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Fast-Track Regulation
Agency Background Document

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

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

Brief Summary

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

This fast-track action is being utilized to conform 12VAC5-410-10 *et seq.* to the Code of Virginia and to update out-of-date regulatory provisions.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

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

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

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

Acronyms and Definitions

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

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

"Board" means the State Board of Health.

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

"Commissioner" means the State Health Commissioner.

"FGI" means The Facility Guidelines Institute.

"SANE" means sexual assault nurse examiner.

"VDH" means the Virginia Department of Health.

Statement of Final Agency Action

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

The Board approved the fast-track amendments for 12VAC5-410-10 *et seq.*, Regulations for the Licensure of Hospitals in Virginia, on December 15, 2022.

Mandate and Impetus

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

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

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

Legal Basis

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

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

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

Purpose

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

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

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

Substance

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

Section 10. Definitions
Adds definitions for "ACIP," "activities of daily living" or "ADL," "campus," "care provider," "CDC," "certified nursing facility," "certified sexual assault nurse examiner," "CMS," "emergency department," "general hospital accrediting organization," "hospital," "inspector," "operating room," "outpatient surgical hospital accrediting organization," "person with a disability," "support and assistance necessary due to the specifics of the person's disability," and "surgery." Revises definitions for "designated support person," "full-time," "general hospital," and "nursing home." Removes definitions for "special hospital." Renames "home health care department/service/program" to "home health services," renamed "nursing care unit" to "long-term care nursing unit," "outpatient hospital" to "outpatient surgical hospital," and "Office of Licensure and Certification" to "OLC."

Section 50. Classification
Removes the "special hospital" as a classification type.

Section 60. Separate license
Changes subsection A to use a consistent and defined term when discussing the location of hospitals and the need for separate licensure.

Section 100. Name
Removes the requirement to report a hospital name change within 30 calendar days as duplicative.

Section 130. Return of license.
Section is renamed to "Surrender of license; mid-term change of license." Clarifies what is a mid-term change to a license and clarifies a hospital's obligations and the process to obtain a changed license.

Section 140. Inspection procedure
Clarifies the inspection process and a hospital's obligations during and after the inspection.

Section 150. Plan of correction
Consolidates the plan of correction language found throughout the regulatory chapter to ensure the plan of correction requirements are consistent. Revisions include minimum elements of a plan of correction and the timeline for submission and completion of a plan of correction.

Section 160. Revocation of license
Section is renamed to "Disciplinary action." Matches statutory provisions about prohibited acts and disciplinary options available.

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

Section 215. Financial assistance in general hospitals

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

Section 225. Newborn safety devices
A new section. Describes minimum requirements for operation of a newborn safety device if a hospital has elected to install a device.

Section 230. Patient care management
Replaces reference to 22-year-old document with a reference to analogous federal requirements for patient rights. Repeals designated support person requirements and discharge requirements for a patient receiving elective surgery who may need outpatient physical therapy.

Section 235. Persons with a disability; designated support persons in general hospitals
A new section. Describes minimum requirements for providing a person with a disability access to a designated support person.

Section 237. Discharge planning
Consolidates into a single section the discharge planning requirements for inpatient admissions and for patients receiving elective surgery who may need outpatient physical therapy.

Section 370. Medical records
Removes an incorrect statutory reference, amends storage and reproduction requirements, amends subsection to address fetal death reporting, and adds subsection to address parent or guardian electronic access to minor patient's medical records.

Section 380. Nursing service
Adds language about when hospitals' quarterly reports are due and what information is to be included in the reports. Corrected out-of-date regulatory references.

Section 442. Obstetric service design and equipment criteria
Updates design and construction standards to the most current edition of the FGI guidelines for hospitals.

Section 444. Newborn service medical direction; physician consultation and coverage; nursing direction, nurse staffing and coverage; policies and procedures
Updates the breast milk storage times to match current CDC recommendations.

Section 445. Newborn service design and equipment criteria
Updates design and construction standards to the most current edition of the FGI guidelines for hospitals.

Section 447. Combined obstetric and clean gynecological service; infection control
Updates documents incorporated by reference for isolation or segregation of mothers, newborns, and patients.

Section 465. Long-term care nursing services
A new section. Describes the minimum statutory standards for certified nursing facilities that are operated under a general hospital's license.

Section 650. General building and physical plan information
Updates design and construction standards to the most current edition of the FGI guidelines for hospitals and outpatient facilities.

Section 760. Long-term care nursing units
Updates design and construction standards to the most current edition of the FGI guidelines for hospitals.

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

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

Section 1170. Policy and procedures manual
Replaces reference to 22-year-old document with a reference to analogous federal requirements for patient rights. Repeals designated support person requirements.

Section 1171. Persons with a disability; designated support person in outpatient surgical hospitals
A new section. Describes minimum requirements for providing a person with a disability access to a designated support person.

Section 1175. Discharge planning
This section is repealed.

Section 1178. Financial assistance in outpatient surgical hospitals
A new section. Describes minimum requirements for providing information about charity care and financial assistance and for payment plans.

Section 1190 Nursing staff
Adds language about when hospitals' quarterly reports are due and what information is to be included in the reports.

Section 1260. Medical records
Removes an incorrect statutory reference and reference to VDH business unit, amends storage and reproduction requirements, and adds subsection to address parent or guardian electronic access to minor patient's medical records.

Section 1350. Local and state codes and standards
Updates design and construction standards to the most current edition of the FGI guidelines for outpatient facilities.

DIBR
Lists all documents incorporated by reference in the regulatory changes.

Issues

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

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

Requirements More Restrictive than Federal

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

VDH is not aware of any applicable federal requirements about:

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

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

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

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

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

Agencies, Localities, and Other Entities Particularly Affected

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

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

Other State Agencies Particularly Affected

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

Localities Particularly Affected

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

Other Entities Particularly Affected

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

Economic Impact

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

Impact on State Agencies

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

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

Impact on Localities

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

Projected costs, savings, fees or revenues resulting from the regulatory change.	There are no known projected savings, fees, or revenues resulting from the regulatory change. Lee County Hospital Authority and Chesapeake Hospital Authority would have one-time costs associated with updating policies and procedures related to designated support persons, certified nursing facilities, parent or guardian electronic access to minor patient's records, discharge planning, financial assistance, and infection control and prevention. For their existing policies and procedures, VDH is estimating it would cost $1,250 one-time to amend their policies on each topic to conform to the regulatory minimums. It may be the case that no amendments are needed

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

Impact on Other Entities

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

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

All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	There are no known projected savings, fees, or revenues resulting from the regulatory change. Hospitals would have one-time costs associated with updating policies and procedures related to designated support persons, certified nursing facilities, parent or guardian electronic access to minor patient's records, discharge planning, financial assistance, and infection control and prevention. For their existing policies and procedures, VDH is estimating it would cost $1,250 one-time to amend their policies on each topic to conform to the regulatory minimums. It may be the case that no amendments are needed if the policies and procedures meet or exceed the proposed regulatory minimums, in which case no cost is expected to be incurred. If hospitals do not already have policies and procedures on these topics, VDH is estimating it would cost $5,000 one-time to develop these policies and procedures per topic. There may be some ongoing recordkeeping and administrative costs because Chapter 1088 of the 2020 Acts of Assembly mandates that hospitals file quarterly reports with VDH about its SANE employment. VDH estimates these costs are not likely to exceed $5,000 per year. There may be some ongoing recordkeeping and administrative costs associated with payment plans. VDH is unable to estimate at this time what the changes, if any, would be needed for hospitals to implement the new requirements or what those changes may cost.
Benefits the regulatory change is designed to produce.	The regulatory change is designed to conform the regulation to the Code of Virginia, and to promote the health, safety, and welfare of hospital patients by incorporating current clinical and industry practices as well as by requiring reasonable timely information from hospitals, access to information to ensure hospital compliance, remedial action within a reasonable and consistently applied timeframe if noncompliance does occur.

Alternatives to Regulation

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

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

Regulatory Flexibility Analysis

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

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

Public Participation

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

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

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

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

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

Detail of Changes

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

Table 1: Changes to Existing VAC Chapter(s)

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

		for patients who have a variety of medical and dental conditions that may require various types of care, such as medical, surgical, and maternity. "Home health care department/service/program" means a formally structured organizational unit of the hospital that is designed to provide health services to patients in their place of residence and meets Part II (12VAC5-381-150 et seq.) of the regulations adopted by the board for the licensure of home care organizations in Virginia. * * * "Nursing care unit" means an organized jurisdiction of nursing service in which nursing services are provided on a continuous basis. * * * "Office of Licensure and Certification" or "OLC" means the Office of Licensure and Certification of the Virginia Department of Health. * * * "Outpatient hospital" means institutions as defined by § 32.1-123 of the Code of Virginia that primarily provide facilities for the performance of surgical procedures on outpatients. Such patients may require treatment in a medical environment exceeding the normal capability found in a physician's office, but do not require inpatient hospitalization. * * * "Special hospital" means institutions as defined by § 32.1-123 of the Code of Virginia that provide care for a specialized group of patients or limit admissions to provide diagnosis and treatment for patients who have specific conditions (e.g.,	"CDC" means the Centers for Disease Control and Prevention. "Certified nursing facility" has the same meaning as ascribed to the term in § 32.1-123 of the Code of Virginia. "Certified sexual assault nurse examiner" means a nurse who is board certified by the International Association of Forensic Nurses as either a Sexual Assault Nurse Examiner-Pediatric (SANE-P) or a Sexual Assault Nurse Examiner-Adult/Adolescent (SANE-A). * * * "CMS" means the Centers for Medicare and Medicaid Services. * * * "Designated support person" or "DSP" ~~means a person who is knowledgeable about the needs of a person with a disability, and who is designated, orally or in writing, by the individual with a disability, the individual's guardian, or the individual's care provider to provide support and assistance, including physical assistance, emotional support, assistance with communication or decision-making, or any other assistance necessary as a result of the person's disability, to the person with a disability at any time during which health care services are provided~~ has the same meaning as ascribed to the term in subsection A of § 32.1-137.08 of the Code of Virginia and is not a visitor. * * * "Emergency department" means a department of the hospital that provides emergency services and is located on, or within a 35-mile radius of, the campus of the hospital. * * * ~~"Full-time" means a 37-1/2 to 40 hour work week.~~ "General hospital" means ~~institutions~~ a hospital ~~as defined by § 32.1-123 of the Code of Virginia~~ with an organized medical staff; with permanent facilities that include inpatient beds; and with medical services, including physician services, dentist services and continuous nursing services, to provide diagnosis and

		tuberculosis, orthopedic, pediatric, maternity).	treatment for patients who have a variety of medical and dental conditions that may require various types of care, such as medical, surgical, and maternity. "General hospital accrediting organization" means the Accreditation Commission for Health Care, the Center for Improvement in Healthcare Quality, DNV - Healthcare, The Joint Commission, or any accrediting organization that has been granted deeming authority for hospitals by CMS. ~~"Home health care department/service/program"~~ "Home health services" means a formally structured organizational unit of the hospital that is designed to provide health services to patients in their place of residence and meets Part II (12VAC5-381-150 et seq.) of the regulations adopted by the board for the licensure of home care organizations in Virginia. "Hospital" has the same meaning ascribed to the term in § 32.1-123 of the Code of Virginia and includes general hospitals and outpatient surgical hospitals. "Inspector" means an individual employed by or contracted by the Virginia Department of Health and designated by the commissioner to conduct inspections, investigations, or evaluations. "Long-term care nursing unit" means an organized jurisdiction of nursing service in which nursing services are provided on a continuous basis. * * * ~~"Nursing care unit" means an organized jurisdiction of nursing service in which nursing services are provided on a continuous basis.~~ "Nursing home" ~~means an institution or any identifiable component of any institution as defined by~~ has the same meaning as ascribed to the term in § 32.1-123 of the Code of Virginia ~~with permanent facilities that include inpatient beds and whose primary function is the provision, on a continuing basis, of nursing and health related services for the treatment of patients who may require~~

			~~various types of long term care, such as skilled care and intermediate care~~. * * * ~~"Office of Licensure and Certification" or~~ "OLC" means the Office of Licensure and Certification of the Virginia Department of Health. "Operating room" means a room in a hospital designated for the performance of surgery. * * * "Outpatient surgical hospital" means ~~institutions~~ a hospital ~~as defined by § 32.1-123 of the Code of Virginia~~ that primarily ~~provide~~ provides facilities for the performance of surgical procedures on outpatients. Such patients may require treatment in a medical environment exceeding the normal capability found in a physician's office, but do not require inpatient hospitalization. "Outpatient surgical hospital accrediting organization" means the Accreditation Commission for Ambulatory Health Care, the Accreditation Commission for Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, The Joint Commission, or any accrediting organization that has been granted deeming authority for ambulatory surgical centers by CMS. * * * "Person with a disability" has the same meaning as ascribed to the term in subsection A of § 32.1-137.08 of the Code of Virginia. * * * ~~"Special hospital" means institutions as defined by § 32.1-123 of the Code of Virginia that provide care for a specialized group of patients or limit admissions to provide diagnosis and treatment for patients who have specific conditions (e.g., tuberculosis, orthopedic, pediatric, maternity).~~ * * * "Support and assistance necessary due to the specifics of the person's disability" has the same meaning as

			<u>ascribed to the term in subsection A of § 32.1-137.08 of the Code of Virginia.</u> <u>"Surgery" has the same meaning as ascribed to the term in subsection A of § 54.1-2400.01:1 of the Code of Virginia.</u> **INTENT:** The intent of the change is to create, remove, and update definitions for terms that have been cause for confusion. **RATIONALE:** The rationale for the change is that commonly used terms that may have multiple meanings depending on the speaker should be defined so that all audiences have a consistent understanding of the terms' intended meaning. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for hospitals, VDH, and the public.
410-50	N/A	**12VAC5-410-50. Classification.** Hospitals to be licensed shall be classified as general hospitals, special hospitals or outpatient hospitals defined by 12VAC5-410-10.	**CHANGE:** The Board is proposing the following change: **12VAC5-410-50. Classification.** Hospitals to be licensed shall be classified as general hospitals~~, special hospitals~~ or outpatient <u>surgical</u> hospitals defined by 12VAC5-410-10. **INTENT:** The intent of the change is to remove "special hospital" as a classification of hospital **RATIONALE:** The rationale for the change is that the Board has not utilized this hospital classification and has no regulatory provisions specific to special hospitals. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for hospitals.
410-60	N/A	**12VAC5-410-60. Separate license.** A. A separate license shall be required by hospitals maintained on separate premises even though they are operated under the same management. Separate license	**CHANGE:** The Board is proposing the following change: **12VAC5-410-60. Separate license.** A. A separate license shall be required by hospitals maintained on separate ~~premises~~ <u>campuses</u> even though they are operated under the same

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

		another or from one location to another. The license issued by the commissioner shall be returned to the OLC for correction or reissuance when any of the following changes occur during the licensing year: 1. Revocation; 2. Change of location; 3. Change of ownership; 4. Change of name; 5. Change of bed capacity, except as provided in 12VAC5-410-110 C; or 6. Voluntary closure.	**12VAC5-410-130. ~~Return of license~~ Surrender of license; mid-term change of license.** A. Upon revocation or suspension of a license, the hospital shall surrender its license to the OLC. B. The hospital shall notify the director of the OLC ~~shall be notified~~ in writing by submitting a mid-term change application ~~at least within 30 working days~~ no less than 30 calendar days in advance of ~~any proposed change in location or ownership of the facility. A license shall not be transferred from one owner to another or from one location to another. The license issued by the commissioner shall be returned to the OLC for correction or reissuance when any of the following changes occur during the licensing year~~ implementing any: ~~1. Revocation;~~ ~~2.~~ 1. Change of location of the hospital, including change of location of any emergency department not located on the hospital's campus; ~~3.~~ 2. Change of ownership of the hospital; 3. Change of operator of the hospital; 4. Change of name of the hospital; 5. Change of bed capacity, except as provided in 12VAC5-410-110 C~~;~~, which shall be accompanied by an approved Certificate of Public Need if the requested change is for an increase in bed capacity; ~~or~~ 6. Change of services being provided, including any proposed addition or discontinuation, regardless of whether licensure is required for the service; or ~~6. Voluntary closure~~ 7. Closure of the hospital. C. The OLC shall: 1. Consider the submission date of a mid-term change application to be the date it is postmarked or

			the date it is received, whichever is earlier; and 2. Notify in writing the licensee if the commissioner will issue a changed license. D. The commissioner's issuance of a changed license to the hospital shall satisfy the requirements of subdivision C 2 of this section. E. Upon receipt of the changed license, the licensee shall return its prior license issued by the commissioner to the OLC and destroy any copies of the prior license. F. A license may not be transferred or assigned. The commissioner may not issue a changed license in response to a change of operator of the hospital, but shall instead require the hospital to obtain a new license. If the hospital intends to implement a change of operator, it shall: 1. File for a new license, in accordance with 12VAC5-410-70, no less than 30 calendar days in advance of any change of operator; and 2. Upon receipt of the new license, surrender its prior license issued by the commissioner to the OLC and destroy any copies of the prior license. G. If the hospital is closing or will otherwise no longer be operational, it shall: 1. Notify patients, legal representatives, and the OLC no fewer than seven calendar days prior to closing or ceasing operations where all clinical records are to be located following closure or cessation of operations; and 2. Surrender its license to the OLC and destroy all copies of its license no more than five calendar days after the hospital closes or ceases operations. H. The OLC shall determine if any changes listed in subsection B affect the terms of the license or the continuing eligibility for a license. An inspector may

			<u>inspect the hospital during the process of evaluating a proposed change.</u> **INTENT:** The intent of the change is to create a consistent list of what changes VDH needs to be aware of, when those changes are reportable, and what changes can result in a changed license versus a new license. **RATIONALE:** The rationale for the change is that transfer or assignment of licenses are prohibited by law, that certain license changes may require a new license, a new inspection (in the case of a change of location), or both, and that VDH needs to be aware of hospitals' active service lines for disaster preparedness planning and implementation. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for hospitals and VDH about when and what changes are reportable, and what changes warrant a new license.
410-140	N/A	**12VAC5-410-140. Inspection procedure.** A. The OLC may presume that a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and certified for participation in Title XVIII of the Social Security Act (Medicare) generally meets the requirements of Part II (12VAC5-410-170 et seq.) of this chapter provided the following conditions are met: 1. The hospital provides to the OLC, upon request, a copy of the most current accreditation survey findings made by the Joint Commission on Accreditation of Healthcare Organizations; and 2. The hospital notifies the OLC within 10 days after receipt of any	**CHANGE:** The Board is proposing the following change: **12VAC5-410-140. Inspection procedure.** <u>A. The OLC shall make periodic unannounced on-site inspections of a hospital as necessary but not less often than biennially. The OLC may make on-site inspections of applicants for licensure. Compliance with all standards shall be determined by the OLC.</u> <u>B. The hospital or applicant shall:</u> <u>1. Make available to the inspector any requested records;</u> <u>2. Permit an inspector to enter upon and into its property to inspect or investigate as the inspector reasonably deems necessary in order to determine the state of compliance with the provisions of this chapter and all laws administered by the board; and</u> <u>3. Allow the inspector access to interview the agents, employees, independent contractors,</u>

		notice of revocation or denial of accreditation by the Joint Commission on Accreditation of Healthcare Organizations. B. The OLC may presume that a unit or part of a hospital licensed or certified by another state agency, or another section, bureau or division of the OLC meets the requirements of Part II of this chapter for that specific unit or part provided the following conditions are met: 1. The hospital provides the OLC, upon request, a copy of the most current inspection report made by the other state agency; and 2. The hospital notifies the OLC within 10 days after receipt of any notice of revocation or suspension by the other state agency. C. Notwithstanding any other provision of this chapter to the contrary, if the licensing agency finds, after inspection, violations pertaining to environmental health or life safety, the hospital shall receive a written licensing report of such findings. The hospital shall be required to submit a plan of correction in accordance with provisions of 12VAC5-410-150.	patients, legal representatives, patients' family members, and any person under the hospital's or applicant's control, direction, or supervision. C. After the on-site inspection, the inspector shall: 1. Discuss the findings of the inspection with the chief executive officer or his designee; and 2. Provide a written inspection report to the chief executive officer or his designee. D. If the OLC cites one or more licensing violations in the written inspection report, the chief executive officer or his designee shall submit a plan of correction in accordance with 12VAC5-410-150. ~~A.~~ E. The OLC may presume that a general hospital ~~accredited~~ deemed by ~~the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)~~ a general hospital accrediting organization and certified for participation in Title XVIII of the Social Security Act ~~(Medicare)~~ (42 U.S.C. § 301 et seq.) generally meets the requirements of Part II (12VAC5-410-170 et seq.) of this chapter provided the following conditions are met: 1. The general hospital provides to the OLC, upon request, a copy of the most current accreditation survey findings made by the ~~Joint Commission on Accreditation of Healthcare Organizations~~ general hospital accrediting organization; and 2. The general hospital notifies the OLC within 10 days after receipt of any notice of revocation or denial of accreditation by the ~~Joint Commission on Accreditation of Healthcare Organizations~~ general hospital accrediting organization. F. The OLC may presume that an outpatient surgical hospital deemed by an outpatient surgical hospital accrediting organization and certified for participation

			in Title XVIII of the Social Security Act (42 U.S.C. § 301 et seq.) generally meets the requirements of Part IV (12VAC5-410-1150 et seq.) of this chapter provided the following conditions are met: 1. The outpatient surgical hospital provides to the OLC, upon request, a copy of the most current accreditation survey findings made by the outpatient surgical hospital accrediting organization; and 2. The outpatient surgical hospital notifies the OLC within 10 days after receipt of any notice of revocation or denial of accreditation by the outpatient surgical hospital accrediting organization. ~~B.~~ G. The OLC may presume that a unit or part of a general hospital licensed or certified by another state agency, or another section, bureau or division of the OLC meets the requirements of Part II (12VAC5-410-170 et seq.) of this chapter for that specific unit or part provided the following conditions are met: 1. The general hospital provides the OLC, upon request, a copy of the most current inspection report made by the other state agency; and 2. The general hospital notifies the OLC within 10 days after receipt of any notice of revocation or suspension by the other state agency. H. The OLC may presume that a unit or part of an outpatient surgical hospital licensed or certified by another state agency, or another section, bureau or division of the OLC meets the requirements of Part IV (12VAC5-410-1150 et seq.) of this chapter for that specific unit or part provided the following conditions are met: 1. The outpatient surgical hospital provides the OLC, upon request, a copy of the most current inspection report made by the other state agency; and

			2. The outpatient surgical hospital notifies the OLC within 10 days after receipt of any notice of revocation or suspension by the other state agency. ~~C.~~ I. Notwithstanding any other provision of this chapter to the contrary, if the ~~licensing agency~~ OLC finds, after inspection, violations pertaining to environmental health or life safety, the hospital shall receive a written licensing report of such findings. The hospital shall be required to submit a plan of correction in accordance with provisions of 12VAC5-410-150. **INTENT:** The intent of the change is to more clearly specify what is expected of a hospital and VDH when an inspection occurs and to create a rebuttable compliance presumption for outpatient surgical hospitals. **RATIONALE:** The rationale for the change is hospitals are better able to anticipate what may be needed during inspection process if parameters are specified in regulation and that there is not rationale reason to exclude outpatient surgical hospitals from a rebuttable presumption of compliance. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for hospitals and more efficient inspection procedures for VDH if it can utilize similar rebuttable compliance presumptions for all hospital types on routine inspections.
410-150	N/A	**12VAC5-410-150. Plan of correction.** A. Upon receipt of a written licensing report each hospital shall prepare a plan for correcting any licensing violations cited at the time of inspection. The plan of correction shall be to the OLC within the specified time limit set forth in the licensing report. The plan of correction shall contain at least the following information:	**CHANGE:** The Board is proposing the following change: **12VAC5-410-150. Plan of correction.** A. Upon receipt of a written ~~licensing~~ inspection report, the chief executive officer or his designee ~~each hospital~~ shall prepare a written plan ~~for correcting~~ of correction addressing ~~any~~ each licensing ~~violations~~ violation cited at the time of inspection. ~~The plan of correction shall be to the OLC within the specified time limit set forth in the licensing report. The plan~~

		1. The methods implemented to correct any violations of this chapter; and 2. The date, on which such corrections are expected to be completed. B. The OLC shall notify the hospital, in writing, whenever any item in the plan of correction is determined to be unacceptable.	~~of correction shall contain at least the following information:~~ B. The chief executive officer or his designee shall submit to the OLC a written plan of correction no more than 15 business days after receipt of the inspection report. The plan of correction shall contain for each licensing violation cited: 1. ~~The methods implemented to correct any violations of this chapter~~ A description of the corrective action or actions to be taken and the position title of the employees to implement the corrective action. If employees share the same position title, the chief executive officer or his designee shall assign the employees a unique identifier to distinguish them; ~~and~~ 2. The expected correction date, ~~on which such corrections are expected to be completed~~ not to exceed 45 business days from the exit date of the inspection~~.~~; and 3. A description of the measures implemented to prevent a recurrence of each licensing violation. C. The chief executive officer or his designee shall ensure that the person responsible for the validity of the plan of correction signs, dates, and indicates their title on the plan of correction. ~~B.~~ D. The OLC shall notify the ~~hospital~~ chief executive officer or his designee, in writing, ~~whenever~~ if the OLC determines any item in the plan of correction is ~~determined to be~~ unacceptable. E. The OLC may conduct an inspection to verify any portion of a plan of correction has been implemented. F. The chief executive officer or his designee shall ensure the plan of correction is implemented and monitored so that compliance is maintained. G. The commissioner may deny licensure or renewal of licensure if the chief executive officer or his designee

			fails to submit an acceptable plan of correction or fails to implement an acceptable plan of correction. H. The OLC shall consider the submission date of a plan of correction to be the date it is postmarked or the date it is received, whichever is earlier. **INTENT:** The intent of the change is to standardize the plan of correction process to make it more similar to federal plan of correction processes. **RATIONALE:** The rationale for the change is that documentation of remedial action and completion of remedial action should be consistently applied to all hospitals. **LIKELY IMPACT:** The likely impact of the change is improved clarity about what should be in a plan of correction, when it is due, and when it should be completed.
410-160	N/A	**12VAC5-410-160. Revocation of license.** The commissioner may revoke or suspend the license to operate a hospital in accordance with § 32.1-135 of the Code of Virginia for the following reasons: 1. Violation of any provision of these rules and regulations. Violations which in the judgment of the commissioner jeopardize the health or safety of patients shall be sufficient cause for immediate revocation or suspension; or 2. Willfully permitting, aiding, or abetting the commission of any illegal act in the hospital.	**CHANGE:** The Board is proposing the following change: **12VAC5-410-160. ~~Revocation of license~~ Disciplinary action.** ~~The commissioner may revoke or suspend the license to operate a hospital in accordance with § 32.1-135 of the Code of Virginia for the following reasons:~~ ~~1. Violation of any provision of these rules and regulations. Violations which in the judgment of the commissioner jeopardize the health or safety of patients shall be sufficient cause for immediate revocation or suspension; or~~ ~~2. Willfully permitting, aiding, or abetting the commission of any illegal act in the hospital.~~ A. A hospital may not: 1. Violate the provisions of this chapter or Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia; 2. Permit, aid, or abet the commission of any illegal act in the hospital;

			<u>3. Engage in a pattern of violations pursuant to § 38.2-3445.01 of the Code of Virginia; or</u> <u>4. Engage in a pattern of violations of subdivision B 13 of § 38.2-3407.15 of the Code of Virginia.</u> <u>B. The commissioner may:</u> <u>1. For each violation of subsection A of this section:</u> <u>a. Deny, revoke, or suspend the license to operate a hospital, in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia);</u> <u>b. Refer a hospital for criminal prosecution pursuant to subsection A of § 32.1-27 of the Code of Virginia; or</u> <u>c. Petition an appropriate court for an injunction, mandamus, or other appropriate remedy or imposition of a civil penalty against a hospital pursuant to subsection B or C of § 32.1-27 of the Code of Virginia;</u> <u>2. For each violation of subsection A of this section by or occurring in a long-term care nursing unit of a general hospital if that unit is a certified nursing facility:</u> <u>a. Restrict or prohibit new admissions to the long-term care nursing unit in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia);</u> <u>b. Petition an appropriate court for imposition of a civil monetary penalty against a hospital pursuant to subsection A of § 32.1-27.1 of the Code of Virginia; or</u> <u>c. Petition an appropriate court for appointment of a</u>

			receiver for the long-term care nursing unit pursuant to subsection B of § 32.1-27.1 of the Code of Virginia; and 3. For each violation of subdivision A 3 of this section, levy a fine upon the hospital in an amount not to exceed $1,000 per violation, in accordance with the Administrative Process Acts (§ 2.2-4000 et seq. of the Code of Virginia). C. Suspension of a license shall in all cases be for an indefinite time. D. For each violation of subsection A of this section and with the consent of the person who has violated subsection A of this section, the board may provide, in an order issued by the board, for the payment of civil charges for past violations in specific sums, which may not exceed the limits specified in § 32.1-27 of the Code of Virginia or if applicable, the limits specified in § 32.1-27.1 of the Code of Virginia. E. Upon receipt of a completed application and a nonrefundable service charge, the commissioner may issue a new license to a hospital that has had its license revoked if the commissioner determines that: 1. The conditions upon which revocation was based have been corrected; and 2. The applicant is in compliance with this chapter, Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia, and all other applicable state and federal law and regulations. F. Upon receipt of a completed application, the commissioner may partially or completely restore a suspended license to a hospital if the commissioner determines that: 1. The conditions upon which suspension was based have been completely or partially corrected; and

			2. The interests of the public will not be jeopardized by resumption of operation. G. The commissioner may not require an additional service charge for restoring a license pursuant to subsection F of this section. H. The hospital shall submit evidence relevant to subdivisions E 1, E 2, F 1, and F 2 of this subsection that is satisfactory to the commissioner or his designee. The commissioner or his designee may conduct an inspection prior to making a determination. **INTENT:** The intent of the change is to describe the grounds upon which the commissioner may take disciplinary action against a hospital, the options available to the commissioner for disciplinary action, and how a hospital may obtain a license after suspension or revocation. **RATIONALE:** The rationale for the change is that the regulation should conform to Chapter 72 of the 2021 Acts of Assembly, Special Session I, Chapters 1080 and 1081 of the 2020 Acts of Assembly, and to Va. Code §§ 32.1-27, 32.1-27.1, and 32.1-135. **LIKELY IMPACT:** The likely impact of the change is improved clarity for hospitals about what acts are not permitted and what consequences may follow if a prohibited act occurs.
N/A	410-215	None	**CHANGE:** The Board is proposing the following change: Part II Organization and Operation of General ~~and Special~~ Hospitals **12VAC5-410-215. Financial assistance in general hospitals.** A. As used in this section, "patient" and "uninsured patient" have the same meanings as ascribed to these terms in subsection A of § 32.1-137.010 of the Code of Virginia.

			B. A general hospital shall make reasonable efforts to screen every uninsured patient to determine whether the individual is eligible for medical assistance pursuant to the state plan for medical assistance or for financial assistance under the general hospital's financial assistance policy. C. A general hospital shall inform every uninsured patient who receives services at the general hospital and who is determined to be eligible for assistance under the general hospital's financial assistance policy of the option to enter into a payment plan with the general hospital. 1. A payment plan entered into pursuant to this subsection shall be provided to the patient in writing or electronically and shall provide for repayment of the cumulative amount owed to the general hospital. 2. The amount of monthly payments and the term of the payment plan shall be determined based upon the patient's ability to pay. 3. Any interest on amounts owed pursuant to the payment plan shall not exceed the maximum judgment rate of interest pursuant to § 6.2-302 of the Code of Virginia. 4. The general hospital may not charge any fees related to the payment plan. 5. The payment plan shall allow prepayment of amounts owed without penalty. D. A general hospital shall develop a process by which either an uninsured patient who agrees to a payment plan pursuant to subsection C of this section or the general hospital may request and shall be granted the opportunity to renegotiate the payment plan. 1. Renegotiation shall include opportunity for a new screening in accordance with subsection B of this section.

			2. A general hospital may not charge any fees for renegotiation of a payment plan pursuant to this subsection. E. A general hospital shall provide written information about: 1. Its charity care policies, including: a. Policies related to free and discounted care; b. Specific eligibility criteria for charity care; and c. Procedures for applying for charity care; 2. The availability of a payment plan for the payment of debt owed to the general hospital pursuant to subsection C of this section; and 3. The renegotiation process described in subsection D of this section. F. To provide the information required by subsection E of this section, a general hospital shall: 1. Post the information conspicuously in public areas of the general hospital, including admissions or registration areas, emergency departments, and associated waiting rooms; 2. Make the information available to: a. A patient at the time of admission or discharge, or at the time services are provided; and b. Persons with limited English proficiency in accordance with the U.S. Department of Health and Human Services' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (August 8, 2003, 68 FR 47311), if the general

			hospital is subject to the requirements of Title VI of the Civil Rights Act of 1964 (Pub. L. No. 88-352), as amended; and 3. Include the information: a. With any billing statements sent to uninsured patients; and b. On any website maintained by the general hospital. G. Notwithstanding any other provision of law, a general hospital may not engage in any action described in § 501(r)(6) of the Internal Revenue Code, as it was in effect on January 1, 2020, to recover a debt for medical services against any patient unless the general hospital has made all reasonable efforts to determine whether the patient: 1. Qualifies for medical assistance pursuant to the state plan for medical assistance; or 2. Is eligible for financial assistance under the general hospital's financial assistance policy. H. Nothing in this section shall be construed to: 1. Prohibit a general hospital, as part of its financial assistance policy, from requiring a patient to: a. Provide necessary information needed to determine eligibility for financial assistance under the general hospital's financial assistance policy, medical assistance pursuant to Title XVIII or XIX of the Social Security Act (42 U.S.C. § 301 et seq.), 10 U.S.C. § 1071 et seq., or other programs of insurance; or b. Undertake good faith efforts to apply for and enroll in the programs of insurance for which the patient may be eligible as a condition of

			awarding financial assistance; 2. Require a general hospital to grant or continue to grant any financial assistance or payment plan pursuant to this section when: a. A patient has provided false, inaccurate, or incomplete information required for determining eligibility for the general hospital's financial assistance policy; or b. A patient has not undertaken good faith efforts to comply with any payment plan pursuant to this section; or 3. Prohibit the coordination of benefits as required by state or federal law. **INTENT:** The intent of the change is to remove "special hospitals" from the name of this Part and to describe the minimum requirements for information disclosure about financial assistance, for payment plans, and for renegotiation of payment plans. **RATIONALE:** The rationale for the change is that the Board does not intend to use "special hospitals" as a classification of hospital and that the regulation should conform to Chapters 678 and 679 of the 2022 Acts of Assembly. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for outpatient surgical hospitals about the minimum requirements for providing information about financial assistance and providing financial assistance to patients.
N/A	410-225	None	**CHANGE:** The Board is proposing the following change:

			12VAC5-410-225. Newborn safety devices. A general hospital that voluntarily installs a newborn safety device for the reception of children shall ensure that: 1. The device is located inside the hospital in an area that is conspicuous and visible to employees or personnel; 2. The device is staffed 24 hours a day by a health care provider; 3. The device is climate controlled and serves as a safe sleep environment for an infant; 4. The device is equipped with a dual alarm system that sounds 60 seconds after a child is placed in the device and automatically places a call to 911 if the alarm is not deactivated within 60 seconds from within the hospital; 5. The dual alarm system is visually checked at least two times per day and tested at least one time per week to ensure the alarm system is in working order; 6. The device automatically locks when a child is placed in the device; and 7. The device is identifiable by appropriate signage that shall include written and pictorial operational instructions. **INTENT:** The intent of the change is to describe the minimum standards a general hospital must meet if it choose to install a newborn safety device. **RATIONALE:** The rationale for the change is that the regulation should be consistent with Chapters 80 and 81 of the 2022 Acts of Assembly **LIKELY IMPACT:** The likely impact of the change is reduced confusion for general hospitals about the minimum requirements if they choose to install a newborn safety device.

410-230	N/A	**12VAC5-410-230. Patient care management.** * * * C. Each hospital shall establish a protocol relating to the rights and responsibilities of patients based on Joint Commission on Accreditation of Healthcare Organizations' 2000 Hospital Accreditation Standards, January 2000. The protocol shall include a process reasonably designed to inform patients of their rights and responsibilities. Patients shall be given a copy of their rights and responsibilities upon admission. * * * G. If the Governor has declared a public health emergency related to the novel coronavirus (COVID-19), each hospital shall allow a person with a disability who requires assistance as a result of such disability to be accompanied by a designated support person at any time during which health care services are provided. 1. In any case in which health care services are provided in an inpatient setting, and the duration of health care services in such inpatient setting is anticipated to last more than 24 hours, the person with a disability may designate more than one designated support person. However, no hospital shall be required to allow more than one designated support person to be present with a person with a disability at any time. 2. A designated support person shall not be subject to any restrictions on visitation	**CHANGE:** The Board is proposing the following change: **12VAC5-410-230. Patient care management.** * * * C. Each hospital shall establish a protocol relating to the rights and responsibilities of patients based on 42 C.F.R. § 482.13 ~~Joint Commission on Accreditation of Healthcare Organizations' 2000 Hospital Accreditation Standards, January 2000~~. The protocol shall include a process reasonably designed to inform patients of their rights and responsibilities. Patients shall be given a copy of their rights and responsibilities upon admission. * * * ~~G. If the Governor has declared a public health emergency related to the novel coronavirus (COVID-19), each hospital shall allow a person with a disability who requires assistance as a result of such disability to be accompanied by a designated support person at any time during which health care services are provided.~~ ~~1. In any case in which health care services are provided in an inpatient setting, and the duration of health care services in such inpatient setting is anticipated to last more than 24 hours, the person with a disability may designate more than one designated support person. However, no hospital shall be required to allow more than one designated support person to be present with a person with a disability at any time.~~ ~~2. A designated support person shall not be subject to any restrictions on visitation adopted by such hospital. However, such designated support person may be required to comply with all reasonable requirements of the hospital adopted to protect the health and safety of patients and staff of the hospital.~~

		adopted by such hospital. However, such designated support person may be required to comply with all reasonable requirements of the hospital adopted to protect the health and safety of patients and staff of the hospital. 3. Every hospital shall establish policies applicable to designated support persons and shall: a. Make such policies available to the public on a website maintained by the hospital; and b. Provide such policies, in writing, to the patient at such time as health care services are provided. H. Each hospital that is equipped to provide life-sustaining treatment shall develop a policy to determine the medical or ethical appropriateness of proposed medical care, which shall include: 1. A process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; 2. Provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical	~~3. Every hospital shall establish policies applicable to designated support persons and shall:~~ ~~a. Make such policies available to the public on a website maintained by the hospital; and~~ ~~b. Provide such policies, in writing, to the patient at such time as health care services are provided.~~ ~~H.~~ G. Each hospital that is equipped to provide life-sustaining treatment shall develop a policy to determine the medical or ethical appropriateness of proposed medical care, which shall include: 1. A process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; 2. Provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the proposed health care of the patient; 3. Requirements for a written explanation of the decision of the interdisciplinary medical review committee, which shall be included in the patient's medical record; and 4. Provisions to ensure the patient, the patient's agent, or the person authorized to make the patient's medical decisions in accordance with § 54.1-2986 of the Code of Virginia is informed of the patient's right to obtain the patient's medical record and the right to obtain an independent medical opinion and afforded reasonable opportunity to

		review committee and a determination by the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the proposed health care of the patient; 3. Requirements for a written explanation of the decision of the interdisciplinary medical review committee, which shall be included in the patient's medical record; and 4. Provisions to ensure the patient, the patient's agent, or the person authorized to make the patient's medical decisions in accordance with § 54.1-2986 of the Code of Virginia is informed of the patient's right to obtain the patient's medical record and the right to obtain an independent medical opinion and afforded reasonable opportunity to participate in the medical review committee meeting. The policy shall not prevent the patient, the patient's agent, or the person authorized to make the patient's medical decisions from obtaining legal counsel to represent the patient or from seeking other legal remedies, including court review, provided that the patient, the patient's agent, person authorized to make the patient's medical decisions, or legal counsel provide written notice to the chief executive officer of the hospital within 14 days of the date of the physician's determination that proposed medical treatment is medically or ethically	participate in the medical review committee meeting. The policy shall not prevent the patient, the patient's agent, or the person authorized to make the patient's medical decisions from obtaining legal counsel to represent the patient or from seeking other legal remedies, including court review, provided that the patient, the patient's agent, person authorized to make the patient's medical decisions, or legal counsel provide written notice to the chief executive officer of the hospital within 14 days of the date of the physician's determination that proposed medical treatment is medically or ethically inappropriate as documented in the patient's medical record. ~~I.~~ H. Each hospital shall establish a protocol requiring that, before a health care provider arranges for air medical transportation services for a patient who does not have an emergency medical condition as defined in 42 USC § 1395dd(e)(1), the hospital shall provide the patient or the patient's authorized representative with written or electronic notice that the patient (i) may have a choice of transportation by an air medical transportation provider or medically appropriate ground transportation by an emergency medical services provider and (ii) will be responsible for charges incurred for such transportation in the event that the provider is not a contracted network provider of the patient's health insurance carrier or such charges are not otherwise covered in full or in part by the patient's health insurance plan. ~~J.~~ I. Each hospital shall provide written information about the patient's ability to request an estimate of the payment amount for which the participant will be responsible pursuant to § 32.1-137.05 of the Code of Virginia. The written information shall be posted conspicuously in public areas of the hospital, including admissions or registration areas, and included on any website maintained by the hospital. ~~K. Each hospital shall establish protocols to ensure that any patient~~

		inappropriate as documented in the patient's medical record. I. Each hospital shall establish a protocol requiring that, before a health care provider arranges for air medical transportation services for a patient who does not have an emergency medical condition as defined in 42 USC § 1395dd(e)(1), the hospital shall provide the patient or the patient's authorized representative with written or electronic notice that the patient (i) may have a choice of transportation by an air medical transportation provider or medically appropriate ground transportation by an emergency medical services provider and (ii) will be responsible for charges incurred for such transportation in the event that the provider is not a contracted network provider of the patient's health insurance carrier or such charges are not otherwise covered in full or in part by the patient's health insurance plan. J. Each hospital shall provide written information about the patient's ability to request an estimate of the payment amount for which the participant will be responsible pursuant to § 32.1-137.05 of the Code of Virginia. The written information shall be posted conspicuously in public areas of the hospital, including admissions or registration areas, and included on any website maintained by the hospital. K. Each hospital shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up treatment after discharge is informed that the patient:	~~scheduled to receive an elective surgical procedure for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up treatment after discharge is informed that the patient:~~ ~~1. Is expected to require outpatient physical therapy as a follow-up treatment; and~~ ~~2. Will be required to select a physical therapy provider prior to being discharged from the hospital.~~ **INTENT:** The intent of the change is to use a more relevant basis for patient rights protocols and to create two new sections of regulation that separately address discharge planning and designated support persons. **RATIONALE:** The rationale for the change is that a document from 2000 is an out-of-date basis for patient rights, that all general hospitals in Virginia are already complying with 42 C.F.R. § 482.13 as a condition of participation in Medicare, and that discharge planning and designated support persons are topics requiring significantly more detail that, if both were to continue to be addressed in the present section of regulation, would make the section more difficult to read. **LIKELY IMPACT:** The likely impact of the change is improved readability of this regulatory section and improved ease in locating provisions addressing discharge planning and designated support persons.

		1. Is expected to require outpatient physical therapy as a follow-up treatment; and 2. Will be required to select a physical therapy provider prior to being discharged from the hospital.	
410-230(G)	410-235	See row above regarding changes proposed for 410-230.	**CHANGE:** The Board is proposing the following change: **12VAC5-410-235. Persons with a disability; designated support person in general hospital.** A. For the purposes of this section: 1. "Admission" means accepting a person for bed occupancy and care that is anticipated to span at least two midnights or for observation; 2. "General hospital" means a general hospital other than one that is certified as a long-term acute care hospital or specialty rehabilitation hospital. B. A general hospital shall allow a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a DSP who will provide support and assistance necessary due to the specifics of the person's disability to the person with a disability during an admission. 1. In any case in which the duration of the admission lasts more than 24 hours, the person with a disability may designate more than one DSP. 2. No general hospital shall be required to allow more than one DSP to be present with a person with a disability at any time. C. A general hospital may: 1. Not subject a DSP to any restrictions on visitation; 2. Require a DSP to comply with all reasonable requirements of a general hospital adopted to

			protect the health and safety of the person with a disability; the DSP; the staff and other patients of, or visitors to, a general hospital; and the public; and 3. Restrict a DSP's access to specified areas of and movement on the premises of a general hospital when such restrictions are determined by a general hospital to be reasonably necessary to protect the health and safety of the person with a disability; the DSP; the staff and other patients of, or visitors to, a general hospital; and the public. D. A general hospital may request that a person with a disability provide documentation indicating that he is a person with a disability. 1. If the person with a disability fails, refuses, or is unable to provide documentation requested pursuant to subsection D of this section, a general hospital may perform an objective assessment of the person to determine whether he is a person with a disability. 2. If a general hospital fails to perform an objective assessment pursuant to subdivision D 1 of this section, a general hospital may not prohibit a DSP from accompanying a person with a disability for the purpose of providing support and assistance necessary due to the specifics of the person's disability. E. A general hospital shall 1. Establish protocols to inform patients, at the time of admission, of the right of a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a DSP for the purpose of providing support and assistance necessary due to the specifics of the person's disability;

			2. Develop and make available to a patient or his guardian, authorized representative, or care provider upon request written information regarding the right of a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a DSP and any policies related to that right; and 3. Make the written information described in subdivision E 2 of this section available to the public on its website. G. This section may not: 1. Alter the obligation of a general hospital to provide patients with effective communication support or other required services, regardless of the presence of a DSP or other reasonable accommodation, consistent with applicable federal or state law or regulations; and 2. Be interpreted to: a. Prevent a general hospital from complying, or interfere with the ability of a general hospital to comply, with or cause a general hospital to violate any federal or state law or regulation; b. Deem a DSP to be acting under the direction or control of a general hospital or as an agent of a general hospital; or c. Require a general hospital to allow a DSP to perform any action or provide any support or assistance necessary due to the specifics of the person's disability when a general hospital reasonably determines that the performance of the action or provision would be: (1) Medically or therapeutically contraindicated; or

			(2) A threat to the health and safety of the person with a disability, the DSP, or the staff or other patients of, or visitors to, a general hospital. **INTENT:** The intent of the change is to describe the minimum requirements for access to designated support persons by persons with disabilities in general hospitals. **RATIONALE:** The rationale for the change is that the regulation should be in conformity with Chapter 220 of the 2021 Acts of Assembly, Special Session I. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for general hospitals about what the minimum requirements for designated support persons are outside of a Governor-declared public health emergency related to COVID-19.
410-230(K) and 410-1175	410-237	See row above regarding proposed changes to 410-230 and row below regarding proposed changes to 410-1175	**CHANGE:** The Board is proposing the following change: **12VAC5-410-237. Discharge planning.** A. A general hospital shall provide each patient admitted as an inpatient or his legal guardian the opportunity to designate: 1. An individual who will care for or assist the patient in his residence following discharge from a general hospital; and 2. To whom a general hospital shall provide information regarding the patient's discharge plan and any follow-up care, treatment, and services that the patient may require. B. Upon admission, a general hospital shall record in the patient's medical record: 1. The name of the individual designated by the patient; 2. The relationship between the patient and the person; and 3. The person's telephone number and address.

			C. If the patient fails or refuses to designate an individual to receive information regarding his discharge plan and any follow-up care, treatment, and services, a general hospital shall record the patient's failure or refusal in the patient's medical record. D. A patient may change the designated individual at any time prior to the patient's release, and a general hospital shall record the changes, including the information referenced in subsection B of this section, in the patient's medical record within 24 hours of such a change. E. Prior to discharging a patient who has designated an individual pursuant to subsections A or D of this section, a general hospital shall: 1. Notify the designated individual of the patient's discharge, 2. Provide the designated individual with a copy of the patient's discharge plan and instructions and information regarding any follow-up care, treatment, or services that the designated individual will provide; and 3. Consult with the designated individual regarding the designated individual's ability to provide the care, treatment, or services. F. The discharge plan prescribed in subdivision E 2 of this section shall include: 1. The name and contact information of the designated individual; 2. A description of follow-up care, treatment, and services that the patient requires; and 3. Information, including contact information, about any health care, long-term care, or other community-based services and supports necessary for the implementation of the patient's discharge plan.

			G. A general hospital shall include a copy of the discharge plan and any instructions or information provided to the designated individual in the patient's medical record. H. A general hospital shall provide each individual designated pursuant to subsection A or D of this section the opportunity for a demonstration of specific follow-up care tasks that the designated individual will provide to the patient in accordance with the patient's discharge plan prior to the patient's discharge, including opportunity for the designated individual to ask questions regarding the performance of follow-up care tasks in a culturally competent manner and in the designated individual's native language. I. A general hospital shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up treatment after discharge is informed that the patient: 1. Is expected to require outpatient physical therapy as a follow-up treatment; and 2. Will be required to select a physical therapy provider prior to being discharged from a general hospital. **INTENT:** The intent of the change is to have all of the inpatient discharge planning information located in the part of the regulatory chapter where inpatient services are addressed. **RATIONALE:** The rationale for the change is that the regulation should be in conformity with statutory/legislative mandates and that many of these requirements were incorrectly located in the part of the regulatory chapter for hospitals that do not provide inpatient services. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for general hospitals about inpatient discharge

			requirements and where they are located in 12VAC5-410.
410-370	N/A	**12VAC5-410-370. Medical records.** * * * E. Provisions shall be made for the safe storage of medical records ~~or~~ accurate and legible reproductions ~~thereof~~ according to § 32.1-127.1:03 of the Code of Virginia and the Health Insurance Portability and Accountability Act~~, or HIPAA~~ (~~42 USC § 1320d et seq.~~). F. All medical records either original or accurate reproductions shall be preserved for a minimum of five years following discharge of the patient. 1. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years. 2. Birth and death information shall be retained for 10 years in accordance with § 32.1-274 of the Code of Virginia.	**CHANGE:** The Board is proposing the following change: **12VAC5-410-370. Medical records.** * * * E. Provisions shall be made for the safe storage of medical records ~~or~~ and the accurate and legible reproductions ~~thereof~~ of medical records according to § 32.1-127.1:03 of the Code of Virginia and the Health Insurance Portability and Accountability Act~~, or HIPAA~~ (~~42 USC § 1320d et seq.)~~ (Pub. L. No. 104-191). F. All medical records either original or accurate reproductions shall be preserved for a minimum of five years following discharge of the patient. 1. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years. 2. Birth and death information shall be retained for 10 years in accordance with § 32.1-274 of the Code of Virginia. 3. Record of abortions and proper information for the issuance of a fetal death certificate shall be furnished the Office of Vital Records, Virginia Department of Health, as required by law. G. A general hospital that makes health records, as defined in § 32.1-127.1:03 of the Code of Virginia, of patients who are minors available to patients through a secure website shall make the health records available to the patient's parent or guardian through the secure website, unless the general hospital cannot make the health record available: 1. In a manner that prevents disclosure of information, the disclosure of which has been denied pursuant to subsection F of § 32.1-127.1:03 of the Code of Virginia; or

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

		in a manner that minimizes the risk of cross infection and accidental contamination.	D. Nursing personnel shall be assigned to patient care units in a manner that minimizes the risk of cross infection and accidental contamination. E. Each hospital shall quarterly report to the department no later than 30 calendar days after January 1st, April 1st, July 1st, and October 1st: 1. The total number of certified sexual assault nurse examiners employed by the hospital; and 2. The location, including street address, and contact information for each location at which such certified sexual assault nurse examiner provides services. Each hospital shall report the information required by this subsection to the Office of Family Health Services, Virginia Department of Health. **INTENT:** The intent of the change is to update regulatory references and to describe what hospitals should report, when they should report, and to whom they should report data regarding SANEs they employ. **RATIONALE:** The rationale for the change is that regulatory references should be accurate and the regulations should be in conformity with Chapter 1088 of the 2020 Acts of Assembly. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for hospitals about their reporting responsibilities and what regulations apply to them and improved consistency in the data being reported.
410-442	N/A	**12VAC5-410-442. Obstetric service design and equipment criteria.** A. Renovation or construction of a hospital's obstetric unit shall be consistent with (i) section 2.2-2.9 of Part 2 of the 2018 Guidelines for Design and Construction of Hospitals of the Facility Guidelines Institute pursuant to § 32.1-127.001 of the Code of Virginia and (ii) the	**CHANGE:** The Board is proposing the following change: **12VAC5-410-442. Obstetric service design and equipment criteria.** A. Renovation or construction of a hospital's obstetric unit shall be consistent with (i) section ~~2.2-2.9~~ 2.2-2.10 of Part 2 of the ~~2018~~ Guidelines for Design and Construction of Hospitals, 2022 Edition ~~of the~~ (The Facility Guidelines Institute) ~~pursuant to § 32.1-127.001 of the Code of~~

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

		1. …The responsibilities of the nurse manager shall include~~, but not be limited to~~: * * * K. The policies and procedures for the general level nursery and all higher levels of newborn services shall include, but not be limited to: * * * 3. …The collaboration agreements shall include~~, but not be limited to~~: * * * 17. The management of mothers who utilize breast milk with their newborns. Breast milk shall be collected in aseptic containers, dated, stored under refrigeration and consumed or disposed of within 24-48 hours of collection if the breast milk has not been frozen. This policy pertains to breast milk collected while in the hospital or at home for hospital use. 18. Preparation and use of formula including, but not limited to: * * * L. The additional policies and procedures required for the intermediate level newborn service shall include, but not be limited to: * * * M. The additional policies and procedures required for the specialty level newborn service shall include, but not be limited to: * * * N. The additional policies and procedures required for the	* * * K. The policies and procedures for the general level nursery and all higher levels of newborn services shall include~~, but not be limited to~~: * * * 3. …The collaboration agreements shall include~~, but not be limited to~~: * * * 17. The management of mothers who utilize breast milk with their newborns. Breast milk shall be collected in aseptic containers, dated, stored under refrigeration and consumed or disposed of within ~~24-48~~ 96 hours of collection if the breast milk has not been frozen. This policy pertains to breast milk collected while in the hospital or at home for hospital use. 18. Preparation and use of formula including~~, but not limited to~~: * * * L. The additional policies and procedures required for the intermediate level newborn service shall include~~, but not be limited to~~: * * * M. The additional policies and procedures required for the specialty level newborn service shall include~~, but not be limited to~~: * * * N. The additional policies and procedures required for the subspecialty level newborn service shall include~~, but not be limited to~~: * * * **INTENT:** The intent of the change is to update breast milk storage requirements to match current recommendations from the CDC and to update the regulatory text to match the style guidelines. **RATIONALE:** The rationale for the change is that regulation should reference

		subspecialty level newborn service shall include, but not be limited to: * * *	current clinical practices as recommended by subject matter experts and that the style guidelines ensure more intelligible regulatory text. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for general hospitals regarding breast milk storage.
410-445	N/A	**12VAC5-410-445. Newborn service design and equipment criteria.** A. Construction or renovation of a hospital's nursery shall be consistent with (i) section 2.2-2.10 of Part 2 of the 2018 Guidelines for Design and Construction of Hospitals of the Facility Guidelines Institute pursuant to § 32.1-127.001 of the Code of Virginia and (ii) the Virginia Uniform Statewide Building Code (13VAC5-63). Hospitals with higher-level nurseries shall comply with section 2.2-2.8 of Part 2 of the 2018 edition of the guidelines as applicable. * * *	**CHANGE:** The Board is proposing the following change: **12VAC5-410-445. Newborn service design and equipment criteria.** A. Construction or renovation of a hospital's nursery shall be consistent with (i) section ~~2.2-2.10~~ 2.2-2.11 of Part 2 of the ~~2018~~ Guidelines for Design and Construction of Hospitals, 2022 Edition ~~of the~~ (The Facility Guidelines Institute) ~~pursuant to § 32.1-127.001 of the Code of Virginia~~ and (ii) the Virginia Uniform Statewide Building Code (13VAC5-63). Hospitals with higher-level nurseries shall comply with section ~~2.2-2.8~~ 2.2-2.9 of Part 2 of the ~~2018~~ 2022 edition of the guidelines as applicable. * * * **INTENT:** The intent of the change is to update the design and construction guidelines to the recently published 2022 edition. **RATIONALE:** The rationale for the change is that the regulation should be in conformity with the mandates in Chapters 177 and 222 of the 2005 Acts of Assembly. **LIKELY IMPACT:** The likely impact of the change is reduced confusion about which edition of the FGI guidelines general hospitals should reference.
410-447	N/A	**12VAC5-410-447. Combined obstetric and clean gynecological service; infection control.** A. A hospital may combine obstetric and clean gynecological services…The policies and procedures shall be	**CHANGE:** The Board is proposing the following change: **12VAC5-410-447. Combined obstetric and clean gynecological service; infection control.** A. A hospital may combine obstetric and clean gynecological services…The

		approved by the medical and nursing staff of these services and adopted by the governing body and shall include, but not limited to the following requirements: * * * B. In addition to the infection control requirements specified in 12VAC5-410-490…The policies and procedures shall be adopted by the governing body and shall include, but not be limited to, the following: * * * 2. Written criteria for the isolation or segregation of mothers and newborns, in accordance with Guidelines for Perinatal Care (American Academy of Pediatrics/American College of Obstetricians and Gynecologists) and Control of Communicable Diseases in Man (American Public Health Association) to include at least the following categories: * * * 3. Written policies and procedures for the isolation of patients in accordance with Guidelines for Perinatal Care (AAP/ACOG) and Control of Communicable Diseases in Man (American Public Health Association) including, but not limited to, the following: * * * 7. Techniques of patient care, including handwashing and the	policies and procedures shall be approved by the medical and nursing staff of these services and adopted by the governing body and shall include~~, but not limited to~~ the following requirements: * * * B. In addition to the infection control requirements specified in 12VAC5-410-490…The policies and procedures shall be adopted by the governing body and shall include~~, but not be limited to, the following~~: * * * 2. Written criteria for the isolation or segregation of mothers and newborns, in accordance with Guidelines for Perinatal Care, 8th Edition, 2017, (American Academy of Pediatrics/American College of Obstetricians and Gynecologists) and Control of Communicable Diseases ~~in Man~~ Manual, 21st Edition, 2022 (American Public Health Association) to include ~~at least the following categories~~: * * * 3. Written policies and procedures for the isolation of patients in accordance with Guidelines for Perinatal Care, 8th Edition, 2017 ~~(AAP/ACOG)~~ (American Academy of Pediatrics/American College of Obstetricians and Gynecologists) and Control of Communicable Diseases ~~in Man~~ Manual, 21st Edition, 2022 (American Public Health Association) including~~, but not limited to,~~ the following: * * * 7. Techniques of patient care, including handwashing and the use of protective clothing such as gowns, masks, and gloves; and 8. Infection control in the nursery, including ~~but not limited to~~: * * * **INTENT:** The intent of the change to update the regulatory text to match the

		use of protective clothing such as gowns, masks, and gloves; and * * *	style guidelines and to cite the current editions of the relevant clinical texts. **RATIONALE:** The rationale for the change is that the style guidelines ensure more intelligible regulatory text, that the regulation should be in conformity with the Virginia Code Commission's regulation on documents incorporated by reference, and that general hospitals should be relying on current clinical texts about infection prevention and control. **LIKELY IMPACT:** The likely impact of the change is general hospitals being able to utilize current clinical texts about infection prevention and control while remaining in compliance with the applicable regulations.
N/A	410-465	None	**CHANGE:** The Board is proposing the following change: **<u>12VAC5-410-465. Long-term care nursing services.</u>** <u>A. The provisions of this section shall apply to a general hospital's long-term care nursing unit if that unit is a certified nursing facility. The general hospital shall be responsible for ensuring its long-term care nursing unit meets the requirements of this section.</u> <u>B. For the purposes of this section, "resident" means any person admitted to a general hospital's long-term care nursing unit.</u> <u>C. A long-term care nursing unit shall fully disclose to the applicant for admission the unit's admissions policies, including any preferences given.</u> <u>D. A long-term care nursing unit shall train, or arrange for training of, all employees who work in the long-term care unit and who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 of the Code of Virginia on such reporting procedures and the consequences for failing to make a required report.</u> <u>E. A long-term care nursing unit shall register with the Department of State Police to receive notice of the registration, reregistration, or verification of</u>

			registration information of any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 of the Code of Virginia within the same or a contiguous zip code area in which the long-term care nursing unit is located, pursuant to § 9.1-914 of the Code of Virginia. F. If a long-term care nursing unit anticipates a potential resident will have a length of stay greater than three days or in fact stays longer than three days, the long-term care nursing unit shall ascertain, prior to admission, whether the potential resident is required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 of the Code of Virginia. G. Upon the request of the unit's family council, a long-term care nursing unit shall send notices and information about the family council mutually developed by the family council and the administration of the unit, and provided to the unit for such purpose, to the listed responsible party or a contact person of the resident's choice up to six times per year. 1. Such notices may be included together with a monthly billing statement or other regular communication. 2. Notices and information shall also be posted in a designated location within the unit. 3. No family member of a resident or other resident representative shall be restricted from participating in meetings in the unit with the families or resident representatives of other residents in the unit. H. A general hospital shall maintain for its long-term care unit liability insurance coverage in a minimum amount of $1 million, and professional liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15 of the Code of Virginia, to compensate residents or individuals for

			injuries and losses resulting from the negligent or criminal acts of the unit. I. During a public health emergency related to COVID-19, a long-term care unit shall establish a protocol to allow each resident to receive visits, consistent with guidance from the CDC and as directed by CMS and the board, which shall include: 1.Provisions describing: a. The conditions, including conditions related to the presence of COVID-19 in the long-term care nursing unit and community, under which in-person visits will be allowed and under which in-person visits will not be allowed and visits will be required to be virtual; b. The requirements with which in-person visitors will be required to comply to protect the health and safety of the residents and staff of the long-term care nursing unit; c. The types of technology, including interactive audio or video technology, and the staff support necessary to ensure visits are provided as required by this subsection; and d. The steps the long-term care unit will take in the event of a technology failure, service interruption, or documented emergency that prevents visits from occurring as required by this subsection; 2. A statement of the frequency with which visits, including virtual and in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each resident; 3. A provision authorizing a resident or the resident's

			personal representative to waive or limit visitation, provided that such waiver or limitation is included in the resident's health record; and 4. A requirement that the general hospital publish on its website or communicate to each resident or the resident's authorized representative, in writing or via electronic means, the long-term care unit's plan for providing visits to residents as required by this subsection. J. Unless the vaccination is medically contraindicated or the resident declines the offer of vaccination, a general hospital shall provide, or arrange for, the administration to the residents of an annual influenza vaccination and a pneumococcal vaccination in accordance with the following recommendations of ACIP: 1. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2022–23 Influenza Season, MMWR 71 (1), 2022, CDC; 2. Use of 15-Valent Pneumococcal Conjugate Vaccine and 20-Valent Pneumococcal Conjugate Vaccine Among U.S. Adults: Updated Recommendations of ACIP — United States, MMWR 71 (4), 2022, CDC; 3. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Adults Aged >65 Years: Updated Recommendations of ACIP, MMWR 68 (46), 2019, CDC; 4. Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of ACIP, MMWR 64 (15), 2015, CDC;

			5. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Adults Aged >65 Years: Recommendations of ACIP, MMWR 63 (37), 2014, CDC; 6. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Children Aged 6–18 Years with Immunocompromising Conditions: Recommendations of ACIP, MMWR 62 (25), 2013, CDC; 7. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine for Adults with Immunocompromising Conditions: Recommendations of ACIP, MMWR 61 (40), 2012, CDC; 8. Prevention of Pneumococcal Disease Among Infants and Children — Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine: Recommendations of ACIP, MMWR 59 (RR-11), 2010, CDC; and 9. Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23), MMWR 59 (34), 2010, CDC. **INTENT:** The intent of the change is to update the general hospital requirements with the minimum requirements required by Virginia law for those general hospitals operating a long-term care nursing unit that is a certified nursing facility.

			RATIONALE: The rationale for the change is that the regulation should be in conformity with Va. Code § 32.1-127. **LIKELY IMPACT:** The likely impact of the change is increased or new awareness by general hospitals that their long-term care nursing units that are certified nursing facilities have state-specific requirements they must meet.
410-650	N/A	**12VAC5-410-650. General building and physical plant information.** A. All construction of new buildings and additions, renovations, alterations or repairs of existing buildings for occupancy as a hospital shall conform to state and local codes, zoning ordinances, and the Virginia Uniform Statewide Building Code (13VAC5-63). In addition, hospitals shall be designed and constructed consistent with Part 1 and Part 2 of the 2018 Guidelines for Design and Construction of Hospitals of the Facility Guidelines Institute pursuant to § 32.1-127.001 of the Code of Virginia. B. Architectural drawings and specifications for all new construction or for additions, alterations, or renovations to any existing building shall be dated, stamped with professional seal, and signed by the architect. The architect shall certify that the drawings and specifications were prepared to conform to the Virginia Uniform Statewide Building Code (13VAC5-63) and be consistent with Part 1 and Part 2 of the 2018 Guidelines for Design and Construction of Hospitals of the Facility Guidelines Institute.	**CHANGE:** The Board is proposing the following change: **12VAC5-410-650. General building and physical plant information.** A. All construction of new buildings and additions, renovations, or alterations ~~or repairs~~ of existing buildings for occupancy as a hospital shall conform to state and local codes, zoning ordinances, and the Virginia Uniform Statewide Building Code (13VAC5-63). In addition, hospitals shall be designed and constructed consistent with Part 1 and Part 2 of the ~~2018~~ Guidelines for Design and Construction of Hospitals, 2022 Edition ~~of the~~ (The Facility Guidelines Institute), as amended by the November 2022 Errata for Guidelines for Design and Construction of Hospitals, 2022 Edition (The Facility Guidelines Institute), and if applicable, Chapter 2.8 of Part 2 of the Guidelines for Design and Construction of Outpatient Facilities, 2022 Edition (The Facility Guidelines Institute), as amended by the November 2022 Errata for Guidelines for Design and Construction of Outpatient Facilities, 2022 Edition (The Facility Guidelines Institute) ~~pursuant to § 32.1-127.001 of the Code of Virginia~~. B. Architectural drawings and specifications for all new construction or for additions, alterations, or renovations to any existing building shall be dated, stamped with professional seal, and signed by the architect. The architect shall certify that the drawings and specifications were prepared to conform to the Virginia Uniform Statewide Building Code (13VAC5-63) and be consistent with Part 1 and Part 2 of the ~~2018~~

			Guidelines for Design and Construction of Hospitals, 2022 Edition ~~of the~~ (The Facility Guidelines Institute), as amended by the November 2022 Errata for Guidelines for Design and Construction of Hospitals, 2022 Edition (The Facility Guidelines Institute), and if applicable, Chapter 2.8 of the Guidelines for Design and Construction of Outpatient Facilities, 2022 Edition (The Facility Guidelines Institute), as amended by the November 2022 Errata for Guidelines for Design and Construction of Outpatient Facilities, 2022 Edition (The Facility Guidelines Institute). **INTENT:** The intent of the change is to update the design and construction guidelines to the recently published 2022 editions, including the move of provisions related to freestanding emergency departments from the hospital guidelines to the outpatient facility guidelines. **RATIONALE:** The rationale for the change is that the regulation should be in conformity with the mandates in Chapters 177 and 222 of the 2005 Acts of Assembly. **LIKELY IMPACT:** The likely impact of the change is reduced confusion about which editions of the FGI guidelines general hospitals should reference.
410-760	N/A	**12VAC5-410-760. Long-term care nursing units.** Construction and renovation of long-term care nursing units, including intermediate and skilled nursing care nursing units, shall be designed and constructed consistent with section ~~2.2-2.13~~ of Part 2 of the ~~2018~~ Guidelines for Design and Construction of Hospitals ~~of the~~ Facility Guidelines Institute ~~pursuant to § 32.1-127.001 of the Code of Virginia~~. …The architect shall certify that the drawings and specifications were prepared to conform to the Virginia Uniform Statewide Building Code	**CHANGE:** The Board is proposing the following change: **12VAC5-410-760. Long-term care nursing units.** Construction and renovation of long-term care nursing units, including intermediate and skilled nursing care nursing units, shall be designed and constructed consistent with section ~~2.2-2.13~~ 2.2-2.15 of Part 2 of the ~~2018~~ Guidelines for Design and Construction of Hospitals, 2022 Edition ~~of the~~ (The Facility Guidelines Institute) ~~pursuant to § 32.1-127.001 of the Code of Virginia~~. …The architect shall certify that the drawings and specifications were prepared to conform to the Virginia Uniform Statewide Building Code

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

		D. If the Governor has declared a public health emergency related to the novel coronavirus (COVID-19), each outpatient surgical hospital shall allow a person with a disability who requires assistance as a result of such disability to be accompanied by a designated support person at any time during which health care services are provided. 1. A designated support person shall not be subject to any restrictions on visitation adopted by such outpatient surgical hospital. However, such designated support person may be required to comply with all reasonable requirements of the outpatient surgical hospital adopted to protect the health and safety of patients and staff of the outpatient surgical hospital. 2. Every outpatient surgical hospital shall establish policies applicable to designated support persons and shall: a. Make such policies available to the public on a website maintained by the outpatient surgical hospital; and b. Provide such policies, in writing, to the patient at such time as health care services are provided. E. Each outpatient surgical hospital shall obtain a criminal history record check pursuant to	~~D. If the Governor has declared a public health emergency related to the novel coronavirus (COVID-19), each outpatient surgical hospital shall allow a person with a disability who requires assistance as a result of such disability to be accompanied by a designated support person at any time during which health care services are provided.~~ ~~1. A designated support person shall not be subject to any restrictions on visitation adopted by such outpatient surgical hospital. However, such designated support person may be required to comply with all reasonable requirements of the outpatient surgical hospital adopted to protect the health and safety of patients and staff of the outpatient surgical hospital.~~ ~~2. Every outpatient surgical hospital shall establish policies applicable to designated support persons and shall:~~ ~~a. Make such policies available to the public on a website maintained by the outpatient surgical hospital; and~~ ~~b. Provide such policies, in writing, to the patient at such time as health care services are provided.~~ ~~E.~~ D. Each outpatient surgical hospital shall obtain a criminal history record check pursuant to § 32.1-126.02 of the Code of Virginia on any compensated employee not licensed by the Board of Pharmacy whose job duties provide access to controlled substances within the outpatient surgical hospital pharmacy. **INTENT:** The intent of the change is to update the Part's name to match Part II and not be confused with Part V, to use a more relevant basis for patient rights protocols, and to create a new section of regulation that separately addresses designated support persons.

		§ 32.1-126.02 of the Code of Virginia on any compensated employee not licensed by the Board of Pharmacy whose job duties provide access to controlled substances within the outpatient surgical hospital pharmacy.	**RATIONALE:** The rationale for the change is that the current Part name gives the incorrect impression it addresses design and construction standards when it does not, that a document from 2000 is an out-of-date basis for patient rights, that over 95% of outpatient surgical hospitals in Virginia are already complying with 42 C.F.R. § 416.50 as a condition for coverage participation in Medicare, and that designated support persons is a topics requiring significantly more detail that, if it were to continue to be addressed in the present section of regulation, would make the section more difficult to read. **LIKELY IMPACT:** The likely impact of the change is improved readability of this regulatory section and improved ease in locating provisions addressing designated support persons and design and constructions for outpatient surgical hospitals.
410-1170(D)	410-1171	See row above about proposed changes to 410-1170	**CHANGE:** The Board is proposing the following change: **12VAC5-410-1171. Persons with a disability; designated support person in outpatient surgical hospital.** A. For the purposes of this section, "admission" means accepting a person for observation. B. An outpatient surgical hospital shall allow a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a DSP who will provide support and assistance necessary due to the specifics of the person's disability to the person with a disability during an admission. 1. In any case in which the duration of the admission lasts more than 24 hours, the person with a disability may designate more than one DSP. 2. No outpatient surgical hospital shall be required to allow more than one DSP to be present with a person with a disability at any time.

			C. An outpatient surgical hospital may: 1. Not subject a DSP to any restrictions on visitation; 2. Require a DSP to comply with all reasonable requirements of an outpatient surgical hospital adopted to protect the health and safety of the person with a disability; the DSP; the staff and other patients of, or visitors to, an outpatient surgical hospital; and the public; and 3. Restrict a DSP's access to specified areas of and movement on the premises of an outpatient surgical hospital when such restrictions are determined by an outpatient surgical hospital to be reasonably necessary to protect the health and safety of the person with a disability; the DSP; the staff and other patients of, or visitors to, an outpatient surgical hospital; and the public. D. An outpatient surgical hospital may request that a person with a disability provide documentation indicating that he is a person with a disability. 1. If the person with a disability fails, refuses, or is unable to provide documentation requested pursuant to subsection D of this section, an outpatient surgical hospital may perform an objective assessment of the person to determine whether he is a person with a disability. 2. If an outpatient surgical hospital fails to perform an objective assessment pursuant to subdivision D 1 of this section, an outpatient surgical hospital may not prohibit a DSP from accompanying a person with a disability for the purpose of providing support and assistance necessary due to the specifics of the person's disability. E. An outpatient surgical hospital shall

			1. Establish protocols to inform patients, at the time of admission, of the right of a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a DSP for the purpose of providing support and assistance necessary due to the specifics of the person's disability; 2. Develop and make available to a patient or his guardian, authorized representative, or care provider upon request written information regarding the right of a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a DSP and any policies related to that right; and 3. Make the written information described in subdivision E 2 of this section available to the public on its website. G. This section may not: 1. Alter the obligation of an outpatient surgical hospital to provide patients with effective communication support or other required services, regardless of the presence of a DSP or other reasonable accommodation, consistent with applicable federal or state law or regulations; and 2. Be interpreted to: a. Prevent an outpatient surgical hospital from complying, or interfere with the ability of an outpatient surgical hospital to comply, with or cause an outpatient surgical hospital to violate any federal or state law or regulation; b. Deem a DSP to be acting under the direction or control of an outpatient surgical hospital or as an agent of an

			outpatient surgical hospital; or c. Require an outpatient surgical hospital to allow a DSP to perform any action or provide any support or assistance necessary due to the specifics of the person's disability when an outpatient surgical hospital reasonably determines that the performance of the action or provision would be: (1) Medically or therapeutically contraindicated; or (2) Would pose a threat to the health and safety of the person with a disability, the DSP, or the staff or other patients of, or visitors to, an outpatient surgical hospital. **INTENT:** The intent of the change is to describe the minimum requirements for access to designated support persons by persons with disabilities in outpatient surgical hospitals. **RATIONALE:** The rationale for the change is that the regulation should be in conformity with Chapter 220 of the 2021 Acts of Assembly, Special Session I. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for outpatient surgical hospitals about what the minimum requirements for designated support persons are outside of a Governor-declared public health emergency related to COVID-19.
410-1175	N/A	**12VAC5-410-1175. Discharge planning.** A. Every hospital shall provide each patient admitted as an inpatient or his legal guardian the opportunity to designate an individual who will care for or assist the patient in his residence following discharge from the hospital and to whom the hospital	**CHANGE:** The Board is proposing to repeal this section. **INTENT:** The intent of the change is to remove provisions about discharge planning in an inpatient setting from the provisions about outpatient surgical hospitals. **RATIONALE:** The rationale for the change is that these discharge planning

		shall provide information regarding the patient's discharge plan and any follow-up care, treatment, and services that the patient may require. B. Every hospital upon admission shall record in the patient's medical record: 1. The name of the individual designated by the patient; 2. The relationship between the patient and the person; and 3. The person's telephone number and address. C. If the patient fails or refuses to designate an individual to receive information regarding his discharge plan and any follow-up care, treatment, and services, the hospital shall record the patient's failure or refusal in the patient's medical record. D. A patient may change the designated individual at any time prior to the patient's release, and the hospital shall record the changes, including the information referenced in subsection B of this section, in the patient's medical record within 24 hours of such a change. E. Prior to discharging a patient who has designated an individual pursuant to subsection A or D of this section, the hospital shall (i) notify the designated individual of the patient's discharge, (ii) provide the designated individual with a copy of the patient's discharge plan and instructions and information regarding any follow-up care, treatment, or services that the designated individual will provide, and (iii) consult with the designated individual regarding the designated individual's ability to provide the care, treatment, or	provisions were inadvertently placed in the wrong Part of this regulation and should be moved to the Part for general hospitals. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for hospitals and improved ease of locating the discharge planning requirements.

		services. Such discharge plan shall include: 1. The name and contact information of the designated individual; 2. A description of follow-up care, treatment, and services that the patient requires; and 3. Information, including contact information, about any health care, long-term care, or other community-based services and supports necessary for the implementation of the patient's discharge plan. A copy of the discharge plan and any instructions or information provided to the designated individual shall be included in the patient's medical record. F. The hospital shall provide each individual designated pursuant to subsection A or D of this section the opportunity for a demonstration of specific follow-up care tasks that the designated individual will provide to the patient in accordance with the patient's discharge plan prior to the patient's discharge, including opportunity for the designated individual to ask questions regarding the performance of follow-up care tasks. Such opportunity shall be provided in a culturally competent manner and in the designated individual's native language.	
N/A	410-1178	None	**CHANGE:** The Board is proposing the following change: **12VAC5-410-1178. Financial assistance in outpatient surgical hospitals.** A. As used in this section, "patient" and "uninsured patient" have the same meanings as ascribed to these terms in

			subsection A of § 32.1-137.010 of the Code of Virginia. B. An outpatient surgical hospital shall make reasonable efforts to screen every uninsured patient to determine whether the individual is eligible for medical assistance pursuant to the state plan for medical assistance or for financial assistance under the outpatient surgical hospital's financial assistance policy. C. An outpatient surgical hospital shall inform every uninsured patient who receives services at the outpatient surgical hospital and who is determined to be eligible for assistance under the outpatient surgical hospital's financial assistance policy of the option to enter into a payment plan with the outpatient surgical hospital. 1. A payment plan entered into pursuant to this subsection shall be provided to the patient in writing or electronically and shall provide for repayment of the cumulative amount owed to the outpatient surgical hospital. 2. The amount of monthly payments and the term of the payment plan shall be determined based upon the patient's ability to pay. 3. Any interest on amounts owed pursuant to the payment plan shall not exceed the maximum judgment rate of interest pursuant to § 6.2-302 of the Code of Virginia. 4. The outpatient surgical hospital may not charge any fees related to the payment plan. 5. The payment plan shall allow prepayment of amounts owed without penalty. D. An outpatient surgical hospital shall develop a process by which either an uninsured patient who agrees to a payment plan pursuant to subsection C of this section or the outpatient surgical hospital may request and shall be granted the opportunity to renegotiate the payment plan.

			1. Renegotiation shall include opportunity for a new screening in accordance with subsection B of this section. 2. An outpatient surgical hospital may not charge any fees for renegotiation of a payment plan pursuant to this subsection. E. An outpatient surgical hospital shall provide written information about: 1. Its charity care policies, including: a. Policies related to free and discounted care; b. Specific eligibility criteria for charity care; and c. Procedures for applying for charity care; 2. The availability of a payment plan for the payment of debt owed to the outpatient surgical hospital pursuant to subsection C of this section; and 3. The renegotiation process described in subsection D of this section. F. To provide the information required by subsection F of this section, an outpatient hospital shall: 1. Post the information conspicuously in public areas of the outpatient surgical hospital, including admissions or registration areas and associated waiting rooms; 2. Make the information available to: a. A patient at the time of admission or discharge, or at the time services are provided; and b. Persons with limited English proficiency in accordance with the U.S. Department of Health and Human Services' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin

			Discrimination Affecting Limited English Proficient Persons (August 8, 2003, 68 FR 47311), if the outpatient surgical hospital is subject to the requirements of Title VI of the Civil Rights Act of 1964 (Pub. L. No. 88-352), as amended; and 3. Include the information: a. With any billing statements sent to uninsured patients; and b. On any website maintained by the outpatient surgical hospital. G. Notwithstanding any other provision of law, an outpatient surgical hospital may not engage in any action described in § 501(r)(6) of the Internal Revenue Code, as it was in effect on January 1, 2020, to recover a debt for medical services against any patient unless the outpatient surgical hospital has made all reasonable efforts to determine whether the patient: 1. Qualifies for medical assistance pursuant to the state plan for medical assistance; or 2. Is eligible for financial assistance under the outpatient surgical hospital's financial assistance policy. H. Nothing in this section shall be construed to: 1. Prohibit an outpatient surgical hospital, as part of its financial assistance policy, from requiring a patient to: a. Provide necessary information needed to determine eligibility for financial assistance under the outpatient surgical hospital's financial assistance policy, medical assistance pursuant to Title XVIII or XIX of the Social Security Act (42 U.S.C. § 301 et seq.) or 10 U.S.C. § 1071

			et seq., or other programs of insurance; or b. Undertake good faith efforts to apply for and enroll in the programs of insurance for which the patient may be eligible as a condition of awarding financial assistance; 2. Require an outpatient surgical hospital to grant or continue to grant any financial assistance or payment plan pursuant to this section when: a. A patient has provided false, inaccurate, or incomplete information required for determining eligibility for the outpatient surgical hospital's financial assistance policy; or b. A patient has not undertaken good faith efforts to comply with any payment plan pursuant to this section; or 3. Prohibit the coordination of benefits as required by state or federal law. **INTENT:** The intent of the change is to describe the minimum requirements for information disclosure about financial assistance, for payment plans, and for renegotiation of payment plans. **RATIONALE:** The rationale for the change is that the regulation should conform to Chapters 678 and 679 of the 2022 Acts of Assembly. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for outpatient surgical hospitals about the minimum requirements for providing information about financial assistance and providing financial assistance to patients.

410-1190	N/A	**12VAC5-410-1190. Nursing staff.** The total number of nursing personnel will vary depending upon the number and types of patients to be admitted and the types of operative procedures to be performed or the services programmed. * * *	**CHANGE:** The Board is proposing the following change: **12VAC5-410-1190. Nursing staff.** A. The total number of nursing personnel will vary depending upon the number and types of patients to be admitted and the types of operative procedures to be performed or the services programmed. * * * B. Each outpatient surgical hospital shall quarterly report to the department no later than 30 calendar days after January 1st, April 1st, July 1st, and October 1st: 1. The total number of certified sexual assault nurse examiners employed by the outpatient surgical hospital; and 2. The location, including street address, and contact information for each location at which such certified sexual assault nurse examiner provides services. Each outpatient surgical hospital shall report the information required by this subsection to the Office of Family Health Services, Virginia Department of Health. **INTENT:** The intent of the change is to describe what hospitals should report, when they should report, and to whom they should report data regarding SANEs they employ. **RATIONALE:** The rationale for the change is that the regulation should be in conformity with Chapter 1088 of the 2020 Acts of Assembly. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for hospitals about their reporting responsibilities and improved consistency about the data being reported.
410-1260	N/A	**12VAC5-410-1260. Medical records.** A. Medical records. An accurate and complete clinical record or chart shall be maintained on each patient. The	**CHANGE:** The Board is proposing the following change: **12VAC5-410-1260. Medical records.** A. ~~Medical records.~~ An accurate and complete clinical record or chart shall be

		record or chart shall contain sufficient information to satisfy the diagnosis or need for the medical or surgical service. It shall include, when applicable, but not be limited to the following: * * * 4. Confirmation of pregnancy, if applicable; * * * 13. Patient instructions, preoperative and postoperative; * * * B. Provisions shall be made for the safe storage of medical records or accurate and legible reproductions thereof according to § 32.1-127.1:03 of the Code of Virginia and the Health Insurance Portability and Accountability Act, or HIPAA (42 USC § 1320d et seq.). C. All medical records, either original or accurate reproductions, shall be preserved for a minimum of five years following discharge of the patient. * * * 3. Record of abortions and proper information for the issuance of a fetal death certificate shall be furnished the Division of Vital Records, Virginia Department of Health, within 10 days after the abortion.	maintained on each patient. The record or chart shall contain sufficient information to satisfy the diagnosis or need for the medical or surgical service. It shall include, when applicable, ~~but not be limited to~~ the following: * * * 4. Confirmation of pregnancy~~, if applicable~~; * * * 13. Patient instructions, preoperative and postoperative; and * * * B. Provisions shall be made for the safe storage of medical records ~~or~~ and the accurate and legible reproductions ~~thereof~~ of medical records according to § 32.1-127.1:03 of the Code of Virginia and the Health Insurance Portability and Accountability Act~~, or HIPAA~~ (~~42 USC § 1320d et seq.)~~ (Pub. L. No. 104-191). C. All medical records, either original or accurate reproductions, shall be preserved for a minimum of five years following discharge of the patient. * * * 3. Record of abortions and proper information for the issuance of a fetal death certificate shall be furnished to the ~~Division~~ Office of Vital Records, Virginia Department of Health, ~~within 10 days after the abortion~~ as required by law. D. An outpatient surgical hospital that makes health records, as defined in § 32.1-127.1:03 of the Code of Virginia, of patients who are minors available to patients through a secure website shall make the health records available to the patient's parent or guardian through the secure website, unless the hospital cannot make the health record available: 1. In a manner that prevents disclosure of information, the disclosure of which has been denied pursuant to subsection F of § 32.1-127.1:03 of the Code of Virginia; or

			<u>2. Because the consent required in accordance with subsection E of § 54.1-2969 of the Code of Virginia has not been provided.</u> **INTENT:** The intent of the change is to correct an erroneous statutory citation, to update the name of a business unit within VDH, to require that hospitals are capable of both safe storage and accurate reproduction of medical records, to update the regulatory text to match the style guidelines, and to describe minimum standards for giving parent's or guardian's electronic access to their minor's medical records. **RATIONALE:** The rationale for the change is that statutory references should be accurate, that VDH business units should be referred to by their current names, that hospitals should not have the discretion to choose between whether to provide safe storage or accurate reproduction of medical records, that the style guidelines ensure more intelligible regulatory text, and that the regulation should be in conformity with Chapter 218 of the 2022 Acts of Assembly. **LIKELY IMPACT:** The likely impact of the change is reduced confusion for general hospitals regarding parental/guardian electronic access to a minor patient's medical records.
410-1350	N/A	**12VAC5-410-1350. Local and state codes and standards.** A. All construction of new buildings and additions, alterations, or repairs to existing buildings for occupancy as a "free-standing" outpatient hospital shall conform to state and local codes, zoning ordinances, and the Virginia Uniform Statewide Building Code (13VAC5-63). In addition, hospitals shall be designed and constructed consistent with Part 1 and sections 2.1 and 2.7 of Part 2 of the 2018 Guidelines for Design and Construction of Outpatient	**CHANGE:** The Board is proposing the following change: **12VAC5-410-1350. Local and state codes and standards.** A. All construction of new buildings and additions, <u>renovations, or</u> alterations~~,~~ ~~or repairs~~ to existing buildings for occupancy as a "free-standing" outpatient hospital shall conform to state and local codes, zoning ordinances, and the Virginia Uniform Statewide Building Code (13VAC5-63). In addition, hospitals shall be designed and constructed consistent with Part 1 and ~~sections~~ <u>Chapters</u> 2.1 and 2.7 of Part 2 of the ~~2018~~ Guidelines for Design and Construction of Outpatient

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

		Guidelines for Design and Construction of Outpatient Facilities, 2018 Edition, Facility Guidelines Institute, Washington, D.C., https://fgiguidelines.org	Association, 21st Edition, 2022, https://www.apha.org Errata for Guidelines for Design and Construction of Hospitals, The Facility Guidelines Institute, 2022 Edition, https://fgiguidelines.org/guidelines/errata-addenda/ (eff. 11/2022). Errata for Guidelines for Design and Construction of Outpatient Facilities, The Facility Guidelines Institute, 2022 Edition, https://fgiguidelines.org/guidelines/errata-addenda/ (eff. 11/2022). Guidelines for Design and Construction of Hospitals, ~~2018 Edition,~~ The Facility Guidelines Institute, ~~Washington D.C.~~ 2022 Edition, ~~http://www.fgiguidelines.org~~ https://fgiguidelines.org. Guidelines for Design and Construction of Outpatient Facilities, ~~2018 Edition,~~ The Facility Guidelines Institute, ~~Washington, D.C.~~ 2022 Edition, https://fgiguidelines.org. Guidelines for Perinatal Care, American Academy of Pediatric/American College of Obstetricians and Gynecologists, 8th Edition, 2017, https://www.aap.org and https://www.acog.org. Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of ACIP, MMWR 64 (15), 2015, CDC. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2022–23 Influenza Season, MMWR 71 (1), 2022, CDC. Prevention of Pneumococcal Disease Among Infants and Children — Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine: Recommendations of ACIP, MMWR 59 (RR-11), 2010, CDC. Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23), MMWR 59 (34), 2010, CDC.

			Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Adults Aged >65 Years: Recommendations of ACIP, MMWR 63 (37), 2014, CDC. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Adults Aged >65 Years: Updated Recommendations of ACIP, MMWR 68 (46), 2019, CDC. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine for Adults with Immunocompromising Conditions: Recommendations of ACIP, MMWR 61 (40), 2012, CDC. Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Children Aged 6–18 Years with Immunocompromising Conditions: Recommendations of ACIP, MMWR 62 (25), 2013, CDC. Use of 15-Valent Pneumococcal Conjugate Vaccine and 20-Valent Pneumococcal Conjugate Vaccine Among U.S. Adults: Updated Recommendations of ACIP — United States, MMWR 71 (4), 2022, CDC. **INTENT:** The intent of these proposed changes is to ensure documents incorporated by reference are current and accurate. **RATIONALE:** The rationale behind these proposed changes is that hospitals should be held to current standards and guidelines. **LIKELY IMPACT:** The likely impact of these proposed changes is improved patient health and safety at hospitals.