

Board of Health Meeting: Nominating Committee

June 12, 2025
Wytheville, Virginia

Agenda

Call to Order and Welcome

Daniel Critzer, Chair

Nomination of Officers

Committee Members

Adjourn

Mr. Critzer

Board of Health Quarterly Meeting

June 12, 2025
Wytheville, Virginia

WELCOME AND INTRODUCTIONS

AGENDA

Agenda	
Call to Order and Welcome	Gary Critzer , Chair
Introductions	Mr. Critzer
Welcoming Remarks	Stephen Bear County Administrator, Wythe County
Review of Agenda	Joe Hilbert Deputy Commissioner for Governmental and Regulatory Affairs
Approval of March 20, 2025 Minutes	Mr. Critzer
Commissioner’s Report	Karen Shelton, MD State Health Commissioner
Regulatory Action Update	John Kotyk Legislative and Regulatory Coordinator
Break	
Public Comment Period	
<u>Lunch Presentation</u> Maternal and Child Health Initiatives	Meagan Helmick, PhD, MPH, CHES Director, Mt. Rogers Health District Mary Anne Hall, RN, BSN Public Health Nurse, Senior Tricia VanHoy, RN, BSN Nurse Manager, Senior Vicky Richardson, RN, BSN Public Health Nurse Supervisor Rebecca Riggins Resource Mother, Certified CHW Donna Surber CHW, Maternal Health Doula

Agenda cont.	
Non-Regulatory Item: Virginia Telehealth Plan 2026-2030	Mara Servaites, MSW, PCMH CCE Executive Director, Virginia Telehealth Network Robin Clair Cummings, MSHA Deputy Advisor, Quality and Strategy Virginia Telehealth Network
Regulatory Action Items: Final Exempt Actions Amending: Rules and Regulations Governing the Construction of Migrant Labor Camps 12VAC5-501 Sewage Handling and Disposal Regulations 12VAC5-610 Private Well Regulations 12VAC5-630	Julie Henderson Director, Office of Environmental Health Services
Rainwater Harvesting System Regulations 12VAC5-635 (Final Exempt Amendments)	Ms. Henderson
Electronic Meeting Policy	Mr. Hilbert
Report of Nominating Committee	Ms. Ramos, Chair
Other Business	
Adjourn	

MINUTES FROM MARCH 20, 2025

**State Board of Health
March 20, 2025- 9:00am
Perimeter Center, Boardroom 2**

Members Present: Gary Critzer, Chair; Douglas Daniels, DVM; Michael Desjadon; Anna Jeng, ScD; Melissa Nelson, MD; Vickie Runk; James Cole; Ann B.R. Vaughters, MD; Walter Vest, MD; and Cindy Warriner, BS, RPh, CDE.

Members Absent: Maribel Ramos; Lee Jones, DMD; Patricia Anne Kinser, PhD, WHNP-BC, RN; Elizabeth Ruffin Harrison

Ann B.R. Vaughters, MD participated virtually due to a personal matter.

Virginia Department of Health (VDH) Staff Present: Kim Beazley, Director, Office of Licensure and Certification; Dr. Maria Beermann-Foat, Director, Office of Emergency Medical Services; Michael Capps, Senior Policy Analyst; Dr. Susan Fischer Davis, Chief Deputy Commissioner for Community Health Services; Stephanie Dunkel, Deputy Commissioner for Population Health and Preparedness; Dr. Laurie Forlano, State Epidemiologist; Melissa Gordon, Deputy Director for Digital Communications; Joe Hilbert, Deputy Commissioner for Governmental and Regulatory Affairs; Breanne Forbes Hubbard, Workforce Development and Engagement Director; John Kotyk, Legislative and Regulatory Coordinator; R. Christopher Lindsay, Chief Operating Officer; Dorinda Mercer, Agency Star; Melissa Gordon, Deputy Director, Office of Communications; John Ringer, Chief Financial Officer; Dr. Karen Shelton, State Health Commissioner; Keshia Singleton, Agency Star; Patrick Wiggins, Cardiovascular Health Supervisor

Other Staff Present: Robin Kurz, Senior Assistant Attorney General

Call to Order

Mr. Critzer called the meeting to order at 9:05 am.

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

Mr. Hilbert reviewed the agenda, and the items contained in the Board's binder.

Approval of December 5, 2024 Minutes

The minutes from the December 5th meeting were reviewed. Ms. Warriner moved to approve the minutes, and Dr. Vest seconded the motion, which was then approved unanimously.

Commissioner's Report

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

- Agency Stars

- Key Personnel Changes
- Respiratory Disease Updates
- Status of Federal Funding
- JLARC Corrective Action Plan Update
- Radiological Health – Fusion Program
- Richmond City Drinking Water Situation
- Health Workforce Incentive Programs Update
- VDH Employee Advisory Council
- State Health Services Plan Task Force Update
- VDH Internship Academy
- State of the Agency

During the Commissioner’s report, Mr. Lindsay gave an update regarding the Office of Emergency Medical Services.

There were discussions regarding respiratory disease outbreaks and the impact of vaccinations; the possible correlation of the increase in rates of Syphilis in women in Virginia with human trafficking; workforce incentive programs for other non-nursing staff such as dentists, pharmacists, veterinarians; COVID-19 as a reportable condition and its funding sustainability; and local health district expectations regarding the new Office of Grants Administration.

Regulatory Action Update

Mr. Kotyk reviewed the summary of all pending VDH regulatory actions. There are 51 pending actions under development:

- 13 NOIRAs
- 11 proposed actions
- 4 final actions
- 23 fast track actions

Since the December 2024 Board Meeting, the Commissioner has not taken any regulatory action on behalf of the Board while the Board was not in session.

Since the December 2024 meeting the Commissioner has not taken any non-regulatory action on behalf of the Board while the Board was not in session.

Mr. Kotyk advised the Board that there are 8 periodic reviews in progress:

- 12 VAC 5-125 Regulations for Bedding and Upholstered Furniture Inspection Program
- 12 VAC 5-371 Regulations for the Licensure of Nursing Facilities
- 12 VAC 5-381 Home Care Organization Regulations
- 12 VAC 5-507 Guidelines for General Assembly Nursing Scholarships and Loan Repayment Program Requiring Service in a Long-Term-Care Facility
- 12 VAC 5-520 Regulations Governing the State Dental Scholarship Program
- 12 VAC 5-545 Guidelines for the Nurse Educator Scholarship
- 12 VAC 5-590 Waterworks Regulations

- 12 VAC 5-620 Regulations Governing Application Fees for Construction Permits for

Onsite Sewage Disposal Systems and Private Wells

Mr. Kotyk and Mr. Hilbert gave a brief overview of the regulatory development and review processes, including anticipated timelines.

Public Comment Period

There was 1 person signed up for the public comment period. Sarah Holland spoke on behalf of Dr. Linden Cooper (Dean of VCU Dental School) regarding the benefits of drinking water fluoridation and urged the Board members to uphold this measure.

Submitted written comment can be found at the end of the minutes document.

Lunch presentation: Travel Meeting June 2025 Overview

Mr. Hilbert reviewed the itinerary, logistics, and next steps regarding the June 11-12, 2025, Board meeting hosted by the Mt. Rogers Health District.

Notice of Intended Regulatory Action: Regulations for the Licensure of Hospices (12VAC5-391)

Ms. Beazley presented a Notice of Intended Regulatory Action (NOIRA) regarding the Board's hospice regulations. This regulatory action seeks to amend the Regulations for the Licensure of Hospices to make updates to better conform the regulatory language to the language in the Code of Virginia and the Virginia Register of Regulation's *Form, Style, and Procedure Manual for Publication of Virginia Regulations*.

Ms. Warriner made a motion to approve the Notice of Intended Regulatory Action, seconded by Mr. Desjadon. The motion passed unanimously by voice vote.

Notice of Intended Regulatory Action: Regulations for the Licensure of Hospitals in Virginia (12VAC5-410)

Ms. Beazley presented a Notice of Intended Regulatory Action (NOIRA) regarding the Board's hospital regulations. This regulatory action seeks to repeal the existing regulations for the Licensure of Hospitals in Virginia and create two new chapters that address inpatient hospitals and outpatient surgical hospitals separately. There was brief discussion regarding the definition of "outpatient hospital" in 12VAC5-410-10.

Mr. Cole made a motion to approve the Notice of Intended Regulatory Action, seconded by Dr. Vest. The motion passed unanimously by voice vote.

Informational Presentation: Virginia Healthy Hearts Initiative

Mr. Wiggins presented the Virginia Health Hearts Initiative to the Board. He shared that this initiative, which is funded by two grants from the U.S. Centers for Disease Control and Prevention, is aimed at improving the cardiovascular health of priority populations currently in three regions in Virginia; Central, Eastern and Southwest, and acknowledges the need to expand to other localities in Virginia. Mr. Wiggins described the Healthy Hearts Learning Collaboratives' community-centered guiding principles and

highlighted the timeline for implementing an action plan and delivering stipends to the Learning Collaborative members. He also mentioned that the initiative collaborates with various state partners and programs in three major categories - hospitals, clinics, and the community - using the Unite Us and other local referral systems.

There were discussions regarding the evaluation metrics to assess the long-term impact of the Healthy Hearts Initiative on particular health outcomes; a recommendation to include the Department of Medical Assistance Services (DMAS); learning collaborations leading to building community relationships and breaking down silos; and collaborations with local farmers.

2025 General Assembly Legislative Update

Mr. Kotyk and Mr. Hilbert gave an update on the 2025 General Assembly Session, including bills related to maternal health, prescription drugs, hospitals, food allergies, homeless youth vital record fees, waterworks, and prescribed pediatric extended care centers. Mr. Hilbert provided information on the Agency Bills that passed out of the 2025 session: HB2253/SB1383 regarding nursing home sanctions and HB2255/SB1484 regarding hospital and nursing home licensure fees.

There was discussion regarding the status of HB2610.

2025 General Assembly Budget Update

Mr. Ringer presented to the Board the VDH budget based on the actions of the 2025 General Assembly Session. The presentation included budget, amendments for VDH programs and offices and salary adjustments.

Appointment of Nominating Committee

Mr. Critzer appointed Dr. Lee Jones (Chair), Maribel Ramos, and Cynthia Warriner to the nominating committee. The nominating committee will meet in June prior to the Board meeting to recommend a slate of officers for the Board.

Member Reports/Updates

Ms. Warriner thanked VDH staff for putting together the information on Pharmacy Benefits Managers (PBMs). There was further discussion on the DMAS initiative to contract with a single PBM across Medicaid Managed Care Organizations; and the need to address pharmacy deserts in communities across Virginia.

Adjourn

The meeting adjourned at 1:32pm.

The remainder of the document is written comment submitted at the Board meeting. It may not reflect the position or opinions of the Board or members.

DRAFT - NOT APPROVED



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March 19, 2025

Dear Members of the Virginia State Board of Health,

As Virginia's only dental school, we train future oral health professionals and see firsthand the impact of fluoride in preventing cavities and reducing dental disease. The science is clear—community water fluoridation is one of our most effective, equitable, and cost-saving public health measures. It benefits everyone, regardless of age, income, or access to dental care, and has been proven to reduce tooth decay by at least 25% in children and adults alike.

In our clinics, we treat far too many patients—particularly children and older adults—who suffer from preventable dental disease. Untreated cavities can lead to pain, missed school and work, and costly emergency care. Unfortunately, every year I personally see 16- to 25-year-old individuals have all of their teeth extracted due to rampant decay, often associated with growing up with unfluoridated water. This condemns them to a very well documented lifetime of reduced well-being. Fluoridation helps prevent these issues before they start, strengthening teeth and protecting smiles across Virginia.

As a healthcare leader, I urge you to uphold and expand this vital public health measure. Fluoridation is safe, effective, and essential for a healthier Virginia.

Respectfully,

Lyndon F. Cooper, DDS, PhD, FACP

Dean, VCU School of Dentistry

cooperlf@vcu.edu

Commissioner's Report

Dr. Karen Shelton
State Health Commissioner

Presentation Outline

- Agency Stars
- Key Personnel Changes
- Infectious Disease Update
- Maternal Health Dashboard
- Federal Funding Update
- Nursing Home Oversight
- Electronic Health Record Project Status
- HIPAA & Privacy Update
- Harmful Algal Blooms
- Hurricane Season Preparation
- Emergency Medical Services Update
- VDH Internship Academy
- Development of Accountability and Performance Metrics
- Public Health Reaccreditation

Agency Stars

Wendy DiGiacomo – Accountant Senior, Mount Rogers Health District

Mary Anne Hall – Public Health Nurse Senior, Mount Rogers Health District

Key Personnel Changes

Assistant Chief Financial Officer: Kathy Czerwonka

Director, Office of Financial Management: Wai Levy

Director, Office of Grants Management: Presepine Fleming

Measles Update

- In March, [two confirmed measles cases](#) were reported in Maryland residents who became ill after traveling internationally. VDH responded to exposures at Dulles International Airport and public locations in Northern Virginia. No secondary cases were reported.
- VDH responded to a [confirmed measles case](#) in a resident of Northwest Virginia identified on April 19. The case-patient was a pre-school-age child who developed measles symptoms after international travel.
 - Over 100 contacts were identified following exposures at multiple healthcare facilities. VDH conducted contact follow-up and provided post-exposure prophylaxis and quarantine recommendations to non-immune contacts. No secondary cases were reported.
- In May, a [second confirmed case](#) was identified in a teenager in the Northwest Region who had recently traveled internationally.
 - VDH identified over 350 contacts across multiple public exposure locations including two healthcare facilities. In partnership with UVA Hospital, VDH provided post-exposure prophylaxis and quarantine recommendations to non-immune contacts.
 - 1 secondary case was reported on June 5 in a child (0-4 years) in Northwest Virginia. VDH distributed a regional [new release](#) to notify the public of two potential exposure locations.
- VDH is closely monitoring measles activity within the United States and abroad. VDH continues to use active and passive surveillance methods to monitor for suspect measles cases requiring public health investigation.

MMR Vaccine Dashboard

[MMR – Immunization \(virginia.gov\)](https://www.virginia.gov/immunization)

Virginia MMR Vaccine Dashboard

Locality Name

(All)

Age Group

2 year olds at least one dose

Data refreshed on : 5/6/2025

Age Group

2 year olds at least one dose

2 year olds at least one dose

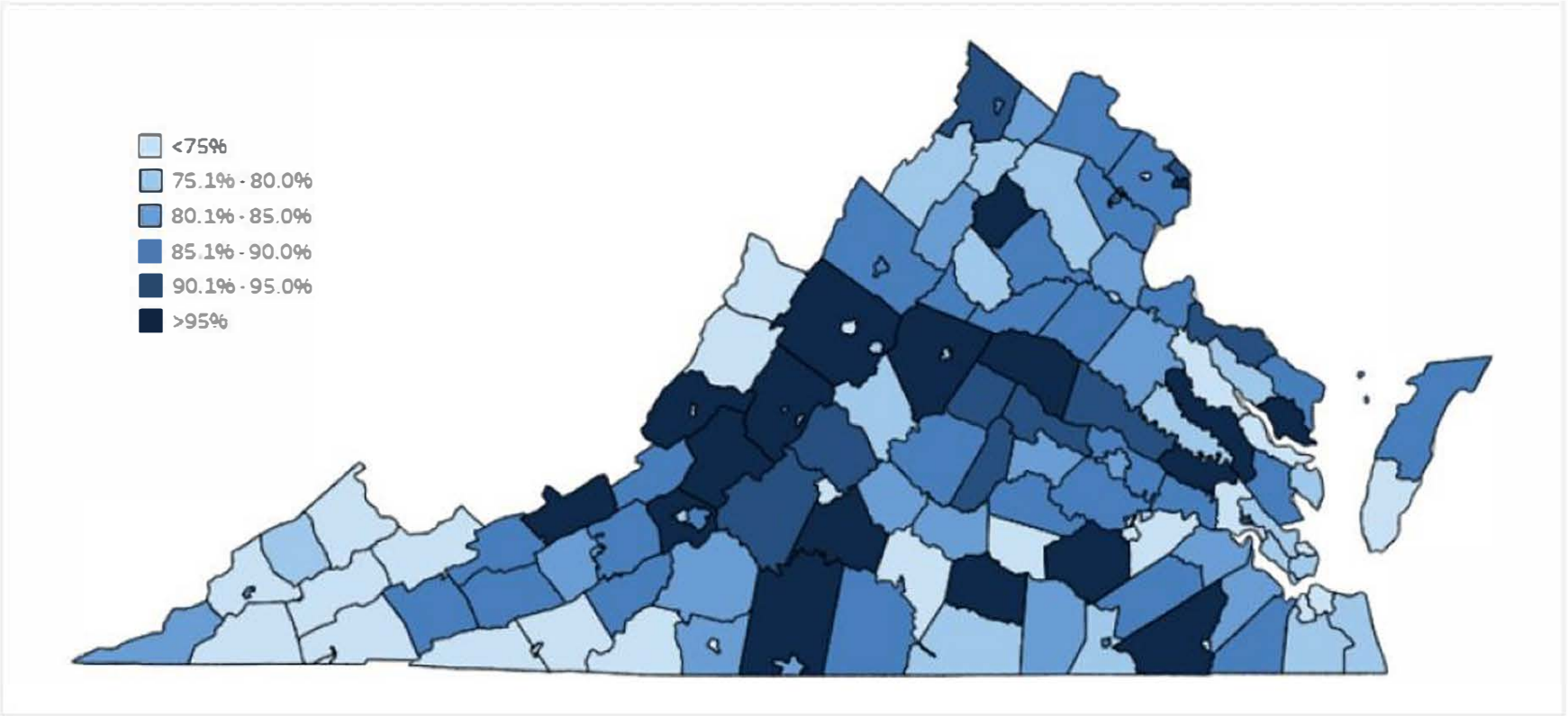
5 year olds at least one dose

5 year olds series complete

7 year olds at least one dose

7 year olds series complete

The MMR Vaccination Rate for 2 year olds in Virginia is 89.2% (86,680 people)

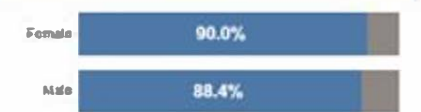


MMR Vaccination Rate for 2 year olds by Race & Ethnicity in Virginia



There were a total of 22,106 (22.8% of all MMR recipients) people who received a MMR vaccination where Race & Ethnicity was not reported (Unknown).

MMR Vaccination Rate for 2 year olds by Sex in Virginia



There were a total of 10 (0.0% of all MMR recipients) people who received a MMR vaccination where Sex was not reported (Unknown).

MMR Vaccine Record Portal

1

Vaccination Record Request Portal

The record request portal allows you to search for your vaccines in the Virginia Immunization Information System (VIIS) for COVID-19, MMRs, Tetanus, and Polio (MMTV) and Measles. The ability to pull down your records of other vaccines is not yet available. Vaccines administered outside of Virginia are unlikely to be in VIIS. Vaccines administered prior to 2017 are less likely to be in VIIS. A phone number associated with your vaccine record needs to be in VIIS to pull down your record.

Search for your Vaccination Record
Please enter the information below to locate your vaccination in the Virginia Immunization Information System, and then click the Search button.

Select Record Type ¹

☐ COVID-19 ☐ MMRs ☐ Tetanus, Shingles, and Polio (MMTV)

First Name

Last Name

DOB (MM/DD/YYYY)

ZIP Code where you live

Search

2

Two-Factor Verification

A verification code will be sent to the SMS or voice phone number associated with your vaccination record. The code will expire in 30 minutes. If you do not have access to the phone number, please call 877-VAX-IN-VA (877-829-4682), Monday through Friday from 8 a.m. to 5 p.m. ET.

Back **Verify Code**

Choose how you would like to receive the verification code and click on "Send Verification Code" button.

☒ Text Message (SMS) to (***) *** 9606 (Message & Data rates may apply)

☐ Voice Call to (***) *** 9606 (Call charges may apply)

Send Verification Code

Please enter the 6 digit verification code if it has been received.

Verification Code

3

VDH VIRGINIA DEPARTMENT OF HEALTH

Mary Lynn Mead
Date of birth: 01/01/2000

Dose 1: 01/01/2001 MMR

Dose 2: 04/22/2025 MMRV

Save & Print PDF Record Please save a copy of your record on your phone or computer, or print to paper. The PDF version of the record contains the following, if known: name, date of birth, dates of vaccination, manufacturer, lot information, and provider for each dose of vaccine received.

This Measles Vaccination Record is based on information recorded in the Virginia Immunization Information System by healthcare providers and may or may not reflect a complete immunization history.

Once you have or print your vaccination record, your copy will not automatically update. If you receive an additional dose of the measles vaccine, be sure to obtain an updated version of your vaccination record at the time you visit your local health department.

For more information about your vaccination record, you can complete an Immunization Record Request.



MMR Vaccination Record Portal Considerations

- Vaccines reported to Virginia Immunization Information System (VIIS)
- Vaccines administered outside of Virginia are unlikely to be in VIIS
- Vaccines administered prior to 2017 are less likely to be in VIIS
- Phone number needs to be in VIIS associated with record.
- Vaccination records can be provided to healthcare providers or VDH to be entered into VIIS on behalf of Virginians, so they are available in VIIS.

Meningococcal Disease Update

- In March, VDH responded to a confirmed case of invasive meningococcal disease identified in a student at University A. The student exhibited symptoms of meningococcal meningitis, including sudden onset of fever, headache, stiff neck, and rash.
- In less than 24 hours of receiving laboratory confirmation of the diagnosis, University A's Student Health Office initiated contact follow-up and provided post-exposure prophylaxis antibiotics (PEP) to 126 students.
- Over the following days, Student Health and the local health department provided PEP to an additional 214 students and healthcare workers.
- University A and the local health department collaborated to host a vaccine clinic for students who were not up to date on meningococcal vaccination in accordance with ACIP recommendations. In total, 162 students received meningococcal vaccine (126 MenB, 41 MenACWY).
- Communication Strategy:
 - Regular email updates to students and parents
 - FAQ website
 - Social media

Maternal Health Dashboard

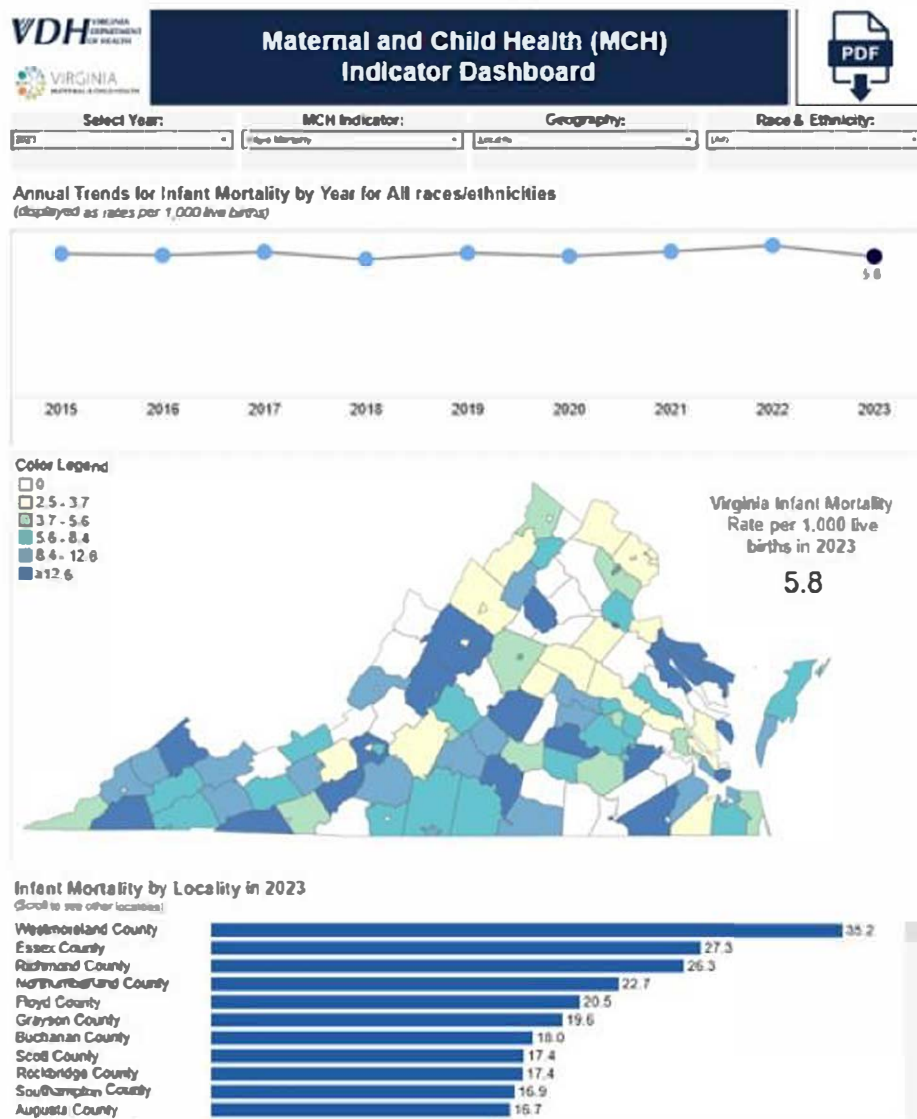
Where is the data located?

- VDH MCH Website - <https://www.vdh.virginia.gov/data/maternal-child-health/>

Overview of the data

- Vital records (including birth and death) data are gathered from the Vital Event Statistics Program at the Virginia Department of Health.
- Live births are reported by the Virginia city or county where the mother normally resided at the time of birth, regardless of where the birth occurred.
- Pregnancies are reported by the Virginia city or county where the mother normally resided.
- Maternal/Infant deaths are reported by the Virginia city or county where the mother/infant resided at the time of death, regardless of where the death occurred.
- Enhancements to the Dashboard were made per the Governor's [Executive Directive 11](#).

Maternal Health Dashboard



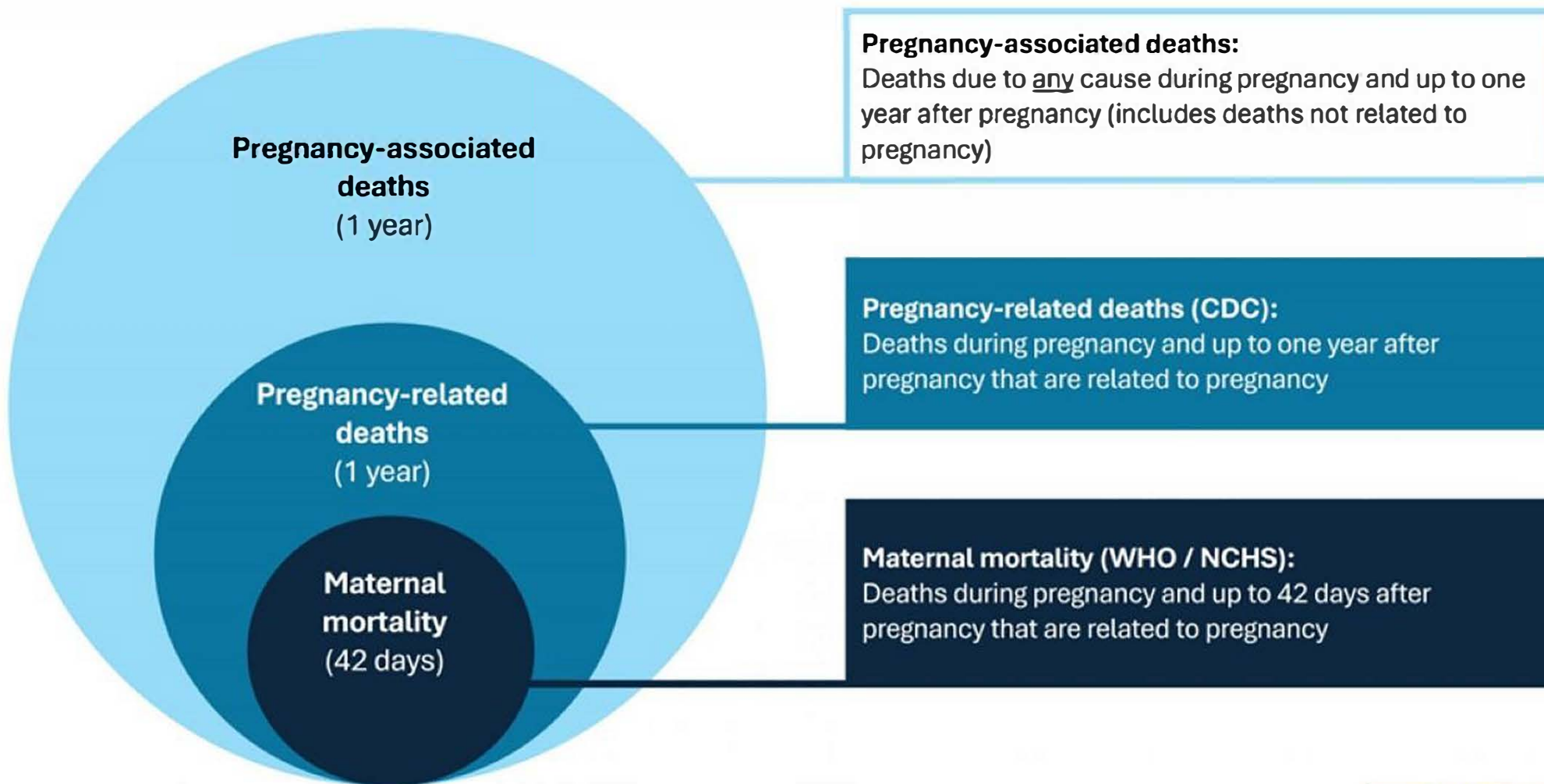
- Years available include 2015-2023
- Geography includes selections from Locality, Health District, or Health Region
- Race/Ethnicity = 5 categories
- Data reported as Percent/Rate for trends

2023 Snapshot of MCH Population: All races/ethnicities

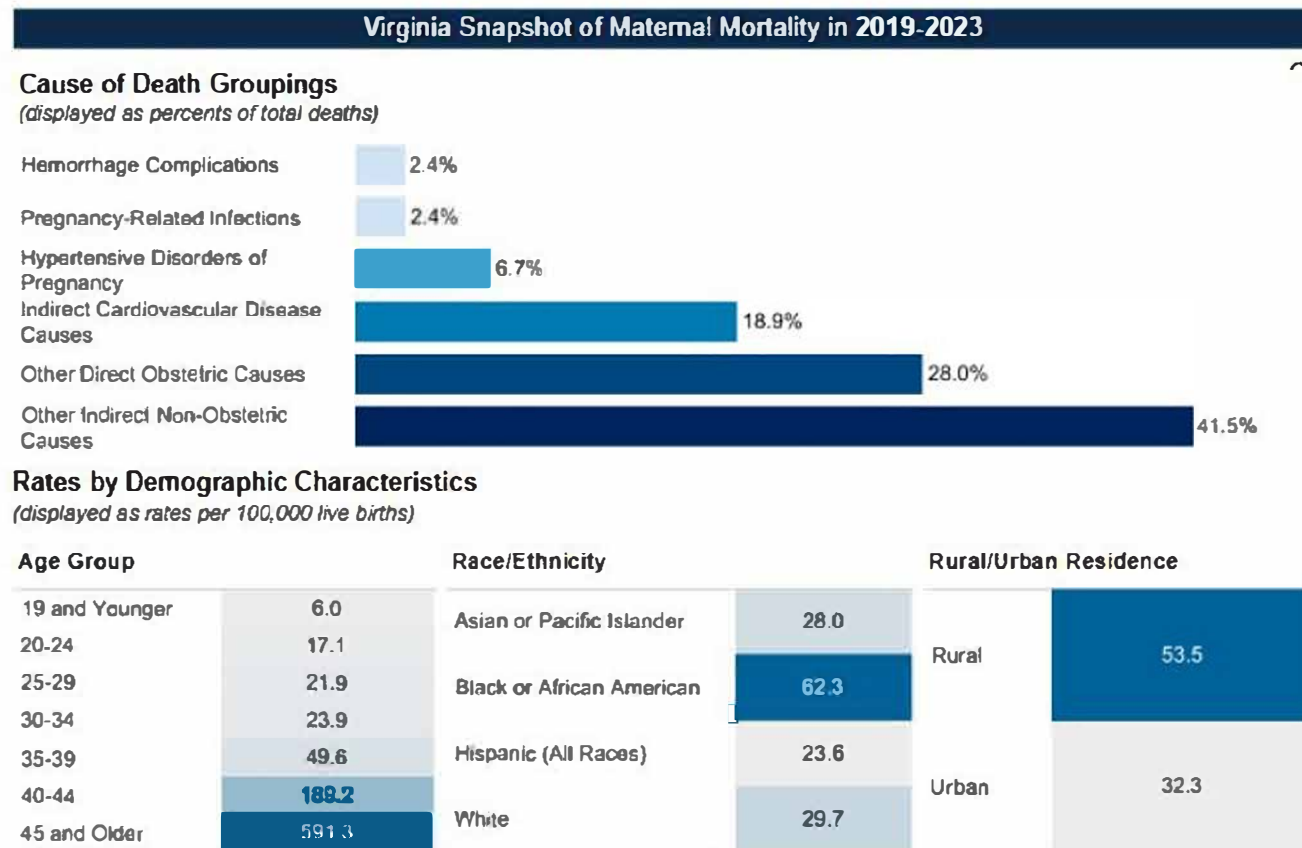
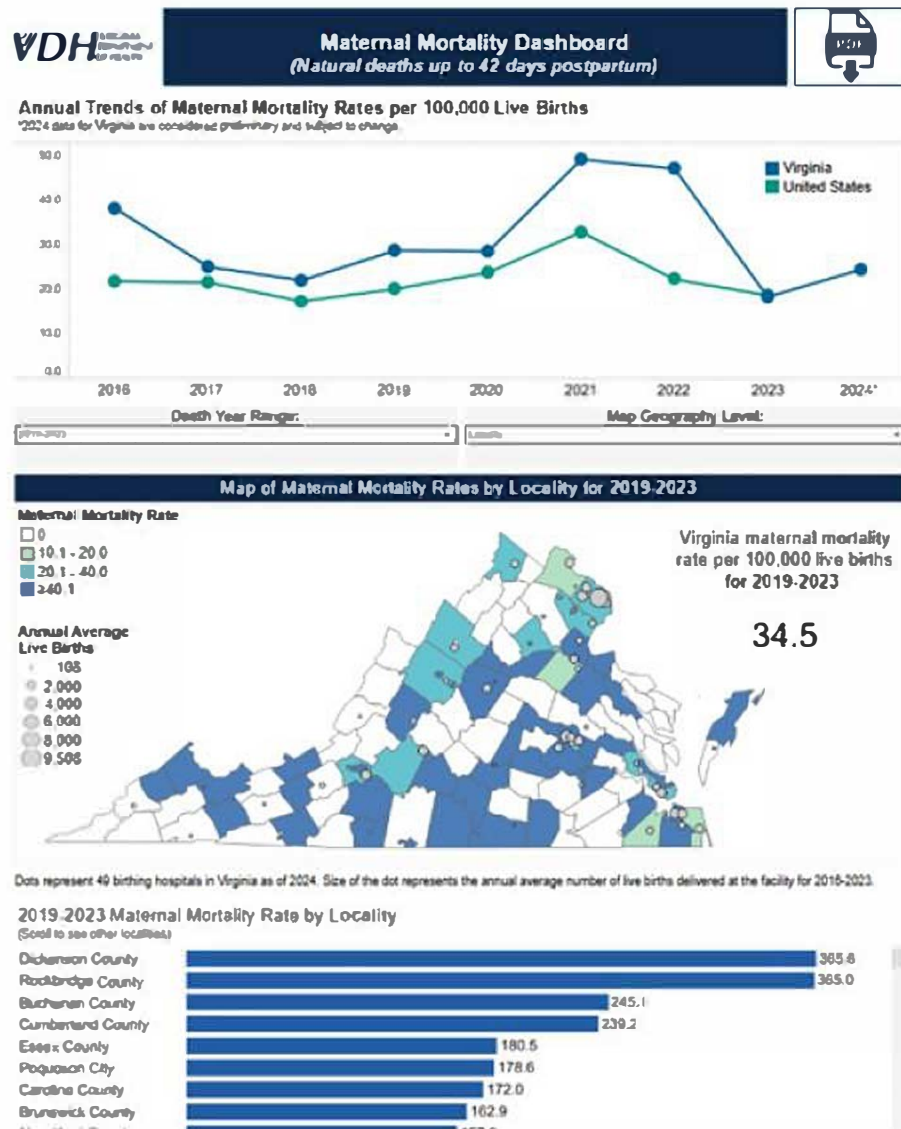
Show data by:		Geography Name or Racial/Ethnic Group:	
Race/Ethnicity		[All]	
Females of reproductive age (15-4..	1,727,063	Total pregnancies	111,363
Number of teen pregnancies	4,215	Total live births	92,639
Teen females aged 15-19^	278,157	Number of infant deaths	534
Teen pregnancy rate	15.2	Infant mortality rate	5.8

Virginia Population Estimates are based on Census population estimates that are updated annually.

Maternal Mortality Dashboard



Maternal Mortality (up to 42 days postpartum)



Pregnancy-Associated Deaths

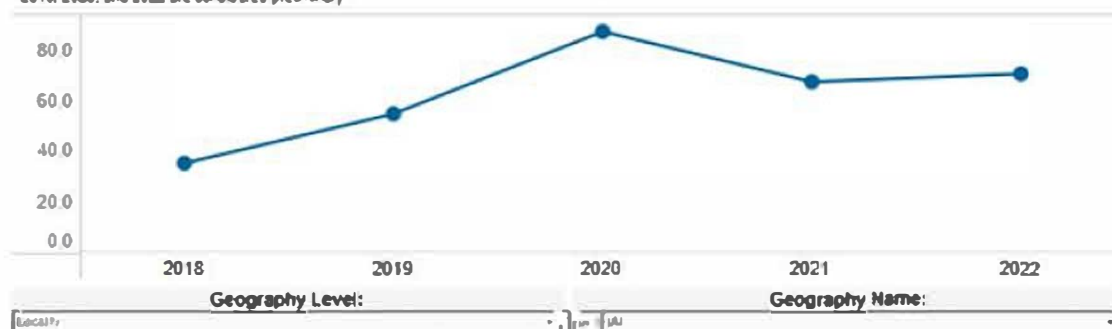


Pregnancy-Associated Deaths Dashboard (Deaths up to 365 days after the end of pregnancy)

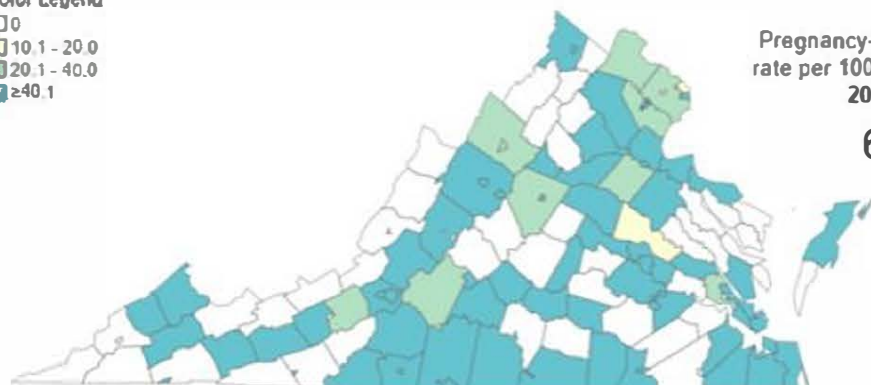
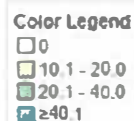


Annual Trends of Pregnancy-Associated Death Rates per 100,000 Live Births

*2019, 2020, and 2022 are considered preliminary



2018-2022 Map of Pregnancy-Associated Death Rates by Locality



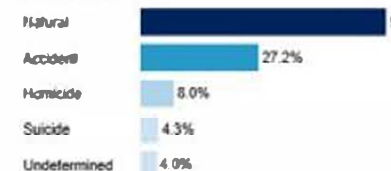
Pregnancy-associated death rate per 100,000 live births for 2018-2022

62.3

Virginia Snapshot of Pregnancy-Associated Deaths in 2018-2022

Select characteristics of deaths
(displayed as percents of total deaths)

Manner of Death



Timing of Death



Top Manner/Causes of Death

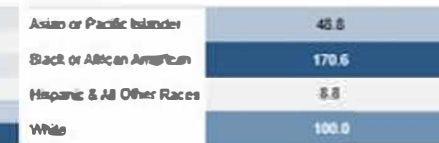


Rates by Demographic Characteristics
(displayed as rates per 100,000 live births)

Age Group



Race/Ethnicity



Insurance Type



Rural/Urban Residence



Education Level



Recent Federal Public Health Funding Changes

- The Centers for Disease Control has rescinded several Covid-era grants, reduced other grant awards, and placed more controls on the payout of incurred expenses.
- VDH leadership has been proactive in planning for potential changes in federal grants– conducting planning budget reduction exercises and discussions with potentially impacted programs to be better prepared when decisions need to be made.
- Program leadership is having daily communications with affected federal agencies and is sharing information with other state agencies in Virginia as information become available.
- For some employees, contractors, and projects, VDH elected to use other funding sources to temporarily continue work to ensure a proper transition, finish work, and plan for continuation of key functions and needs.

Rescinded Federal Grants

- **VDH was informed by the federal government programs that three COVID era federal grant awards ended at midnight March 24th.**
 - **CK19-1904 Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases – Enhancing Detection (ELC-COVID Funds)**
 - **CDC-RFA-IP19-1901 Immunization and Vaccines for Children (COVID Funds)**
 - **Virginia Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved**

Funding Update- HIV/Ryan White

- The Virginia Ryan White Part B program is facing some funding uncertainty due to:
 - Partial federal grant award
 - Reduced rebate dollars (which have historically served as a large resource for this program)
- As a result, program priorities needed to shift to preserve critical functions.
- Cost-containment measures have been implemented including maintaining several VDH position vacancies, shifting personnel to allowable alternative funding sources where available, and reductions or eliminations in funding to several community partners (subrecipients) who provide RW Part B services.

Nursing Home Oversight

- Increase in “Immediate Jeopardy” complaint intakes and findings during onsite surveys
- Use of contract surveyors – procurement with two separate vendors to assist with backlog of surveys and complaint investigations
- Increased salaries for nursing home inspector positions
- Aggressive hiring campaign to fill nursing home inspector positions through additional dedicated human resources staff assigned to the Office of Licensure and Certification.

VDH Electronic Health Record

Electronic Health Record

An **Electronic Health Record (EHR)** captures a broad and deep array of information related to a **client's health and medical care**.

This includes:

- | | |
|--------------------|------------------------------|
| ✓ Demographic Data | ✓ Clinical Encounters |
| ✓ Medical History | ✓ Medications |
| ✓ Lab Results | ✓ Social Health Determinants |
| ✓ Treatments | |

The EHR is designed to support **interoperability** across VDH, facilitating improved care coordination and outcomes.

Mission

Digitize Virginia Department of Health's health record system to improve delivery of quality health care to the communities and citizens of Virginia, enhance team workflow and experience, and promote interoperability with public and private care providers.

Vision

Establish a robust and integrated EHR solution to:

- Optimize timely public health interventions.
- Inform & support improvement in community health through real-time reporting and data analysis.
- To deliver services in support of public health programming.
- Provide accessible health records to enhance the quality of public health services.

PROJECT STATUS REPORT

Details

EHR vendor: Oracle Health (Formerly Cerner)

Contract Award: August 2024

Project Start: October 2024

Initial ARPA Funded Budget: \$30Mil

Project Completion Rate: 25%

Expected Project Completion: December 2026

Gateways to Project Completion:

<i>Initiate</i>	<i>Align</i>	<i>Validate</i>	<i>Test</i>	<i>Train</i>	<i>Activate</i>
10/15/24	5/19/25	7/28/25	11/17/25	1/5/26	4/20/26

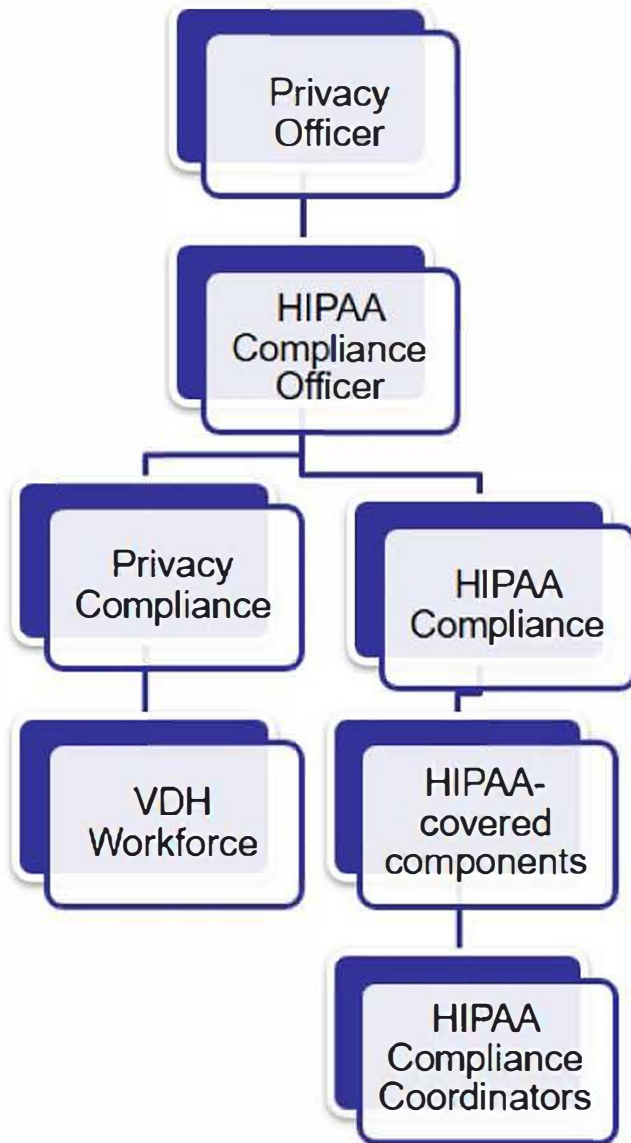
Gateways: milestones and required critical path check points to meet and evaluate the status of critical items and key risk factors to ensure value achievement.

Project Manager: Dawn Strang

Project Sponsor(s): Dr. Susan Fischer Davis Deputy Commissioner CHS;
Suresh Soundararajan CIO

Phase	Milestones & Events	Status	Start
ALIGN	Gateway 1- Project Initiation ²	Complete	10/15/24
	Kick-Off	Complete	10/15/24
	Current State Review	Complete	11/12/24
	Pre-Workshop Design Event	Complete	12/2/24
ENGAGE	Workshop 1	Complete	1/13/25
	EHR Fundamentals Training	Complete	2/24/25
	Workshop 2	Complete	4/7/25
	Design Team Kick-Off	In-Progress	4/7/25
	Change Network Kick-Off	Complete	4/22/25
	Workshop 3	In-Progress	5/12/25
	Gateway 2 – Align	On Schedule	5/19/25
	Workshop 4	On Schedule	6/16/25
	Workshop 5	On Schedule	7/21/25
	Gateway 3 – Validate	On Schedule	7/28/25
	Workshop 6	On Schedule	9/8/25
	Workshop 7	On Schedule	10/13/25
	Workshop 8	On Schedule	11/10/25
	Gateway 4 – Test	On Schedule	11/17/25
	Maintenance Training	On Schedule	11/17/25
	Integration Testing 1	On Schedule	12/1/25
	Gateway 5 – Train	On Schedule	1/5/26
	Integration Testing 2	On Schedule	1/12/26
	Scan Fest (dates TBD)	On Schedule	~1/12/26
	Gateway 6 – Activate	On Schedule	4/20/26
ACTIVATE	Go-Live Pilot	On Schedule	5/4/26
	Go-Live Wave 1	On Schedule	7/20/26
	Go-Live Wave 2	On Schedule	9/21/26
	Go-Live Final	On Schedule	11/2/26

HIPAA and Privacy Update



VDH is committed to the protection and responsible use of information collected from and about its workforce, staff, patients, clients, and constituents.

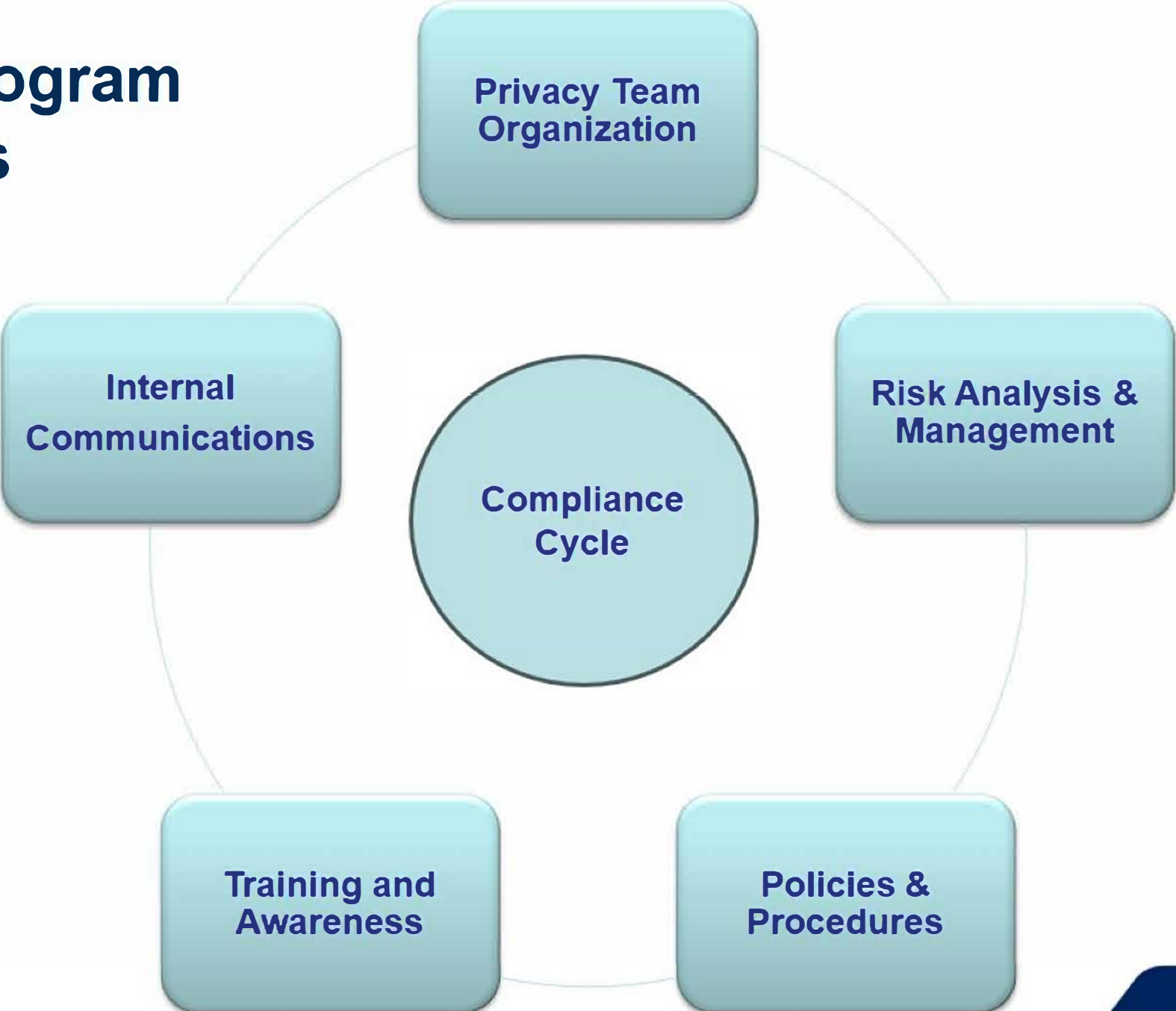
The VDH Privacy Program is an important component that ensures compliance with all laws and government regulations related to privacy, confidentiality, and HIPAA.

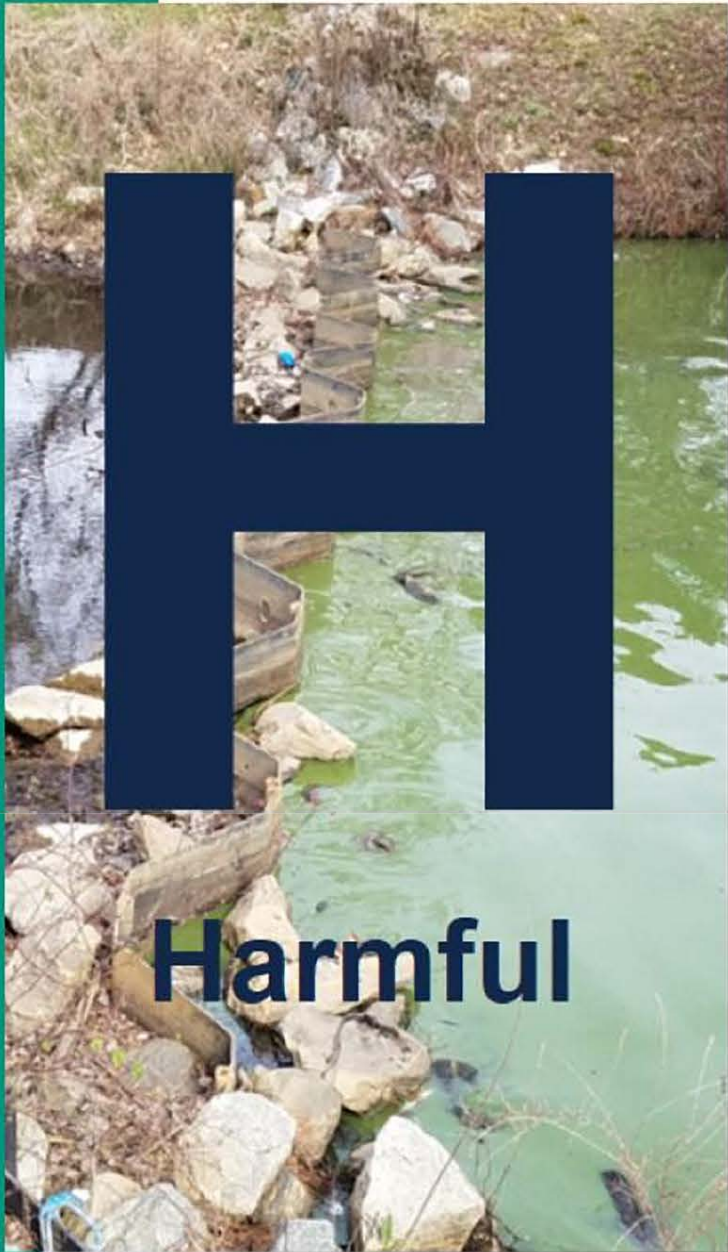
The Privacy Program has been fortified by:

- (1) identifying the privacy team structure and roles;
- (2) updating policies & procedures;
- (3) increasing workforce training & engagement;
- (4) focusing on risk analysis & management; and
- (5) implementing consistent privacy & security controls.

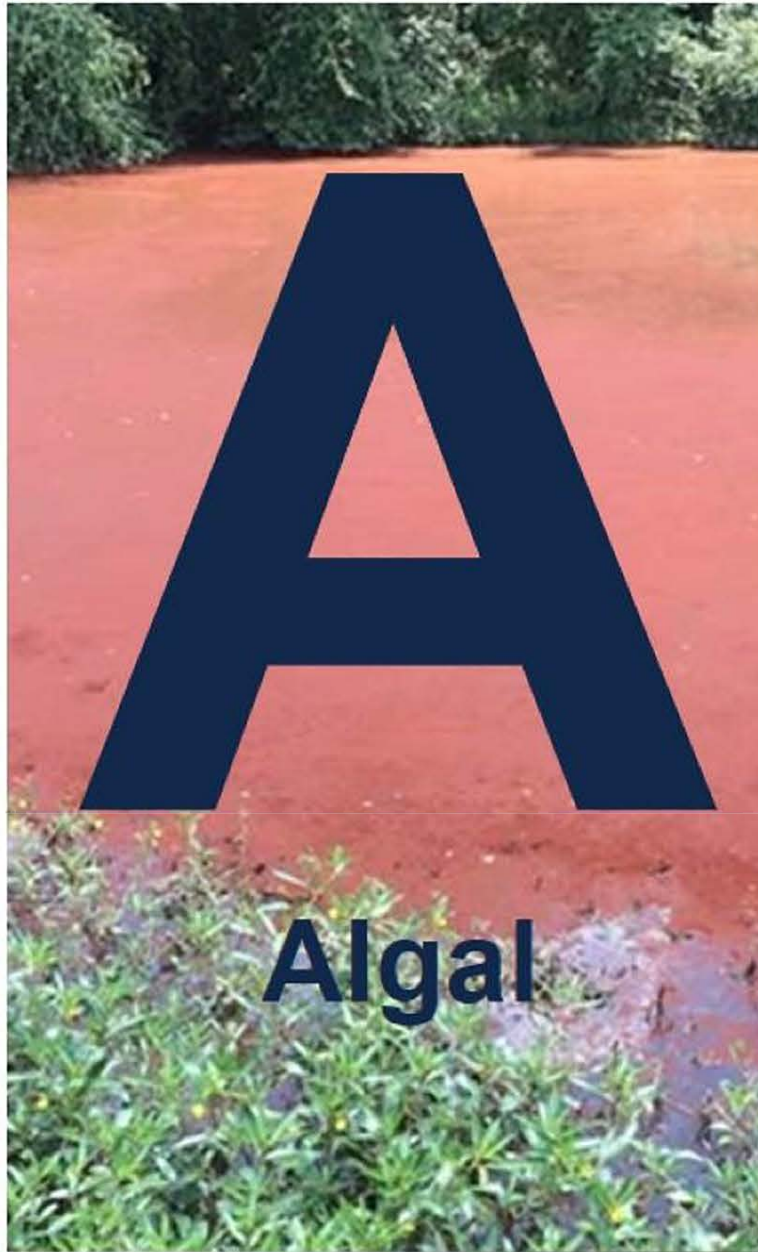
Privacy Resources: <https://vdhweb.vdh.virginia.gov/hipaa/>

Privacy Program Mitigations

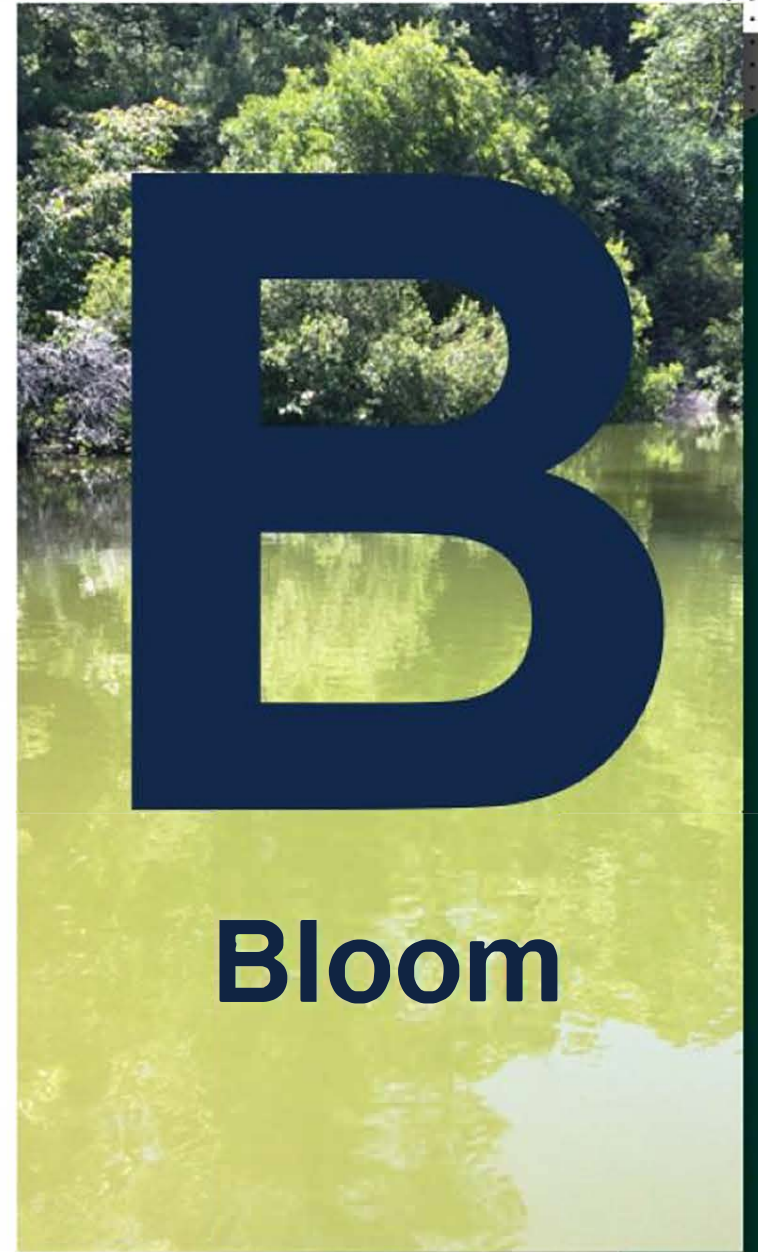




Harmful

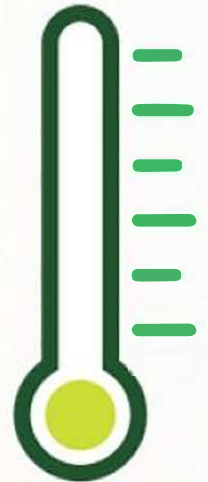
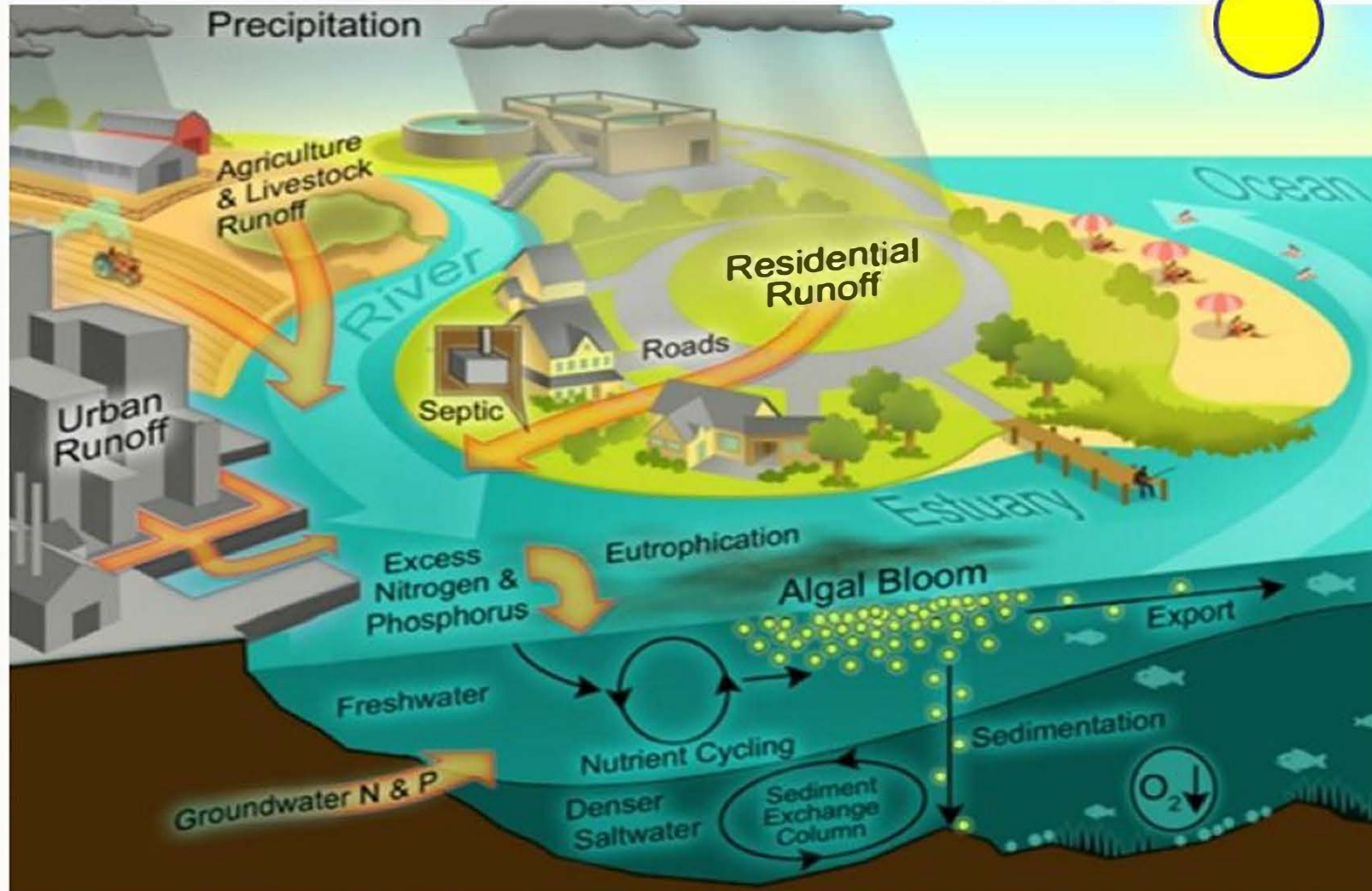


Algal



Bloom

HOW DO HABS DEVELOP?



RISK ...

ROUTES & SYMPTOMS OF EXPOSURE TO HABs

SYMPTOMS CAN VARY DEPENDING ON HOW THE PERSON OR ANIMAL WAS EXPOSED, AND WHETHER THE HAB IS IN SALT OR FRESH WATER.

ROUTES OF EXPOSURE



SKIN CONTACT



INGESTION



INHALATION

SYMPTOMS OF EXPOSURE



Ear, eye, nose, skin,
and throat irritation,
and headache



Paralysis, respiratory
illness, and seizures

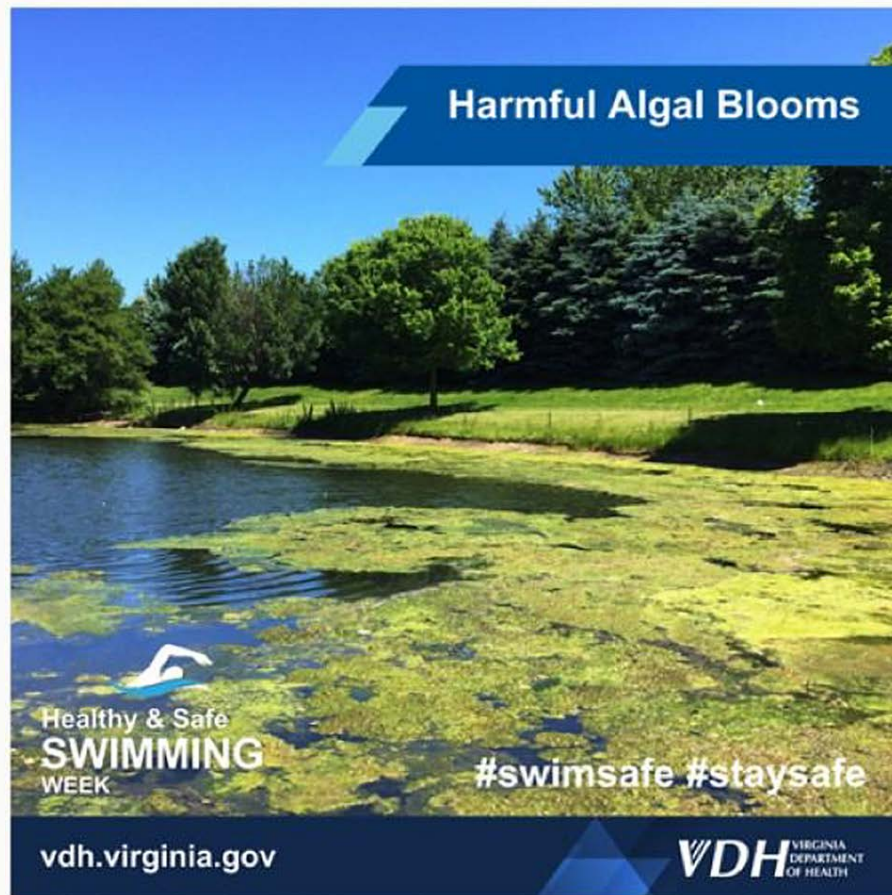


Abdominal pain,
diarrhea, liver and
kidney damage,
and vomiting



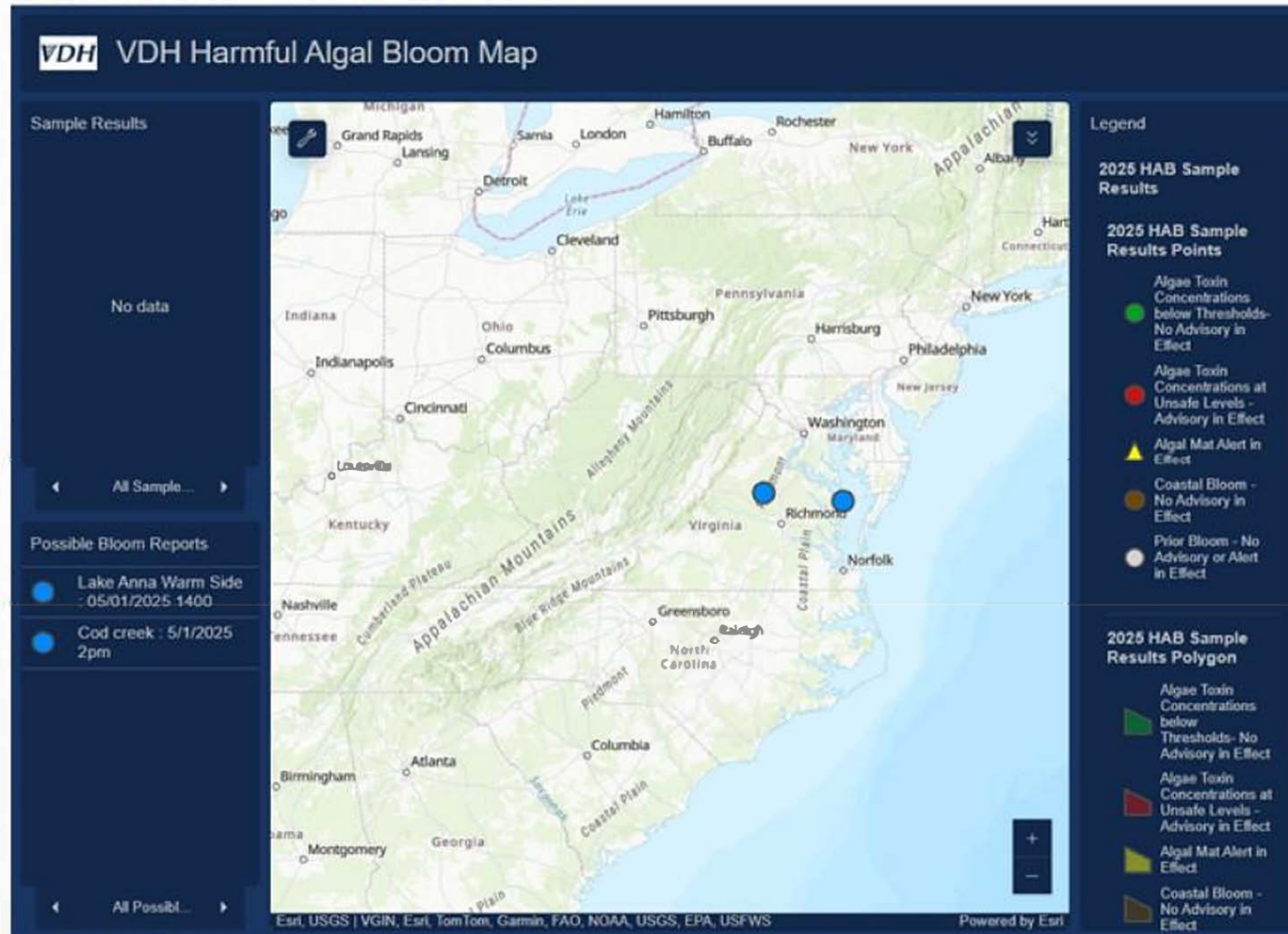
Drooling, diarrhea, low
energy, not eating,
stumbling, tremors,
and vomiting

EDUCATIONAL OUTREACH



RECREATIONAL ADVISORIES

ALGAL BLOOM SURVEILLANCE MAP



TOXIN-ONLY APPROACH

- ▶ **Consistent with the EPA**
- ▶ **Supported by existing data**
- ▶ **More efficient investigations**
- ▶ **Reduces uncertainty in messaging**



Hurricane Preparedness



Photo: Mount Rogers Health District staff with a mobile health unit after Hurricane Helene caused devastating flooding in Damasus - September, 2024.



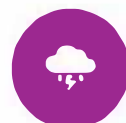
Incident
Coordination



Public Health
Surveillance



Public
Information &
Outreach



Mass Care
and Shelter
Support



Vaccinations



Local Health
District &
MRC
Readiness



Safe Drinking
Water



Healthcare
Coordination



Recovery

Emergency Medical Services Update

- OEMS will be budget neutral coming into FY26 after experiencing a \$33 million shortfall due to misappropriation and fraud by previous leadership two years ago
- Community and EMS Advisory Board Engagement is a priority as we reimagine the role of OEMS.
- RSAF- Rescue Squad Assistance Funds Spring 2025 Cycle: \$4.2M awarded to 118 agencies.
- [Return to Localities Dashboard – Emergency Medical Services](#)
- Regional EMS Council infrastructure is in strategic planning and alignment following changes in Budget:
 - Regional EMS Councils will be shifting from 11 to 7 regions on January 1, 2026, as voted on by current Regional Council presidents and unanimously approved by the Governor's EMS Advisory Board.
 - EMS Stakeholders including Councils, EMS Advisory Board, local governments, and EMS agency leadership are tightly engaged to reimagine the role of EMS Councils to align with needs of today's EMS system.
 - In the fall SBOH meetings, OEMS will bring forward organizations for regional designation starting January 1, 2026.

Cohort 3



38 Interns

Kick Off: May 27- 28 in Richmond

Closing Ceremonies: July 31 - Aug 1 in Richmond

Local Health Depts (n=30)

Location	#	Location	#
Alexandria	1	Loudoun	1
Blue Ridge	1	Mount Rogers	1
Central Shenandoah	2	New River	1
Central Virginia	1	Norfolk	1
Chesapeake	1	Peninsula	2
Chesterfield	2	Portsmouth	1
Chickahominy	1	Prince William	1
Crater	1	Rappahannock	1
Cumberland Plateau	1	Richmond/Henrico	3
Fairfax	2	Roanoke	1
Lenowisco	1	Virginia Beach	1
Lord Fairfax	1	Western Tidewater	1
	<u>15</u>		<u>15</u>

Central Offices (n=8)

Location	#
Community Relations	1
Dep Commissioner for Pop Health & Preparedness	1
Drinking Water	1
Emergency Medical Services	1
Environmental Health	1
Epidemiology	1
Governmental Relations	1
Human Resources	1
	<u>8</u>

**INTERNSHIP
ACADEMY**



The VDH Internship Academy has been named a 2025 TOP Employer for Interns. The Academy has received this designation all three years since inception in 2023.

# of Applications	Year 2023 -- 411	Year 2024 – 546	↑	Year 2025 -- 799	↑
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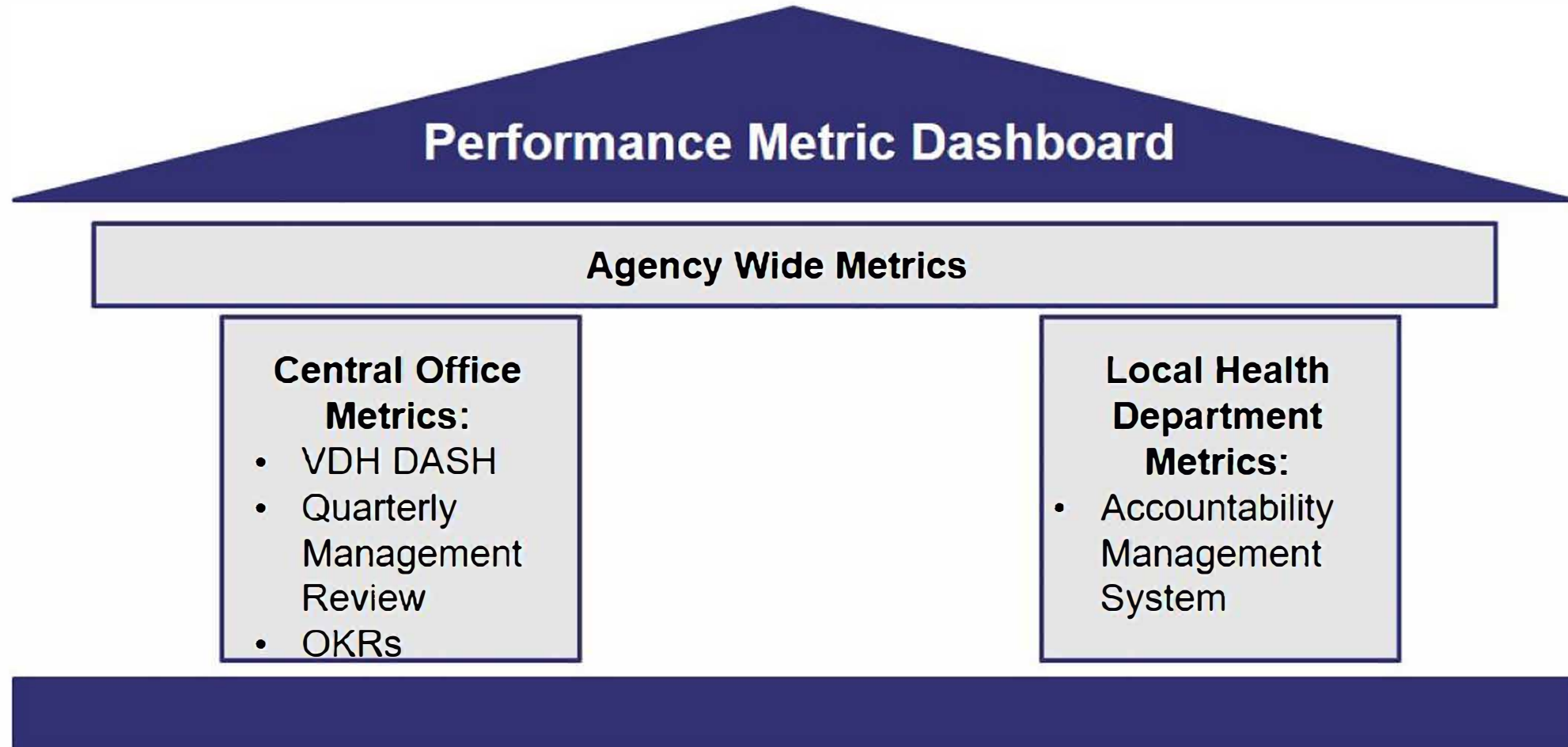
Universities

In-State (n=10)

Out-Of-State (n=11)



Accountability and Performance Metrics



Public Health Reaccreditation Readiness Assessment

- VDH received accreditation from the Public Health Accreditation Board ([PHAB](#)) in 2021.
- Accreditation is for five years, so VDH is up for reaccreditation next year in 2026.
- Accreditation from PHAB enhances VDH's reputation, demonstrating that the agency operates with the highest standards of competence and integrity. It serves as a tangible validation of VDH's commitment to continue improving and advancing public health initiatives, becoming increasingly effective at improving the well-being of those living in the Commonwealth.



Public Health Reaccreditation Readiness Assessment

- **10 Domains:**
 - **Community Health Assessment/Population Health**
 - **Disease Investigation/Environmental Health Hazards/Emergency Response**
 - **Communication**
 - **Community Partnerships and Coalitions**
 - **Policy**
 - **Enforcement**
 - **Equitable Access to Services**
 - **Public Health Workforce**
 - **Evaluation/Research/Quality Improvement**
 - **Organizational Administrative Infrastructure**
- **Timeline:**
 - **April 28th: Kickoff Meeting**
 - **May 5th: Initial Group Meetings by Domain**
 - **Month of May: Interviews and Documentation Collection**
 - **Month of June: Finalize Responses and Documentation Collected**
 - **June 30th: Deadline to submit Reaccreditation Readiness Assessment to PHAB**

REGULATORY ACTION UPDATE

**State Board of Health
Regulatory Action Update
June 12, 2025**

Overview of Pending Regulatory Actions:

There are 55 pending actions under development:

- 13 NOIRAs
- 11 proposed actions
- 11 final actions
- 20 fast track actions

A spreadsheet containing additional detail concerning each of these actions is attached.

A Notice of Intended Regulatory Action (NOIRA) is the first stage in the standard rulemaking process in Virginia. It describes the nature and scope of the regulatory changes being considered. Should a NOIRA be approved, the next stage in the rulemaking process (the proposed stage) would involve the drafting of actual amending regulatory language for consideration. The proposed stage—if approved—is in turn followed by the final stage. Each of these three stages includes a public comment period.

The Virginia Administrative Process Act (§ 2.2-4000 et. seq. of the Code of Virginia) provides that certain types of regulatory actions are exempt from certain requirements of the state regulatory process. This includes regulatory actions that are:

- i. Necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved, or
- ii. Necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation, and the Registrar has so determined in writing.

The Administrative Process Act also describes a “Fast Track” rulemaking process, which is utilized for regulations that are expected to be noncontroversial. The Fast Track process generally involves an action with a single stage.

Regulatory Actions Taken by the Commissioner on Behalf of the Board pursuant to § 32.1-20 of the Code of Virginia since the March 20, 2025 Board Meeting while the Board was not in Session:

Approved Final Exempt Regulatory Action for 12VAC5-410 – Regulations for the Licensure of Hospitals in Virginia

- This action is being taken to comply with Chapters 207, 249, 441, and 505 of the 2024 Acts of Assembly.

Approved Final Exempt Regulatory Action for 12VAC5-90 – Disease Reporting and Control Regulations

- This action is being taken to comply with Chapter 375 of the 2024 Virginia Acts of Assembly.

Non-Regulatory Actions Taken by the Commissioner on Behalf of the Board since the March 20, 2025 Board Meeting while the Board was not in Session:

None

Periodic Review of Regulations

The process for conducting periodic reviews of regulations is governed by the Virginia Administrative Process Act and Executive Order 19 (2022).

All regulations are to be reviewed every four years to determine whether they should be continued without change or be amended or repealed, consistent with the stated objectives of applicable law, to minimize the economic impact on small businesses in a manner consistent with the stated objectives of applicable law.

VDH has 8 periodic reviews in progress:

Chapter		Status
12 VAC 5-125	Regulations for Bedding and Upholstered Furniture Inspection Program	Intend to issue result after current action becomes effective.
12 VAC 5-371	Regulations for the Licensure of Nursing Facilities	Issued with NOIRA, Result will be published with Proposed stage.
12 VAC 5-381	Home Care Organization Regulations	Issued with NOIRA, Result will be published with Proposed stage.
12 VAC 5-507	Guidelines for General Assembly Nursing Scholarships and Loan Repayment Program Requiring Service in a Long-Term-Care Facility	Result under OCOM review
12 VAC 5-520	Regulations Governing the State Dental Scholarship Program	Result under OCOM review
12 VAC 5-545	Guidelines for the Nurse Educator Scholarship	Result under OCOM review
12 VAC 5-590	Waterworks Regulations	Result under OCOM review
12 VAC 5-620	Regulations Governing Application Fees for Construction Permits for Onsite Sewage Disposal Systems and Private Wells	Intend to issue result after current action becomes effective.

Executive Branch Review Activity Completed since the March 20, 2025 Board Meeting:

The Office of the Attorney General certified:

None

The Department of Planning and Budget completed the review of:

- NOIRA for the Regulations for the Licensure of Hospice (12VAC5-391)
- Final Amendments to the Regulations Governing the Dental Scholarship and Loan Repayment Programs (12VAC5-520)
- Fast Track Amendments to the Regulations Governing Cooperative Agreements (12VAC5-221)
- Fast Track Amendments to the Regulations Governing Virginia Newborn Screening Services (12VAC5-71)
- Fast Track Amendments to the Virginia Immunization Information System regulations (12VAC5-115)

- Fast Track Amendments to the Regulations Governing Durable Do Not Resuscitate Orders (12VAC5-66)

The Secretary of Health and Human Resources completed the review of:

- NOIRA for the Regulations for Administration of the Virginia Hearing Impairment Identification and Monitoring System (12VAC5-80)
- NOIRA for the Regulations for the Licensure of Nursing Facilities (12VAC5-371)
- NOIRA for the Certified Nursing Facility Staffing Standards Regulation (12VAC5-375)
- NOIRA for the Regulations for the Licensure of Hospitals in Virginia (12VAC5-410)
- Proposed Amendments to the Prescription Drug Price Transparency Regulation (12VAC5-219)
- Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations (12VAC5-220)
- Final Amendments to the Regulations for Disease Reporting and Control (12VAC5-90)
- Fast Track Amendments to the Food Regulations (12VAC5-421)

The Office of Regulatory Management completed the review of:

- NOIRA for the Regulations for Administration of the Virginia Hearing Impairment Identification and Monitoring System (12VAC5-80)
- NOIRA for the Regulation for the Licensure of Nursing Facilities (12VAC5-372)
- NOIRA for the Regulations for the Licensure of Hospitals in Virginia (12VAC5-410)
- NOIRA for the Sewage Handling and Disposal Regulations (12VAC5-610)
- Fast Track Amendments to the Food Regulations (12VAC5-421)

The Governor approved:

- NOIRA for the Regulations for Administration of the Virginia Hearing Impairment Identification and Monitoring System (12VAC5-80)
- NOIRA for the Regulation for the Licensure of Nursing Facilities (12VAC5-372)
- NOIRA for the Regulations for the Licensure of Hospitals in Virginia (12VAC5-410)
- NOIRA for the Sewage Handling and Disposal Regulations (12VAC5-610)
- Fast Track Amendments to the Food Regulations (12VAC5-421)

Petitions for Rulemaking

A petition for rulemaking is a request to an agency/board to develop a new regulation or amend an existing regulation pursuant to § 2.2-4007 of the Code of Virginia.

The Board has received 1 Petition for Rulemaking since the March 20, 2025 Board Meeting:

- *Prevent biological males from female-only athletics and certain female-designated spaces*

Following receipt of public comment and within 90 days of the end of the public comment period, a written decision to grant or deny the petition will be issued.

- Published in the Virginia Register of Regulations: 05/05/2025
- Public Comment Period start date: 05/05/2025
- Public Comment Period end date: 05/26/2025
- Deadline to Issue Decision: 08/24/2025

PUBLIC COMMENT

Public Comment Period

- There is a two minute time limit for each person to speak.
- We will be calling from the list in the room.
- After the 2 minute public comment limit is reached we will let you complete the sentence and move on to the next attendee.
- We will call the name of the person on list and also the name of the person is next on the list.

BREAK

LUNCH PRESENTATION: MATERNAL & CHILD HEALTH HOME VISITATION PROGRAM

Maternal & Child Health Home Visitation Programs

BabyCare Program

Resource Mothers Program

Maternal Health Doula Program



Presenters

Vicky Richardson, BSN, RN, Nurse Supervisor

Mary Anne Hall, BSN, RN, Nurse Senior

Rebecca Riggins, CCHW, Resource Mother

Donna Surber, CHW, Maternal Health Doula

Patricia VanHoy, BSN, RN, Nurse Manager Senior

Presentation Objectives

- Historical perspective
- Review of Data
- BabyCare Program
- Resource Mothers Program
- Maternal Health Doula Program
- Success Stories
- Sustainability for the Future

What Are Maternal Child Health Home Visitation Programs?

Patient centered programs which provide case management and supportive services to pregnant women and their infants who face physical and psychosocial issues which may adversely impact the outcome of the woman's pregnancy.

Purpose of Home Visitation Programs

- Improve birth outcomes
- Reduce infant mortality and morbidity
- Ensure provision of comprehensive services to pregnant women and infants
- Assist pregnant women and caretakers of infants in receiving wrap-around services that affect their well-being and that of their families

Referral Sources

- WIC—Critical for referrals
- Department of Social Services
- Health Department Clinics (ex. Family planning, pregnancy testing, Sexually transmitted infection clinic, child health)
- Physicians
- Hospitals
- Health department staff
- Self-referrals
 - Clients who have previously participated in the program or have friends or family who have benefited from the service

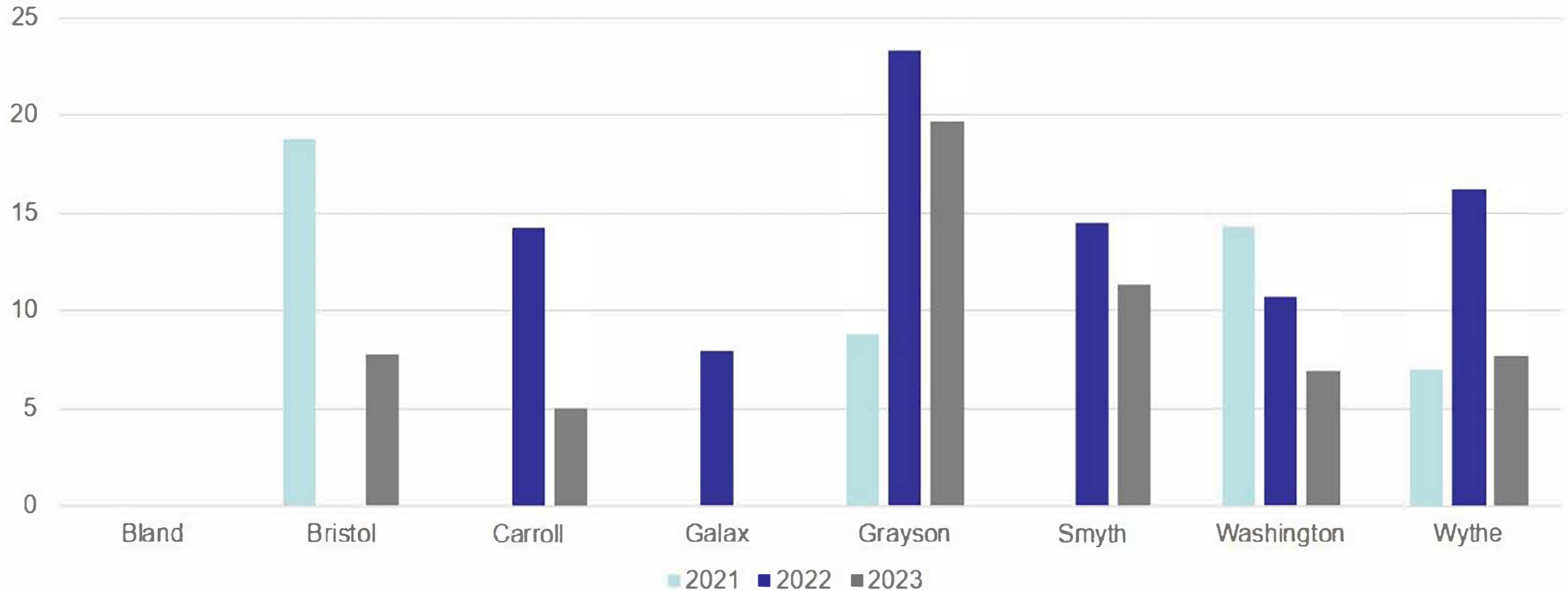
Referrals from these sources can be for all home visitation programs

Infant Mortality Rates

Death of an Infant up to 1 year of age

Infant Mortality per 1,000 live births

State rates:
2021-6.0
2022-6.2
2023-5.8

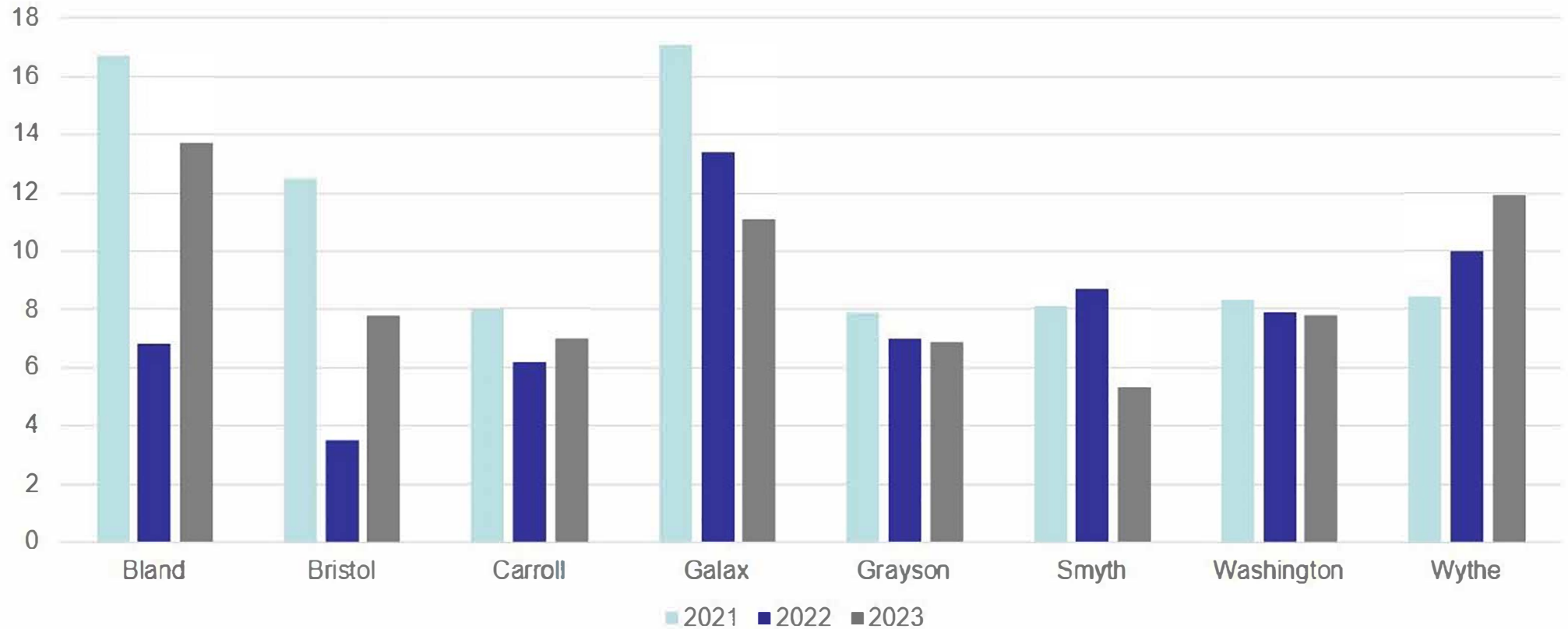


Localities with less than 5 per 1,000 births may not have a value noted

Low Birth Weight

Live Births weighing less than 2500 grams (5.5 pounds)

Low Birth Weight % of Total Live Births



State rates:
2021-8.3%
2022-8.5%
2023-8.5%

Late or No Prenatal Care

No prenatal care or care started during 3rd Trimester

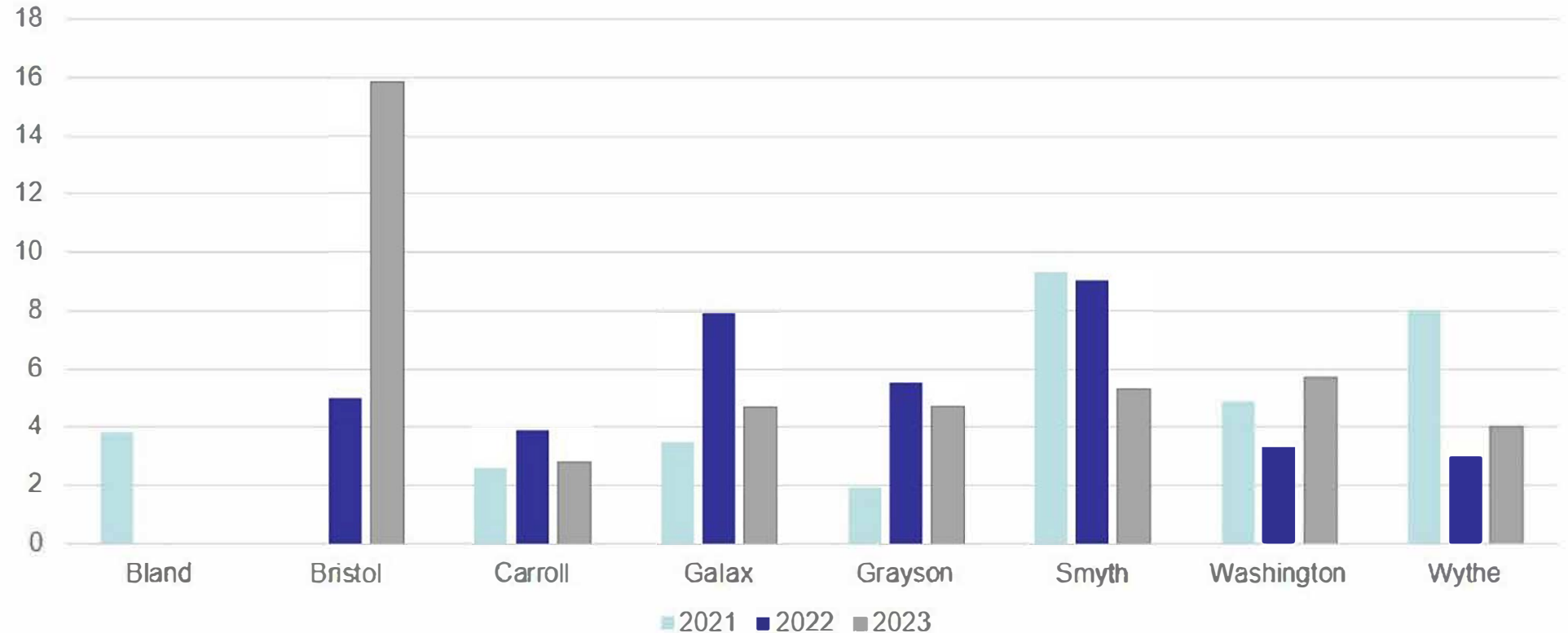
State rates:

2021-4.5%

2022-5.1%

2023-5.8%

Late or No Prenatal Care shown as % of live births



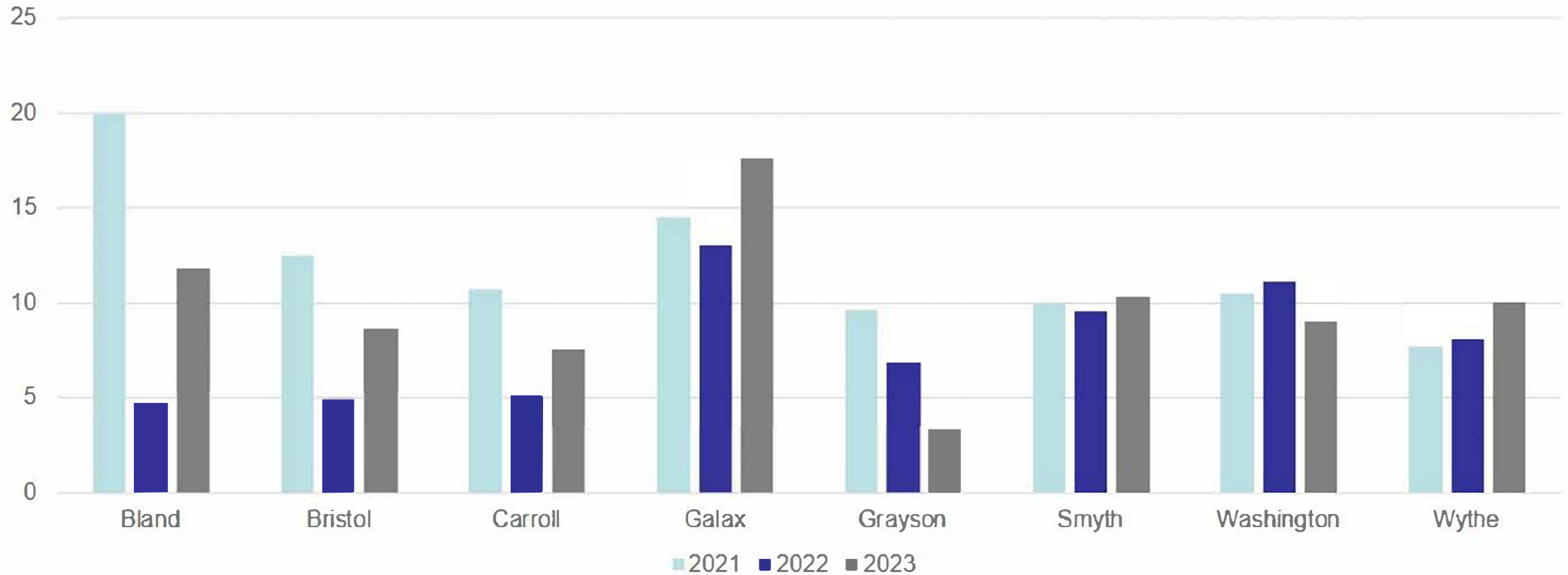
Localities with less than 5 persons during the year will not have a value on the graph

Preterm Births

Live births less than 37 weeks gestation

Preterm deliveries % of live total births

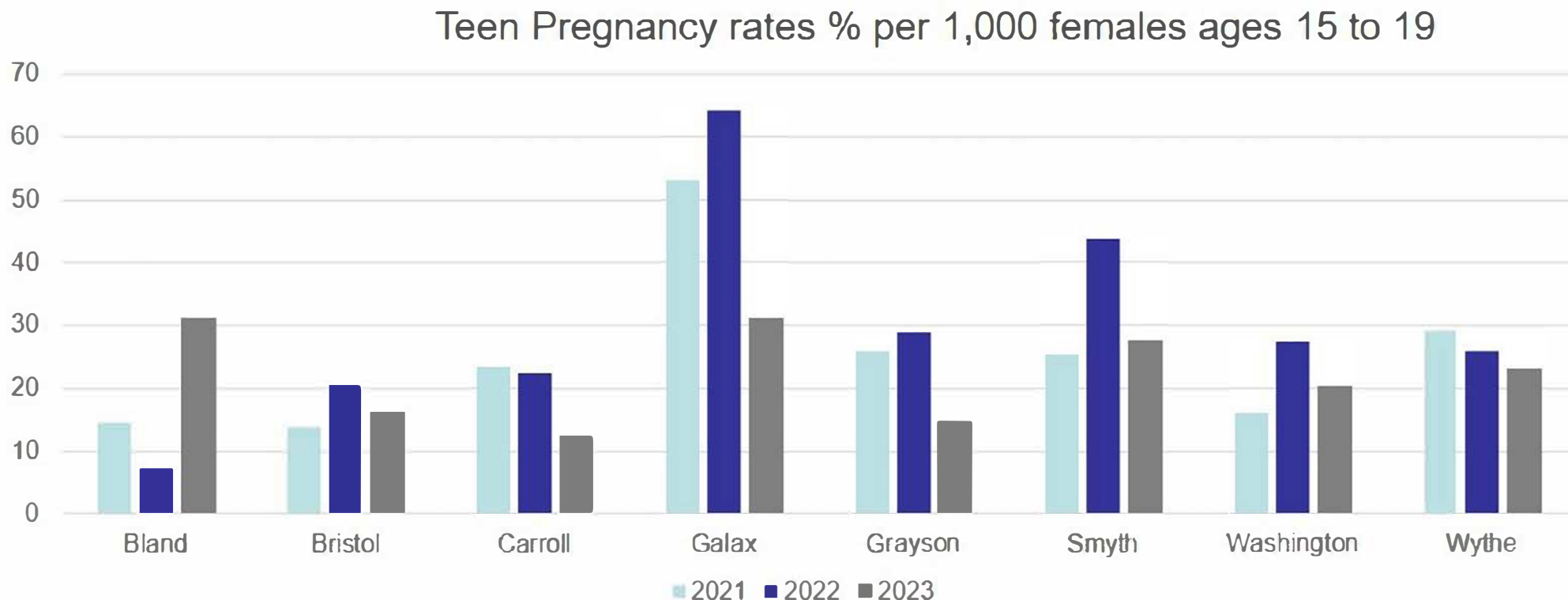
State rates:
2021-9.9%
2022-9.6%
2023-9.8%



Teen Pregnancy Rates

Number of Teen pregnancies per 1,000 females ages 15 to 19

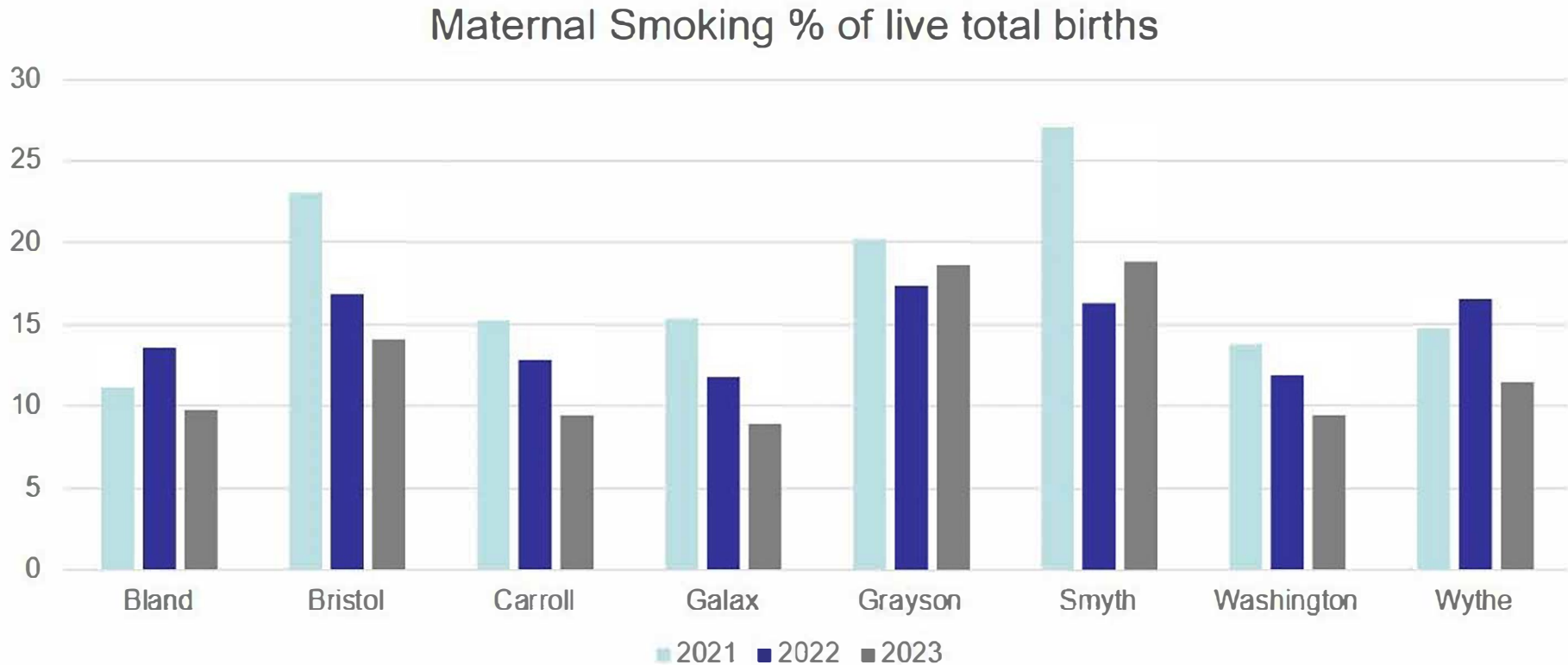
State rates:
2021-15.3%
2022-15.1%
2023-15.2%



Maternal Smoking

Live births where the mother reported tobacco use/smoking cigarettes during pregnancy

State rates:
2021-4.1%
2022-3.2%
2023-2.6%



Neonatal Abstinence Syndrome

Neonatal Abstinence Syndrome (NAS) is a condition when babies are exposed to certain drugs in the womb before birth. Drugs, such as pain medications (opioids) or stimulants (like cocaine or meth), can cause NAS.

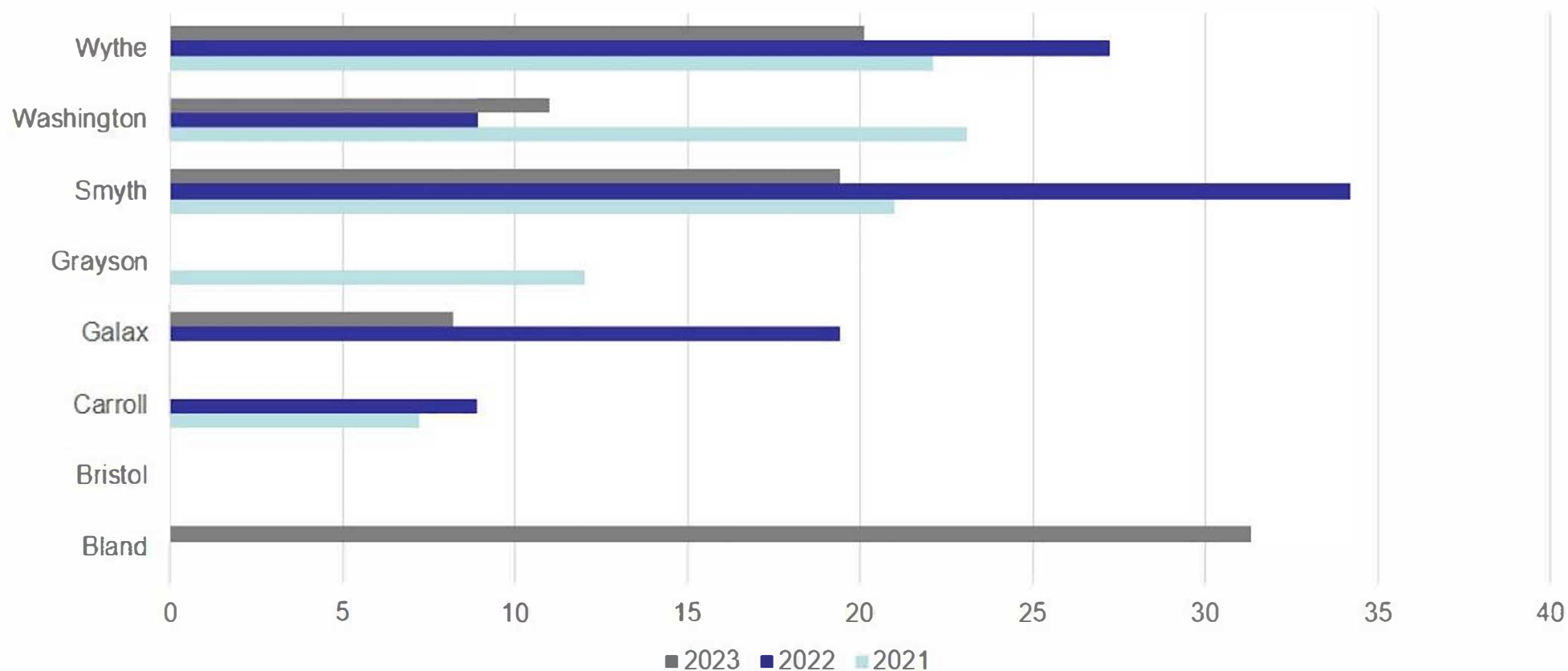
When a baby is born, they are no longer getting the drug they used to get in the womb. This can cause withdrawal symptoms including:

- crying a lot
- sleep problems
- poor feeding
- shaking
- stiff muscles
- diarrhea
- fever
- seizures

Neonatal Abstinence Syndrome Rates

NAS rates per 1,000 birth hospitalizations

State rates:
2021-5.7
2022-4.8
2023-4.6



BabyCare Basics

- Medicaid funded program
- Must be Medicaid eligible and at risk of poor birth or child health outcomes to qualify
- Home visitation program provided by a registered nurse or social worker
- For pregnant women up to one year postpartum and infants up to two years of age.
- Monthly visits or more frequently as needed.

BabyCare Program Focus

- Home visiting
- Case Management
- Individualized goals and outcomes centered around patient needs
- Focus on client's strengths
- Education, support and intervention
- Active involvement of client and family
- Screening and referrals for developmental delays for infants using Ages and Stages assessments
- Screening and referral for substance use, depression and intimate partner violence using the Behavioral Health Risks Screening Tool.

BabyCare Program Staff & Caseload in Mount Rogers

- 1 full-time Senior Nurse
- 19 Public Health Nurses who carry a BabyCare caseload.
 - Caseloads are standard per PHN
 - Average caseloads are 10 to 15
- Combined caseload of 200 patients over 8 localities.



Additional Benefits

- Weight check for infants; newborn assessments to 6 month
- Administer immunizations for pregnant women, in conjunction with OB provider
- Referral for dental services
- Assure women receive access to birth control
- Repeat newborn testing screening, if needed
- WIC
- Car seats
- Safe Sleep: Pack and Plays
- Developmental Milestones: Developmental Kits
- Injury Prevention Program: Safety Kits



Resource Mothers Program

- Resource Mothers (RM) is a community-based home visitation program designed to improve maternal and child health outcomes among pregnant and parenting teens.
- Any pregnant teen, 19 years of age and younger, is eligible for the program.
- The program promotes adolescent health, positive youth development, and empowers teen parents to thrive.
- The Resource Mother makes frequent contacts (weekly) during pregnancy and until the infant is 6 months of age.

Resource Mothers Program Goals

- The program's main goal is to improve birth outcomes for the teen and the baby.
- The program uses the evidence-based curriculums Growing Kids and Aim4Teen Moms.
- The program works to assure that pregnant and parenting teens receive evidence-based, client centered services.
- This is achieved through screening and referral for support services.
 - Services can include education, employment, Medicaid, nutrition, substance use treatment, mental health, intimate partner violence and child development.

Meet our Resource Mothers

Rebecca Riggins



Shea Howlett



Resource Mothers Impact and Success Story

Mount Rogers' Maternal Health Doulas

What is a Doula?

Trained, community-based, non-medical professionals who offer a broad set of non-clinical, continuous support services to pregnant women throughout pregnancy, at labor and delivery, and during the postpartum period.

Provide support to pregnant and postpartum women through their grounding within the community, languages, and value systems of the populations they serve.

The emotional, physical, and informational support provided by doulas include childbirth education, lactation support, and referrals for health or social services.

Mount Rogers Maternal Health Doulas

Donna Surber and Grace Lowe



Doula Support Services Program

- Virginia is the 4th state in the nation to offer community doula services as a benefit for Medicaid members.
- Due to the lack of Medicaid certified doulas in southwest Virginia the Mount Rogers Health District hired 2 Maternal Health Doulas to provide services to our Medicaid community.
- As of May 23, the doulas were certified in both prenatal, birth doula, and postpartum training.

Doula Support Services

- Our Maternal Health Doulas are in the process of observing births at the local hospital as recommended by Medicaid.
- Application for NPI and Medicaid certification will be submitted this month.
- Doulas to begin home visitation services and support as soon as certification received.
- Doulas offer a broad range of non-clinical support services.

Doula Support Services

- Maternal Health Doulas provide 4 prenatal home visits, 4 postpartum home visits, and attend the births of their clients
- Provide emotional, physical and educational support, including childbirth education, lactation support, and referrals for health or social services
- Education focuses on the health and well being of the mother and infant, with an emphasis on the postpartum medical appointments, access to family planning services, mental health support, and establishing a medical home for the infant, as well as maintaining the well child visit schedule.

Success Stories

- BabyCare and Resource Mother client who completed high school was with the father of the baby. Both enrolled in college and completed the home visitation programs.
- 16-year-old dual enrolled client who finished high school. Completed certified nursing assistant training and enrolled in the licensed practical nursing program along with 17-year-old partner, father of the baby

Success Story

- Personal story, from 35 years ago, about a public health nurse who called a family with an infant in NICU.
- The nurse offered services and related the desire to serve all clients with home visitation services, whether enrolled in Medicaid or private insurance coverage.

Future Direction / Actions

Consider funding home visitation services for all pregnant and parenting women as a standard of care.

Consider state-wide addition and adoption of evidenced-based program or curriculum such as:

- *Parents As Teachers*
- *Healthy Families of America*

Questions/Answers

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Donna Surber, CHW, Maternal Health Doula

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Phone: 276-228-5507

Non-Regulatory Item: **Virginia Telehealth Plan** **2026-2030**

Mara Servaites, MSW, PCMH CCE
Executive Director, Virginia Telehealth Network

Robin Clair Cummings, MSHA
Deputy Advisor, Quality and Strategy
Virginia Telehealth Network

2026-2030 | DRAFT

VIRGINIA'S STATE TELEHEALTH PLAN

Presented by Virginia Telehealth Network



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INTRODUCTION

Following the passage of legislation that required the Virginia Board of Health to develop and implement a statewide telehealth plan, momentum for telehealth adoption has grown significantly – bolstered by telehealth’s capacity to enhance patient access to care, its embrace by patients, providers, and payers alike, as well as its many practical efficiencies.

Since the release of the initial State Telehealth Plan – published in 2021 by the Virginia Department of Health – support for and the growth of the telehealth ecosystem in Virginia has continued to accelerate and today remains on an upward trajectory.

The Virginia Telehealth Network (VTN) – a 501(c)(3) nonprofit organization dedicated to supporting telehealth efforts in the Commonwealth – was tapped by the legislature to facilitate the Plan by tracking implementation and informing enhancements. To fulfill this annual responsibility, VTN has engaged collaborative partners, conducted research, and facilitated stakeholder and community input through listening sessions and other forums.

This work includes:

- Conducting an annual “Benchmarking Telehealth Usage in the Commonwealth” survey of actively licensed providers in Virginia (including 2021, 2023, and 2024), a 2024 survey of EMS Agencies, and in 2021, designated surveys to collect insights from Virginia’s mental health providers, long-term care providers, free and charitable clinics, and federally qualified health centers.
- Hosting strategy discussions during the 2023 and 2024 VTN Summits, in partnership with the Mid-Atlantic Telehealth Resource Center and the Virginia Department of Health, to address necessary changes at federal, state, and local levels, spotlight Virginia-grown telehealth innovations as potential models for replication, and foster cross-sector dialogue on Virginia’s telehealth future.



- Conducting stakeholder interviews and establishing an advisory group to develop formal recommendations for enhancing the Plan - incorporating themes and information stemming from these discussions.
- Hosting listening sessions in partnership with the Virginia Department of Health and Virginia Rural Health Association focused on the needs of telehealth providers and patients in rural areas.
- Compiling recent recommendations and proposed legislation.
- Creating an inventory of interstate licensure compacts, relevant state plans and data sets (e.g., Virginia Rural Health Plan, Virginia Digital Opportunity Plan), other states' plans, and emerging quality standards (e.g., NCQA).
- Launching a statewide telehealth mapping system in partnership with the Mid-Atlantic Telehealth Resource Center.

Building upon the approved 2021 Plan, these efforts have directly shaped the 2026-2030 State Telehealth Plan. Key themes include the integration of remote patient monitoring and store-and-forward technology (particularly for chronic illness); expansion of telehealth in hospitals, schools, and state agencies; and the collection of usage and access data. The Plan also addresses broadband and technology gaps, accessibility for patients with hearing/visual impairments and limited English proficiency, and opportunities for improved care delivery, licensure, and workforce development. **A draft of this plan was posted on the VTN website for public feedback from April 25 to May 7, 2025.** Additionally, the 4,200 individuals who requested updates on the plan were sent the draft.

The 2026-2030 Plan reflects a collective commitment to advancing telehealth by continually learning and evaluating the best ways to employ telehealth so that it is sustainable, equitable, and cost-effective. VTN is grateful to our partners across the Commonwealth, including our partners at the Virginia Department of Health, for their assistance and support.

The 2021 Virginia State Telehealth Plan is available at: vdh.virginia.gov.

MONITORING THE HEALTH CARE AND TECHNOLOGY LANDSCAPES

At the time of this draft's release, numerous proposals have been announced that, if adopted, would have significant impact on the federal landscape. With the outcome of those proposals uncertain, this plan represents the current state of federal programming. The plan contributors will be charged with maintaining awareness of how federal developments, and resulting state response, impact plan implementation and prioritization.

FACILITATION TEAM

Virginia Telehealth Network	Virginia Department of Health	Subject Matter Experts
Mara Servaites, MSW, PCMH, CCE Executive Director	Sandra Serna Director, Office of Health Equity	Karen Rheuban, MD University of Virginia
Robin Cummings, MSHA Deputy Advisor for Strategy and Quality	Kandi Chamberlain Rural Health Manager	Kathy Wibberly, PhD Mid-Atlantic Telehealth Resource Center
Tom Anesta Operations Manager	Tim Perkins Community Health and Technical Resources Division Director	

STATE TELEHEALTH PLAN ADVISORY GROUP

Name	Organization
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Heidi Dix	Virginia Association of Health Plans
Ericca Facetti	Virginia Health Catalyst
Jamie Fisher	Virginia Pharmacy Association
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W. Davis Gammon, MPA	Virginia Hospital and Healthcare Association
Tamarah Holmes, PhD	Virginia Department of Housing and Community Development
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Mary Ochsner Krampen	Bay Rivers Telehealth Alliance
Elizabeth Parker, MEd	Henrico County Public Schools Department of Student Support and Wellness
Hallie Pence	Right Help, Right Now
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Abraham Segres	Virginia Hospital and Healthcare Association
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Jim Werth, MD	Tri-Area Community Health Center
Kathy Wibberly, PhD	Mid-Atlantic Telehealth Resource Center & Virginia Telemental Health Initiative

VIRGINIA STAKEHOLDER GROUPS INVITED TO PARTICIPATE

Bay Rivers Telehealth Alliance	Right Help, Right Now
Birth in Color	Secretary of Health and Human Resources
CareFirst BlueCross BlueShield	Tri-Area Community Health Center
Community Pharmacy Association	University of Virginia Center for Telehealth
Department for Deaf and Hard of Hearing	VCTA: Broadband Association of Virginia
Department of Behavioral Health and Developmental Services	VDH Office of Emergency Medical Services
Department of Education	Virginia Association of Community Services Boards
Department of Health	Virginia Association of Free and Charitable Clinics
Department of Health Professions	Virginia Association of Health Plans
Department of Housing and Community Development	Virginia Board for People with Disabilities
Department of Juvenile Justice	Virginia Health Care Association
Department of Medical Assistance Services	Virginia Health Catalyst
Henrico County Public Schools	Virginia Health Workforce Development Authority
Joint Commission on Health Care	Virginia Hospital and Healthcare Association
Medical Society of Virginia	Virginia Neonatal Perinatal Collaborative
Mid-Atlantic Telehealth Resource Center	Virginia Pharmacy Association
Pittsylvania-Danville and Southside Health District	Virginia Rural Health Association

§ 32.1-122.03:1. Statewide Telehealth Plan.

A. As used in this section:

"Remote patient monitoring services" has the same meaning as in § [38.2-3418.16](#).

"Telehealth services" means the use of telecommunications and information technology to provide access to health assessments, diagnosis, intervention, consultation, supervision, and information across distance. "Telehealth services" includes the use of such technologies as telephones, facsimile machines, electronic mail systems, store-and-forward technologies, and remote patient monitoring devices that are used to collect and transmit patient data for monitoring and interpretation. Nothing in this definition shall be construed or interpreted to amend the appropriate establishment of a bona fide practitioner-patient relationship, as defined in § [54.1-3303](#).

"Telemedicine services" has the same meaning as in § [38.2-3418.16](#).

B. The Board shall amend and maintain, in consultation with the Virginia Telehealth Network, as a component of the State Health Plan a Statewide Telehealth Plan to promote an integrated approach to the introduction and use of telehealth services and telemedicine services. The Board shall contract with the Virginia Telehealth Network, or another Virginia-based nongovernmental, nonprofit organization focused on telehealth if the Virginia Telehealth Network is no longer in existence, to (i) provide direct consultation to any advisory groups and groups tasked by the Board with implementation and data collection as required by this section, (ii) track implementation of the Statewide Telehealth Plan, and (iii) facilitate changes to the Statewide Telehealth Plan as accepted medical practices and technologies evolve.

C. The Statewide Telehealth Plan shall include but not be limited to provisions for:

1. The promotion of the inclusion of telehealth services and telemedicine services in the operating procedures of hospitals, primary care facilities, public primary and secondary schools, state-funded post-secondary schools, emergency medical services agencies, and such other state agencies and practices deemed necessary by the Board;
2. The promotion of the use of remote patient monitoring services and store-and-forward technologies, including in cases involving patients with chronic illness;

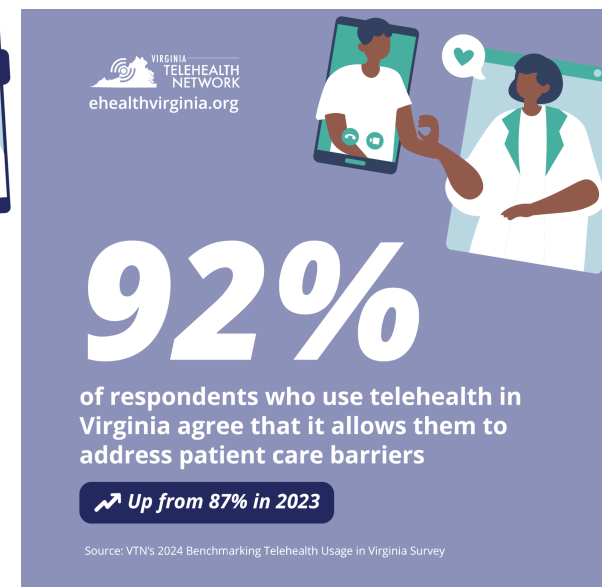
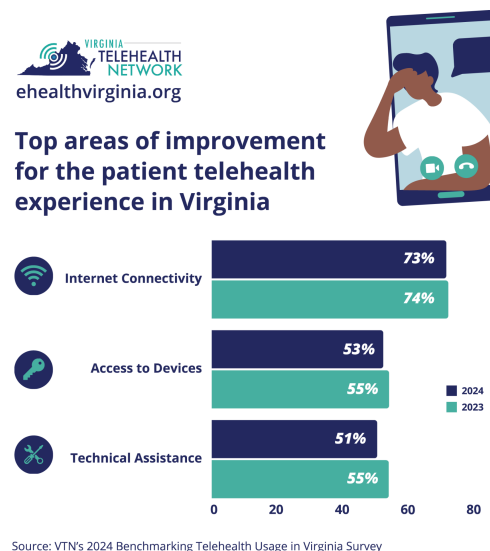
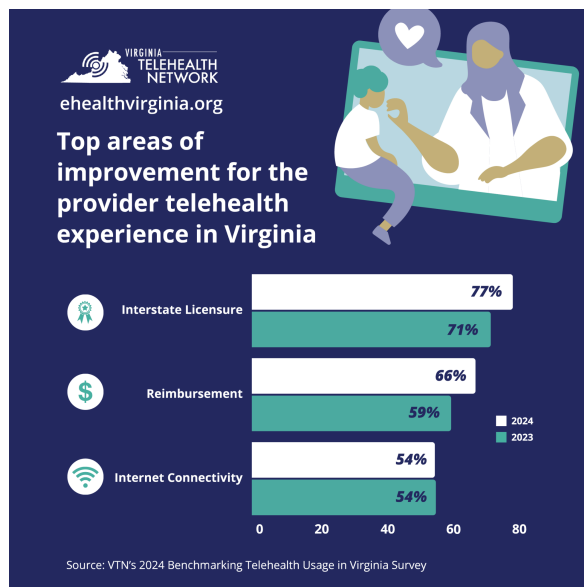
3. A uniform and integrated set of proposed criteria for the use of telehealth technologies for prehospital and interhospital triage and transportation of patients initiating or in need of emergency medical services developed by the Board in consultation with the Department of Health Professions, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, the Virginia Chapter of the American College of Surgeons, the American Stroke Association, the American Telemedicine Association, and prehospital care providers. The Board may revise such criteria from time to time to incorporate accepted changes in medical practice and appropriate use of new and effective innovations in telehealth or telemedicine technologies, or to respond to needs indicated by analysis of data on patient outcomes. Such criteria shall be used as a guide and resource for health care providers and are not intended to establish, in and of themselves, standards of care or to abrogate the requirements of § [8.01-581.20](#). A decision by a health care provider to deviate from the criteria shall not constitute negligence per se;
4. A strategy for integration of the Statewide Telehealth Plan with the State Health Plan, the Statewide Emergency Medical Services Plan, the Statewide Trauma Triage Plan, and the Stroke Triage Plan to support the purposes of each plan;
5. A strategy for the maintenance of the Statewide Telehealth Plan through (i) the development of an innovative payment model for emergency medical services that covers the transportation of a patient to a destination providing services of appropriate patient acuity and facilitates in-place treatment of a patient at the scene of an emergency response or via telehealth services and telemedicine services, where appropriate; (ii) the development of collaborative and uniform operating procedures for establishing and recording informed patient consent for the use of telehealth services and telemedicine services that are easily accessible by those medical professionals engaging in telehealth services and telemedicine services; and (iii) appropriate liability protection for providers involved in such telehealth and telemedicine consultation and treatment; and
6. A strategy for the collection of data regarding the use of telehealth services and telemedicine services in the delivery of inpatient and outpatient services, treatment of chronic illnesses, remote patient monitoring, and emergency medical services to determine the effect of use of telehealth services and telemedicine services on the medical service system in the Commonwealth, including (i) the potential for reducing unnecessary inpatient hospital stays, particularly among patients with chronic illnesses or conditions; (ii) the impact of the use of telehealth services and telemedicine services on patient morbidity, mortality, and quality of life; (iii) the potential for reducing unnecessary prehospital and interhospital transfers; and (iv) the impact on annual expenditures for health care services for all payers, including expenditures by third-party payers and out-of-pocket expenditures by patients.

2020, c. [729](#); 2022, cc. [724](#), [742](#).

PROVIDER SURVEYS & STRATEGY SESSIONS

BENCHMARKING TELEHEALTH USAGE IN VIRGINIA

As part of ongoing efforts to monitor the impact of telehealth on Virginia's patients and providers, the Virginia Telehealth Network (VTN) collaborates with the Virginia Department of Health Professions to conduct periodic "Benchmarking Telehealth Usage in Virginia" surveys of actively practicing licensed providers across the Commonwealth. This research effort is designed to help us better understand Virginia's current and future needs with virtual care.



- [2024 Benchmarking Telehealth Usage in Virginia](#) (.pdf)
- [2024 Telehealth Survey of Virginia's EMS agencies](#) (.pdf)
- [2023 Benchmarking Telehealth Usage in Virginia](#) (.pdf)

- [2021 Benchmarking Telehealth Usage in Virginia](#) (.pdf)
- [2021 In-depth follow-up survey results](#) (.pdf)

PROVIDER AND STAKEHOLDER STRATEGY SESSIONS

The Virginia Telehealth Network has hosted, in partnership with the Virginia Department of Health, two statewide strategy sessions. These community gatherings provided insights from a variety of stakeholders and their input has been incorporated into this draft of the Virginia State Telehealth Plan.

Highlights from 2023 VTN Summit: 105 Registrants

STRENGTHS: What successes and lessons learned can we build on?	OPPORTUNITIES: Where should we prioritize our efforts?
• Virginia is a national leader in telehealth policy, innovation • Virginia legislators, leaders have been telehealth champions • Medicaid expenditure data during the COVID-19 pandemic showed telehealth services are largely substitutive • Telehealth waivers and subsequent legislative changes enabled a significant scaling of telehealth services • Improved access to mental health care • DMAS accessibility and responsiveness • Community paramedicine innovations	• Integrated care model: right-sizing of virtual care • Alignment across payers; public policies must stay abreast with innovations in health care • Creative problem solving for enhanced access: school-based, telehealth access points, FQHCs as distant site • Broadband access, health information exchange, identifying community-based collaborative care settings • Advance conversations on alternative payment models, building upon lessons learned from fee-for-service
ASPIRATIONS: What are you most excited about?	RESULTS: How will we know we made an impact?
• Workforce development: support provider burnout, address provider shortages, leveraging paraprofessionals • Identifying other services that telehealth can support • Investments in digital health and value-based contracting • Continued improvements gained via telehealth: improved no-show rates, improved access to psychiatric care, improved access to timely appointments • Opportunities to integrate lessons learned in various use cases and care settings (e.g., primary care integration, teledentistry, correctional facilities) • How can virtual care enhance quality best?	• Improved access to care and reduction in barriers to receiving care: access for low-income and older adults, reduction in transportation as a barrier, ensuring functionally equivalent access • Less complexity in care delivery (e.g., simplifying billing and coding, reduction in administrative burden) • Patient satisfaction, provider satisfaction • Utilization, costs per visit, reduction in duplicative care, improved patient compliance • Improved clinical outcomes; patients receiving the right care at the right time

Highlights from 2024 VTN Summit: 56 Registrants

What are one or two health care challenges TELEHEALTH can help with in Virginia?	
• Maternity care access • Provider shortages • School-based shortages • Access • Providing speciality services • Support for patients with restricted mobility	• Transportation • Triage - sick visits • Supporting rural areas • Psychiatry services • Substance Use Disorder treatment • Access to care in correctional facilities
Based on the 2021 State Telehealth Plan, where does more work need to be done?	
• School-based telehealth for medical, teledentistry and behavioral health • EMS-centric telehealth • Further data collection on usage	• Remote patient monitoring (RPM) for management of pregnant and postpartum patients • Enhance use in primary care • Broad expansion of RPM

VISION STATEMENT

Embed and leverage telehealth as a solution to achieve the health priorities of the Commonwealth of Virginia.

The benefits of telehealth apply to the entire person, extending beyond physical health to include education, workforce development, connectivity, public safety, and infrastructure objectives, thereby **creating a healthier Virginia**.

AREAS OF IMPACT

How will we know we're making progress?

Several themes and priority areas emerged across all discussions and data analysis. These are the areas where all stakeholders agreed telehealth could be a focused solution for **patient access** and **provider distribution** challenges. Plan activities will be intentionally targeted towards advancing solutions that **support the health of the Commonwealth**.

Access to the right care at the right time

- Maternal health
- Behavioral and mental health including crisis supports and substance use disorder supports
- Preventive health
- Skilled nursing care
- Oral health
- Emergency medical care

Advancing the health of the Commonwealth

- Education
- Workforce development
- Connectivity
- Public safety
- Infrastructure
- Private-public collaboration

COMPONENTS OF VIRGINIA'S STATE TELEHEALTH PLAN

1. BROADBAND AND TECHNOLOGY ACCESS

Leveraging infrastructure opportunities to achieve cross-sector gains

2. CARE INNOVATIONS

Deploying proven models that can positively impact the health of Virginia's communities

3. PERSON-CENTERED ACCOMMODATIONS

Care that supports individual access needs and accommodations

4. SOLUTIONS TAILORED FOR HIGH-NEED AREAS

Improving network adequacy where enhanced access to care is most needed

5. SUSTAINABILITY, QUALITY, AND EFFICACY

Aligning in-person, virtual, and technology standards

6. WORKFORCE DEVELOPMENT AND OPTIMIZATION

Expanding telehealth capacity to achieve Virginia's workforce goals

7. PLAN ACCOUNTABILITY

Providing for stakeholder collaboration, effective oversight, benchmarking, and implementation of this plan



1. BROADBAND AND TECHNOLOGY ACCESS

Leveraging infrastructure opportunities to achieve cross-sector gains

Significant investment is occurring statewide to enhance access to broadband. Targeted initiatives, such as the [State Digital Opportunity Plan](#) created by the Virginia Department of Housing and Community Development, help create a roadmap for enhancing access to care via telehealth. Collaboration between health and sectors such as community development, the broadband industry, education, and other efforts to expand technology access will allow for leveraging limited resources for optimal impact.

1.1 Improve access to adequate broadband technology for users of telehealth - both organizational (e.g., health clinics in rural areas, emergency medical service providers, hospitals, medical practices, etc.) and individual (e.g., patients, telehealth access points, work-from-home telehealth providers).

1.1.1 Leverage existing programs, such as the Federal Communications Commission (FCC) Rural Health Care Program, among others, for community investment.

1.1.1.1 Create and maintain a library of these programs and resources and communicate opportunities to relevant audiences.

1.1.1.2 Monitor and promote the state's efforts regarding investment of Broadband Equity Access and Deployment (BEAD) Program funds.

1.1.1.3 Create opportunities for shared learning and cross-sector investment. For instance, connect the work of the Library of Virginia to offer privacy pods and equipment to library patrons with the efforts of pharmacies seeking to implement telehealth access points in rural communities.

1.1.2 Create and/or promote publicly available mapping tools to help patients, providers, and navigators know what community resources are available to support access to broadband and/or technology.



1.1.2.1 Collaborate with the Mid-Atlantic Telehealth Resource Center, Commonwealth Connection, and other relevant stakeholders to create and maintain maps of telehealth providers (including hospitals) and telehealth access points to support decision-making regarding investment prioritization.

1.1.2.2 Overlay mapping of maternity deserts, pharmacy deserts, psychiatry deserts, etc. to understand where publicly available telehealth access points may be a critical local investment opportunity.

1.1.2.3 Collaborate with relevant stakeholders to develop a plan to centralize a lookup and scheduling option for telehealth access points and alternative access solutions that are publicly available for consumer use.

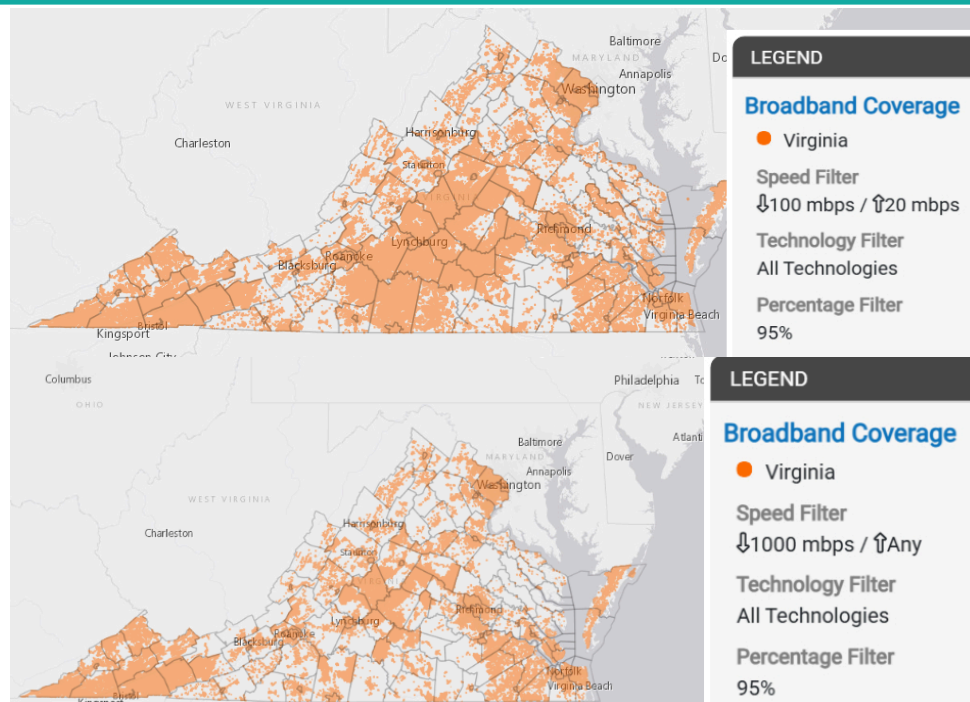
What Internet Speed Do Providers Need?

The Federal Communications Commission recommends the following **minimum** bandwidth speed for:

- Clinic (5 to 25 providers) = 25 Mbps
- Hospital = 100 Mbps
- Large medical center = 1,000 Mbps

in order to:

- Support management functions, email, and web browsing
- Allow simultaneous use of EHR and high-quality video consultations
- Enable real-time image transfer
- Enable continuous remote monitoring
- Make possible use of HD video consultations



Source: <https://www.healthit.gov/faq/what-recommended-bandwidth-different-types-health-care-providers> and <https://broadbandmap.fcc.gov/home>

1.1.3 Support private investment in telehealth infrastructure through the development of cost analyses related to telehealth deployment, growth, and replication.

1.2 Support digital literacy of Virginians through deployment of training materials and navigation supports.

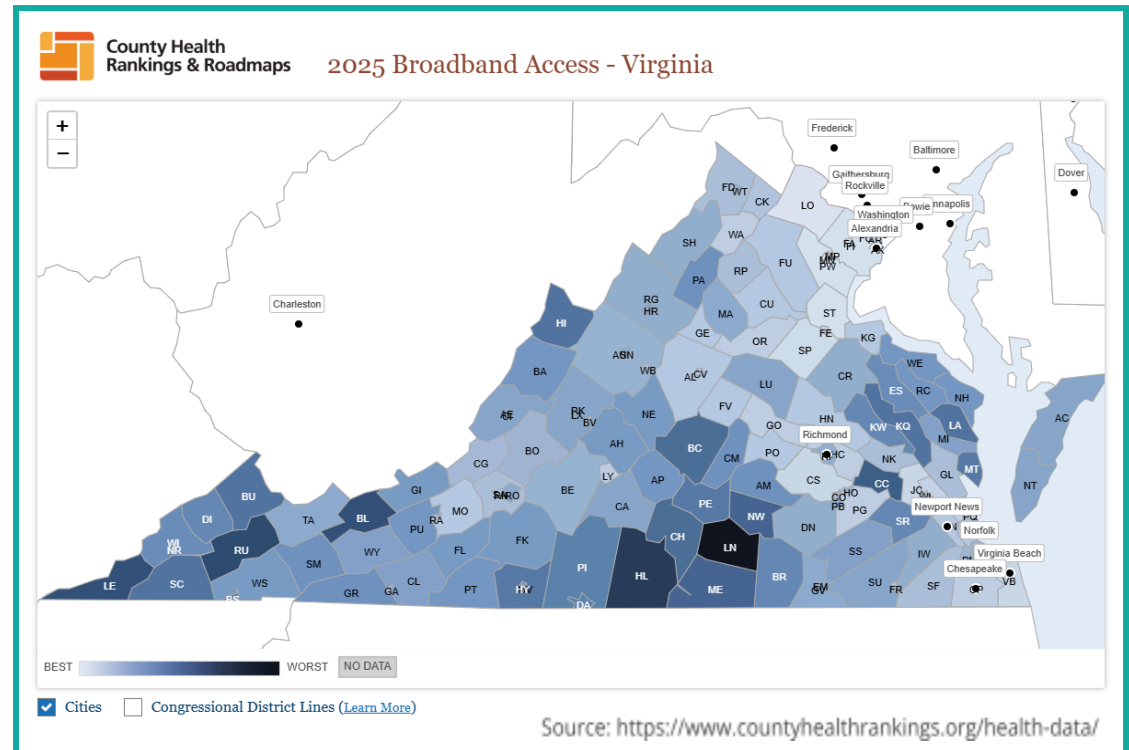
1.2.1 Provide digital literacy and broadband connection support, focusing on vulnerable and underserved communities of the state.

1.2.1.1 Collaborate with the Virginia Broadband Council on mapping low cost internet provider options for the benefit of patients who may not be able to easily afford a connection.

1.2.1.2 Collaborate with relevant stakeholders on the identification of low-cost technology options that are telehealth-compatible.

1.2.1.3 Support initiatives that would provide digital navigation to Virginians in need of technology support. These navigators could be available to support other technology needs - such as job searching - and there are models for library deployment of these efforts.

1.2.2 Establish a forum comprised of a broad group of constituents to foster statewide collaboration and alignment in delivering telehealth technology solutions and support.



2. CARE INNOVATIONS

Deploying proven models that can positively impact the health of Virginia's communities

Virginia is home to many of the country's leading health care innovators, with telehealth policy and innovation at the national level being driven by Virginia providers and governmental leaders. With our wealth of creative communities who are eager to collaborate in order to enhance care for their constituents, Virginia continues to be a space where new technology can be vetted and replicated.

2.1 Examine and evaluate the outcomes of telehealth innovation, integration, and expansion in Virginia, with a focus on measuring effectiveness, scalability, and long-term impact.

2.1.1 Establish a working group to prioritize data needs for measuring the impact of telehealth on accessibility, quality of care, cost of care, and patient outcomes.

2.1.1.1 Identify existing dashboards that can inform data collection and analysis (e.g., FCC's Mapping Broadband Health in America).

2.1.1.2 Define measures specific to this plan's objectives.

2.1.1.3 Define measures specific to: maternal health; behavioral and mental health (including crisis supports and substance use disorder supports); preventive health; skilled nursing care; oral health; and emergency medical services.

2.1.1.4 Define measures specific to telehealth technologies being utilized in Virginia, including audio-only services, eVisits, eConsults, and remote patient monitoring.

2.1.1.5 Develop and present a plan for data collection, analysis, and prioritization of these efforts.



2.1.2 Curate a library of Virginia-grown telehealth innovations, with priority given to programs that advance one or more of the plan priorities for enhancing access to the right care at the right time.

2.1.2.1 Collaborate with the Department of Housing and Community Development to identify BEAD projects that are scalable.

2.1.2.2 Prioritize information sharing in the areas of maternal health; behavioral and mental health (including crisis supports and substance use disorder supports); preventive health; skilled nursing care; oral health; and emergency medical services.

2.1.3 Identify opportunities for cross-sector collaboration and sustainability in replicating and growing “innovations that work.”

2.2 Promote and support integration of school-based telehealth options that can create a model for comprehensive student health and improved wellness.

2.2.1 Collaborate with the Virginia Department of Education and the Virginia Department of Health on mapping various counties in Virginia that are offering school-based telehealth.

2.2.1.1 Survey school districts and/or individual schools about needs, barriers, and wins in this space.

2.2.1.2 Spotlight Virginia success stories for school district consideration of replication.

2.2.1.3 Provide a venue for sharing best practices and innovation development for school-based telehealth.

2.2.2 Based on survey findings, collaborate with the Virginia Department of Education, the Virginia Department of Health, the Virginia Department of Behavioral Health and Developmental Services, and the Mid-Atlantic Telehealth Resource Center to deploy educational materials to interested schools and school districts.

2.2.2.1 Establish a resource center for schools and school districts to access for toolkits, guidance, and models for consideration.

2.2.2.2 Identify best practices in referral, informed consent, communication between providers - patients - parents/caregivers, HIPAA and FERPA, etc.

2.2.2.3 Create health literacy tools and educational content that can help schools best communicate about offerings to parents and students.

2.2.2.4 Identify best practices in how telehealth can support exceptional learners, such as virtual assessments and access to specialized support services such as school psychologists, therapists, and social workers.

2.2.2.5 Participate in learning collaboratives, such as the [School-Based Telehealth Learning Collaborative](#), to maintain information on best practices.

2.3 Promote telehealth opportunities and benefits to the Virginia EMS system.

2.3.1 Create a library of best practices in mobile integrated health care, including local innovations, and disseminate information through email lists and social media.

2.3.2 Develop basic template for telehealth operating procedures for EMS agencies.

2.3.3 Monitor the progress of the Virginia Department of Health in establishing a uniform and integrated set of proposed criteria for the use of telehealth technologies for prehospital and interhospital triage and transportation of patients initiating or in need of emergency medical services developed by the Board in consultation with the Department of Health Professions, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, the Virginia Chapter of the American College of Surgeons, the American Stroke Association, the American Telemedicine Association, and prehospital care providers.

2.3.4 Collaborate with the Office of EMS to:

2.3.4.1 Review State EMS formulary and make recommendations regarding telehealth-appropriate services.



2.3.4.2 Recommend a uniform and integrated set of proposed criteria for the use of telehealth technologies for pre-hospital and inter-hospital triage and transportation; and (3) identify example programs that may present opportunities for replication at Virginia EMS agencies.

2.4 Promote Remote Patient Monitoring (RPM), particularly for monitoring of chronic illness, high risk pregnancies, and for prevention of hospital readmission.

2.4.1 Survey impacted stakeholders statewide on utilization of RPM to determine gaps.

2.4.2 Disseminate information regarding best practices, payer policies and promote educational opportunities regarding use cases for remote patient monitoring.

2.5 Monitor areas of evolving technology, such as artificial intelligence, and make adjustments to plan as needed.

3. PERSON-CENTERED ACCOMMODATIONS

Care that supports individual access needs and accommodations

To fully realize the benefits of telehealth and its potential to resolve barriers to care, ensuring patient access is paramount. Innovations and adaptations in telehealth delivery can help support individual patient needs - including access to fundamental technology knowledge and skills, often termed digital literacy.

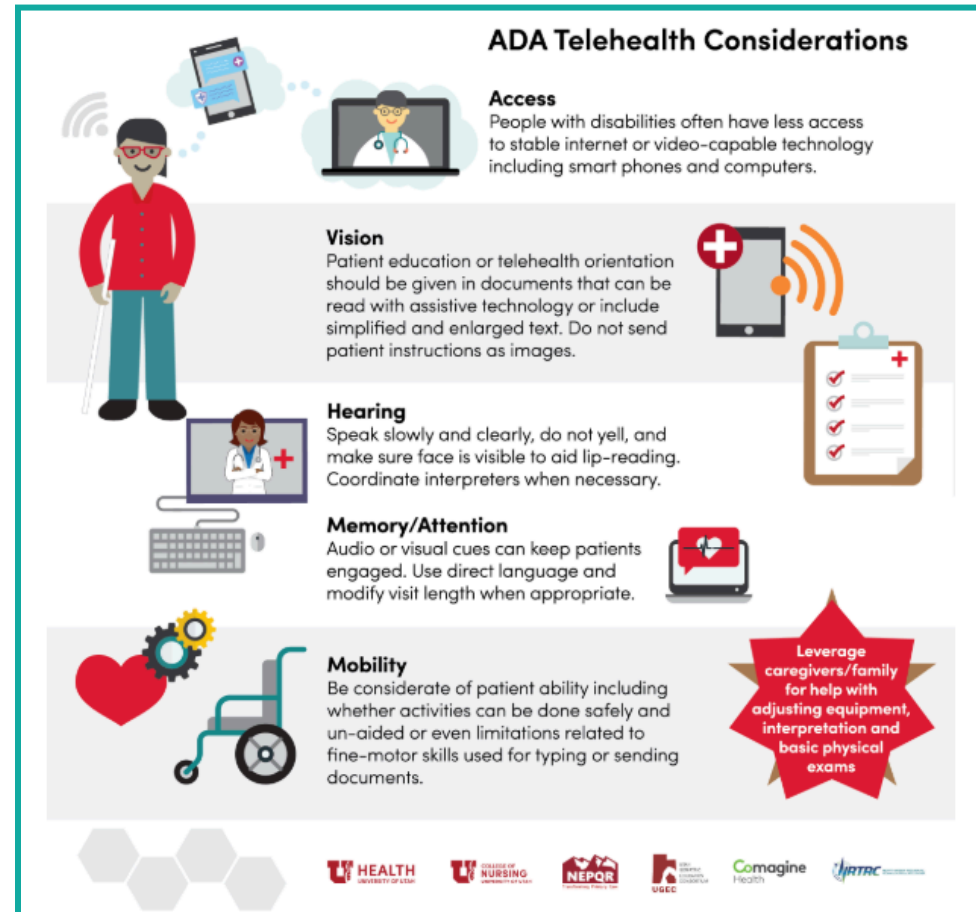
3.1 Incorporate patient representation in workgroups.

3.1.1 Collaborate with patient-facing organizations to identify representatives that can support inclusive policy development that meets individual access needs and accommodations.

3.2 Examine accessibility issues such as gaps in service accessibility for older adults, those with limited English language proficiency, and people with physical, sensory, cognitive or developmental disabilities including people who are deaf or hard of hearing, blind, or visually impaired.

3.2.1 Conduct surveys and/or focus groups and interviews regarding satisfaction with telehealth and how delivery can be improved to meet accessibility needs. Identify providers doing this well and promote them as a model.

3.2.2 Collaborate with patient-facing organizations, such as Area Agencies on Aging and the Department of Aging and Rehabilitative Services, to disseminate relevant information to constituents and providers.



3.3 Partner with the Mid-Atlantic Telehealth Resource Center, payers, and provider associations to disseminate information on resources and best practices in patient-centered accessibility.

3.3.1 Explore how the intersection of telehealth and assistive technologies, such as Virginia Relay, can best support patient access.

3.3.2 Establish best practice guidance for telehealth access points in affordable housing developments.

3.3.4 Identify training opportunities and collaborative spaces for digital navigators to support local connection needs.

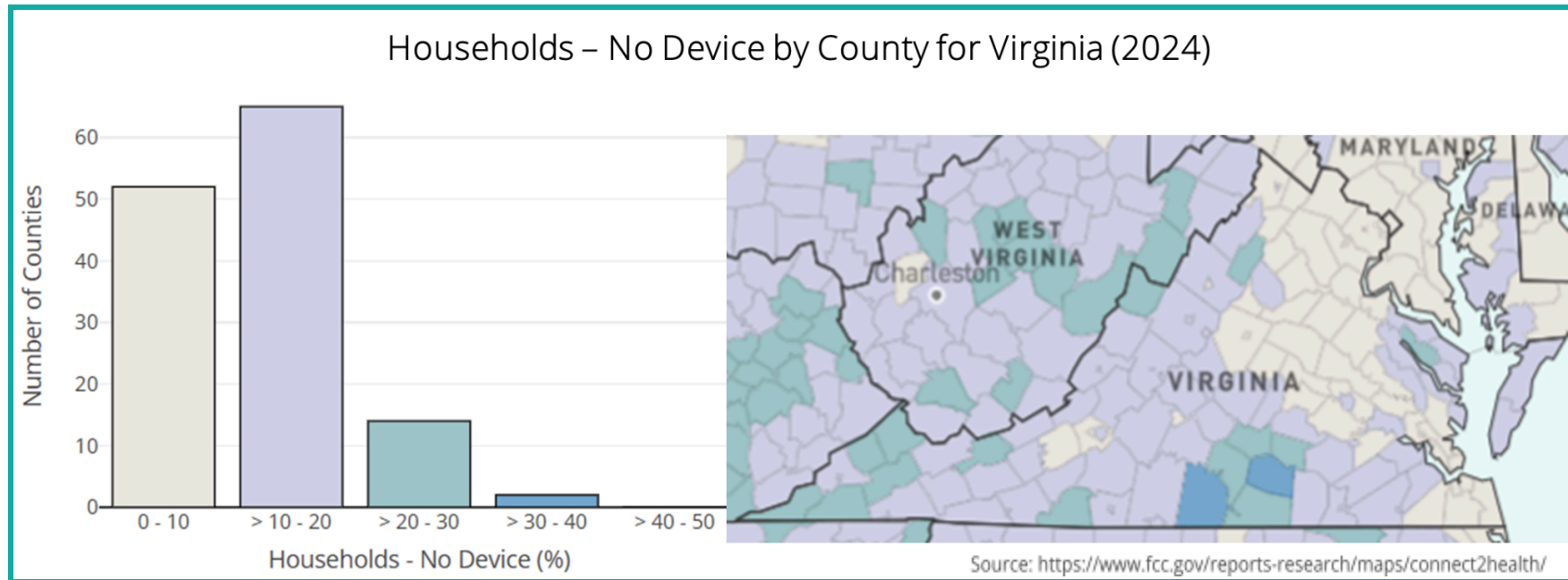
3.3.5 Identify Telehealth 101 digital literacy training opportunities and collaborative spaces for community learning (e.g., libraries).

3.3.6 Collaborate with the Virginia Board for People with Disabilities and the VCU Partnership for People with Disabilities to disseminate training materials and opportunities to stakeholders.

4. SOLUTIONS TAILORED FOR HIGH-NEED AREAS

Improving network adequacy where enhanced access to care is most needed

The most important consideration for patient access to telehealth services is appropriate technological infrastructure (e.g., devices, Internet connectivity) and the ability to use it effectively (digital literacy).



4.1 Collaborate with the Virginia Department of Health Division of Social Epidemiology to map access deserts in Virginia, overlaid with telehealth access points and broadband availability so as to define areas for targeted infrastructure investment.

4.1.1 Utilize existing tools such as the [Telehealth Broadband Project](#) to help inform these efforts.

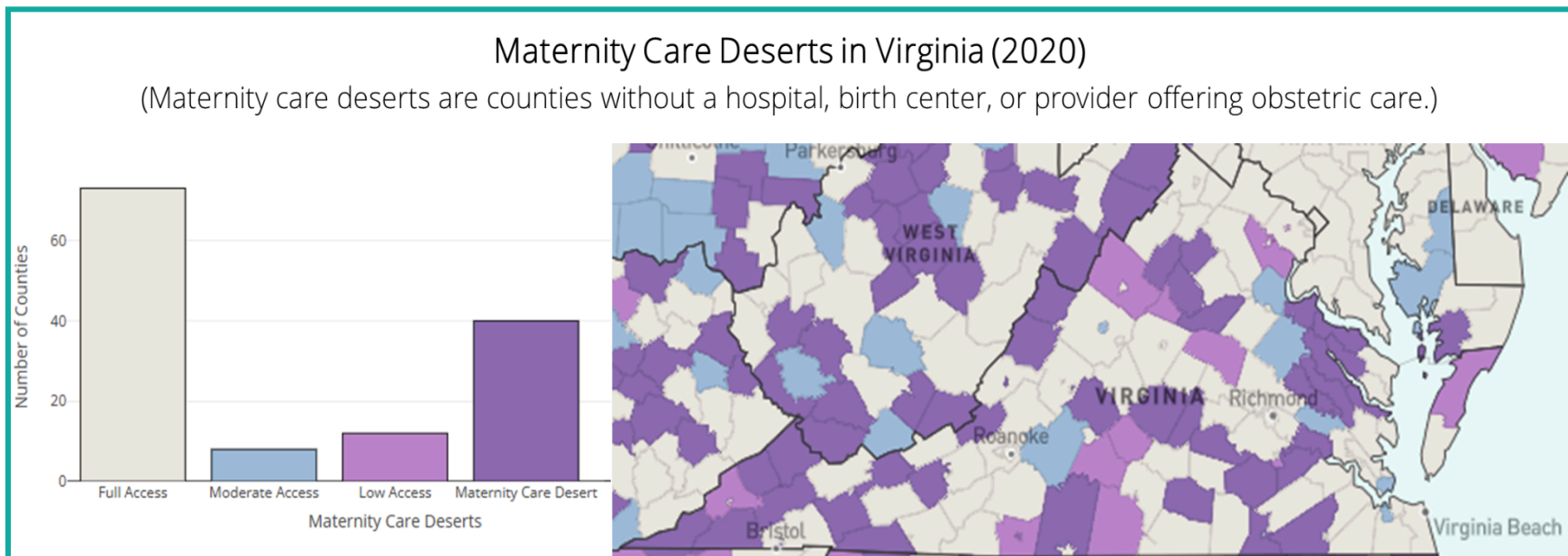
4.2 Explore alternatives for situations where video feed is unstable.

4.2.1 Identify low-cost technology solutions for individuals who lack the resources for video-compatible technology.

4.2.1.1 Identify potential solutions for improved access, such as technology lending libraries and telehealth access points.

4.2.1.2 Advocate for opportunities for utilization of audio-only telehealth services in the event of patient technology difficulties.

4.2.1.3 Provide recommendations, based on cost and potential impact, for enhancing technology access for Virginians.



Source: <https://www.fcc.gov/reports-research/maps/connect2health/>

4.2.2 Benchmark audio-only usage and determine best use cases, barriers, and suggestions for enhanced use.

4.3 Promote Remote Patient Monitoring (RPM) for high risk patients, including mental health, maternal health, child protection, and chronic disease management.

4.3.1 Provide education and best practices for providers around accessing and using RPM technology.

4.3.2 Work collaboratively with payers to provide information to providers on current coverage options and potentials for expansion to coverage.

4.4 Address barriers to providers utilizing telehealth.

4.4.1 Identify opportunities for loan repayment options for telehealth providers.

4.4.2 Advocate for continued remote prescribing of controlled substances and provide up-to-date information on any changes.

4.4.3 Advocate for confidentiality of telehealth providers' personal information that can include home address.

4.5 Prioritize telehealth supports for state institutions where provider access is limited.

4.5.1 Collaborate with the Department of Corrections, regional jails, and the Department of Juvenile Justice to explore opportunities and barriers for telehealth in such facilities.

4.5.2 Collaborate with the Department of Behavioral Health and Developmental Services to explore opportunities and barriers for telehealth in state mental health facilities and programs.

4.6 Collaborate with the Virginia Department of Health to explore opportunities and barriers for telehealth as an emergency/pandemic response resource.

4.7 In prioritizing areas of focus, seek alignment with Virginia Rural Health Plan, VBPD Geographic Disparities in Healthcare Access.



5. SUSTAINABILITY, QUALITY, AND EFFICACY

Aligning in-person, virtual, and technology standards

Virginia has served as a leader nationally in its policy and advocacy efforts for telehealth. As the industry shifts against environmental impacts, remaining vigilant and flexible will remain necessary to keep telehealth sustainable and efficient.

5.1 Advocate for policy permanency.

5.1.1 Monitor federal shifts in telehealth reimbursement regulations and policies and develop strategies to support telehealth at the statewide level as needed.

5.1.2 With state and private payers, develop guidance regarding telehealth payment, codes, and reimbursement.

5.1.3 Develop guidance for implementation, sustainability, and replication of new and effective use cases.

5.1.4 Work with community partners to identify channels to keep Virginians providers abreast of policy changes that may impact practice.

5.2 Encourage planning and investment by creating transparency around payer policies and requirements.

5.2.1 Partner with payers to create a statewide resource that continuously monitors the telehealth reimbursement landscape in Virginia and nationally.

5.3 Maintain information regarding telehealth certifications, quality standards, and other areas of interest impacting telehealth quality.

5.4 Data collection regarding the potential for reducing unnecessary inpatient hospital stays.



5.4.1 Support evaluation of instances where screening via telehealth could have reduced or eliminated unnecessary emergency department visits.

5.4.2 Identify areas where telehealth could prevent hospitalizations from skilled nursing facilities.

5.4.3 Explore the prevention of unnecessary hospitalizations and emergency department visits by accessing care with primary care and/or emergency medical services via telehealth.

5.4.4 Monitor telehealth integrated environments/hybrid environments (e.g., mobile integrated health care) for lessons learned, opportunities for replication.

6. WORKFORCE DEVELOPMENT AND OPTIMIZATION

Expanding telehealth capacity to achieve Virginia's workforce goals

Virginia has a long history of growing and developing the next generation of health care leaders. It has developed supportive ways to encourage homegrown innovation in health care and ensuring health care providers can provide services to their patients in a safe and ethical manner. Telehealth offers an opportunity to further support workforce development in the Commonwealth.

6.1 Provider benchmarking to determine workforce originating state and state licensure status.

6.1.1 Promote and support interstate licensure compacts to ensure providers can serve patients in accordance with licensing laws.

6.1.2 Develop guidance for acquiring a Virginia state license for those in another state through compacts or expedited licensure and track the number of providers seeking these licenses.

6.1.3 Develop guidance for providers serving Virginia residents across state lines based on the needs of these providers.

6.1.4 Develop guidance and infrastructure recommendations for provider-to-provider eConsults.

6.2 Registry of providers offering telehealth.

6.2.1 Collaborate with the Mid-Atlantic Telehealth Resource Center to identify and promote.

6.3 Consider workforce potential.

6.3.1 Identify best practices used by provider training programs from across the country that incorporate telehealth as part of their curriculum. Develop a forum to communicate potential options for inclusion of telehealth in provider training programs.

6.3.2 Support workforce expansion programs that offer opportunities for providers to expand their scope of practice and/or accelerate their path to licensure.



6.3.3 Identify innovative training programs that support telehealth such as virtual medical interpreters, digital navigators, military medics, and/or virtual scribes.

6.3.4 Utilize collaborative partners, such as Virginia Workforce Development Authority, Area Health Education Centers, and Go Virginia, to identify innovative workforce development opportunities improved by the use of telehealth.

6.3.5 Pulling from national best practices and statewide innovators, develop standards for telemental health services and telehealth substance misuse services.

7. PLAN ACCOUNTABILITY

Providing for stakeholder collaboration, effective oversight, benchmarking, and implementation of this plan

A critical component to any plan development is creating accountability strategies to keep the plan relevant, timely, and useful. Structures developed in the updating of the State Telehealth Plan can be maintained to serve as a source of support. The Virginia Telehealth Network is prepared to serve as the facilitator and convener, allowing the plan to morph and change as necessary.

7.1 Establish benchmarks for ongoing monitoring of plan implementation.

7.2 In collaboration with the Virginia Department of Health, develop a timeline, budget and staffing plan for ensuring up to date monitoring, evaluation, and modifications of this plan.

7.2.1 Prioritize elevation and sustainability of replicable and scalable programs that improve access to care, such as school-based telehealth programs, the Virginia Telemental Health Initiative, Department of Corrections-Bay Rivers substance use disorder supports, mobile mammography, etc.

7.3 Utilizing the existing advisory group structure, continue regular communications and bi-annual meetings to review efforts and discussion modifications.

7.3.1 Monitor federal and state priorities and changes in telehealth to give to the group for input.

7.3.2 As needed, update the plan to reflect current telehealth status.

7.4 In collaboration with the Virginia Department of Health, create a communication plan to disseminate the plan.

7.4.1 Identify a central location (i.e., VTN website) to store the plan and communications about the plan.

7.4.2 Maintain a database of interested constituents (e.g., VTN) with a vested interest in the plan.

7.4.2 As able, incorporate related elements of the plan into existing plans such as:

- State Health Plan
- State Emergency Medical Services Plan

- State Trauma Triage Plan
- Stroke Triage Plan
- VDOE, VDOC, VDHP, VDMAS, VDVS agency telehealth plans

7.5 Explore option to provide a forum for interagency information sharing on telehealth and related opportunities.

APPENDIX A: GRATITUDE FOR YOUR COLLABORATION & INSIGHTS

STAKEHOLDER INTERVIEWS & FOCUS GROUPS (SCHEDULED)

Date:	Organization:	Attendees:
2023	Medical Society of Virginia	Clark Barrineau Scott Castro
2023	Virginia Rural Health Association	Beth O'Connor, M Ed.
2023	American Telemedicine Association	Kyle Zebley Tom Mann
2023	Virginia Community Healthcare Association	Daniel Neal Fernan Caparas Kevin Ajmera Roopak Manchanda
2023	Virginia Health Catalyst	Ericca Facetti
2023	Virginia Hospital and Healthcare Association	Kelly Cannon Abraham Segres R. Brent Rawlings
2023	Virginia Association of Health Plans	Heidi Dix
2023	Birth in Color	Chelsea Dade Galina Varchena
2023	Virginia Rural Health Association - Conference Listening Session	Heather Anderson 15 individuals representing hospitals, academia, nursing, and health nonprofits

DRAFT VIRGINIA STATE TELEHEALTH PLAN
2026 - 2030

2023	Northwest Regional Telehealth Resource Center (NRTRC) - AK, WA, OR, MT, ID, WY, UT and the US-Affiliated Pacific Islands	Jaleen Johnson
2023	California Telehealth Resource Center (CTRC)	Aislynn Taylor
2023	Heartland Telehealth Resource Center (HTRC) - Missouri, Oklahoma and Kansas	Molly Brown
2023	Southeastern Telehealth Resource Center (SETRC) - Alabama, Florida, Georgia, Puerto Rico, South Carolina, and USVI	Boyd Mark
2023	National Consortium of Telehealth Resource Centers (NRTRC)	Christine Calouro
2023	National Center for Quality Assurance	Peter Fourinier
2025	Virginia Department of Medical Assistance Services	Lisa Price Stevens, MD, MBA, MPH, FACP Rhonda Newsome, ODA
2025	Virginia Department of Behavioral Health and Developmental Services	Curt Gleeson Alexis Ablasca, MD Nicole Gore
2025	Virginia Association of Health Plans	Heidi Dix
2025	Chair, Joint Commission on Health Care Chair, House Select Committee on Advancing Rural and Small Town Health Care	Del. Rodney Willett
2025	Virginia Department of Health (invited)	Karen Shelton, MD
2025	Office of Emergency Medical Services	George Lindbeck, MD
2025	Virginia Department of Health Professions	Erin Barrett, JD Yetty Shobo, PhD

2025	Virginia Pharmacy Association	Jamie Fisher
2025	Tri-Area Community Health	Jim Werth, PhD, ABPP
2025	Virginia Board for People with Disabilities	Jennifer Krajewski
2025	Virginia Department of Education	Joseph Wharff Martha Montgomery Na-Keisha White, MSN-PH, RN, NCSN
2025	Secretary of Health and Human Resources	Mindy Diaz Monay Leah Mills

The following organizations were also invited to participate:

Department of Juvenile Justice, Virginia Association of Community Services Boards, Virginia Community Pharmacy Association

APPENDIX B: GLOSSARY OF ACRONYMS

ADA	Americans with Disabilities Act
BEAD	Broadband Equity, Access and Deployment Program
DBHDS	(Virginia) Department of Behavioral Health and Developmental Services
DMAS	(Virginia) Department of Medical Assistance Services
EMS	Emergency Medical Services
FCC	Federal Communications Commission
FERPA	Family Educational Rights and Privacy Act
FQHC	Federally Qualified Health Center
HIPAA	Health Insurance Portability and Accountability Act
MATRC	Mid-Atlantic Telehealth Resource Center
MBPS	Megabits per second
NCQA	National Committee for Quality Assurance
OEMS	Office of Emergency Medical Services
RPM	Remote Patient Monitoring
VBPD	Virginia Board for People with Disabilities
VCTA	Virginia Cable Telecommunications Association - Broadband Association of Virginia

VCU	Virginia Commonwealth University
VDH	Virginia Department of Health
VDHP	Virginia Department of Health Professions
VDOC	Virginia Department of Corrections
VDOE	Virginia Department of Education
VTN	Virginia Telehealth Network

2026-2030

Virginia State Telehealth Plan

Presentation to the Virginia Board of Health
June 12, 2025



Presentation Overview

1

Background

Research Highlights

Review of 2021 STHP

Review of 2026 STHP

Next Steps

Important note...

2

MONITORING THE HEALTH CARE AND TECHNOLOGY LANDSCAPES

At the time of this draft's release, numerous proposals have been announced that, if adopted, would have significant impact on the federal landscape. With the outcome of those proposals uncertain, this plan represents the current state of federal programming.

The plan contributors will be charged with maintaining awareness of how federal developments, and resulting state response, impact plan implementation and prioritization.

§ 32.1-122.03:1. Statewide Telehealth Plan.

B. The Board shall amend and maintain, in consultation with the Virginia Telehealth Network, as a component of the State Health Plan a Statewide Telehealth Plan to promote an integrated approach to the introduction and use of telehealth services and telemedicine services. The Board shall contract with the Virginia Telehealth Network, or another Virginia-based nongovernmental, nonprofit organization focused on telehealth if the Virginia Telehealth Network is no longer in existence, to (i) provide direct consultation to any advisory groups and groups tasked by the Board with implementation and data collection as required by this section, (ii) track implementation of the Statewide Telehealth Plan, and (iii) facilitate changes to the Statewide Telehealth Plan as accepted medical practices and technologies evolve.

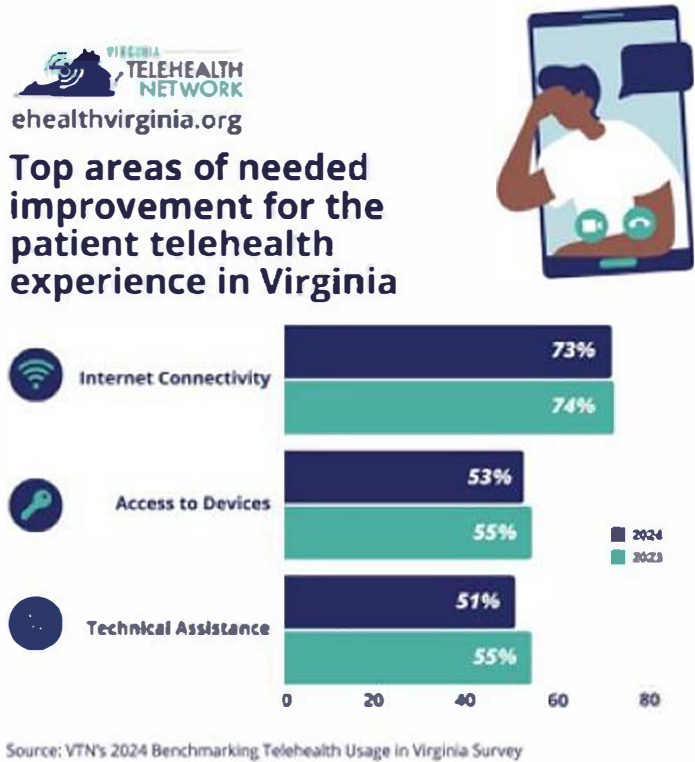
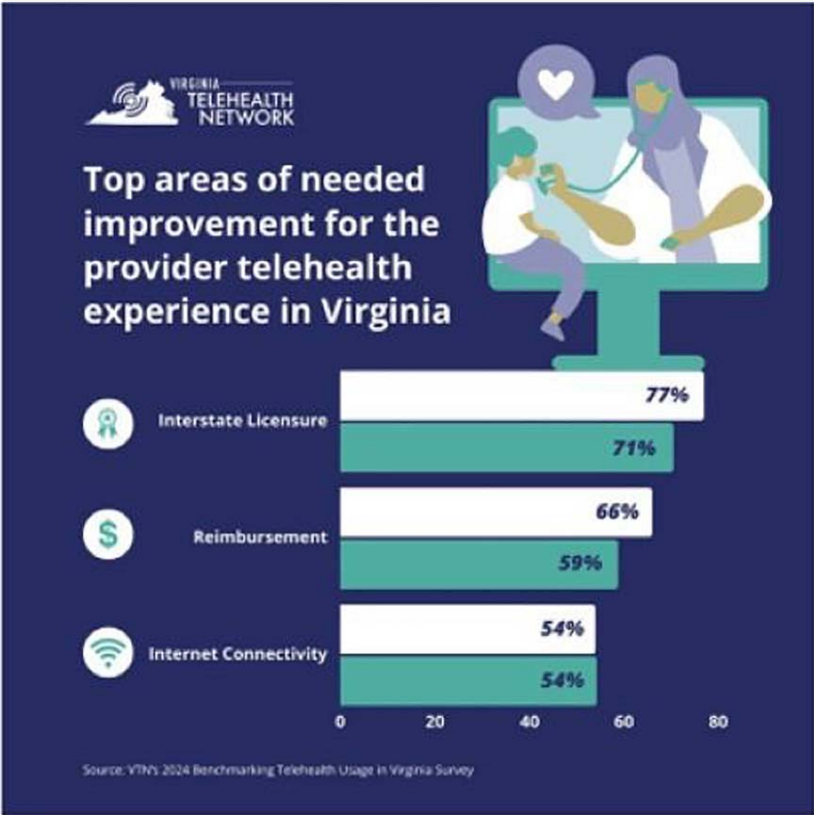
<https://law.lis.virginia.gov/vacode/title32.1/chapter4/section32.1-122.03:1/>

Research Background

4

- [Benchmarking Telehealth Usage in the Commonwealth](#): 2024 . 2023 . 2021 . 2024 EMS Agencies
- VTN Summit strategy discussions: 2024 . 2023
- Stakeholder interviews
- Compilation of recent recommendations and proposed legislation
 - [Inventory of interstate licensure compacts](#)
- Inventory of relevant state plans and data sets (e.g., [Virginia Rural Health Plan](#); [Virginia Digital Opportunity Plan](#))
- Inventory of other states' plans
- Inventory of emerging quality standards (e.g., NCQA)
- [Telehealth mapping project with MATRC](#)
- [ATA Policy Priorities](#) (2025)
- [2021 Virginia State Telehealth Plan](#)

Research Highlights: Benchmarking Telehealth

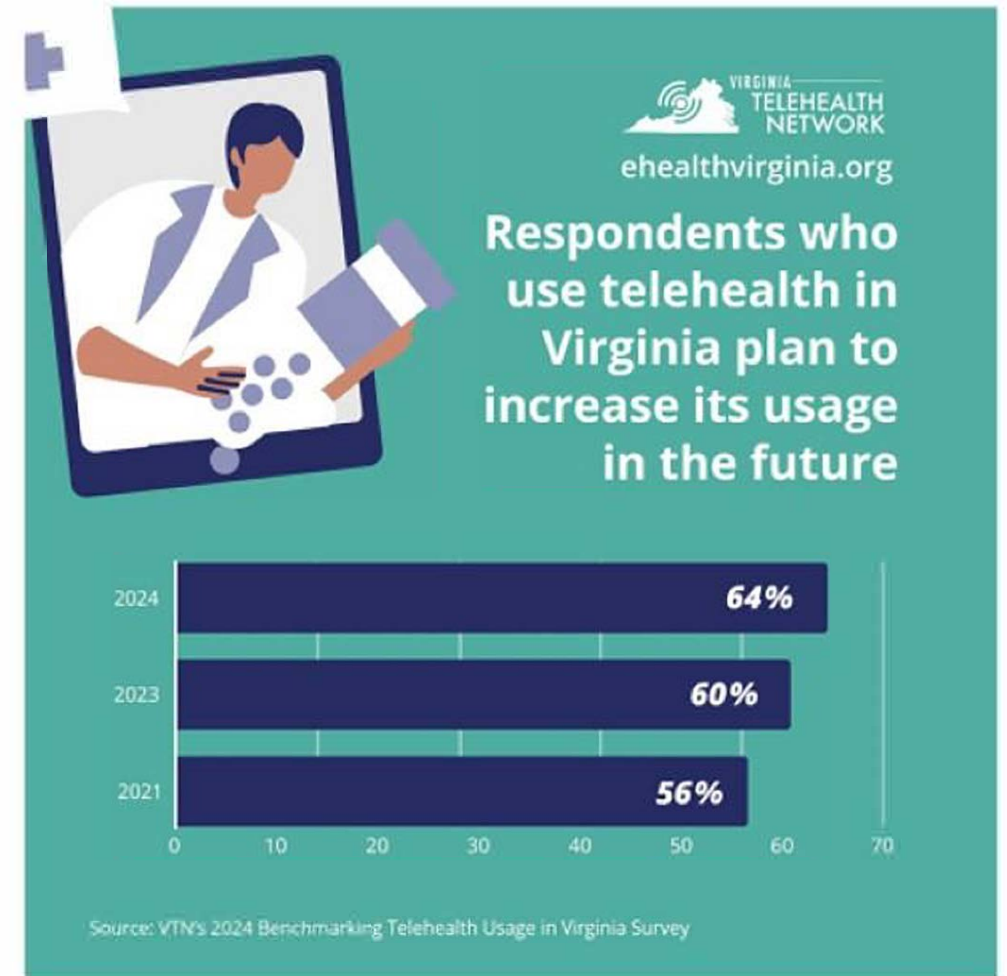


ehealthvirginia.org/telehealth-survey

Reflections on 2021 Virginia State Telehealth Plan

6

- Drafted pre-pandemic – in a very different telehealth landscape
- Significant sections of the plan were no longer relevant following the rapid and widespread adoption of telehealth
- **Many milestones** - such as incorporating telehealth in health care operations - were **achieved organically** and much more expeditiously than anyone could have imagined pre-2020



2021 Virginia State Telehealth Plan

7



CORE STRATEGY 1 – INCLUSION OF TELEHEALTH SERVICES IN OPERATING PROCEDURES

- Hospitals and primary care facilities
- Public primary and secondary schools and state funded post-secondary schools
- Emergency medical services agencies
- State agencies



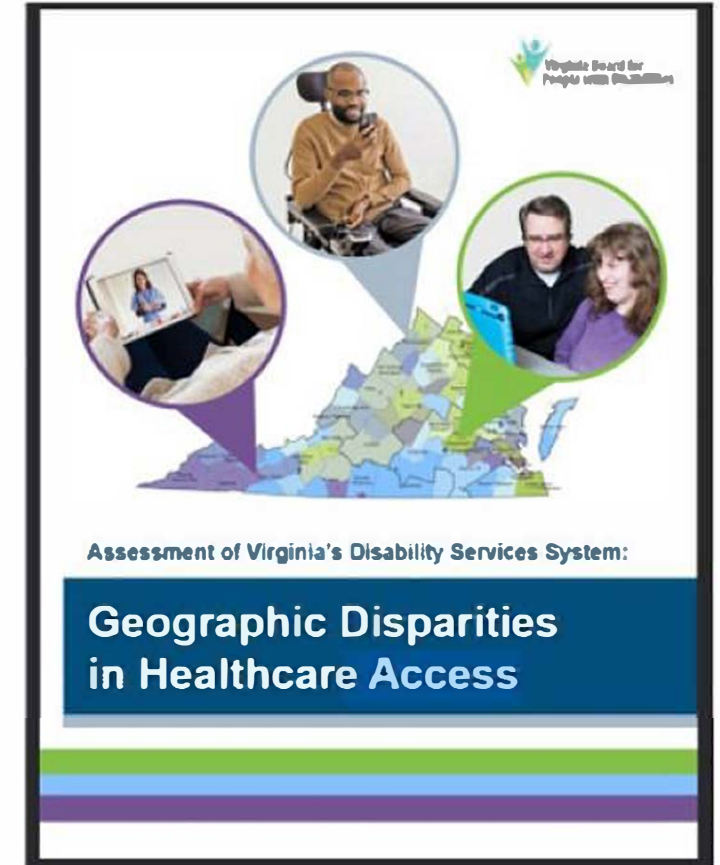
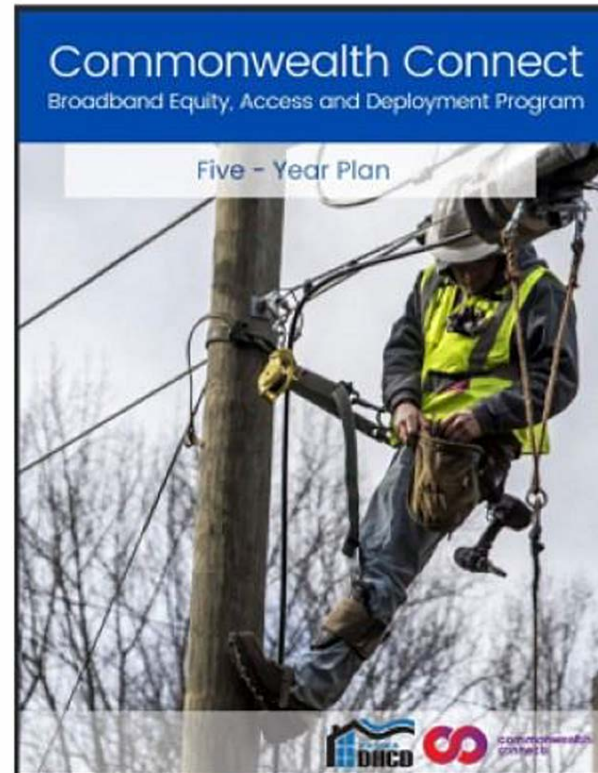
2021 Virginia State Telehealth Plan

8



CORE STRATEGY 2 – REMOTE PATIENT MONITORING

- Promote use of RPM and store-and-forward technologies, including with patients with chronic illness
- Assess cost of telehealth and broadband access
- Assess access for individuals with disabilities
- Data monitoring and management



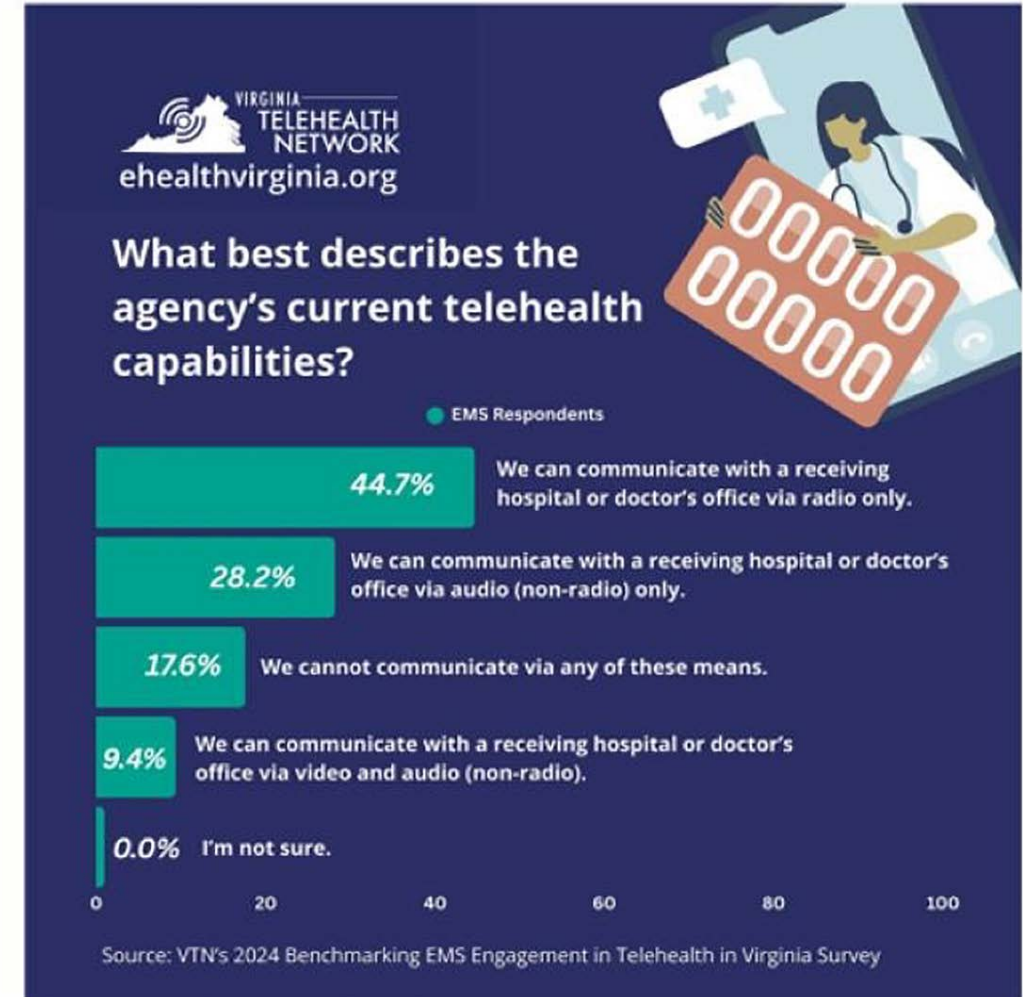
2021 Virginia State Telehealth Plan

9



CORE STRATEGY 3 – UNIFORM AND INTEGRATED CRITERIA

- Review of State EMS Formulary to rule in/rule out procedures that may be telehealth appropriate
- OEMS report to the Board of Health with recommended changes in medical practice and/or appropriate use of new and effective innovations in telehealth technologies, or to respond to needs indicated by analysis of data on patient outcomes



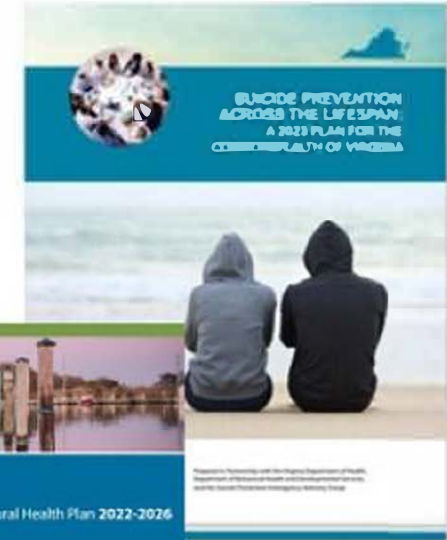
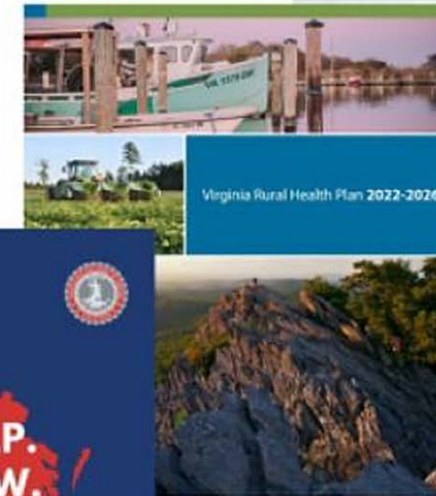
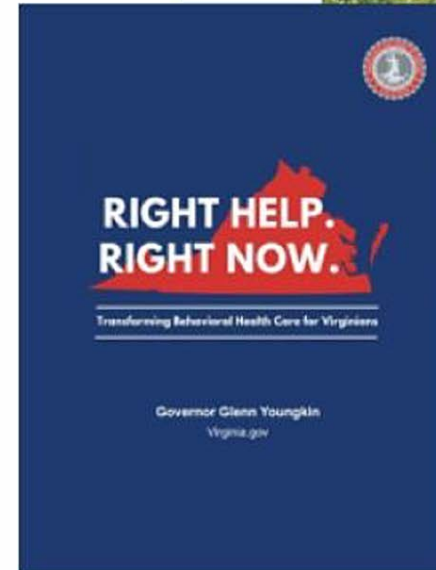
2021 Virginia State Telehealth Plan

10



CORE STRATEGY 4 – INTEGRATION INTO OTHER PLANS

- State Health Plan
- Statewide Emergency Medical Services Plan
- Statewide Trauma Triage Plan
- Stroke Triage Plan
- Other state plans



2021 Virginia State Telehealth Plan

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CORE STRATEGY 5 – MAINTENANCE OF THE PLAN

through the development of...

- An innovative payment model for emergency services that covers patient transport to a destination providing services of appropriate patient acuity and facilitates in-place treatment services
- Uniform procedures for establishing and recording patient informed consent for the use of telehealth services
- Appropriate liability protection for providers involved in such telehealth consultation and treatment



AHRQ's Easy-to-Understand Telehealth Consent Form

AHRQ has created a [sample telehealth consent form](#) (Word, 27 KB) that is easy to understand. The form includes language for healthcare providers that have curtailed in-person visits due to COVID-19. AHRQ has also created [how-to guidance for clinicians](#) on how to obtain informed consent for telehealth.

Why should we use easy-to-understand telehealth consent forms?

Some States do not require documented informed consent for telehealth, but there are still advantages to using the AHRQ Easy-to-Understand Telehealth Consent Form.

- Clinicians can use the easy-to-understand language from the form when they are having the consent discussion.
- Clinicians can use the form as a checklist to make sure they have covered all the information required by informed consent rules.

ahrq.gov/health-literacy/improve/informed-consent/index.html

2021 Virginia State Telehealth Plan

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CORE STRATEGY 6 – DATA COLLECTION

- Establish minimum documentation requirements and a registry of telehealth businesses
- Potential for reducing unnecessary: in-patient hospital stays; pre- and inter-hospital transfers
- Impact of the use of telehealth services on patient morbidity, mortality, and the quality of life
- Impact on annual expenditures for health care services for all payers, including expenditures by third-party payers and out-of-pocket expenditures by patients

The screenshot shows the NIH National Cancer Institute website. The navigation bar includes links for About Cancer, Cancer Types, Research, Grants & Training, News & Events, and About NCI. The breadcrumb trail reads: Home > News & Events > Cancer Currents Blog > Telehealth Can Save People with Cancer Time, Travel, and Money. The article title is 'Telehealth Can Save People with Cancer Time, Travel, and Money'. Below the title is a 'Subscribe' button and the date 'February 16, 2023, by Edward Winnead'. The main text states: 'Since the start of the COVID-19 pandemic, many people with cancer have had telehealth visits with their doctors. Compared with in-person visits, telehealth may save people with cancer time, travel, and money, a new study suggests.' It then mentions: 'The findings are based on an analysis of nearly 25,500 telehealth visits by more than 11,600 adults with cancer during the pandemic. The patients were seen virtually by clinicians at the Moffitt Cancer Center, an NCI Designated Comprehensive Cancer Center in Florida.' A photo shows a person wearing a white headband and using a smartphone. A caption below the photo reads: 'For people with cancer, telehealth visits might be particularly well suited for follow-up care, such as checking in with their doctors as part of long-term monitoring. Credit: iStock.' A green-bordered box at the bottom of the article contains the text: 'The use of telehealth was associated with an average cost savings of: of between \$147 and \$186 per visit for patients, according to findings published January 10 in JAMA Network Open.'

cancer.gov/news-events/cancer-currents-blog/2023/telehealth-cancer-care-saves-time-money

Telehealth in the Commonwealth: 2026 to 2030

13

VISION STATEMENT:

Embed and leverage telehealth as a solution to achieve the health priorities of the Commonwealth of Virginia.

AREAS OF IMPACT:

Access to the right care at the right time

- Maternal health
- Behavioral and mental health including crisis supports and substance use disorder supports
- Preventive health
- Skilled nursing care
- Oral health
- Emergency medical care

Advancing the health of the Commonwealth

- Education
- Workforce development
- Connectivity
- Public safety
- Infrastructure
- Private-public collaboration



Ready to go



Requires funding



VDH effort needed



Multi-faceted opportunity

Broadband and Technology Access

Leveraging infrastructure opportunities to achieve cross-sector gains

1. Improve access to adequate broadband technology for users of telehealth - both organizational (e.g., health clinics in rural areas, emergency medical service providers, hospitals, medical practices, etc.) and individual (e.g., patients, telehealth access points, work-from-home telehealth providers).
2. Support digital literacy of Virginians through deployment of training materials and navigation supports.

What this could look like...

Leverage and promote existing programs to address broadband infrastructure needs

Mapping tools for prioritization - technology assistance, access points, telehealth providers

Analysis of care deserts compared to technology access and broadband availability

Training of digital navigators to support digital literacy



Care Innovations

15

Deploying proven models that can positively impact the health of Virginia's communities

1. Examine and evaluate the outcomes of telehealth innovation, integration, and expansion in Virginia, with a focus on measuring effectiveness, scalability, and long-term impact.
2. Promote and support integration of school-based telehealth options that can create a model for comprehensive student health and improved wellness.

What this could look like...

SME working group to develop and present a plan for data collection, analysis, prioritization



Knowledgebank of Virginia-grown innovations for dissemination and replication



VDOE and VDH collaboration to map school-based telehealth sites



School-based telehealth resource center, toolkits, and learning collaborative



Care Innovations

16

Deploying proven models that can positively impact the health of Virginia's communities

3. Promote telehealth opportunities and benefits to the Virginia EMS system.
4. Promote Remote Patient Monitoring (RPM), particularly for monitoring of chronic illness, high risk pregnancies, and for prevention of hospital readmission.
5. Monitor areas of evolving technology, such as artificial intelligence, and make adjustments to plan as needed.

What this could look like...

Library of best practices and a template of telehealth operating procedures for EMS

VDH Office of EMS to identify appropriate services and establish uniform criteria

Payer and provider analysis of RPM utilization analysis and dissemination of opportunities, best practices, and innovations

Bi-annual advisory group meetings to stay on top of emerging technologies



Person-Centered Accommodations

17

Care that supports individual access needs and accommodations

1. Incorporate patient representation.
2. Examine accessibility issues for older adults, those with limited English language proficiency, and people with physical, sensory, cognitive or developmental disabilities including people who are deaf or hard of hearing, blind, or visually impaired.
3. Partner with MATRC, payers, and providers to disseminate information on resources and best practices in patient-centered accessibility.

What this could look like...

Establishing connections with relevant patient advocacy organizations



Surveys and focus groups to consumers via trusted sources such as the AAAs



Establish best practice guidelines for telehealth access points in settings such as affordable housing developments



Training of digital navigators to support digital literacy



Solutions Tailored for High-Need Areas

18

Improving network adequacy where enhanced access to care is most needed

1. Collaborate with VDH Division of Social Epidemiology to map access deserts in Virginia, overlaid with telehealth access points and broadband availability so as to define areas for targeted infrastructure investment.
2. Explore alternatives for situations where video feed is unstable.
3. Promote Remote Patient Monitoring (RPM) for high risk patients, including mental health, maternal health, child protection, and chronic disease management.

What this could look like...

Expand utilization of existing tools like the Telehealth Broadband Project

Inventory technology lending libraries and telehealth access points

Provider recommendations regarding use cases for audio-only telehealth

Collaborate with payers to disseminate information regarding payer policies with RPM, coding/billing standards, and evidence-based use cases



Solutions Tailored for High-Need Areas

19

Improving network adequacy where enhanced access to care is most needed

4. Address barriers to providers utilizing telehealth.
5. Prioritize telehealth supports for state institutions where provider access is limited.
6. Collaborate with VDH to explore opportunities and barriers for telehealth as an emergency/pandemic response resource.
7. In prioritizing areas of focus, seek alignment with Virginia Rural Health Plan, VBPD Geographic Disparities in Healthcare Access.

What this could look like...

Determine how loan repayment options could incentivize telehealth provision of care where access is most needed



Seek permanency of pandemic exceptions - such as not publishing providers' home address if providing care via telehealth



Collaborate with the Department of Corrections, regional jails, and the Department of Juvenile Justice to explore opportunities and barriers for telehealth in such facilities



Sustainability, Quality, and Efficacy

20

Aligning in-person, virtual, and technology standards

1. Advocate for policy permanency.
2. Encourage planning and investment by creating transparency around payer policies and requirements.
3. Maintain information regarding telehealth certifications, quality standards, and other areas of interest impacting telehealth quality.
4. Data collection regarding the potential for reducing unnecessary inpatient hospital stays.

What this could look like...

Guidance for implementation, sustainability, and replication of new and effective use cases



Partnership with payers to create a statewide resource that continuously monitors the telehealth reimbursement landscape in Virginia and nationally



Identification of areas where telehealth could prevent hospitalizations from skilled nursing facilities



Workforce Development and Optimization

21

Expanding telehealth capacity to achieve Virginia's workforce goals

1. Provider benchmarking to determine workforce originating state and state licensure status.
2. Registry of providers offering telehealth.
3. Consider workforce potential.

What this could look like...

Develop licensure guidance and monitor trends for out-of-state providers



Promote provider-to-provider eConsults in program planning and payer policy



Establish a registry of telehealth providers in Virginia, including out-of-state licensed in VA



Add telehealth best practices to provider training requirements



Promote workforce development via telehealth



Plan Accountability

22

Providing for stakeholder collaboration, effective oversight, benchmarking, implementation

1. Establish benchmarks for ongoing monitoring of plan implementation.
2. In collaboration with VDH, develop a timeline, budget and staffing plan for ensuring up to date monitoring, evaluation, and modifications of this plan.
3. Utilizing the existing advisory group structure, continue regular communications and bi-annual meetings to review efforts and discussion modifications.

What this could look like...

Continue provider benchmarking to understand telehealth impact and gaps



Leverage “models that work” to expand telehealth deployment - SUD in DOC facilities



Continue telehealth advisory group for plan updates and insights



Plan Accountability

23

Providing for stakeholder collaboration, effective oversight, benchmarking, implementation

4. In collaboration with VDH, create a communication plan to disseminate the plan.
5. Explore option to provide a forum for interagency information sharing on telehealth and related opportunities.

What this could look like...

Maintain central space to share learnings - currently 4,200 individuals are signed up to be updated on Virginia's telehealth plan

Integrate telehealth into relevant state plans

Establish inter-agency group for telehealth collaboration and information sharing



Gratitude to Plan Contributors

24

Bay Rivers Telehealth Alliance
Birth in Color
CareFirst BlueCross BlueShield
Community Pharmacy Association
Department for Deaf and Hard of Hearing
Department of Behavioral Health and Developmental Services
Department of Education
Department of Health
Department of Health Professions
Department of Housing and Community Development
Department of Juvenile Justice
Department of Medical Assistance Services
Henrico County Public Schools
Joint Commission on Health Care
Medical Society of Virginia
Mid-Atlantic Telehealth Resource Center
Office of Emergency Medical Services

Pittsylvania-Danville and Southside Health District
Right Help, Right Now
Secretary of Health and Human Resources
Tri-Area Community Health Center
University of Virginia Center for Telehealth
VCTA: Broadband Association of Virginia
Virginia Association of Community Services Boards
Virginia Association of Free and Charitable Clinics
Virginia Association of Health Plans
Virginia Board for People with Disabilities
Virginia Health Care Association
Virginia Health Catalyst
Virginia Health Workforce Development Authority
Virginia Hospital and Healthcare Association
Virginia Neonatal Perinatal Collaborative
Virginia Pharmacy Association
Virginia Rural Health Association

What's next?

25

- Renewal of VTN's agreement with VDH for plan monitoring and facilitation is in process
- Prioritization of 2026-27 activities:
 - Collaborate with VDH staff to understand where there is capacity for implementation vs. where additional resources are needed
 - Collaborate with VDH staff and leadership on developing implementation plans
 - Monitor federal landscape for shifts and opportunities
- Convene Advisory Group biannually
- Develop recommendations for Virginia General Assembly and/or state agency action
- Continue monitoring of implementation and report to the Board of Health annually

Questions

26

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Additional Background

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Research Highlights: Recent Recommendations

28

- During the 2025 session, numerous bills and budget items relating to telehealth were introduced.
- The increased interest in telehealth was due to the work of the Joint Commission of Health Care, the House Select Committee on Rural Health and other legislative committees and commissions throughout 2024.
- Budget impacts limited expansion; the legislative items below were signed by the Governor:
 - [SB 843](#): Study to expand remote patient monitoring for patients with chronic conditions
 - [HB 1945](#): Directs School Boards to consider creating policies to support students' access to telehealth
 - [HB 1976](#): Remote patient monitoring during pregnancy, pilot program
 - [HB 2543](#): Model memorandum of understanding for counseling by school counselors via telehealth
 - [SB 1038](#): DBHDS to develop best practices for telehealth when serving patients with disabilities
 - [SB 1039](#): DOC and State Board of Local and Regional Jails to develop policies supporting inmates access to telehealth

Research Highlights: Benchmarking Telehealth

Telehealth ~~increases access~~ to care for patients.

Respondents who do use telehealth also shared telehealth allows them to:

- "Provide greater convenience to my clients in how they attend sessions, resulting in **fewer cancellations** and late-starts."
- "Have better accessibility for my patients and **less disruption** in their day-to-day lives."
- "Provide services to individuals that otherwise could not attend therapy due to being **homebound** or residing too far from the service agency in **rural** areas."
- "Provide health care to those who do not have **transportation** to my office."

TELEHEALTH HAS ALLOWED ME TO...

"...serve patients in underserved areas!"

"...provide follow-up quickly on abnormal results."

"...provide therapy to clients with transportation barriers or health conditions preventing them from being seen in person."

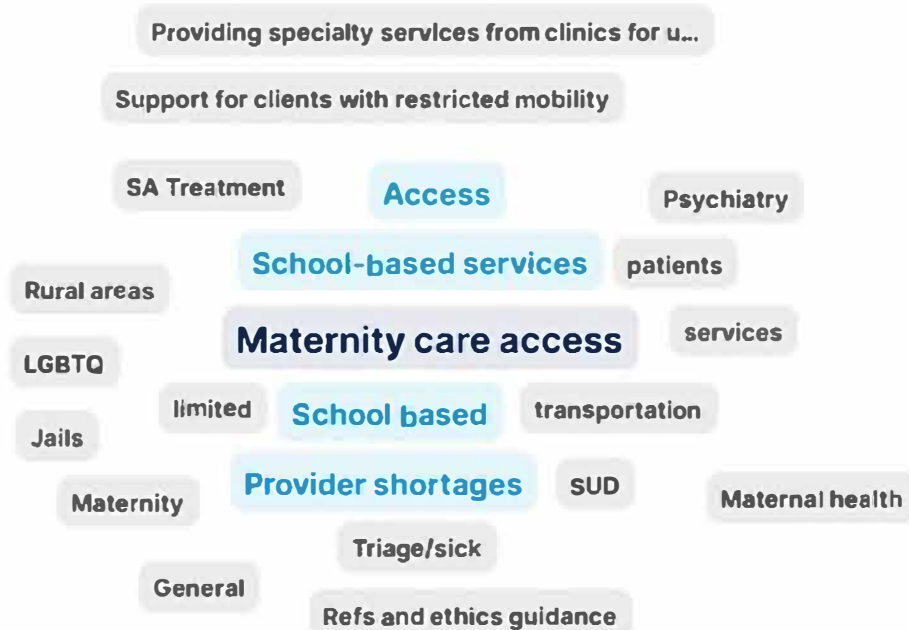
Source: VTN's 2024 Benchmarking Telehealth Usage in Virginia Survey



Research Highlights: VTN Summit Discussions

30

What are one or two health care challenges telehealth can help with in Virginia?



What is one telehealth-related innovation you think Virginia should replicate and grow?



Research Highlights: VTN Summit Discussions

31

TELEHEALTH AS A SOLUTION...

*In two to three words, how would you define **high quality, accessible telehealth**?*



BLOC - Final Exempt Amendments to:

**Rules and Regulations Governing the Construction of
Migrant Labor Camps
12VAC5-501**

**Sewage Handling and Disposal Regulations
12VAC5-610**

**Private Well Regulations
12VAC5-630**

Julie Henderson
Director, Office of Environmental Health Services



COMMONWEALTH of VIRGINIA

Karen Shelton, MD
State Health Commissioner

Department of Health
P O BOX 2448
RICHMOND, VA 23218

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

MEMORANDUM

DATE: April 24, 2025

TO: State Board of Health

FROM: Julie Henderson
Director, Office of Environmental Health Services

SUBJECT: Final Exempt Action Bloc – 12VAC5-501, 12VAC5-610, 12VAC5-630

Enclosed for your review and approval are final exempt actions to amend; (i) the Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps (12VAC5-501), (ii) Sewage Handling and Disposal Regulations (12VAC5-610), and (iii) Private Well Regulations (12VAC5-630).

As these regulatory actions are substantively similar, they are being presented to the Board as a single, combined action.

These actions amend the associated Administrative Code sections to remove a requirement that only a health director may conduct an informal hearing (or informal fact-finding conference) and allows a designee, such as a presiding officer, to conduct these hearings pursuant to 2.2-4019 of the Code of Virginia. These actions also provide technical and stylistic corrections.

These actions are exempt from the requirements of the Administrative Process Act under § 2.2-4006(A)(2) and (3) of the Code of Virginia, which states, in part:

A. The following agency actions otherwise subject to this chapter and § 2.2-4103 of the Virginia Register Act shall be exempted from the operation of this article:

2. Regulations that establish or prescribe agency organization, internal practice or procedures, including delegations of authority.

3. Regulations that consist only of changes in style or form or corrections of technical errors. Each promulgating agency shall review all references to sections of the Code of Virginia within their regulations each time a new supplement or replacement volume to the Code of Virginia is published to ensure the accuracy of each section or section subdivision identification listed.

The State Board of Health is requested to approve these final exempt actions. Should the Board approve the actions, the amendments will be published in the Virginia Register of Regulations and on the Virginia Regulatory Town Hall website. There will be no additional public comment period following publication. Thirty days after publication, the regulation will become effective.



townhall.virginia.gov

Exempt Action: Final Regulation Agency Background Document

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 5-501
VAC Chapter title(s)	Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps
Action title	Amend Regulation to Revise Informal Hearing Procedures
Final agency action date	
Date this document prepared	04/04/2025

This information is required for executive branch review pursuant to 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. In addition, this information is required by the Virginia Registrar of Regulations pursuant to the Virginia Register Act (§ 2.2-4100 et seq. of the Code of Virginia). Regulations must conform to 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 Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps protect the health, safety, and welfare of migrant workers and their families during their employment and residence in Virginia. These regulations establish standards for (i) licensure and enforcement, (ii) adequate and convenient supply of water, (iii) disposal of sewage, and (iv) general maintenance of facilities such as bathrooms, cooking facilities, sleeping quarters, and lighting and ventilation.

This action amends the regulations to remove the requirement that only a health director may conduct an informal hearing and allows a designee such as a presiding officer to conduct these hearings pursuant to 2.2-4019 of the Code of Virginia.

This action is exempt from the Administrative Process Act under § 2.2-4006(A)(2) of the Code of Virginia, which states, in part:

A. The following agency actions otherwise subject to this chapter and § 2.2-4103 of the Virginia Register Act shall be exempted from the operation of this article:

2. Regulations that establish or prescribe agency organization, internal practice or procedures, including delegations of authority.

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, internal staff review, 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."

There is no legal mandate or impetus for this regulatory change.

The current regulatory scheme requires the district health director to preside over informal hearings, including Informal Fact-Finding Conferences (IFFCs). IFFCs are preliminary hearings where permit holders, applicants, or other interested parties can present evidence and arguments to help determine the facts of a case such as the denial of an application or to address alleged violations of administrative or state law. Amending the language allows the department greater flexibility in providing a presiding officer. In the current language, an informal hearing must be presided over by the district health director. This often causes scheduling delays as Health Directors have many obligations. Health Directors may also need to recuse themselves from presiding over hearings when they have been significantly involved in the decision making of an enforcement case prior to the informal hearing.

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) that the agency has "adopted final amendments" to the regulation; 3) the name of the agency taking the action; and 4) the title of the regulation. A suggested statement is, "On [insert date] the Board/Department of [insert name] adopted final amendments to the [title of regulation(s)]."

Office of Regulatory Management
Economic Review Form

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 5-501
VAC Chapter title(s)	Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps
Action title	Amend Regulation to Revise Informal Hearing Procedures
Date this document prepared	04/04/2025
Regulatory Stage (including Issuance of Guidance Documents)	Final Exempt

Cost Benefit Analysis

Complete Tables 1a and 1b for all regulatory actions. You do not need to complete Table 1c if the regulatory action is required by state statute or federal statute or regulation and leaves no discretion in its implementation.

Table 1a should provide analysis for the regulatory approach you are taking. Table 1b should provide analysis for the approach of leaving the current regulations intact (i.e., no further change is implemented). Table 1c should provide analysis for at least one alternative approach. You should not limit yourself to one alternative, however, and can add additional charts as needed.

Report both direct and indirect costs and benefits that can be monetized in Boxes 1 and 2. Report direct and indirect costs and benefits that cannot be monetized in Box 4. See the ORM Regulatory Economic Analysis Manual for additional guidance.

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

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct costs associated with this proposed change. Indirect Costs: There are no indirect costs associated with this proposed change. Direct Benefits: Indeterminate; will likely allow the agency greater expediency in scheduling informal fact-finding conferences which may reduce costs associated with conducting informal fact-finding conferences such as staff time. Indirect Benefits: There are no direct benefits associated with this proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) Indeterminate
(3) Net Monetized Benefit	Indeterminate	
(4) Other Costs & Benefits (Non-Monetized)	Currently, informal hearings, including informal fact-finding conferences (IFFCs) must be presided over by the district health director. This often causes scheduling delays as Health Directors have many obligations. Health Directors may also have to recuse themselves from presiding over informal hearings when they have been significantly involved in decision making in a case prior to the informal conference.	
(5) Information Sources		

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

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct costs associated with maintaining the status quo. Indirect Costs: There are no indirect costs associated with maintaining the status quo. Direct Benefits: There are no direct benefits associated with maintaining the status quo.
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	Indirect Benefits: There are no indirect benefits associated with maintaining the status quo.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) None
(3) Net Monetized Benefit	N/A	
(4) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits associated with maintaining the status-quo.	
(5) Information Sources	N/A	

Table 1c: Costs and Benefits under Alternative Approach(es)

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There is no known alternate approach Indirect Costs: There is no known alternate approach. Direct Benefits: There is no known alternate approach. Indirect Benefits: There is no known alternate approach.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) N/A	(b) N/A
(3) Net Monetized Benefit	N/A	
(4) Other Costs & Benefits (Non-Monetized)	There is no known alternate approach.	
(5) Information Sources	N/A	

Impact on Local Partners

Use this chart to describe impacts on local partners. See Part 8 of the ORM Cost Impact Analysis Guidance for additional guidance.

Table 2: Impact on Local Partners

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct monetized costs to local partners with the proposed change. Indirect Costs: There are no indirect monetized costs to local partners with the proposed change. Direct Benefits: There are no direct monetized benefits to local partners with the proposed change. Indirect Benefits: There are no indirect monetized benefits to local partners with the proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) \$0	(b) \$0
(3) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits to local partners.	
(4) Assistance	N/A	
(5) Information Sources	N/A	

Impacts on Families

Use this chart to describe impacts on families. See Part 8 of the ORM Cost Impact Analysis Guidance for additional guidance.

Table 3: Impact on Families

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct monetized costs to families with the proposed change. Indirect Costs: There are no indirect monetized costs to families with the proposed change. Direct Benefits: There are no direct monetized benefits to families with the proposed change.
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	Indirect Benefits: There are no indirect monetized benefits to families with the proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) None
(3) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits to families.	
(4) Information Sources	N/A	

Impacts on Small Businesses

Use this chart to describe impacts on small businesses. See Part 8 of the ORM Cost Impact Analysis Guidance for additional guidance.

Table 4: Impact on Small Businesses

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct monetized costs to small businesses with the proposed change. Indirect Costs: There are no indirect monetized costs to small businesses with the proposed change. Direct Benefits: There are no direct monetized benefits to small businesses with the proposed change. Indirect Benefits: There are no indirect monetized benefits to small businesses with the proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) None
(3) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits to small businesses.	
(4) Alternatives	There are no known alternatives.	

(5) Information Sources	
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Changes to Number of Regulatory Requirements

Table 5: Regulatory Reduction

For each individual action, please fill out the appropriate chart to reflect any change in regulatory requirements, costs, regulatory stringency, or the overall length of any guidance documents.

Change in Regulatory Requirements

VAC Section(s) Involved*	Authority of Change	Initial Count	Additions	Subtractions	Total Net Change in Requirements
130	(M/A):				
	(D/A):	1	1	1	0
	(M/R):				
	(D/R):				
Grand Total of Changes in Requirements:					(M/A):
					(D/A):0
					(M/R):
					(D/R):

Key:

Please use the following coding if change is mandatory or discretionary and whether it affects externally regulated parties or only the agency itself:

(M/A): Mandatory requirements mandated by federal and/or state statute affecting the agency itself

(D/A): Discretionary requirements affecting agency itself

(M/R): Mandatory requirements mandated by federal and/or state statute affecting external parties, including other agencies

(D/R): Discretionary requirements affecting external parties, including other agencies

*If the agency is modifying a guidance document that has regulatory requirements, it should report any change in requirements in the appropriate chart(s).

Project 8278 - Exempt Final

Department of Health

Chapter 501 Amend APA Language

12VAC5-501-130. Case decisions.

The commissioner or his designee may make case decisions based on informal hearings. An informal hearing is conducted by ~~a district or local health department with the district or local health director presiding~~ the department and held in conformance with § 2.2-4019 of the Code of Virginia. The district or local health department may record the hearing or create a written summary or record of the proceedings.



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Exempt Action: Final Regulation Agency Background Document

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 5-610
VAC Chapter title(s)	Sewage Handling and Disposal Regulations
Action title	Amend Regulation to Revise Internal IFFC Procedures and Provide Technical Corrections
Final agency action date	
Date this document prepared	04/04/2025

This information is required for executive branch review pursuant to 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. In addition, this information is required by the Virginia Registrar of Regulations pursuant to the Virginia Register Act (§ 2.2-4100 et seq. of the Code of Virginia). Regulations must conform to 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 Sewage Handling and Disposal Regulations serve to assure all sewage within the Commonwealth is handled and disposed of in a safe and sanitary manner to protect the safety, health, and welfare of the public. These regulations establish standards for (i) the determination of whether a permit for handling or disposing of sewage should be issued or denied, and (ii) the requirements necessary to secure a permit for handling and disposing of sewage.

This action amends the Regulations as follows:

- i. Removes the requirement that only a health director may conduct informal fact-finding conferences (IFFC) and allows a designee such as a presiding officer to conduct these conferences pursuant to 2.2-4019 of the Code of Virginia;

- ii. Amends cross references to Title 9 of the Code of Virginia as it was recodified to Titled 2.2;
- iii. Removes restriction of subpoena power as it is allowed under 2.2-4022 of the Code of Virginia;
- iv. Aligns the timetable to render a case decision with 2.2-4021(B) of the Code of Virginia; and
- v. Removes the requirement for a hearings officer to submit their findings of fact to the Commissioner of Health for final decision.

This action is exempt from the Administrative Process Act under § 2.2-4006(A)(2) and (3) of the Code of Virginia, which states, in part:

A. The following agency actions otherwise subject to this chapter and § 2.2-4103 of the Virginia Register Act shall be exempted from the operation of this article:

2. Regulations that establish or prescribe agency organization, internal practice or procedures, including delegations of authority.

3. Regulations that consist only of changes in style or form or corrections of technical errors. Each promulgating agency shall review all references to sections of the Code of Virginia within their regulations each time a new supplement or replacement volume to the Code of Virginia is published to ensure the accuracy of each section or section subdivision identification listed.

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, internal staff review, 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."

There is no legal mandate or impetus for this regulatory change.

The current regulatory scheme requires the district health director to preside over Informal Fact-Finding Conferences (IFFCs). IFFCs are preliminary hearings where permit holders, applicants, or other interested parties can present evidence and arguments to help determine the facts of a case such as the denial of an application or to address alleged violations of administrative or state law. Amending the language describing an informal conference allows the department greater flexibility in providing a presiding officer. In the current language, an informal conference must be presided over by the district health director. This often causes scheduling delays as health directors have many obligations. Health Directors may also need to recuse themselves from presiding over conferences when they have been significantly involved in the decision making of an enforcement case prior to the IFFC. Also, the regulatory text, in its current form restricts the Department's ability to issue subpoenas. This language is in direct conflict with 2.2-4022 of the Code of Virginia which outlines the process in which all state agencies may issue a subpoena.

In addition, the Regulations require the health director to render a case decision within 15 working days from the date of the IFFC. A case decision is a written determination made by a presiding officer that includes an outcome such as a finding of violation or denial of an application. This timeline does not align with state law wherein a case decision shall be rendered within 90 days from the date of an IFFC. Aligning this timeline with state law will promote consistency in administrative hearings as these are the only regulations with a shortened timeline.

The Regulations at 12VAC5-610-200 includes a reference to 9-6.14:11 of the Code of Virginia. This section, among others pertaining to the administration of government, were recodified in the 2001 Virginia

Acts of Assembly Chapter 844. The proposed amendment will amend the citation to 2.2-4019 of the Code of Virginia which brings the section in line with current law. Lastly, the current regulatory text requires a hearings officer to submit their findings of fact to the commissioner for a final decision. This process is in direct conflict with state law as hearings officers are empowered to render case decisions independently.

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) that the agency has "adopted final amendments" to the regulation; 3) the name of the agency taking the action; and 4) the title of the regulation. A suggested statement is, "On [insert date] the Board/Department of [insert name] adopted final amendments to the [title of regulation(s)]."

Office of Regulatory Management
Economic Review Form

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 5-610
VAC Chapter title(s)	Sewage Handling and Disposal Regulations
Action title	Amend Regulation to Revise Internal IFFC Procedures and Provide Technical Corrections
Date this document prepared	04/04/2025
Regulatory Stage (including Issuance of Guidance Documents)	Final Exempt

Cost Benefit Analysis

Complete Tables 1a and 1b for all regulatory actions. You do not need to complete Table 1c if the regulatory action is required by state statute or federal statute or regulation and leaves no discretion in its implementation.

Table 1a should provide analysis for the regulatory approach you are taking. Table 1b should provide analysis for the approach of leaving the current regulations intact (i.e., no further change is implemented). Table 1c should provide analysis for at least one alternative approach. You should not limit yourself to one alternative, however, and can add additional charts as needed.

Report both direct and indirect costs and benefits that can be monetized in Boxes 1 and 2. Report direct and indirect costs and benefits that cannot be monetized in Box 4. See the ORM Regulatory Economic Analysis Manual for additional guidance.

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

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct costs associated with this proposed change. Indirect Costs: There are no indirect costs associated with this proposed change. Direct Benefits: Indeterminate; will likely allow the agency greater expediency in scheduling informal fact-finding conferences which may reduce costs associated with conducting informal fact-finding conferences such as staff time. Indirect Benefits: There are no direct benefits associated with this proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) Indeterminate
(3) Net Monetized Benefit	Indeterminate	
(4) Other Costs & Benefits (Non-Monetized)	The current regulations state informal fact-finding conferences (IFFCs) must be presided over by the district health director. This often causes scheduling delays as Health Directors have many obligations. Health Directors may also have to recuse themselves from presiding over IFFCs when they have been significantly involved in decision making in a case prior to the informal conference.	
(5) Information Sources		

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

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct costs associated with maintaining the status quo. Indirect Costs: There are no indirect costs associated with maintaining the status quo. Direct Benefits: There are no direct benefits associated with maintaining the status quo.
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	Indirect Benefits: There are no indirect benefits associated with maintaining the status quo.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) None
(3) Net Monetized Benefit	N/A	
(4) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits associated with maintaining the status-quo.	
(5) Information Sources	N/A	

Table 1c: Costs and Benefits under Alternative Approach(es)

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There is no known alternate approach Indirect Costs: There is no known alternate approach. Direct Benefits: There is no known alternate approach. Indirect Benefits: There is no known alternate approach.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) N/A	(b) N/A
(3) Net Monetized Benefit	N/A	
(4) Other Costs & Benefits (Non-Monetized)	There is no known alternate approach.	
(5) Information Sources	N/A	

Impact on Local Partners

Use this chart to describe impacts on local partners. See Part 8 of the ORM Cost Impact Analysis Guidance for additional guidance.

Table 2: Impact on Local Partners

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct monetized costs to local partners with the proposed change. Indirect Costs: There are no indirect monetized costs for local partners with the proposed change. Direct Benefits: There are no direct monetized benefits to local partners with the proposed change. Indirect Benefits: There are no indirect monetized benefits to local partners with the proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) \$0	(b) \$0
(3) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits to local partners.	
(4) Assistance	N/A	
(5) Information Sources	N/A	

Impacts on Families

Use this chart to describe impacts on families. See Part 8 of the ORM Cost Impact Analysis Guidance for additional guidance.

Table 3: Impact on Families

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct monetized costs for families with the proposed change. Indirect Costs: There are no indirect monetized costs for families with the proposed change. Direct Benefits: There are no direct monetized benefits to families with the proposed change.
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	Indirect Benefits: There are no indirect monetized benefits to families with the proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) None
(3) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits to families.	
(4) Information Sources	N/A	

Impacts on Small Businesses

Use this chart to describe impacts on small businesses. See Part 8 of the ORM Cost Impact Analysis Guidance for additional guidance.

Table 4: Impact on Small Businesses

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct monetized costs to small businesses with the proposed change. Indirect Costs: There are no indirect monetized costs for small businesses with the proposed change. Direct Benefits: There are no direct monetized benefits to small businesses with the proposed change. Indirect Benefits: There are no indirect monetized benefits to small businesses with the proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) None
(3) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits to small businesses.	
(4) Alternatives	There are no known alternatives.	

(5) Information Sources	
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Changes to Number of Regulatory Requirements

Table 5: Regulatory Reduction

For each individual action, please fill out the appropriate chart to reflect any change in regulatory requirements, costs, regulatory stringency, or the overall length of any guidance documents.

Change in Regulatory Requirements

VAC Section(s) Involved*	Authority of Change	Initial Count	Additions	Subtractions	Total Net Change in Requirements
200	(M/A):				
	(D/A):	3	3	3	0
	(M/R):				
	(D/R):				
Grand Total of Changes in Requirements:					(M/A):
					(D/A):0
					(M/R):
					(D/R):

Key:

Please use the following coding if change is mandatory or discretionary and whether it affects externally regulated parties or only the agency itself:

(M/A): Mandatory requirements mandated by federal and/or state statute affecting the agency itself

(D/A): Discretionary requirements affecting agency itself

(M/R): Mandatory requirements mandated by federal and/or state statute affecting external parties, including other agencies

(D/R): Discretionary requirements affecting external parties, including other agencies

*If the agency is modifying a guidance document that has regulatory requirements, it should report any change in requirements in the appropriate chart(s).

1 **Project 8312 - Exempt Final**

2 **Department of Health**

3 **Chapter 610 Amend APA Language**

4 **12VAC5-610-200. Hearing types.**

5 Hearings before the board, commissioner or the commissioner's designees shall include any
6 of the following forms depending on the nature of the controversy and the interests of the parties
7 involved.

8 A. Informal hearings. ~~An informal hearing is a meeting with the district or local health~~
9 ~~department with the district or local health director presiding and held in conformance with § 9-~~
10 ~~6.14:11 of the Code of Virginia. An informal fact-finding proceeding, is an informal conference~~
11 ~~between the department and the named party held in accordance with § 2.2-4019 of the Code of~~
12 ~~Virginia. The district or local health department shall consider all evidence presented at the~~
13 ~~meeting which is relevant to the issue in controversy. Presentation of evidence, however, is~~
14 ~~entirely voluntary. The district or local health department shall have no subpoena power. No~~
15 ~~verbatim record need be taken at the informal hearing. The local or district health director~~
16 ~~department shall review the facts presented and based on those facts render a decision. A written~~
17 ~~copy of the decision and the basis for the decision shall be sent to the appellant within 15 work~~
18 ~~days of the hearing unless the parties mutually agree to a later date in order to allow the~~
19 ~~department to evaluate additional evidence. If the decision is adverse to the interests of the~~
20 ~~appellant, an aggrieved appellant may request an adjudicatory hearing pursuant to 12VAC5-610-~~
21 ~~200 B.~~

22 B. Adjudicatory hearing for appeals of denials of sewage system construction permits. The
23 adjudicatory hearing is a formal, public adjudicatory proceeding before the commissioner, the
24 Sewage Handling and Disposal Appeal Review Board or a designated hearing officer, and held

in conformance with § ~~9-6.14:12~~ 2.2-4020 of the Code of Virginia. An adjudicatory hearing includes the following features:

1. Notice. Notice which states the time and place and the issues involved in the prospective hearing shall be sent to the owner or the person who is the subject of the hearing. Notice shall be sent by certified mail at least 15 calendar days before the hearing is to take place.

2. Record. A verbatim record of the hearing shall be made by a court reporter. A copy of the transcript of the hearing, if transcribed, will be provided within a reasonable time to any person upon written request and payment of the cost.

3. Evidence. All interested parties shall attend the hearing and submit oral and documentary evidence and rebuttal proofs, expert or otherwise, that is material and relevant to the issues in controversy. The admissibility of evidence shall be determined in accordance with § ~~9-6.14:12~~ 2.2-4020 of the Code of Virginia.

4. Counsel. All parties may be accompanied by and represented by counsel and are entitled to conduct such cross-examination as may elicit a full and fair disclosure of the facts.

5. Subpoena. Pursuant to § ~~9-6.14:13~~ 2.2-4022 of the Code of Virginia, the commissioner, Sewage Handling and Disposal Appeal Board, or hearing officer may issue subpoenas on behalf of themselves for the attendance of witnesses and the production of books, papers, maps or other materials. Failure to appear or to testify or to produce materials without adequate excuse may be reported by the commissioner to the appropriate circuit court for enforcement.

6. Judgement and final order. The commissioner may designate a hearing officer or subordinate to conduct the hearing as provided in § ~~9-6.14:12~~ 2.2-4020 of the Code of Virginia, and to make written recommended findings of fact and conclusions of law ~~to be submitted for review and final decision by the commissioner~~ . The final decision of the commissioner shall be reduced to writing and will contain the explicit findings of fact upon which his decision is based. A

49 certified copy of the decision shall be delivered to the affected owner. Notice of a decision will be
50 served upon the parties and become a part of the record. Service may be by personal service or
51 certified mail, return receipt requested.

DRAFT



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Exempt Action: Final Regulation Agency Background Document

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC5-630
VAC Chapter title(s)	Private Well Regulations
Action title	Amend Regulations to Revise Internal IFFC Procedures
Final agency action date	
Date this document prepared	04/04/2025

This information is required for executive branch review pursuant to 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. In addition, this information is required by the Virginia Registrar of Regulations pursuant to the Virginia Register Act (§ 2.2-4100 et seq. of the Code of Virginia). Regulations must conform to 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 Private Well Regulations protect the health, safety, and welfare of the Commonwealth through the proper construction and permitting of private wells. These regulations establish standards for (i) private well locations, their construction, and maintenance to ensure protection of groundwater resources, (ii) issuance and denial of permits, (iii) standards for obtaining a permit, and (iv) the process for inspections and abandonment of private wells. This action amends the Regulations as following:

- i. Removes the requirement that only a health director may conduct informal fact-finding conferences (IFFC) and allows a designee such as a presiding officer to conduct these conferences pursuant to 2.2-4019 of the Code of Virginia;
- ii. Removes restriction of subpoena power as it is allowed under 2.2-4022 of the Code of Virginia;

- iii. Aligns the timetable to render a case decision with 2.2-4021(B) of the Code of Virginia; and
- iv. Removes the requirement for a hearings officer to submit their findings of fact to the Commissioner of Health for final decision.

This action is exempt from the Administrative Process Act under § 2.2-4006(A)(2) of the Code of Virginia, which states, in part:

A. The following agency actions otherwise subject to this chapter and § 2.2-4103 of the Virginia Register Act shall be exempted from the operation of this article:

- 2. Regulations that establish or prescribe agency organization, internal practice or procedures, including delegations of authority.

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, internal staff review, 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."

There is no legal mandate or impetus for this regulatory change.

The current regulatory scheme requires the district health director to preside over Informal Fact-Finding Conferences (IFFCs). IFFCs are preliminary hearings where permit holders, applicants, or other interested parties can present evidence and arguments to help determine the facts of a case such as the denial of an application or to address alleged violations of administrative or state law. Amending the language describing an informal conference allows the department greater flexibility in providing a presiding officer. In the current language, an informal conference must be presided over by the district health director. This often causes scheduling delays as Health Directors have many obligations. Health Directors may also need to recuse themselves from presiding over conferences when they have been significantly involved in the decision making of an enforcement case prior to the IFFC. Also, the regulatory text, in its current form restricts the Department's ability to issue subpoenas. This language is in direct conflict with 2.2-4022 of the Code of Virginia which outlines this process in which all state agencies may issue a subpoena.

In addition, the Regulations require the health director to render a case decision within 15 working days from the date of the IFFC. A case decision is a written determination made by a presiding officer that includes an outcome such as a finding of violation or denial of an application. This timeline does not align with state law wherein a case decision shall be rendered within 90 days from the date of an IFFC. Aligning this timeline with state law will promote consistency in administrative hearings as these are the only regulations with a shortened timeline.

Lastly, the current regulatory text requires a hearings officer to submit their findings of fact to the commissioner for a final decision. This process is in direct conflict with state law as hearings officers are empowered to render case decisions independently.

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) that the agency has "adopted final amendments" to the regulation; 3) the name of the agency taking the

action; and 4) the title of the regulation. A suggested statement is, "On [insert date] the Board/Department of [insert name] adopted final amendments to the [title of regulation(s)]."

Office of Regulatory Management
Economic Review Form

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 5-630
VAC Chapter title(s)	Private Well Regulations
Action title	Amend Regulations to Revise Internal IFFC Procedures
Date this document prepared	04/04/2025
Regulatory Stage (including Issuance of Guidance Documents)	Final Exempt

Cost Benefit Analysis

Complete Tables 1a and 1b for all regulatory actions. You do not need to complete Table 1c if the regulatory action is required by state statute or federal statute or regulation and leaves no discretion in its implementation.

Table 1a should provide analysis for the regulatory approach you are taking. Table 1b should provide analysis for the approach of leaving the current regulations intact (i.e., no further change is implemented). Table 1c should provide analysis for at least one alternative approach. You should not limit yourself to one alternative, however, and can add additional charts as needed.

Report both direct and indirect costs and benefits that can be monetized in Boxes 1 and 2. Report direct and indirect costs and benefits that cannot be monetized in Box 4. See the ORM Regulatory Economic Analysis Manual for additional guidance.

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

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct costs associated with this proposed change. Indirect Costs: There are no indirect costs associated with this proposed change. Direct Benefits: Indeterminate; will likely allow the agency greater expediency in scheduling informal fact-finding conferences which may reduce costs associated with conducting informal fact-finding conferences such as staff time. Indirect Benefits: There are no direct costs associated with this proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) Indeterminate
(3) Net Monetized Benefit	Indeterminate	
(4) Other Costs & Benefits (Non-Monetized)	Currently, informal fact-finding conferences (IFFCs) must be presided over by the district health director. This often causes scheduling delays as Health Directors have many obligations. Health Directors may also have to recuse themselves from presiding over IFFCs when they have been significantly involved in decision making in a case prior to the informal conference.	
(5) Information Sources		

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

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct costs associated with maintaining the status quo. Indirect Costs: There are no indirect costs associated with maintaining the status quo. Direct Benefits: There are no direct benefits associated with maintaining the status quo. Indirect Benefits: There are no indirect benefits associated with maintaining the status quo.
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(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) None
(3) Net Monetized Benefit	N/A	
(4) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits associated with maintaining the status-quo.	
(5) Information Sources	N/A	

Table 1c: Costs and Benefits under Alternative Approach(es)

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There is no known alternate approach Indirect Costs: There is no known alternate approach. Direct Benefits: There is no known alternate approach. Indirect Benefits: There is no known alternate approach.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) N/A	(b) N/A
(3) Net Monetized Benefit	N/A	
(4) Other Costs & Benefits (Non-Monetized)	There is no known alternate approach.	
(5) Information Sources	N/A	

Impact on Local Partners

Use this chart to describe impacts on local partners. See Part 8 of the ORM Cost Impact Analysis Guidance for additional guidance.

Table 2: Impact on Local Partners

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct monetized costs to local partners with the proposed change. Indirect Costs: There are no indirect monetized costs to local partners with the proposed change. Direct Benefits: There are no direct monetized benefits to local partners with the proposed change. Indirect Benefits: There are no indirect monetized benefits to local partners with the proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) \$0	(b) \$0
(3) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits to local partners.	
(4) Assistance	N/A	
(5) Information Sources	N/A	

Impacts on Families

Use this chart to describe impacts on families. See Part 8 of the ORM Cost Impact Analysis Guidance for additional guidance.

Table 3: Impact on Families

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct monetized costs to families with the proposed change. Indirect Costs: Describe the indirect monetized costs to families with the proposed change. Direct Benefits: There are no direct monetized benefits to families with the proposed change.
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	Indirect Benefits: There are no indirect monetized benefits to families with the proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) None
(3) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits to families.	
(4) Information Sources	N/A	

Impacts on Small Businesses

Use this chart to describe impacts on small businesses. See Part 8 of the ORM Cost Impact Analysis Guidance for additional guidance.

Table 4: Impact on Small Businesses

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct monetized costs to small businesses with the proposed change. Indirect Costs: There are no indirect monetized costs to small businesses with the proposed change. Direct Benefits: There are no direct monetized benefits to small businesses with the proposed change. Indirect Benefits: There are no indirect monetized benefits to small businesses with the proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) None
(3) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits to small businesses.	
(4) Alternatives	There are no known alternatives.	

(5) Information Sources	
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Changes to Number of Regulatory Requirements

Table 5: Regulatory Reduction

For each individual action, please fill out the appropriate chart to reflect any change in regulatory requirements, costs, regulatory stringency, or the overall length of any guidance documents.

Change in Regulatory Requirements

VAC Section(s) Involved*	Authority of Change	Initial Count	Additions	Subtractions	Total Net Change in Requirements
180	(M/A):				
	(D/A):	3	3	3	0
	(M/R):				
	(D/R):				
Grand Total of Changes in Requirements:					(M/A):
					(D/A):0
					(M/R):
					(D/R):

Key:

Please use the following coding if change is mandatory or discretionary and whether it affects externally regulated parties or only the agency itself:

(M/A): Mandatory requirements mandated by federal and/or state statute affecting the agency itself

(D/A): Discretionary requirements affecting agency itself

(M/R): Mandatory requirements mandated by federal and/or state statute affecting external parties, including other agencies

(D/R): Discretionary requirements affecting external parties, including other agencies

*If the agency is modifying a guidance document that has regulatory requirements, it should report any change in requirements in the appropriate chart(s).

Project 8311 - Exempt Final

Department of Health

Amend 630 APA Language

12VAC5-630-180. Hearing types.

Hearings before the commissioner or the commissioner's designees shall include any of the following forms depending on the nature of the controversy and the interests of the parties involved.

1. Informal hearings. ~~An informal hearing is a meeting with a district or local health department with the district or local health director presiding and held in conformance with § 2.2-4019 of the Code of Virginia. An informal fact-finding proceeding, is an informal conference between the department and the named party held in accordance with § 2.2-4019 of the Code of Virginia.~~ The district or local health department director shall consider all evidence presented at the meeting that is relevant to the issue in controversy. Presentation of evidence, however, is entirely voluntary. ~~The district or local health department shall have no subpoena power.~~ No verbatim record need be taken at the informal hearing. ~~The local or district health director~~ department shall review the facts presented and based on those facts render a decision. ~~A written copy of the decision and the basis for the decision shall be sent to the appellant within 15 work days of the hearing, unless the parties mutually agree to a later date in order to allow the department to evaluate additional evidence.~~ If the decision is adverse to the interests of the appellant, an aggrieved appellant may request an adjudicatory hearing pursuant to subdivision 2 of this section.

2. Adjudicatory hearing. The adjudicatory hearing is a formal, public adjudicatory proceeding conducted pursuant to § 2.2-4020 of the Code of Virginia.

25 The commissioner shall designate a hearing officer to conduct the hearing as provided in
26 § 2.2-4024 of the Code of Virginia and to make written recommended findings of fact and
27 conclusions of law ~~to be submitted for review and final decision by the commissioner~~ . The
28 final decision of the commissioner shall be reduced to writing and will contain the explicit
29 findings of fact upon which the decision is based. Certified copies of the decision shall be
30 delivered to the owner affected by it. Notice of a decision will be served upon the parties
31 and become a part of the record. Service may be by personal service or certified mail
32 return receipt requested.

Final Exempt Action Amending Rainwater Harvesting System Regulations 12VAC5-635

Julie Henderson

Director, Office of Environmental Health Services



COMMONWEALTH of VIRGINIA

Karen Shelton, MD
State Health Commissioner

Department of Health
P O BOX 2448
RICHMOND, VA 23218

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

MEMORANDUM

DATE: April 29, 2025

TO: State Board of Health

FROM: Julie Henderson
Director, Office of Environmental Health Services

SUBJECT: Final Exempt Action – Amend Rainwater Harvesting System Regulations to Revise Rain Barrel Definition

Enclosed for your review and approval is an exempt action to amend the Rainwater Harvesting System Regulations (12VAC5-635).

The Rainwater Harvesting System Regulations protect the health, safety, and welfare of the Commonwealth through the proper design, construction, and permitting of rainwater harvesting systems. The Regulations establish the relationship with the statutes and regulations applicable to other agencies and seek to avoid duplication of regulatory oversight for both non-potable uses of harvested rainwater and potable use for users below the threshold qualifying as a waterworks. The Regulations also establish administrative processes for permitting, inspecting, and issuing construction and operation permits for intended potable rainwater harvesting systems, along with appropriate exclusions from the regulations (e.g. rain barrels are exempt).

The exclusion for use of rain barrels identifies a rain barrel as an individual container of up to 100-gallon capacity used to collect and temporarily store rainwater solely for Tier 1 (non-potable and non-treated) end use. This capacity limitation is inconsistent with national customary practices and eliminates the exclusion for users of larger rain barrels. This represents an economic burden on a community intended to be excluded from regulation. The proposed change to the regulations is to eliminate the capacity limitation from the definition of a rain barrel.

This action is technical in nature and is therefore exempt from the Administrative Process Act under § 2.2-4006(A)(3) of the Code of Virginia.

The State Board of Health is requested to approve this final exempt action. Should the Board approve the action, the amendments will be published in the Virginia Register of Regulations and on the Virginia Regulatory Town Hall website. There will be no additional public comment period following publication. Thirty days after publication, the regulation will become effective.


townhall.virginia.gov

Exempt Action: Final Regulation Agency Background Document

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 5-635
VAC Chapter title(s)	Rainwater Harvesting System Regulations
Action title	Amend Regulation to Revise Rain Barrel Definition
Final agency action date	
Date this document prepared	4/28/2025

This information is required for executive branch review pursuant to 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. In addition, this information is required by the Virginia Registrar of Regulations pursuant to the Virginia Register Act (§ 2.2-4100 et seq. of the Code of Virginia). Regulations must conform to 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 Rainwater Harvesting System Regulations provide standards for the use of rainwater harvesting systems, including systems that collect rainwater for human consumption. The Regulations promote the use of rainwater as means to reduce fresh water consumption, ease demands on public treatment works and water supply systems, and promote conservation. The Regulations establish the relationship with the statutes and regulations applicable to other agencies and seek to avoid duplication of regulatory oversight for both non-potable uses of harvested rainwater and potable use for users below the threshold qualifying as a waterworks. The Regulations also establish administrative processes for permitting, inspecting, and issuing construction and operation permits for intended potable rainwater harvesting systems, along with appropriate exclusions from the regulations (e.g. rain barrels are excluded).

The existing exclusion of the use of rain barrels identifies a rain barrel as an individual container of up to 100-gallon capacity used to collect and temporarily store rainwater solely for Tier 1 end use. This capacity

limitation is inconsistent with national customary practices and subjects users of rain barrels of over 100-gallon capacity to the full requirements of the Regulations. This represents an economic burden on a community intended to be excluded from regulation. The proposed change to the regulations is to eliminate a capacity limitation from the definition of a rain barrel

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, internal staff review, 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."

The Regulations include an exclusion for the use of rain barrels. The definition of a rain barrel in 12VAC5-635-20.B.1 limits the capacity of a rain barrel to 100 gallons. There is no nationally recognized standard for a rain barrel that limits its capacity. It is not unusual to see containers of 500-gallon capacity or higher retailed as rain barrels. The rain barrel capacity limitation inadvertently creates an artificial subdivision of regulated vs unregulated when the intention is for all rain barrel use to be excluded from regulation.

This artificial subdivision places a significant economic burden on users of rain barrels larger than 100 gallons because they will be required by the remainder of the Regulations to rely on certified designers and installers.

The removal of a capacity limit from the definition of rain barrel will result in all users of rain barrels qualifying for the exclusion from the Regulations, which was the intended purpose of the exclusion.

Section 2.2-4006 (A)(3) of the Code of Virginia provides for revision of a regulation as an exempt action when limited to a correction of a technical error.

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) that the agency has "adopted final amendments" to the regulation; 3) the name of the agency taking the action; and 4) the title of the regulation. A suggested statement is, "On [insert date] the Board/Department of [insert name] adopted final amendments to the [title of regulation(s)]."

Office of Regulatory Management
Economic Review Form

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 5-635
VAC Chapter title(s)	Rainwater Harvesting System Regulations
Action title	Amend Regulation to Revise Rain Barrel Definition
Date this document prepared	04/28/2025
Regulatory Stage (including Issuance of Guidance Documents)	Final Exempt

Cost Benefit Analysis

Complete Tables 1a and 1b for all regulatory actions. You do not need to complete Table 1c if the regulatory action is required by state statute or federal statute or regulation and leaves no discretion in its implementation.

Table 1a should provide analysis for the regulatory approach you are taking. Table 1b should provide analysis for the approach of leaving the current regulations intact (i.e., no further change is implemented). Table 1c should provide analysis for at least one alternative approach. You should not limit yourself to one alternative, however, and can add additional charts as needed.

Report both direct and indirect costs and benefits that can be monetized in Boxes 1 and 2. Report direct and indirect costs and benefits that cannot be monetized in Box 4. See the ORM Regulatory Economic Analysis Manual for additional guidance.

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

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct costs of this proposed change. Indirect Costs: There are no indirect costs of the proposed change. Direct Benefits: Indeterminate; will likely remove burden to process variances, which may reduce costs such as staff time. Indirect Benefits: There are no indirect benefits of the proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) Indeterminate
(3) Net Monetized Benefit	Indeterminate	
(4) Other Costs & Benefits (Non-Monetized)	Removal of the 100 gallon limit for rain barrel exemptions will reduce regulatory burdens on Virginians using rain barrels larger than 100 gallons to collect and temporarily store rainwater solely for non-potable and non-treated use.	
(5) Information Sources		

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

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct costs associated with maintaining the status quo. Indirect Costs: Indirect costs associated with maintaining the status quo might include additional staff resources to approve variances for Virginian's using rain barrels with a capacity greater than 100 gallons. Direct Benefits: There are no direct benefits associated with maintaining the status quo. Indirect Benefits: There are no indirect benefits associated with maintaining the status quo.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) None

(3) Net Monetized Benefit	NA
(4) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits associated with maintaining the status quo.
(5) Information Sources	NA

Table 1c: Costs and Benefits under Alternative Approach(es)

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: No feasible alternative approaches have been identified. Indirect Costs: No feasible alternative approaches have been identified. Direct Benefits: No feasible alternative approaches have been identified. Indirect Benefits: No feasible alternative approaches have been identified.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) NA	(b) NA
(3) Net Monetized Benefit	NA	
(4) Other Costs & Benefits (Non-Monetized)	No feasible alternative approaches have been identified.	
(5) Information Sources	NA	

Impact on Local Partners

Use this chart to describe impacts on local partners. See Part 8 of the ORM Cost Impact Analysis Guidance for additional guidance.

Table 2: Impact on Local Partners

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct monetized costs to local partners with the proposed change. Indirect Costs: There are no indirect monetized costs to local partners with the proposed change.
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	Direct Benefits: There are no direct monetized benefits to local partners with the proposed change. Indirect Benefits: There are no indirect monetized benefits to local partners with the proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) \$0	(b) \$0
(3) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits to local partners.	
(4) Assistance	NA	
(5) Information Sources	NA	

Impacts on Families

Use this chart to describe impacts on families. See Part 8 of the ORM Cost Impact Analysis Guidance for additional guidance.

Table 3: Impact on Families

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: This will eliminate the need for families using rain barrels of greater than 100 gallon capacity from expending funds to comply with the regulation by means of (i) connecting smaller rain barrels in series, (ii) requesting a variance to the regulation, or (iii) contracting for the professional services of designer and an installer. Indirect Costs: There are no indirect monetized costs to families with the proposed change. Direct Benefits: This will eliminate the need for families using rain barrels of greater than 100 gallon capacity from loss of productivity pending the need to comply with the regulation by means of (i) connecting smaller rain barrels in series, (ii) requesting a variance to the regulation, or (iii) contracting for the professional services of designer and an installer.
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	Indirect Benefits: There are no indirect monetized benefits to families with the proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) \$100 to \$2000 per household	(b) The time to process a variance or obtain private sector services can be up to 60 days.
(3) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits to families.	
(4) Information Sources	VDH variance processing history.	

Impacts on Small Businesses

Use this chart to describe impacts on small businesses. See Part 8 of the ORM Cost Impact Analysis Guidance for additional guidance.

Table 4: Impact on Small Businesses

(1) Direct & Indirect Costs & Benefits (Monetized)	Direct Costs: There are no direct monetized costs to small businesses with the proposed change. Indirect Costs: There are no indirect monetized costs to small businesses with the proposed change. Direct Benefits: There are no direct monetized benefits to small businesses with the proposed change. Indirect Benefits: There are no indirect monetized benefits to small businesses with the proposed change.	
(2) Present Monetized Values	Direct & Indirect Costs	Direct & Indirect Benefits
	(a) None	(b) None
(3) Other Costs & Benefits (Non-Monetized)	There are no non-monetized costs or benefits to small businesses.	
(4) Alternatives	There are no known alternatives.	

(5) Information Sources	NA
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Changes to Number of Regulatory Requirements

Table 5: Regulatory Reduction

For each individual action, please fill out the appropriate chart to reflect any change in regulatory requirements, costs, regulatory stringency, or the overall length of any guidance documents.

Change in Regulatory Requirements

VAC Section(s) Involved*	Authority of Change	Initial Count	Additions	Subtractions	Total Net Change in Requirements
	(M/A):				
	(D/A):				
	(M/R):	1		1	-1
	(D/R):				
				Grand Total of Changes in Requirements:	(M/A): (D/A): (M/R):-1 (D/R):

Key:

Please use the following coding if change is mandatory or discretionary and whether it affects externally regulated parties or only the agency itself:

(M/A): Mandatory requirements mandated by federal and/or state statute affecting the agency itself

(D/A): Discretionary requirements affecting agency itself

(M/R): Mandatory requirements mandated by federal and/or state statute affecting external parties, including other agencies

(D/R): Discretionary requirements affecting external parties, including other agencies

Other Decreases or Increases in Regulatory Stringency (if applicable)

VAC Section(s) Involved*	Description of Regulatory Change	Overview of How It Reduces or Increases Regulatory Burden
12VAC5-635-20.B.1	Remove rain barrel capacity limitation.	Excludes ALL rain barrel users from regulation.

Project 8315 - Exempt Proposed

Department of Health

Chapter 635 Amend Exclusions

12VAC5-635-20. Applicability of regulation.

A. This chapter does not apply to rainwater harvesting systems installed, altered, or rehabilitated prior to November 20, 2024, unless the rainwater harvesting system is altered or rehabilitated after November 20, 2024.

B. The following are excluded from the requirements of this chapter.

1. Rain barrels (individual containers ~~of up to 100-gallon capacity~~ used to collect and temporarily store rainwater solely for Tier 1 end use);
2. Rainwater harvesting systems that serve as a source for a waterworks as regulated by the Waterworks Regulations (12VAC5-590);
3. Rainwater harvesting systems for Tier 1, 2, or 3 end use conducted for an agricultural operation as defined by § 3.2-300 of the Code of Virginia; and
4. Stormwater reclamation and reuse systems authorized by the Department of Environmental Quality in accordance with regulations adopted pursuant to § 62.1-44.15:28 of the Code of Virginia, including stormwater reclamation and reuse systems that may reclaim combined stormwater and harvested rainwater.

REPORT OF THE NOMINATING COMMITTEE

ELECTRONIC MEETING POLICY

TITLE: Procedures for Electronic Participation in Board of Health Meetings and All-Virtual Meetings

EFFECTIVE DATE: 7/1/25

AUTHORITY: § 2.2-3708.3 of the Code of Virginia

DEFINITIONS:

The following definitions shall apply to the words used in this policy unless otherwise noted:

“Participate electronically” means participating in an in-person meeting through electronic communication from a location that is not the location advertised in the public meeting notice.

“Electronic communication” means the use of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities to transmit or receive information.

“In-person meeting” refers to a meeting that has not been approved as an all-virtual meeting pursuant to this policy. All in-person meetings must have a quorum assembled in one physical location.

“All-virtual meeting” refers to a meeting that has been approved as an all-virtual meeting pursuant to this policy. During an all-virtual meeting, all members, staff, and the public may participate through electronic communication. No more than two members may be assembled in one physical location that is not open to the public.

PARTICIPATING ELECTRONICALLY DURING IN-PERSON MEETINGS:

Process for making requests

Each individual member shall request approval to participate electronically from the Board of Health (Board) Chair, and Board staff. Each request shall state a specific reason for electronic participation. Electronic participation is limited to the following reasons:

1. A member is unable to attend the meeting because of a temporary or permanent disability or other medical condition that prevents their ability to physically attend such meeting,
2. A medical condition of a family member of a member requires the member to provide care that prevents their physical attendance,
3. A member’s principal residence is more than 60 miles from the location of the meeting, or
4. A member is unable to attend due to an emergency or personal matter – the specific nature of which shall be shared with the Chair and staff.

If a member is requesting to participate electronically pursuant to reasons 1, 2, or 3, they must make their request 10 business days before the meeting. The Chair may make exceptions to this rule in his or her discretion.

If a member is requesting to participate electronically pursuant to reason 4, they may make their request up to 24 hours before the scheduled start time of the meeting. The Chair may make exceptions to this rule in his or her discretion.

Other requirements

Whenever an individual member is to participate electronically, the following conditions must be present:

1. A quorum of the Board must be physically assembled at the primary or central meeting location.
2. There must be arrangements for the voice of the remote participant to be heard by all persons at the primary or central meeting location.

If a member is participating electronically, the minutes shall reflect which of the four reasons the member has given. Members participating virtually due to caregiver duties (reason 2) are considered present for the physical quorum.

If a member is participating electronically pursuant to reason 4 (above), the minutes shall also include the specific nature of the personal matter cited by the member. Furthermore, such electronic participation by any one member is limited to by law to two of the Board's meetings or 25% of the meetings per year, whichever is greater. There is no limit to the number of times a member may participate electronically due to other allowable reasons.

Automatic approval; vote required if challenged

Individual electronic participation from a remote location shall be approved unless such participation would violate this policy or the provisions of the Virginia Freedom of Information Act. If a member's participation from a remote location is challenged by one or more members, then the Board shall vote whether to allow such participation and the results of such vote shall be recorded in the minutes with specificity.

If a member is approved to participate electronically the meeting minutes shall reflect the remote location from which the member participated; however, the remote location need not be open to the public and may be identified by a general description.

ALL-VIRTUAL MEETINGS:

The Board of Health may convene all-virtual meetings in accordance with the Virginia Freedom of Information Act. An indication of whether a meeting will be in-person or all-virtual will be included in the meeting notice. The type of meeting will not be changed once the notice is published unless the Board provides a new notice in accordance with the Virginia Freedom of Information Act.

At the third regular meeting of the calendar year, the Board shall discuss potential dates for all-virtual meetings during the following calendar year based on the planned work load of the Board and the schedules of the members. The members may then, by consensus, suggest two meetings that may be held as all-virtual meetings.

At least 15 business days prior to any regular or special meeting, the Chair of the Board shall confirm with staff whether a meeting will be an in-person meeting or an all-virtual meeting. Staff will then communicate the type of meeting to the other members and the public. There is a strong

preference to follow the suggested schedule created each calendar year. However, the Chair may, to the extent allowed by law, change a scheduled in- person meeting to an all-virtual meeting in extenuating circumstances. The Chair may also change a scheduled all-virtual meeting to an in-person meeting at the request of other members and/or Board staff.

The Board may not convene an all-virtual public meeting (i) more than two times per calendar year or 50 percent of its meetings held per calendar year rounded up to the next whole number, whichever is greater, or (ii) consecutively with another all-virtual public meeting.

During all-virtual public meetings, members will be considered absent for portions of the meeting where their video or audio connection fail or are disconnected.

CLARIFICATIONS:

The limits on electronic participation from a remote location due to emergencies or personal matters (reason 4) are separate from the limits on all-virtual meetings and will be counted separately. If a member's request to participate electronically is disapproved, said member may still continue to monitor the meeting from the remote location, but may not participate and may not be counted as present for the meeting.

Three or more members may be gathered in one location during an all-virtual meeting so long as that location is open to the public.

The Board shall review and certify this policy annually by recorded vote.

OTHER BUSINESS

ADJOURN