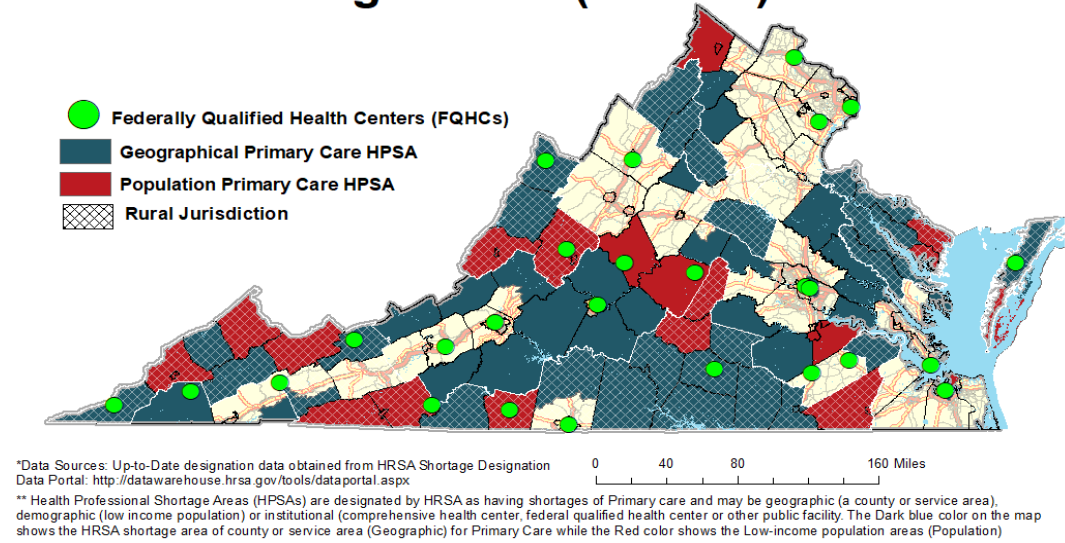
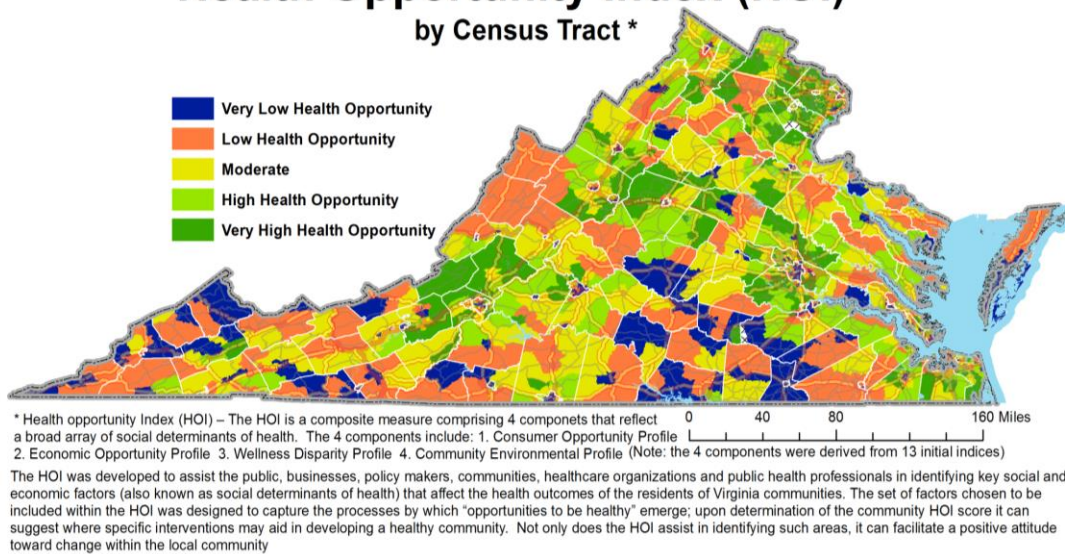


Figure 16

Virginia Health Opportunity Index (HOI) by Census Tract *



INFANT MORTALITY

In 2020, 543 infants died before their first birthday in Virginia, making the overall infant mortality rate 5.7 per 1,000 live births, improved from 5.9 in 2019. Since 2011, the overall infant mortality numbers have remained relatively constant, with a slight downward trend apparent in recent years. However, infant mortality rate varies by race and ethnicity. As Figure 17 shows, the infant mortality rate among the non-Hispanic white population was 4.8, while the rate among non-Hispanic Black infants was 10.7, which has remained stable in recent years. This disparity in infant mortality rates shows that Black infants were 2.2 times more likely to die than their White counterparts. Infant mortality also differed by locality. The top ten localities by highest counts had infant mortality rates ranging from 4.0 to 12.7 deaths per 1,000 live births (Figure 18). Due to the small numbers, localities could not be further broken down by race/ethnicity.

Figure 17

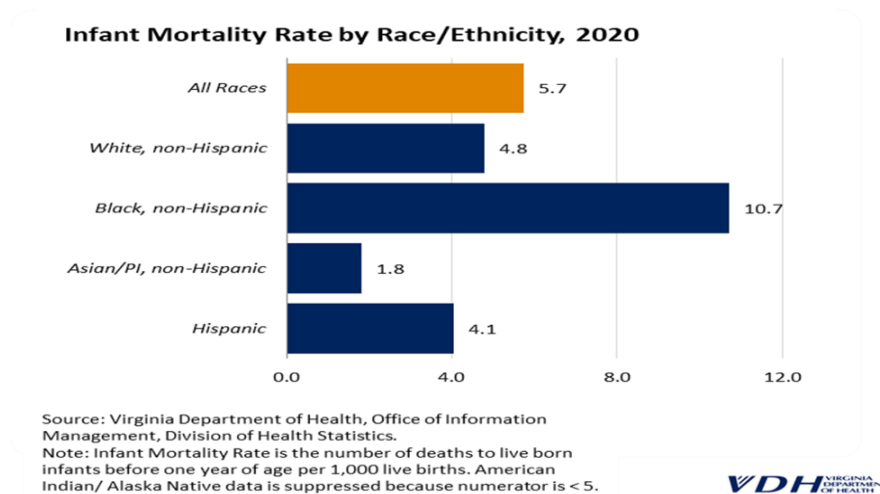
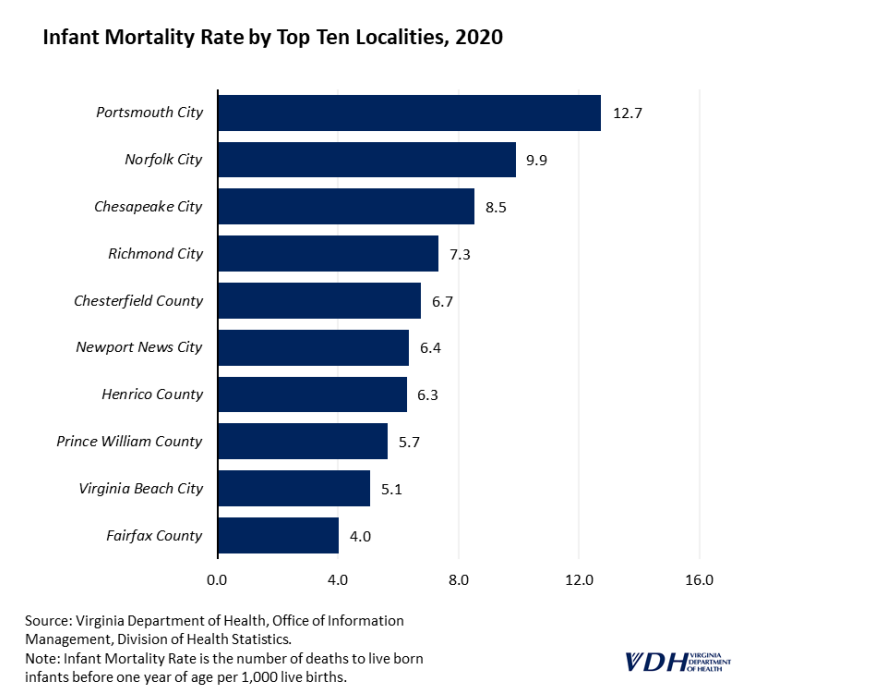


Figure 18

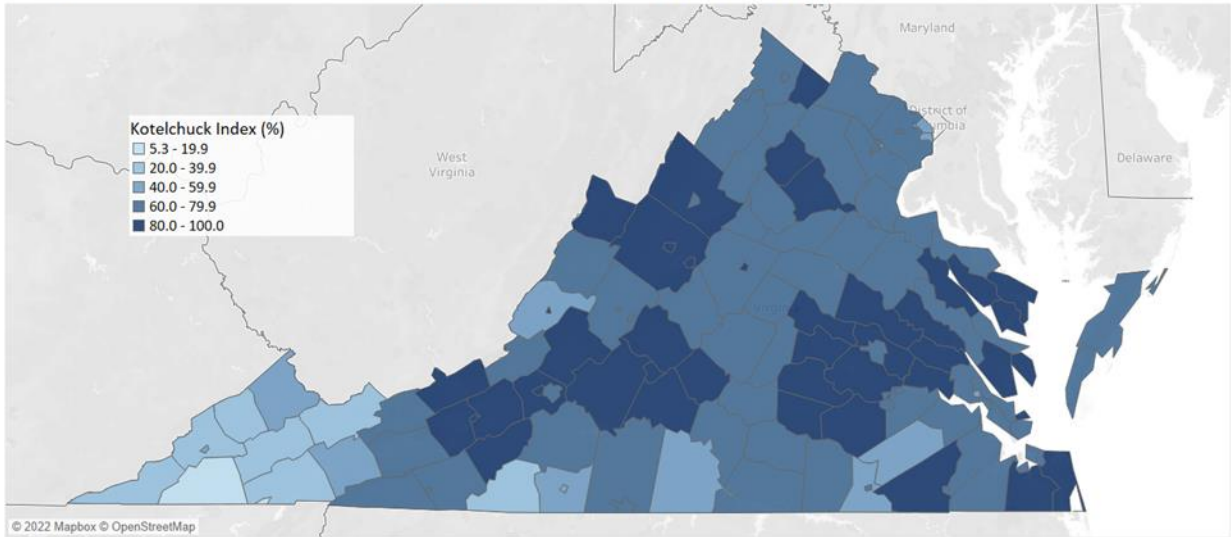


PRENATAL CARE

Adequacy of Prenatal Care is measured by the Kotelchuck Index. The index accounts for when prenatal care began (initiation) and the number of prenatal visits from when prenatal care began until delivery (received services), as documented on the birth record. Adequacy of initiation is classified as months 1-2, months 3-4, months 5-6, and months 7-9 of pregnancy. Adequacy of received services is classified by comparing the number of prenatal visits to the expected number of visits for the period between when care began and the delivery date, based on the ACOG prenatal care standards, and adjusted for gestational age when care began and at delivery. A ratio of observed to expected visits is calculated, with at least adequate care to have received 80% or more of expected visits. Overall, in 2020, nearly three-quarters (73.1%) of pregnant women received at least adequate prenatal care in Virginia, as measured by the Kotelchuck Index. However, this percentage varies by locality, from less than 25.0% (counties in the Southwest region) to 91.1% (Figure 19). Note that the Kotelchuck Index does not measure the quality of prenatal care services received.

Figure 19

Adequacy of Prenatal Care Utilization (Kotelchuck Index) by Locality, 2020



Source: Virginia Department of Health, Office of Information Management, Division of Health Statistics; Compiled from birth and death certificate files by the Division of Population Health Data, Office of Family Health Services.
Note: The Kotelchuck Index does not measure the quality of prenatal care services received.

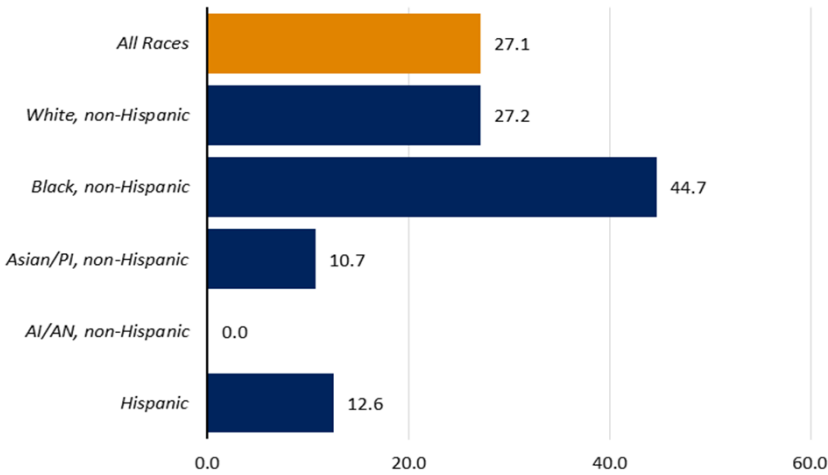


MATERNAL MORTALITY

Maternal mortality, as defined by the World Health Organization, is deaths related to or aggravated by pregnancy (not due to accidental/incidental causes) and occurring within 42 days of the end of a pregnancy. Maternal mortality has been trending upwards in Virginia. For 2016-2020, the five-year maternal mortality rate was 21.6 per 100,000 live births, higher than the US rate (19.3 per 100,000 live births). The maternal mortality rate is more than two times higher among non-Hispanic Black birthing mothers when compared with their non-Hispanic White counterparts (49.1 vs 23.7 per 100,000, respectively) (Figure 20). For 2016-2020, maternal deaths were highest in the most populous counties in Virginia, with rates ranging from 11.7 to 39.4 (Figure 21), well above the national rate for 2016-2020. (Note that in smaller counties, numbers are too small to make meaningful interpretations.)

Figure 20

Maternity Mortality Rate by Race/Ethnicity, 2016-2020

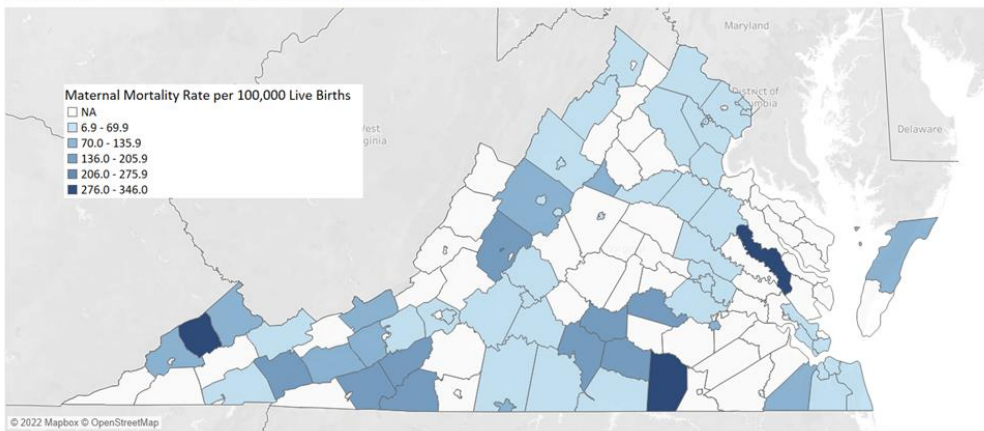


Source: Virginia Department of Health, Office of Information Management, Division of Health Statistics.
 Note: Maternal Mortality Rate is the number of maternal deaths due to direct and indirect obstetric causes per 100,000 live births.



Figure 21

Maternal Mortality Rate by Locality, 2016-2020



Source: Virginia Department of Health, Office of Information Management, Division of Health Statistics;
 Compiled from birth and death certificate files by the Division of Population Health Data, Office of Family Health Services.
 Note: Suppression rules must apply where rates of counts < 5. True zeros shown.

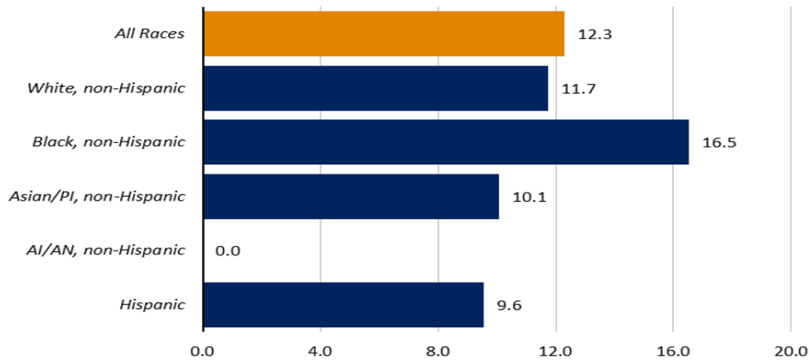


CHILD MORTALITY

In 2020, there were 139 deaths among children ages 1 through 9, with a rate of 12.3 per 100,000 children aged 1-9, which is below the national rate. The child mortality rate varied by race/ethnicity, with higher rates among non-Hispanic Black children (Figure 22) and by county, ranging from 36.9 to 7.2 (Figure 23).

Figure 22

Child Mortality Rate by Race/Ethnicity, 2020

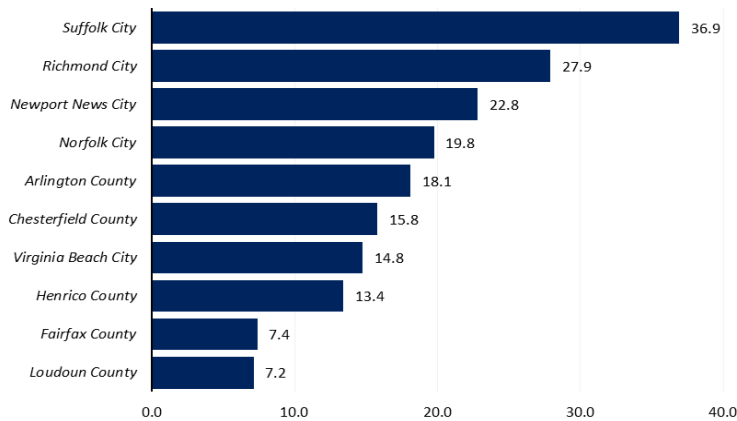


Source: Virginia Department of Health, Office of Information Management, Division of Health Statistics.
 Note: Child Mortality Rate is the number of deaths among children, ages 1 through 9 per 100,000 children, ages 1 through 9.



Figure 23

Child Mortality Rate by Top Ten Localities, 2020



Source: Virginia Department of Health, Office of Information Management, Division of Health Statistics.
 Note: Child Mortality Rate is the number of deaths among children, ages 1 through 9 per 100,000 children, ages 1 through 9.



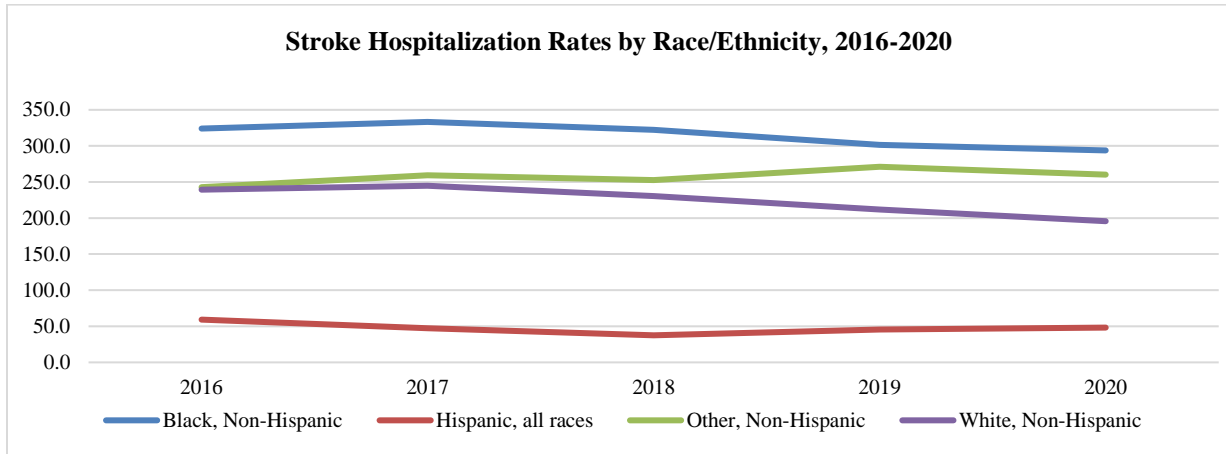
STROKE

Six in ten Americans live with at least one chronic disease, like asthma, heart disease, cancer, stroke, or diabetes. These and other chronic diseases are a leading causes of death and disability in Virginia, and they are also a leading driver of health care costs. Chronic conditions are typically defined as lasting one year or more. These conditions may limit the activities of daily living and may require ongoing medical attention.

Virginia is a member of the Stroke Belt, a region of southeastern states with high stroke incidence (stroke is the fourth leading cause of death in Virginia) and prevalence of cardiometabolic conditions including hypertension, diabetes, hypercholesterolemia, and obesity. Age is still the strongest predictive factor for stroke hospitalization and stroke death. Stroke and stroke death disproportionately impact Black or African American communities, where the stroke death rate is 50.8 compared to 38.3 for Virginia overall. The same disparities appear in stroke hospitalization rates in Virginia as shows in Figure 24. Disparities are also evident by geographic location. The localities with three

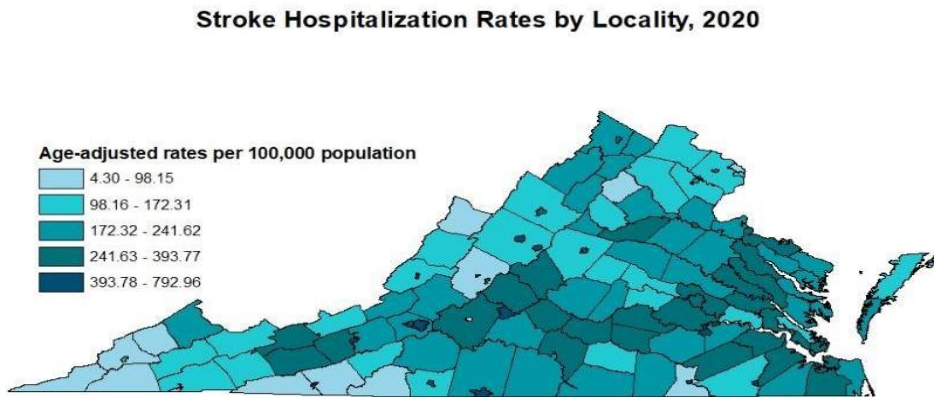
highest age-adjusted stroke mortality rates per 100,000 population for 2016-2020 were Franklin City at 96.3, Martinsville City at 94.4, and Galax City at 82.6. Figure 25 shows stroke hospitalization rates by locality.

Figure 24



Data Source: Virginia Health Information, 2020

Figure 25

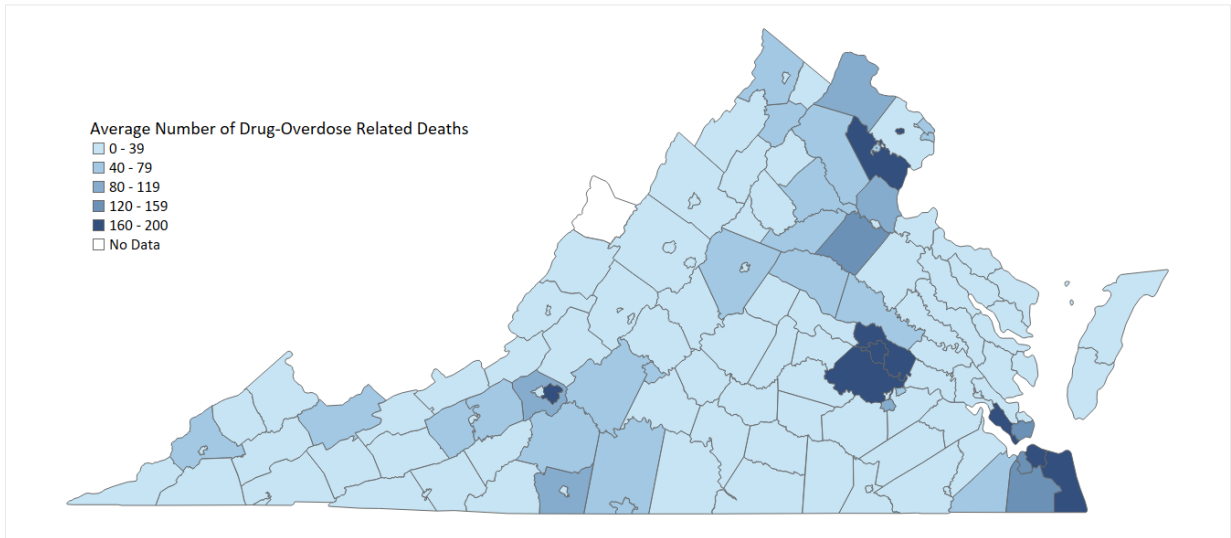


SUBSTANCE USE DISORDER

On average, almost six Virginians died by drug overdose every day during 2019-2021. Drug overdose deaths increased 70% from 2019 to 2021, and more than eight out of ten drug overdose deaths involved an opioid. Figure 26 shows drug overdose-related deaths by locality for 2019-2021.

Figure 26

Drug Overdose-Related Deaths by Locality, 2019-2021



Source: Virginia Department of Health, Office of Vital Records, Virginia Vital Events and Screening Tracking System; Analyzed by the OFHS Division of Population Health Data.
Note: Data are death certificate data maintained by VDH; data include Virginia residents only. Counts by locality are based on the locality of residence at time of death, whether or not the death occurred within the state.

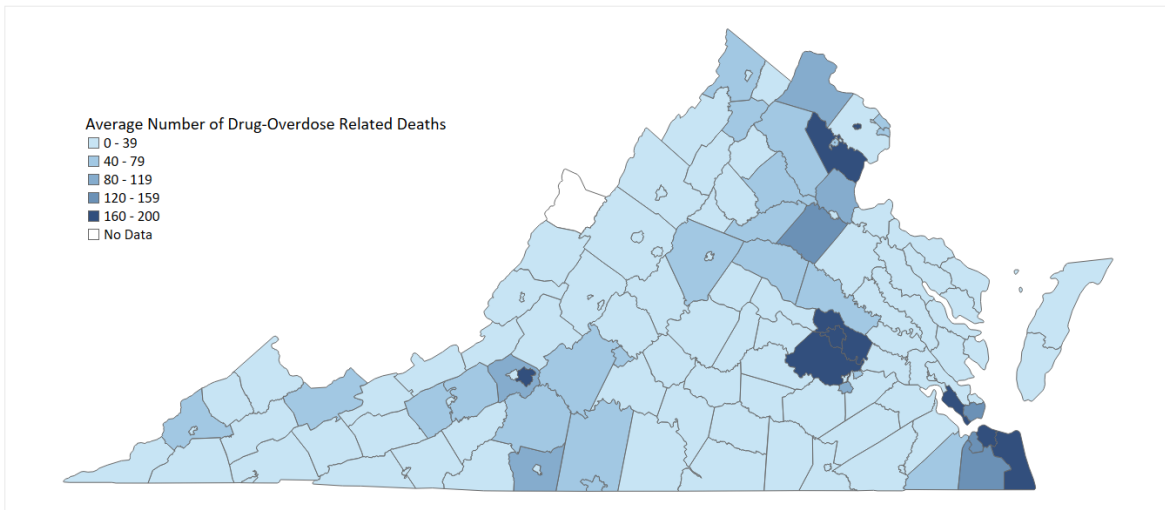


INJURY DEATHS

On average, three Virginians died by a firearm every day during 2019-2021. Virginia saw a 21% increase in firearm-related deaths from 2019 to 2021. Most firearm-related deaths in 2019-2021 were suicide deaths (60%), followed by homicide deaths (37%). Firearm-related homicide deaths increased 47% from 2019 to 2021 (342 in 2019 to 502 in 2021). Figure 27 shows firearm-related deaths by locality in Virginia for 2019-2021.

Figure 27

Drug Overdose-Related Deaths by Locality, 2019-2021



Source: Virginia Department of Health, Office of Vital Records, Virginia Vital Events and Screening Tracking System; Analyzed by the OFHS Division of Population Health Data.
Note: Data are death certificate data maintained by VDH; data include Virginia residents only. Counts by locality are based on the locality of residence at time of death, whether or not the death occurred within the state.

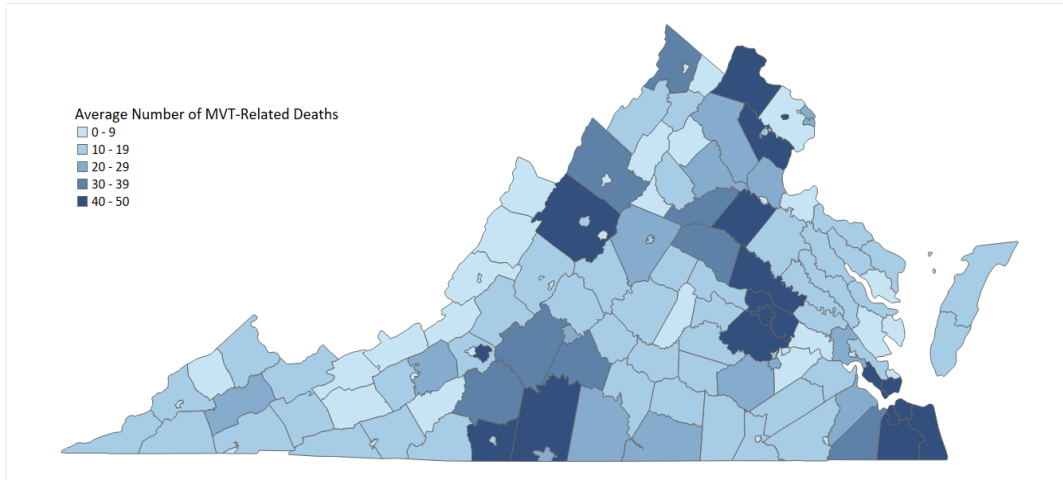


MOTOR VEHICLE DEATHS

On average, more than two Virginians died due to a motor vehicle traffic-related crash every day during 2019-2021. Motor vehicle-related deaths increased 14% from 2019 to 2021. Figure 27 shows motor vehicle traffic-related deaths by locality in Virginia for 2019-2021.

Figure 28

Motor Vehicle Traffic-Related Deaths by Locality, 2019-2021



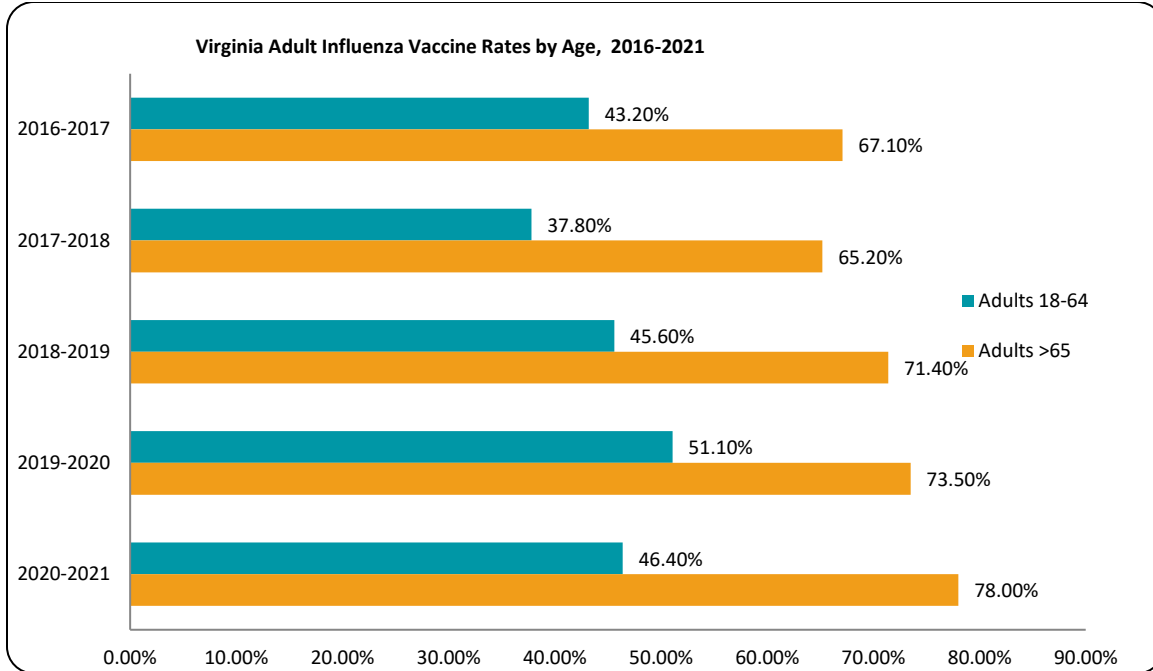
Source: Virginia Department of Health, Office of Vital Records, Virginia Vital Events and Screening Tracking System; Analyzed by the OFHS Division of Population Health Data.
Note: Data are death certificate data maintained by VDH; data include Virginia residents only. Counts by locality are based on the locality of residence at time of death, whether or not the death occurred within the state.



FLU IMMUNIZATION

In 2021 the proportion of adults > 65 years in Virginia who received their annual influenza vaccine reached 78%, an increase of 10.9% between 2016 and 2021, and exceeded the Healthy People 2030 goal of 70%.

Figure 29



APPENDIX: State Health Assessment 2022 Data Highlights Report

Indicators with Improving Trends

1. **Beach Water Quality Monitoring** The number of days for which beaches are under advisory in Virginia decreased from **67** days in 2017 to **61** days in 2021. The number of advisories decreased annually from **68** in 2018 to **32** in 2021. The number of beaches under advisory has been fairly stable with little variations over the years from 18 in 2017 to 16 in 2021.
2. **Elevated Blood Lead Levels in Children** The percentage of children < 6 years with elevated blood lead levels decreased from **2.9%** in 2016 to **1.9%** in 2019. (The number of children < 6 years tested for blood lead levels increased from **53,474** to **62,293** in 2021 from the previous year). The number of children < 16 years with elevated blood lead levels decreased from **3.0%** in 2017 to **2.0%** in 2021. (The number of children < 16 years tested for blood lead levels increased from **57,013** to **64,919** in 2021 from the previous year).
3. **Percent Population Served with Lead Levels Below Action Limit (0.015mb/L) (NTNC School and Non-School)** The percentage of the population served by non-transient non-community water systems that serve a school (NTNC School) and had lead levels below the action limit increased from **89.20%** in 2020 to **96.25%** in 2021. The percentage of the population served by non-transient non-community that do not serve a school (NTNC Non-school) increased from **84.75%** in 2020 to **97.80%** in 2021.
4. **Water Systems with Optimized Fluoride levels** The number of systems with optimized fluoride levels decreased yearly from **71** in 2016 to **63** in 2019; however, the number increased substantially in 2020 to **73**.
5. **Stroke Hospitalization Rate** The rate of stroke hospitalization decreased from **244.4** per 100,000 in 2016 to **208.1** per 100,000 in 2020. The rate of stroke hospitalization decreased yearly prior to 2020.
6. **Ischemic Heart Disease Hospitalization Rate** The incidence of hospitalizations due to ischemic heart disease decreased from **1,456.2** per 100,000 people in 2016 to **1,221.4** in 2020.

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7. **Asthma Hospitalization Rate** The asthma hospitalization rate in 2020 was **447.95** per 100,000 people, lower than it was in 2016 at **662.62**.
8. **Alzheimer’s and Dementia-related Disorders (ADRD) Hospitalization** The rate of ADRD hospitalization decreased from **555.76** in 2016 per 100,000 people to **466.27** in 2020.
9. **Arthritis Hospitalization Rate** The rate of arthritis hospitalizations decreased each year between 2016 and 2020, from **1059.78** per 100,000 people to **621.94** in 2020.
10. **Tuberculosis** The rate of tuberculosis infection in Virginia has decreased within 5 years from **2.4** per 100,000 population in 2017 to **1.9** per 100,000 population in 2021. However, Virginia has not met the Healthy People 2030 goal of 1.4 per 100,000 population.
11. **High School Students Who Reported Being in a Physical Fight** The percentage of high school students who reported being in a physical fight decreased between 2013 and 2019 from **23.5%** to **19.5%**.
12. **Non-Fatal Assault Hospitalizations** The number of hospitalizations from nonfatal assaults declined from **1,058** to **816** between 2016 and 2020.
13. **Nonfatal Hospitalizations from Traumatic Brain Injury among Youths in Virginia Aged 10-24 Years** The number of hospitalizations due to traumatic brain injury among Virginia youths decreased from 2016 at **742** to **591** in 2020.
14. **Nonfatal Hospitalizations from Non-Drug Poisoning** The number of hospitalizations from non-drug poisoning decreased yearly between 2016 and 2020 from **683** to **435**.
15. **Deaths From Non-Drug Poisoning** The number of non-drug poisoning deaths declined from **107** in 2016 to **78** in 2020.
16. **Influenza Vaccination Rate in Adults >65 Years Old** The proportion of adults > 65 years in Virginia who received their annual influenza vaccine increased between 2016 and 2021 from **67.1%** to **78.0%**. Virginia met the Healthy People 2030 goal of 70%.
17. **HPV Vaccination Among Adolescent Males** Among adolescent males, the HPV vaccination rate increased yearly from 2015 to 2019 from **32.0%** to **62.6%**. However, this is below the Healthy People 2030 goal of 80%.
18. **Combined 7-Series Vaccination among Children Aged 24 Months and Aged 35 Months** The percentage of children aged 24 months who received the combined 7-series vaccine increased to **73.3%** in 2018 from **68.8%** in 2017. The proportion of children aged 35 months increased between 2015 and 2018 from **75.2%** to **84.0%**
19. **Percentage of High School Students Who Reported Current Alcohol Use** The percentage of high school students who reported current alcohol use declined from **30.5%** in 2011 to **25.4%** in 2019.
20. **Percentage of High School Students Who Rode With A Driver Who Had Been Drinking** The percentage of high school students who rode with a driver who had been drinking declined for both male and females. For males, this percentage reduced from **19.6%** to **11.9%** between 2011 and 2019. For females, the percentage declined from **20.2%** to **14.1%**.
21. **Adults Who Reported Binge Drinking In The Past Month** The percentage of adults who reported binge drinking in the past month declined yearly from **16.0%** to **14.8%** between 2017 and 2020. Virginia met the Healthy People 2030 goal of 25.4% or below.
22. **Drug Overdose Deaths from Heroin** The number of deaths from heroin overdose declined annually from **540** deaths in 2017 to **414** deaths in 2020.
23. **Drug Overdose Deaths from Benzodiazepines** The number of deaths from benzodiazepine overdose decreased yearly from 210 in 2016 to 174 deaths in 2020.
24. **Uninsured Children under the Age of 19** The rate of uninsured children under the age of 19 decreased from **7%** in 2010 to **4.50%** in 2020.

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25. **Avoidable Hospitalizations** The percentage of avoidable hospitalizations in Virginia decreased from **14.20%** in 2016 to **12.60%** in 2019.
26. **Proportion of Adults that Delayed Medical Care due to Cost** The percentage of adults that delayed medical care due to cost decreased yearly from **12.10%** in 2015 to **10.40%** in 2020.
27. **Lung and Bronchus Cancer** The lung and bronchus cancer incidence declined yearly from 62.3 in 2012 to 53 in 2019. The rate of deaths from lung and bronchus cancer declined yearly from **48.5** per 100,000 population in 2010 to **33.8** in 2019. This is below the Healthy People 2030 goal of 25.1 per 100,000 population.
28. **Colorectal Cancer** The incidence of colorectal cancer in Virginia decreased from **37.8 in 2015** to **34.7 in 2019**. The rate of deaths due to colorectal cancer decreased from **15.2** deaths per 100,000 population in 2010 to **12.8** in 2019. However, Virginia has not met the Healthy People 2030 goal of 8.9 per 100,000 population.
29. **Teen Pregnancy** The rate of teen pregnancy in Virginia declined steadily from **40.2** per 1,000 females in 2010 to **17.3** per 1,000 females in 2020. The rates decreased for all races and ethnicities.
30. **Maternal Opioid Use Disorder** The rate of maternal opioid use disorder declined yearly from **5.6** to **4.7** per 1,000 delivery hospitalizations between 2016 and 2020. The rates decreased for all races.
31. **Children (ages 0 -17 years) with Special Health Care Needs** The percentage of children with special care needs decreased from **21%** in 2016 to **18%** in 2019-2020.
32. **HIV Incidence and Linkage to Care** The HIV incidence in Virginia declined from **925** in 2016 to **631** in 2020. The percentage of people with HIV diagnosis that were not linked in 90 days declined between 2016 and 2020 from **19.26%** to **13.47%**. The percentage of HIV Viral suppression increased from **74%** in 2016 to **80%** in 2020.

Indicators with Little or No Change in Trend

1. **Percent Population Served by Community Water Systems with Lead Levels Below Action Limit (0.015mb/L)** © Although on the increase, there have been subtle changes in the percentage of the population served with lead levels below action limit by community water systems © in Virginia over the years from **98.55%** in 2017 to **98.15%** in 2021.
2. **Hypertension Hospitalization Rate** The rate of hospitalizations due to hypertension decreased from 3,968.2 per 100,000 population in 2017 to 3,814.9 in 2018. In 2019, it increased to 3,900.2 and then decreased to 3,410.8 in 2020. The decrease in 2020 may be affected by issues with access to care during the pandemic.
3. **Chronic Kidney Disease (CKD) Hospitalization Rate** The rate of CKD hospitalization remained fairly stable in a 5-year period between 2016 and 2020 with rates ranging from **2,267.56** per 100,000 people to **2,277.28**.
4. **Nonfatal Hospitalizations From Traumatic Brain Injury (TBI)** Nonfatal traumatic brain injury related hospitalizations remained relatively stable within 5 years from **4,742** to **4,752** hospitalizations between 2016 and 2020.
5. **Households With No Vehicle Available** The proportion of households with no available vehicles remained fairly constant with mild variations within 11 years from **6.3%** in 2010 to **6.1%** in 2020.
6. **Proportion of Adults With a Usual Primary Care Provider** The proportion of adults with a usual primary care provider was relatively stable at around **69.5%** from 2013 to 2019.
7. **Female Breast Cancer** The female cancer incidence increased slightly from **126.1** in 2010 to **132.3** in 2019. The rate of deaths from breast cancer decreased from **22.2** per 100,000 population in 2010 to **19.2** per 100,000 population in 2019; however, it has not met the Healthy People 2030 goal of 15.3 per 100,000 females.

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8. **Prostate Cancer** The incidence rate of prostate cancer has fluctuated over the past 10 years; it increased from **99** in 2018 to **107.6** in 2019. The rate of prostate cancer deaths had mild variations over 10 years from 2010 to 2019, from **22.2** deaths per 100,000 population to **19.9**. However, Virginia has not met the Healthy People 2030 goal of 16.9 per 100,000 population.
9. **Hepatitis C Infection** The incidence rate of Hepatitis C infection decreased yearly between 2016 and 2018 from **75.2** to **52.4** cases per 100,000 population. It increased in 2019 to **65.2** and decreased in 2020 (**42.2**) and 2021(**41.1**).
10. **Infant Mortality** The overall infant mortality rate in Virginia remained fairly constant in 11 years from **5.26** per 1,000 live births in 2010 to **5.73** per 1,000 live births in 2020. This is true for all races and ethnicities except for American Indian/Alaska Natives whose infant mortality rate varied from **6.37** per 1,000 live births in 2016 decreasing to **0.00** in 2018 and then increased yearly between 2019 and 2020 from **6.25** to **12.12** per 1,000 live births in 2020. However, the AI/AN population in Virginia is very small, which leads to instability in the rates when comparing them annually to other races.
11. **Child (1 to 9 years) Mortality Rate** The child mortality rate had little variation between 2009 and 2020, from **15.7** per 100,000 population to **15.0**.

Indicators with Worsening Trends/Issues of Concern from the Virginia State Health Assessment 2022

1. **Adults Reporting Poor Physical Health** The percentage of adults reporting 14 or more days of poor physical health in the past 30 days increased from **11%** in 2016 to **11.7%** in 2019
2. **Adult Consumption of Fruits and Vegetables** The percentage of adults who consumed fruits and vegetables 5+ more times a day decreased from **17.8%** in 2013 to **16.1%** in 2019. The percentage of adults who did not eat fruits and vegetables at least once a day increased from **37.4%** in 2013 to **38.3%** in 2019
3. **Adults Who are Aerobically Active For 150 Minutes Each Week and No Leisure Time Physical Activity in the Past Month** The percentage of adults who are aerobically active for 150 minutes each week has decreased from **51.9%** in 2013 to **50%** in 2019. This is below the Healthy People 2030 goal of 59.2%. The percentage of people with no leisure activity has worsened in four years increasing from **23.3%** in 2016 to **25.3%** in 2019. This has not met the Healthy People 2030 target of 21.2%.
4. **Adults who are Overweight or Obese** The percentage of adults who are overweight or obese had a little increase from **65.4%** in 2016 to **66.4%** in 2019. However, Virginia is far from meeting the Healthy People 2030 goal of 36.0%
5. **Diabetes Hospitalization Rate** The rate of hospitalization due to diabetes increased yearly from **1588.8** in 2016 to **1852.49** in 2019. The rate decreases in 2020 to 1,648.15 in 2020; however, this may be due to decreased access to care during the COVID 19 pandemic.
6. **Hotline Calls Related to Sexual Violence** Hotline calls to the state sexual and domestic violence increased between 2017 and 2021, from **9,077** to **11,086** calls.
7. **Nonfatal Hospitalizations and Deaths from Firearms** The rate of nonfatal hospitalizations from firearms worsened, increasing from **728** in 2016 to **756** in 2020. The number of deaths from firearms increased from **1,027** in 2016 to **1,164** in 2020.
8. **Homicide Deaths** The number of deaths from homicides worsened, increasing from **434** deaths in 2016 to **516** deaths in 2020.
9. **Middle School Students Who Reported Being in a Physical Fight** The proportion of middle school students who reported being in a physical fight increased from **44.4%** in 2013 to **45.8%** in 2019.
10. **Deaths from Unintentional Falls** Deaths from unintentional falls increased yearly from **811** in 2016 to **981** in 2020.
11. **Deaths from Traumatic Brain Injury** The number of deaths from traumatic brain injury increased between 2016 and 2020 from **1,644** to **1,876**. The number of traumatic brain injury deaths among youths in Virginia worsened, increasing from **258** to **317** between 2016 and 2020.

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12. **Influenza Vaccine Rates in Adults 18-64 years and in Minority Groups** The percentage of adults who received influenza vaccine declined from **51.1%** from 2019-2020 to **46.40%** in 2020-2021. While the percentage of the white population who received influenza vaccine increased between 2016 and 2021 from 51.3% to 60.9%, it decreased among the Black population from **52.5%** in 2019 to **45.6%** in 2021 and decreased among the Hispanic population from **51.4%** in 2016 to **45.2%** in 2021. For other/multiple races, the influenza vaccine rates declined from **61.3%** to **56.6%** between 2019 and 2021.
13. **HPV Vaccine Among Adolescent Females** The proportion of females who received the HPV vaccine declined from **60.1%** in 2018 to **56.6%** in 2019. This is below the Healthy People 2030 goal of 80%.
14. **Percentage of Middle School Students Who Rode With A Driver Who Had Been Drinking** The percentage of middle school students who rode with a driver who had been drinking worsened for both boys and girls. For boys, it increased from **13.7%** in 2017 to **15.3%** in 2019, and for girls, it increased from **16.5%** in 2017 to **18.0%** in 2019.
15. **Alcohol Attributable Deaths** Alcohol attributable deaths in Virginia increased every year between 2016 and 2020, from **2,926** to **3,667** deaths.
16. **High School Students Who Reported Marijuana Use in the Past 30 Days** The percentage of high school students who reported marijuana use in the past 30 days increased yearly between 2015 and 2019 from **16.2%** to **17.3%**.
17. **Nonfatal Cannabis Hospitalizations** Hospitalizations from cannabis increased every year from **17,796** in 2016 to **20,303** in 2019. There was a decrease to **19,837** in 2020, which may be related to the pandemic.
18. **Drug Overdose Deaths** While the number of nonfatal drug overdose hospitalizations decreased yearly from 2016 (except in 2019) to 2020 from **8,069** to **7,526**, the number of deaths from drug overdose increased yearly between 2016 and 2020 from **1,324** to **1,749** deaths. This is true for all opioids, which increased from 1,078 deaths in 2016 to 1,478 deaths in 2020; synthetic opioids (except methadone), which increased from 624 in 2016 to 1,303 deaths in 2020; cocaine, which increased from 335 in 2016 to 435 in 2020; and psychostimulants, which increased from 66 in 2016 to 326 in 2020.
19. **Cost Burdened Households** The percentage of cost burdened households in Virginia increased from **28.5%** in 2017 to **29.0%** in 2020.
20. **Homeless Students in Virginia** The number of homeless students in Virginia increased from **7,663** in 2011 to **10,268** students in 2020.
21. **Average Commute To Work Driving Alone** The average commute to work driving alone increased yearly 2010 to 2020 from **25.9** minutes to **28.6** minutes.
22. **Early Syphilis Infection** The rate of early syphilis increased in Virginia from **13.5** in 2017 to **16.4** per 100,000 population in 2021.
23. **Congenital Syphilis Infection** The number of congenital syphilis increased from **0-2** cases per year in 2009- 2012 to **17** cases in 2021.
24. **Gonorrhea Infection** The rate of gonorrhea infections per 100,000 population increased yearly from **144.08** in 2017 to **174.12** in 2020. However, this rate decreased to **167.1** in 2021
25. **Prenatal Care** The number of women who received inadequate care increased for all races. It increased from **7.7%** in 2012 to **21.6%** in 2020 for Hispanics, **2.8%** in 2012 to **14.5%** in 2020 for Blacks, and **4.0%** in 2012 to **9.3%** in 2020 for White.
26. **Proportion of Adults Who Have Seen a Dentist in the Past Year** Although the proportion of adults who have seen a dentist in the past year has varied widely in 11 years, it decreased from **76.2%** in 2019 to **70.0%** in 2020.
27. **Life Expectancy and Years of Potential Life Lost** The overall life expectancy in Virginia decreased from **79.7** years in 2019 to **78.3** years in 2020. The years of potential life lost increased between 2016 and 2020, from **6,584.3** per 100,000 population to **7,549.4**.

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28. **Chronic Obstructive Pulmonary Disease (COPD) Hospitalization Rate** The rate of COPD hospitalization increased yearly from **1,188.3** per 100,000 people in 2016 to **1,357.5** in 2019. It decreased in 2020 to 1,202.9, likely due to factors associated with the COVID-19 pandemic.
29. **Deaths From Drowning** The number of deaths from drowning in Virginia increased yearly from **78** in 2017 to **93** in 2019. There was a decline in 2020 to **88**, but this may have been affected by the pandemic.
30. **Reports of Forcible Sex Offenses** Although the number of forcible sex offenses reported to the police decreased in 2020, this number had an increasing trend between 2016 and 2019 from **5,529** to **5,854**. The decrease in 2020 may be due to the effect of the pandemic
31. **Maternal Opioid Related Diagnosis** The rate of maternal opioid related diagnosis increased yearly from **7.7** in 2016 to **9.0** in 2019. However, this rate decreased to **7.7** per 1000 delivery hospitalizations in 2020. The decline in 2020 may be due to the effects of the pandemic.
32. **Rate of Neonatal Abstinence Syndrome** The overall rate of neonatal abstinence syndrome decreased between 2016 and 2018 from **6.5** to **7.0** per 1,000 birth hospitalizations and then increased to **7.2** in 2019. However, in 2020, there was a marked decrease to **5.8** per 1,000 birth hospitalizations. This decline in 2020 may be due to the effects of the pandemic.