

**State of Board of Health
Agenda
March 26, 2020 – 9:00 a.m.
Perimeter Center – Boardroom 2**

Call to Order and Welcome	Faye Prichard, Chair
Pledge of Allegiance	Linda Hines
Introductions	Ms. Prichard
Review of Agenda	Joseph Hilbert Deputy Commissioner for Governmental and Regulatory Affairs
Approval of December 12, 2019 Minutes	Ms. Prichard
Commissioner’s Report	M. Norman Oliver, MD, MA State Health Commissioner
Regulatory Action Update	Mr. Hilbert
Break	
Public Comment Period	
<u>Regulatory Action Items</u>	
Regulations for Licensure of Nursing Facilities 12VAC5-371 (Fast Track Amendments)	Rebekah Allen, JD Senior Policy Analyst Office of Licensure and Certification
Regulations Governing Virginia Newborn Screening Services 12VAC5-71 (Proposed Amendments)	Jennifer MacDonald, MPH, BSN, RN Division Director, Child and Family Health Office of Family Health Services
<u>Action Items</u>	
State EMS Plan	Gary Brown Director Office of Emergency Medical Services
<u>Working Lunch</u>	
Coronavirus Update	Lilian Peake, MD, MPH Director Office of Epidemiology
Legislative Update	Mr. Hilbert

Budget Update

Stephanie Gilliam
Deputy Director for Budget
Office of Financial Management

Break

Impact of Medicaid Expansion on
Population Health and Public Health

Lauryn Walker
Senior Advisor for Health Economics and
Economic Policy
Department of Medical Assistance Services

Policy Research, Analysis and Development Plan

Brenden Rivenbark
Senior Policy Analyst
Office of the Commissioner

Member Reports

Other Business

Adjourn

**State of Board of Health
December 12, 2019 – 9:00 a.m.
Perimeter Center – Boardroom 2**

Members Present: Faye Prichard, Chair; Gary Critzer, Tommy East; James Edmondson; Elizabeth Harrison; Linda Hines, RN; Anna Jeng, ScD; Patricia Kinser, PhD; Wendy Klein, MD; Benita Miller, DDS; Holly Puritz, MD; Jim Shuler, DVM; Stacey Swartz, PharmD; Katherine Waddell; and Mary Margaret Whipple.

VDH Staff Present: Dr. Norm Oliver, State Health Commissioner; Dr. Laurie Forlano, Deputy Commissioner for Population Health; Joe Hilbert, Deputy Commissioner for Governmental and Regulatory Affairs; Mona Bector, Deputy Commissioner for Administration Mylam Ly, Policy Analyst; Dr. Parham Jaber, Chief Deputy Commissioner for Public Health and Preparedness; Alex Jansson, Policy Analyst; Michael Capps, Policy Analyst; Rebekah Allen, Senior Policy Analyst; Aaron Kesecker, the Exercise Coordinator with the Office of Emergency Preparedness; Delilah McFadden, Public Health Emergency Coordinator for the Lenowisco Health District; Kristin Marie Clay, Policy Analyst; Maria Reppas; Director of the Office of Communications

Other Staff: Grant Kronenberg, Assistant Attorney General; Robin Kurz, Senior Assistant Attorney General; Vanessa MacLeod, Assistant Attorney General; Allyson Tysinger, Senior Assistant Attorney General/Chief.

Call to Order and Pledge of Allegiance

Ms. Prichard called the meeting to order at 9:00am. Mr. East led those in attendance in the pledge of allegiance.

Introductions

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

Review of Agenda

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

Approval of September 5, 2019 Minutes

Dr. Klein made the motion to approve the minutes from the September 5, 2019 meeting with Dr. Kinser seconding the motion. The minutes were approved unanimously by voice vote.

Commissioner's Report

Dr. Oliver provided the Commissioner's Report to the Board. He began with the introduction of the "agency stars" for the meeting. Delilah McFadden, Public Health Emergency Coordinator for the Lenowisco Health District, and Aaron Kesecker, the Exercise Coordinator with the Office of Emergency Preparedness.

Dr. Oliver then updated the Board on key issues and projects that VDH is currently involved with, including:

- Population Health Update
- Cardinal Revolve Statewide Emergency Preparedness Exercise
- Centers for Disease Control and Prevention (CDC) Opioid Crisis Response Funding
- Accreditation Update
- Performance Measurement System
- E-cigarette, or Vaping, Product Use-Associated Lung Injuries (EVALI)
- Cooperative Agreement with Ballad Health
- Gun Violence as a Public Health Issue
- VDH Policy Research and Analysis Plan
- Rural Health Plan Update

Dr. Oliver ended his report by informing the Board about recent VDH personnel changes:

- New Staff: Maria Reppas as Director of the Office of Communications; Leslie Hoglund, PhD as State Health Assessment/State Health Improvement Plan Manager; Mona Bector, Deputy Commissioner for Administration;
- Retiring: Dave Crabtree retiring as Business Process Director for Community Health Services (CHS); Steve Sullivan as the incoming CHS Business Process Director; and
- Resignation: Lauren Powell, PhD, MPA resigning as Director of the Office of Health Equity.

Regulatory Action Update

Mr. Hilbert reviewed the summary of all pending VDH regulatory actions. Since the June 2019 meeting the Commissioner has approved no regulatory actions on behalf of the Board while the Board was not in session.

No actions were taken by the Commissioner on behalf of the Board, since September 5, 2019 Board meeting.

Mr. Hilbert advised the Board that there are 18 periodic review in progress:

- Public Participation Guidelines (12VAC5-11)
- Virginia Emergency Medical Services Regulations (12VAC5-66)
- Regulations for the Repacking of Crabmeat (12VAC5-165)
- Regulations Governing Eligibility Standards and Charges for Medical Services to Individuals (12VAC5-200)
- Rules and Regulations Governing Health Data Reporting (12VAC5-215)
- Methodology to Measure Efficiency and Productivity of Health Care Institutions (12VAC5-216)
- Regulations of the Patient Level Data System (12VAC5-217)
- Rules and Regulations Governing Outpatient Data Reporting (12VAC5-218)
- Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations (12VAC5-220)
- Regulations for the Licensure of Nursing Facilities (12VAC5-371)

- Home Care Organizations Regulations (12VAC5-381)
- Regulations for the Submission of Health Maintenance Organization Quality of Care Performance Information (12VAC5-407)
- Certificate of Quality Assurance of Managed Care Health Insurance Plan Licensees (12VAC5-408)
- Regulations for Licensure of Abortion Facilities (12VAC5-412)
- Regulations Governing the Virginia Physician Loan Repayment Program (12VAC5-508)
- Guidelines for Virginia General Assembly Nursing Scholarships (12VAC5-510)
- Regulations for Identification of Medically Underserved Areas in Virginia (12VAC5-540)
- Regulations for Alternative Onsite Sewage Systems (12VAC5-613)

There was a discussion about fast-track comments and the standard process of regulatory changes.

Public Comment Period

Following a short break, Ms. Prichard announced there were no speakers signed up for the Public Comment Period.

Regulations of Licensure of Nursing Facilities (12VAC5-371) - Final Amendments

Ms. Allen presented the final amendments. She told the Board this regulatory action would bring 12VAC5-371 into conformity with the provisions of Va. Code § 32.1-127.001.

Ms. Allen stated the final amendments do the following:

- Specify that nursing facilities shall be designed and constructed consistent with the *Guidelines for Design and Construction of Residential Health, Care, and Support Facilities*
- Removes language which states the Virginia Uniform Statewide Building Code takes precedence over the Guidelines.

Dr. Kinser moved the amendments be approved with Mr. East seconding.

The motion was approved unanimously by voice vote.

Regulations of Licensure of Hospitals (12 VAC5-410) – Fast Track Amendments

Ms. Allen presented on Fast Track Amendments to the Licensure of Hospitals. These amendments will add perinatal anxiety to the list of information hospitals are required to make available to maternity patients, the father of the infant, and other relevant family members or caretakers prior to such patients' release. The existing list of information from that statutory section is not currently included in the hospital regulations and this action is being used to conform to the requirements of Va. Code § 32.1-134.01. This action is also being used to correct a spelling error in 12VAC5-410-441.

Ms. Hines made the motion to approve the fast track amendments to the Regulations of Licensures of Hospitals with Ms. Whipple seconding the motion.

There was a discussion on notification of the father if he was not present.

The motion was approved unanimously by voice vote.

Regulations of Licensure of Hospice (12VAC5-391) - Fast Track Amendments

Ms. Allen presented on Fast Track Amendments for the Licensure of Hospice. These amendments were initiated following a periodic review as required by Va. Code § 2.2-4007.1(D) and Executive Order 14. In response to public comment received on the notice of periodic review, these amendments were initiated.

These amendments will do the following:

- Repeal subsection B of 12VAC5-391-330, which requires hospice medical directors to have admitting privileges at local hospitals and nursing homes.
- Update out-of-date references to Board of Nursing regulations, Department of Health Professions' sections of the Code of Virginia, and the current edition of the Guidelines for Design and Construction of Residential Health, Care, and Support Facilities.
- Update training options for volunteer home attendants in section 380.

Dr. Puritz made the motion to approve the Fast Track Amendments with Mr. Critzer seconding the motion.

The fast track amendments were approved unanimously by voice vote.

Food Regulations (12VAC5-421) – Fast Track Amendments

Ms. Clay presented Fast Track Amendments for the Food Regulations. The Board of Health adopted the current food regulations in 2016; that regulatory action incorporated the provisions of the 2013 Food and Drug Administration (FDA) Food Code. These amendments were initiated to incorporate provisions of the 2017 FDA Food Code.

These amendments will do the following:

- Remove, add, and revise definitions;
- Require the person in charge to be a certified food protection manager;
- Include standards for the use of bandages, finger cots, or finger stalls;
- Require written procedures for the clean-up of vomiting and diarrheal events;
- Require the separation of raw animal foods from fruits and vegetables in certain instances;
- New cooking time for raw animal foods;
- Removal of the Food Service Advisory Committee to reflect changes within the Food and Drug Administration; and
- Clarify enforcement procedures when impounding food.

Dr. Swartz motioned to approve the fast track amendments with Ms. Whipple seconding the motion.

There was a discussion about if farm made products sold on a farm were considered a food establishment and regulations around farmers markets.

The fast track amendments were approved unanimously by voice vote.

The Plan for Well-Being

Dr. Forlano presented an update on the Plan for Well-Being (The Plan). The Plan outlines a path for improving the health and well-being of Virginians through four aims, 13 goals, and 29 measures.

Of the 29 measures, 16 show improvement, when compared to baseline measures, although at different degrees. Of these, four measures (Percent of Adults Who Report Positive Well-Being, Disability-Free Life Expectancy, Percent of High School Graduates Enrolled in an Institution of Higher Learning, and Teen Pregnancy Rates) have exceeded the goal that was originally set forth in The Plan. The remaining 13 measures have evidenced little to no change, or have decreased further away from the intended goal.

Over the next year, a Plan for Well-Being 2.0 will be developed after a State Health Assessment project that began in November.

Member Reports

Dr. Stacy Swartz – *Virginia Pharmacists Association* – No Report.

Ms. Mary Margaret Whipple – *Hospital Industry* – Ms. Whipple reported that the Virginia Hospital and Healthcare Association (VHHA) is pleased to partner with VDH in the Partnership for Healthy Virginia.

Mr. Tommy East – *Nursing Home Industry* – No Report.

Mr. James Edmondson – *Corporate Purchaser of Health Care* – Mr. Edmondson shared that it may be a good idea to have VDH partner around affordable housing to increase access to healthcare.

Ms. Linda Hines – *Managed Care Health Insurance Plan* – Ms. Hines shared that the Medicaid expansion will hopefully help with access to healthcare and that the Governor had asked for a pause on developing the work requirements until after the 2020 General Assembly session.

Dr. James Shuler – *Virginia Veterinary Medical Association* – No report.

Dr. Anna Jeng – *Public Environmental Health* – Dr. Jeng reported that she is pleased with the proactive approach VDH is taking in engaging stakeholders and developing priorities.

Ms. Katherine Waddell – *Consumer* – No Report.

Mr. Gary Critzer – *EMS* – Mr. Critzer reported to the board EMS had its 40th annual symposium in November. He also shared that EMS is actively engaged with VHHA in guide activity around trauma systems.

Ms. Elizabeth Harrison – *Consumer* – No Report.

Dr. Patricia Kinser – *Virginia Nurses Association* – Dr. Kinser shared that she is happy that maternal mortality is a priority and the activity around the Maternal Mortality Review Team.

Dr. Wendy Klein – *Medical Society of Virginia* – Dr. Klein shared that she would like to see a speaker about the impact of Medicaid expansion in the next year.

DRAFT NOT APPROVED

Dr. Benita Miller – *Virginia Dental Association* – Dr. Miller shared that the Dental Association is watching the tele-dentistry bills for the General Assembly and is supportive of the vaccination portion, particularly around HPV, in the Plan for Well-Being.

Dr. Holly Puritz – *Medical Society of Virginia* – Dr. Puritz reported that the American College of Obstetrics and Gynecologists is supportive of an expansion of Expedited Partner Therapy. She also suggested that maternal health should start before pregnancy and that the Medicaid expansion is helpful once a woman is pregnant.

Other Business

There was no other business discussed.

Adjourn

Meeting adjourned at 12:43pm.



COMMONWEALTH of VIRGINIA

Department of Health

P O BOX 2448

RICHMOND, VA 23218

M. NORMAN OLIVER, MD, MA
STATE HEALTH COMMISSIONER

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

MEMORANDUM

DATE: February 24, 2020

TO: Virginia State Board of Health

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

SUBJECT: Regulations for the Licensure of Nursing Facilities – Amending Regulation Following Periodic Review

Enclosed for your review are proposed amendments to Regulations for the Licensure of Nursing Facilities (12VAC5-371).

In response to internal review conducted by the Office of Licensure and Certification (OLC) following the publication of a notice of periodic review, the action will add new defined terms, update existing definitions, update the regulatory text for internal consistency with the terms defined in 12VAC5-371-10 and with statutory authority, update out-of-date references to immunization standards and the current edition of the *Guidelines for Design and Construction of Residential Health, Care, and Support Facilities*, and consolidate duplicative reporting requirements. Further, a new section 75 has been added to address the statutorily mandated criminal records checks nursing facilities must perform, which has been modeled after regulatory language already existing for hospices and home care organizations. The action also updates the Documents Incorporated by Reference to reflect updated references in the regulatory text.

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



townhall.virginia.gov

Fast-Track Regulation Agency Background Document

Agency name	Virginia Board of Health
Virginia Administrative Code (VAC) citation(s)	12VAC5-371
Regulation title(s)	Regulations for the Licensure of Nursing Facilities
Action title	Amend Regulation Following Periodic Review
Date this document prepared	February 24, 2020

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1 VAC7-10), and the *Virginia Register Form, Style, and Procedure Manual for Publication of Virginia Regulations*.

Brief Summary

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

The Virginia Board of Health recently concluded a periodic review of 12VAC5-371, in which it decided to amend the regulation. References to outdated vaccination protocols have been updated, as has the associated Documents Incorporated by Reference section, and duplicative requirements were removed. A new section and additional definitions has been added to address the statutorily mandated criminal background checks and the remaining sections have been updated for consistency with the statutes and the defined terms in 12VAC5-371-10.

Acronyms and Definitions

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.

“Agency” means the Virginia Department of Health.

“Board” means the Virginia Board of Health.

“Nursing facility” means any nursing home as defined in § 32.1-123 of the Code of Virginia.

Statement of Final Agency Action

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

Mandate and Impetus

Please 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, board decision, etc.). For purposes of executive branch review, “mandate” has the same meaning as defined in Executive Order 14 (as amended, July 16, 2018), “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.”

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

The Board is mandated by Va. Code § 2.2-4007.1(D) and Executive Order 14 to conduct a periodic review of its regulations. The most recent periodic review and the opinion of subject matter experts within the agency prompted the Board to amend this regulation. The rulemaking is expected to be noncontroversial because it is being utilized to conform to the statutes and existing regulatory definitions, and no new requirements are being developed that did not already exist in statute. Additionally, the agency’s subject matter experts believe that proposed changes would not jeopardize the protection of public health, safety, and welfare. Further, the additional updates to the regulations do not alter the intent of the regulations or the requirements placed on regulated entities.

Legal Basis

Please identify (1) the agency or other promulgating entity, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia or Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency or promulgating entity’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, nursing homes 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, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; (iv) conditions under which a hospital or nursing home 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, nursing homes, and certified nursing facilities.

Purpose

Please 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's intended to solve.

The rationale or justification for this regulatory change is that regulations should be clearly written, up to date, conform to the law, and should be the least burdensome means of protecting the health, safety, and welfare of citizens. The regulatory change is essential to protect the health, safety, and welfare of citizens because unclear regulations hamper licensees' ability to comply, out of date regulations may make reference to standards and practices that are not current, and reducing regulatory burden on nursing facilities allows them to redirect resources to resident care. The goals of this regulatory change are to improve consistency across the sections of this regulatory text, bring the regulatory text into alignment with the statutes; and update references to current medical guidelines.

Substance

Please 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

Added definitions for "barrier crime", "criminal record report", "legal representative", and "sworn disclosure." Removed definitions for "guardian" and "responsible person or party." Revised definition for "facility-managed."

Section 30 License

Added language about the non-applicability of the chapter to certain entities and facilities. Revised text regarding what constitutes an appropriate name and removed text about notifying OLC about name changes. Revised text to more closely align with Section 10's definitions.

Section 40 Licensing process

Revised text to clarify that all nursing facilities must have a COPN prior to receiving a license. Removed text about modifications to the nursing facility that may impact the terms of a license.

Section 60 On-site inspections

Revised text to more closely align with Section 10's definitions.

Section 70 Complaint investigation

Revised text to more closely align with Section 10's definitions.

Section 75 Criminal records check

Created new section to include statutorily mandated criminal records check, including language on how nursing facilities satisfy this requirement when utilizing staff from temporary staffing agencies.

Section 80 Variances

Revised text to reflect the commissioner grants variances and to more closely align with Section 10's definitions.

Section 110 Management and administration

Added language about a nursing facility's requirement to inform the OLC of changes impacting its license. Updated references to documents incorporated by reference. Revised text to more closely align with Section 10's definitions.

Section 120 Governing body

Removed text about notifying OLC about changes impacting a nursing facility license.

Section 130 Administrator

Revised text to more closely align with Section 10's definitions.

Section 140 Policies and procedures

Revised text to more closely align with Section 10's definitions.

Section 150 Resident rights

Revised text to more closely align with Section 10's definitions.

Section 160 Financial controls and resident funds

Revised text to more closely align with Section 10's definitions.

Section 170 Quality assessment and assurance

Revised text to more closely align with Section 10's definitions.

Section 180 Infection control

Revised text to more closely align with Section 10's definitions.

Section 190 Safety and emergency procedures

Revised text to more closely align with Section 10's definitions.

Section 191 Electronic monitoring in resident rooms

Revised text to more closely align with Section 10's definitions.

Section 210 Nurse staffing

Revised text to more closely align with Section 10's definitions.

Section 260 Staff development and inservice training

Revised text to more closely align with Section 10's definitions.

Section 300 Pharmaceutical services

Revised text to more closely align with Section 10's definitions.

Section 330 Restraint usage

Revised text to more closely align with Section 10's definitions.

Section 360 Clinical records

Revised text to more closely align with Section 10's definitions.

Section 380 Laundry services

Revised text to more closely align with Section 10's definitions.

Section 390 Transportation

Revised text to more closely align with Section 10's definitions.

Section 400 Unique design solutions

Repealed this section.

DOCUMENTS INCORPORATED BY REFERENCE (12VAC5-371)

Updated to reflect the changes in the proposed text and to reference the most current edition of each relevant document.

Issues

Please 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 is removal of language that was unclear, inconsistent, or outdated. There are no primary disadvantages to the public. There are no primary advantages to the agency or the Commonwealth. There are no primary disadvantages to the agency or the Commonwealth. There is no other pertinent matters of interest to the regulated community, government officials and the public.

Requirements More Restrictive than Federal

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

There are no requirements in this proposal that exceed applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

Please identify any other state agencies, localities, or other entities particularly affected by the regulatory change. "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.

No other state agency or locality is particularly affected by this proposed regulatory change.

Nursing facilities and nursing facility applicants will be particularly affected by this proposed regulatory change.

Economic Impact

Pursuant to § 2.2-4007.04 of the Code of Virginia, please 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. Please keep in mind that this is change versus the status quo.

Impact on State Agencies

<p><i>For your agency:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including:</p> <ul style="list-style-type: none"> a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources 	<p>There are no projected costs, savings, fees, or revenues resulting from the regulatory change.</p>
<p><i>For other state agencies:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.</p>	<p>There are no projected costs, savings, fees, or revenues resulting from the regulatory change for other state agencies.</p>
<p><i>For all agencies:</i> Benefits the regulatory change is designed to produce.</p>	<p>This regulatory action is designed to promote and ensure the health and safety of nursing facility residents.</p>

Impact on Localities

<p>Projected costs, savings, fees or revenues resulting from the regulatory change.</p>	<p>There are no projected costs, savings, fees or revenues resulting from the regulatory change for localities.</p>
<p>Benefits the regulatory change is designed to produce.</p>	<p>This regulatory action is designed to promote and ensure the health and safety of nursing facility residents.</p>

Impact on Other Entities

<p>Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.</p>	<p>The individuals, businesses, or other entities likely to be affect by the regulatory change include nursing facility residents, persons seeking to become residents at nursing facilities; licensed nursing facilities; and persons or entities seeking licensure to operate a nursing facility.</p>
<p>Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that:</p> <ul style="list-style-type: none"> a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million. 	<p>Nursing facility residents and persons seeking to become residents at nursing facilities will be affected. As of February 1, 2020, 32,341 nursing facility beds are authorized in the Commonwealth.</p> <p>As of February 1, 2020, there are 290 licensed nursing facilities in Virginia, of which 12 are believed to be small businesses.</p>
<p>All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Please be specific and include all costs including, but not limited to:</p> <ul style="list-style-type: none"> a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements. 	<p>There are no projected costs for affected individuals, businesses, or other entities resulting from the regulatory change.</p>

Benefits the regulatory change is designed to produce.	This regulatory action is designed to promote and ensure the health and safety of nursing facility residents.
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Alternatives

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

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

Regulatory Flexibility Analysis

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

No alternatives to the regulatory action were considered because the General Assembly required the Board to adopt regulations governing the licensure of nursing facilities. The regulatory action does not change any standards for small businesses or negatively affect small businesses.

Public Participation

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.

Detail of Changes

Please 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.

If the regulatory change will be a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory change. Delete inapplicable tables.

If the regulatory change is intended to replace an emergency regulation, please follow the instructions in the text following the three chart templates below. Please include citations to the specific section(s) of the regulation that are changing.

For changes to existing regulation(s), please use the following chart:

Current section number	New section number, if applicable	Current requirement	Change, intent, rationale, and likely impact of new requirements
10	N/A	<p style="text-align: center;">CHAPTER 371 REGULATIONS FOR LICENSURE OF NURSING FACILITIES Part I Definitions and General Information 12VAC5-371-10. Definitions. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:</p> <p>"Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, or deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This includes verbal, sexual, physical or mental abuse.</p> <p>"Administrator" means the individual licensed by the Virginia Board of Long-Term Care Administrators and who has the necessary authority and responsibility for management of the nursing facility.</p> <p>"Admission" means the process of acceptance into a nursing facility, including orientation, rules and requirements, and assignment to appropriate staff. Admission does not include readmission to the facility after a temporary absence.</p> <p>"Advance directive" means (i) a witnessed written document, voluntarily executed by the declarant in accordance with the requirements of § 54.1-2983 of</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p style="text-align: center;">CHAPTER 371 REGULATIONS FOR LICENSURE OF NURSING FACILITIES Part I Definitions and General Information 12VAC5-371-10. Definitions. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:</p> <p>"Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, or deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This includes verbal, sexual, physical or mental abuse.</p> <p>"Administrator" means the individual licensed by the Virginia Board of Long-Term Care Administrators and who has the necessary authority and responsibility for management of the nursing facility.</p> <p>"Admission" means the process of acceptance into a nursing facility, including orientation, rules and requirements, and assignment to appropriate staff. Admission does not include readmission to the facility after a temporary absence.</p>

	<p>the Code of Virginia, or (ii) a witnessed oral statement, made by the declarant subsequent to the time he is diagnosed as suffering from a terminal condition and in accordance with the provision of § 54.1-2983 of the Code of Virginia.</p> <p>"Assessment" means the process of evaluating a resident for the purpose of developing a profile on which to base services. Assessment includes information gathering, both initially and on an ongoing basis, designed to assist the multi-disciplinary staff in determining the resident's need for care, and the collection and review of resident-specific data.</p> <p>"Attending physician" means a physician currently licensed by the Virginia Board of Medicine and identified by the resident, or legal representative, as having the primary responsibility in determining the delivery of the resident's medical care.</p> <p>"Board" means the Board of Health.</p> <p>"Certified nurse aide" means the title that can only be used by individuals who have met the requirements to be certified, as defined by the Virginia Board of Nursing, and who are listed in the nurse aide registry.</p> <p>"Chemical restraint" means a psychopharmacologic drug (a drug prescribed to control mood, mental status, or behavior) that is used for discipline or convenience and not required to treat medical symptoms or symptoms from mental illness or mental retardation that prohibit an individual from reaching his highest level of functioning.</p> <p>"Clinical record" means the documentation of health care services, whether physical or mental, rendered by direct or indirect resident-provider interactions. An account compiled by physicians and other health care professionals of a variety of resident health information, such as assessments and care details, including</p>	<p>"Advance directive" means (i) a witnessed written document, voluntarily executed by the declarant in accordance with the requirements of § 54.1-2983 of the Code of Virginia, or (ii) a witnessed oral statement, made by the declarant subsequent to the time he is diagnosed as suffering from a terminal condition and in accordance with the provision of § 54.1-2983 of the Code of Virginia.</p> <p>"Assessment" means the process of evaluating a resident for the purpose of developing a profile on which to base services. Assessment includes information gathering, both initially and on an ongoing basis, designed to assist the multi-disciplinary staff in determining the resident's need for care, and the collection and review of resident-specific data.</p> <p>"Attending physician" means a physician currently licensed by the Virginia Board of Medicine and identified by the resident, or legal representative, as having the primary responsibility in determining the delivery of the resident's medical care.</p> <p><u>"Barrier crime" means any offense set forth in clause (i) of the definition of barrier crime in § 19.2-392.02 of the Code of Virginia.</u></p> <p>"Board" means the Board of Health.</p> <p>"Certified nurse aide" means the title that can only be used by individuals who have met the requirements to be certified, as defined by the Virginia Board of Nursing, and who are listed in the nurse aide registry.</p> <p>"Chemical restraint" means a psychopharmacologic drug (a drug prescribed to control mood, mental status, or behavior) that is used for discipline or convenience and not required to treat medical symptoms or symptoms from mental illness or mental retardation that prohibit an individual from reaching his highest level of functioning.</p> <p>"Clinical record" means the documentation of health care services,</p>
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	<p>testing results, medicines, and progress notes.</p> <p>"Commissioner" means the State Health Commissioner.</p> <p>"Complaint" means any allegation received by the Department of Health other than an incident reported by the facility staff. Such allegations include abuse, neglect, exploitation, or violation of state or federal laws or regulations.</p> <p>"Comprehensive plan of care" means a written action plan, based on assessment data, that identifies a resident's clinical and psychosocial needs, the interventions to meet those needs, treatment goals that are measurable and that documents the resident's progress toward meeting the stated goals.</p> <p>"Construction" means the building of a new nursing facility or the expansion, remodeling, or alteration of an existing nursing facility and includes the initial and subsequent equipping of the facility.</p> <p>"Department" means the Virginia Department of Health.</p> <p>"Dignity" means staff, in their interactions with residents, carry out activities which assist a resident in maintaining and enhancing the resident's self-esteem and self-worth.</p> <p>"Discharge" means the process by which the resident's services, delivered by the nursing facility, are terminated.</p> <p>"Discharge summary" means the final written summary of the services delivered, goals achieved and post-discharge plan or final disposition at the time of discharge from the nursing facility. The discharge summary becomes a part of the clinical record.</p> <p>"Drug" means (i) articles or substances recognized in the official United States "Drug" Pharmacopoeia National Formulary or official Homeopathic Pharmacopoeia of the United States, or any supplement to any of them; (ii)</p>	<p>whether physical or mental, rendered by direct or indirect resident-provider interactions. An account compiled by physicians and other health care professionals of a variety of resident health information, such as assessments and care details, including testing results, medicines, and progress notes.</p> <p>"Commissioner" means the State Health Commissioner.</p> <p>"Complaint" means any allegation received by the Department of Health other than an incident reported by the facility staff. Such allegations include abuse, neglect, exploitation, or violation of state or federal laws or regulations.</p> <p>"Comprehensive plan of care" means a written action plan, based on assessment data that identifies a resident's clinical and psychosocial needs, the interventions to meet those needs, treatment goals that are measurable and that documents the resident's progress toward meeting the stated goals.</p> <p>"Construction" means the building of a new nursing facility or the expansion, remodeling, or alteration of an existing nursing facility and includes the initial and subsequent equipping of the facility.</p> <p>"Criminal record report" means either <u>the criminal record clearance with respect to convictions for barrier crimes or the criminal history record from the Central Criminal Records Exchange of the Virginia Department of State Police.</u></p> <p>"Department" means the Virginia Department of Health.</p> <p>"Dignity" means staff, in their interactions with residents, carry out activities which assist a resident in maintaining and enhancing the resident's self-esteem and self-worth.</p> <p>"Discharge" means the process by which the resident's services, delivered by the nursing facility, are terminated.</p>
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	<p>articles or substances intended for the use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animal; (iii) articles or substances, other than food, intended to affect the structure or any function of the body of man or other animal; and (iv) articles or substances intended for use as a component of any article specified in clause (i), (ii), or (iii). This does not include devices or their components, parts or accessories.</p> <p>"Electronic monitoring" means an unmanned video recording system with or without audio capability installed in the room of a resident.</p> <p>"Emergency preparedness plan" means a component of a nursing facility's safety management program designed to manage the consequences of natural disasters or other emergencies that disrupt the nursing facility's ability to provide care.</p> <p>"Employee" means a person who performs a specific job function for financial remuneration on a full-time or part-time basis.</p> <p>"Facility-managed" means an electronic monitoring system that is installed, controlled, and maintained by the nursing facility with the knowledge of the resident or resident's responsible party in accordance with the facility's policies.</p> <p>"Full-time" means a minimum of 35 hours or more worked per week in the nursing facility.</p> <p>"Guardian" means a person legally invested with the authority and charged with the duty of taking care of the resident, managing his property, and protecting the rights of the resident who has been declared by the circuit court to be incapacitated and incapable of administering his own affairs. The powers and duties of the guardian are defined by the court and are limited to matters within the areas where the resident in need of a guardian has been determined to be incapacitated.</p>	<p>"Discharge summary" means the final written summary of the services delivered, goals achieved and post-discharge plan or final disposition at the time of discharge from the nursing facility. The discharge summary becomes a part of the clinical record.</p> <p>"Drug" means (i) articles or substances recognized in the official United States "Drug" Pharmacopoeia National Formulary or official Homeopathic Pharmacopoeia of the United States, or any supplement to any of them; (ii) articles or substances intended for the use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animal; (iii) articles or substances, other than food, intended to affect the structure or any function of the body of man or other animal; and (iv) articles or substances intended for use as a component of any article specified in clause (i), (ii), or (iii). This does not include devices or their components, parts or accessories.</p> <p>"Electronic monitoring" means an unmanned video recording system with or without audio capability installed in the room of a resident.</p> <p>"Emergency preparedness plan" means a component of a nursing facility's safety management program designed to manage the consequences of natural disasters or other emergencies that disrupt the nursing facility's ability to provide care.</p> <p>"Employee" means a person who performs a specific job function for financial remuneration on a full-time or part-time basis.</p> <p>"Facility-managed" means an electronic monitoring system that is installed, controlled, and maintained by the nursing facility with the knowledge of the resident or resident's responsible party <u>legal representative</u> in accordance with the facility's policies.</p> <p>"Full-time" means a minimum of 35 hours or more worked per week in the nursing facility.</p>
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	<p>"Medication" means any substance, whether prescription or over-the-counter drug, that is taken orally or injected, inserted, topically applied, or otherwise administered.</p> <p>"Neglect" means a failure to provide timely and consistent services, treatment, or care to a resident necessary to obtain or maintain the resident's health, safety, or comfort or a failure to provide timely and consistent goods and services necessary to avoid physical harm, mental anguish, or mental illness.</p> <p>"Nursing facility" means any nursing home as defined in § 32.1-123 of the Code of Virginia.</p> <p>"OLC" means the Office of Licensure and Certification of the Virginia Department of Health.</p> <p>"Person" means any individual, corporation, partnership, association, trust, or other legal entity, whether governmental or private, owning, managing, or operating a nursing facility.</p> <p>"Physical restraint" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's own body.</p> <p>"Policy" means a written statement that describes the principles and guides and governs the activities, procedures and operations of the nursing facility.</p> <p>"Procedures" means a series of activities designed to implement program goals or policy, which may or may not be written, depending upon the specific requirements within this chapter. For inspection purposes, there must be evidence that procedures are actually implemented.</p> <p>"Progress note" means a written statement, signed and dated by the person delivering the care, consisting of</p>	<p>"Guardian" means a person legally invested with the authority and charged with the duty of taking care of the resident, managing his property, and protecting the rights of the resident who has been declared by the circuit court to be incapacitated and incapable of administering his own affairs. The powers and duties of the guardian are defined by the court and are limited to matters within the areas where the resident in need of a guardian has been determined to be incapacitated.</p> <p><u>"Legal representative" means a person legally responsible for representing or standing in the place of the resident for the conduct of his affairs. This may include a guardian, conservator, attorney-in-fact under durable power of attorney, trustee, or other person expressly named by a court of competent jurisdiction or the resident as his agency in a legal document that specifies the scope of the representative's authority to act. A legal representative may only represent or stand in the place of a resident for the function or functions for which he has legal authority to act.</u></p> <p>"Medication" means any substance, whether prescription or over-the-counter drug, that is taken orally or injected, inserted, topically applied, or otherwise administered.</p> <p>"Neglect" means a failure to provide timely and consistent services, treatment, or care to a resident necessary to obtain or maintain the resident's health, safety, or comfort or a failure to provide timely and consistent goods and services necessary to avoid physical harm, mental anguish, or mental illness.</p> <p>"Nursing facility" means any nursing home as defined in § 32.1-123 of the Code of Virginia.</p> <p>"OLC" means the Office of Licensure and Certification of the Virginia Department of Health.</p>
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	<p>a pertinent, chronological report of the resident's care. A progress note is a component of the clinical record.</p> <p>"Qualified" means meeting current legal requirements of licensure, registration or certification in Virginia; having appropriate training and experience commensurate with assigned responsibilities; or, if referring to a professional, possessing an appropriate degree or having documented equivalent education, training or experience.</p> <p>"Quality assurance" means systematic activities performed to determine the extent to which clinical practice meets specified standards and values with regard to such things as appropriateness of service assignment and duration, appropriateness of facilities and resources utilized, adequacy and clinical soundness of care given. Such activities should also assure changes in practice that do not meet accepted standards. Examples of quality assurance activities include the establishment of facility-wide goals for resident care, the assessment of the procedures used to achieve the goals, and the proposal of solutions to problems in attaining those goals.</p> <p>"Readmission" means a planned return to the nursing facility following a temporary absence for hospitalization, off-site visit or therapeutic leave, or a return stay or confinement following a formal discharge terminating a previous admission.</p> <p>"Resident" means the primary service recipient, admitted to the nursing facility, whether that person is referred to as a client, consumer, patient, or other term.</p> <p>"Resident-managed" means an electronic monitoring system that is installed, controlled, and maintained by the resident with the knowledge of the nursing facility.</p> <p>"Responsible person or party" means an individual authorized by the resident to act for him as an official delegate or agent. The responsible person may be a</p>	<p>"Person" means any individual, corporation, partnership, association, trust, or other legal entity, whether governmental or private, owning, managing, or operating a nursing facility.</p> <p>"Physical restraint" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's own body.</p> <p>"Policy" means a written statement that describes the principles and guides and governs the activities, procedures and operations of the nursing facility.</p> <p>"Procedures" means a series of activities designed to implement program goals or policy, which may or may not be written, depending upon the specific requirements within this chapter. For inspection purposes, there must be evidence that procedures are actually implemented.</p> <p>"Progress note" means a written statement, signed and dated by the person delivering the care, consisting of a pertinent, chronological report of the resident's care. A progress note is a component of the clinical record.</p> <p>"Qualified" means meeting current legal requirements of licensure, registration or certification in Virginia; having appropriate training and experience commensurate with assigned responsibilities; or, if referring to a professional, possessing an appropriate degree or having documented equivalent education, training or experience.</p> <p>"Quality assurance" means systematic activities performed to determine the extent to which clinical practice meets specified standards and values with regard to such things as appropriateness of service assignment and duration, appropriateness of facilities and resources utilized, adequacy and clinical soundness of</p>
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	<p>guardian, payee, family member or any other individual who has arranged for the care of the resident and assumed this responsibility. The responsible person or party may or may not be related to the resident. A responsible person or party is not a guardian unless so appointed by the court.</p> <p>"Supervision" means the ongoing process of monitoring the skills, competencies and performance of the individual supervised and providing regular, face-to-face guidance and instruction.</p> <p>"Volunteer" means a person who, without financial remuneration, provides services to the nursing facility.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>care given. Such activities should also assure changes in practice that do not meet accepted standards. Examples of quality assurance activities include the establishment of facility-wide goals for resident care, the assessment of the procedures used to achieve the goals, and the proposal of solutions to problems in attaining those goals.</p> <p>"Readmission" means a planned return to the nursing facility following a temporary absence for hospitalization, off-site visit or therapeutic leave, or a return stay or confinement following a formal discharge terminating a previous admission.</p> <p>"Resident" means the primary service recipient, admitted to the nursing facility, whether that person is referred to as a client, consumer, patient, or other term.</p> <p>"Resident-managed" means an electronic monitoring system that is installed, controlled, and maintained by the resident with the knowledge of the nursing facility.</p> <p>"Responsible person or party" means an individual authorized by the resident to act for him as an official delegate or agent. The responsible person may be a guardian, payee, family member or any other individual who has arranged for the care of the resident and assumed this responsibility. The responsible person or party may or may not be related to the resident. A responsible person or party is not a guardian unless so appointed by the court.</p> <p>"Supervision" means the ongoing process of monitoring the skills, competencies and performance of the individual supervised and providing regular, face-to-face guidance and instruction.</p> <p><u>"Sworn disclosure" means a written statement or affirmation disclosing any criminal convictions or any pending criminal charges, whether within or outside the Commonwealth, by an applicant for compensated employment with a nursing facility.</u></p>
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			<p>"Volunteer" means a person who, without financial remuneration, provides services to the nursing facility.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of these proposed changes is to include definitions related to the criminal records check and to consolidate overlapping terms into a single defined term.</p> <p>RATIONALE: The rationale behind these proposed changes is to create umbrella terms and definitions related to criminal records checks that would improve readability and clarify of the proposed new Section 75. Additionally, the use of overlapping terms throughout the chapter to refer to a person who can act in the stead of the resident was confusing for regulants and staff.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
30	N/A	<p>12VAC5-371-30. License.</p> <p>A. A license to operate a facility is issued to a person or organization. An organization may be a partnership, association, corporation, or public entity.</p> <p>B. Each license and renewal thereof shall be issued for one year. A nursing facility shall operate within the terms of its license, which include the:</p> <ol style="list-style-type: none"> 1. Name of the facility; 2. Name of the operator; 3. Physical location of the nursing facility; 4. Maximum number of beds allowed; and 5. Date the license expires. <p>C. A separate license shall be required for nursing facilities maintained on separate premises, even though they are owned or are operated under the same management.</p> <p>D. Every nursing facility shall be designated by a permanent and appropriate name. The name shall not be changed without first notifying the OLC.</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-30. License.</p> <p>A. <u>This chapter is not applicable to:</u></p> <ol style="list-style-type: none"> 1. <u>Those entities listed in § 32.1-124 of the Code of Virginia; and</u> 2. <u>Facilities established or operated for the practice of religious tenets pursuant to § 32.1-128 of the Code of Virginia, except that such facilities shall comply with the statutes and regulations on environmental protection and life safety.</u> <p>B. A license to operate a <u>nursing facility</u> is issued to a person or organization. An organization may be a partnership, association, corporation, or public entity.</p> <p>B. <u>C.</u> Each license and renewal thereof shall be issued for one year. A nursing facility shall operate within the terms of its license, which include the:</p> <ol style="list-style-type: none"> 1. Name of the <u>nursing facility</u>; 2. Name of the operator;

	<p>E. The number of resident beds allowed in a nursing facility shall be determined by the department. Requests to increase beds must be made in writing and must include an approved Certificate of Public Need, except as provided in 12VAC5-371-40 J.</p> <p>F. Nursing facility units located in and operated by hospitals shall be licensed under Regulations for the Licensure of Hospitals in Virginia (12VAC5-410). Approval for such units shall be included on the annual license issued to each hospital.</p> <p>G. Any person establishing, conducting, maintaining, or operating a nursing facility without a license shall be guilty of a Class 6 felony.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>3. Physical location of the nursing facility;</p> <p>4. Maximum number of beds allowed; and</p> <p>5. Date the license expires.</p> <p>G. D. A separate license shall be required for nursing facilities maintained on separate premises, even though they are owned or are operated under the same management.</p> <p>D. E. Every nursing facility shall be designated by a permanent and <u>appropriate unique</u> name. The name shall not be changed without first notifying the OLC.</p> <p>E. F. The number of resident beds allowed in a nursing facility shall be determined by the department. Requests to increase beds must be made in writing and must include an approved Certificate of Public Need, except as provided in 12VAC5-371-40 J.</p> <p>F. G. Nursing facility units located in and operated by hospitals shall be licensed under Regulations for the Licensure of Hospitals in Virginia (12VAC5-410). Approval for such units shall be included on the annual license issued to each hospital.</p> <p>G. H. Any person establishing, conducting, maintaining, or operating a nursing facility without a license shall be guilty of a Class 6 felony.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of these proposed changes is to align the terminology used with the defined terms in Section 10, clarify that an appropriate name means a unique name, and clarify which facilities are exempt from all or part of the chapter.</p> <p>RATIONALE: The rationale behind these proposed changes is that use of undefined terms is disfavored when a defined term is available, that appropriate is an ambiguous standard to administer whereas “unique” is clearer, and that the chapter had previously failed to identify what facilities were exempt from all or part of the chapter.</p>
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			<p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees, applicants, and exempted facilities.</p>
<p>40</p>	<p>N/A</p>	<p>12VAC5-371-40. Licensing process. A. Upon request, the OLC will provide consultation to any person seeking information about obtaining a license. The purpose of such consultation is to: 1. Explain the standards and the licensing process; 2. Provide assistance in locating other sources of information; 3. Review the potential applicant's proposed program plans, forms, and other documents, as they relate to standards; and 4. Alert the potential applicant regarding the need to meet other state and local ordinances, such as fire and building codes and environmental health standards, where applicable. B. Upon request, the OLC will provide an application form for a license to operate a nursing facility. C. The OLC shall consider the application complete when all requested information and the application fee is submitted with the form required. If the OLC finds the application incomplete, the applicant will be notified of receipt of the incomplete application. D. The applicant shall complete and submit the initial application to the OLC at least 30 days prior to a planned opening date to allow the OLC time to act on the application. An application for a license may be withdrawn at any time. E. Application for initial license of a nursing facility shall include a statement of any agreement made with the commissioner as a condition for Certificate of Public Need approval to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care. Any initial license issued to any nursing facility that made such agreement as a condition of its Certificate of Public Need approval shall not be renewed without demonstrating</p>	<p>CHANGE: The Board is proposing the following changes: 12VAC5-371-40. Licensing process. A. Upon request, the OLC will provide consultation to any person seeking information about obtaining a license. The purpose of such consultation is to: 1. Explain the standards and the licensing process; 2. Provide assistance in locating other sources of information; 3. Review the potential applicant's proposed program plans, forms, and other documents, as they relate to standards; and 4. Alert the potential applicant regarding the need to meet other state and local ordinances, such as fire and building codes and environmental health standards, where applicable. B. Upon request, the OLC will provide an application form for a license to operate a nursing facility. <u>Licensees and applicants shall obtain licensure applications from the OLC.</u> C. The OLC shall consider the application complete when all requested information and the application fee is submitted with the form required. If the OLC finds the application incomplete, the applicant will be notified of receipt of the incomplete application. D. The applicant shall complete and submit the initial application to the OLC at least 30 days prior to a planned opening date to allow the OLC time to act on the application. An application for a license may be withdrawn at any time. E. <u>A nursing facility may not be licensed without first complying with the requirements for a Certificate of Public Need as required by Article 1.1. (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia.</u></p>

	<p>prior to or at the time of applying for renewal that it is substantially complying with its agreement.</p> <p>F. The renewal of a nursing facility license shall be conditioned upon the up-to-date payment of any civil penalties owed as a result of willful refusal, failure, or neglect to honor certain conditions established in their award of a Certificate of Public Need pursuant to § 32.1-102.4 F of the Code of Virginia.</p> <p>G. Prior to changes in operation which would affect the terms of the license, the licensee must secure a modification to the terms of the license from the OLC.</p> <p>H. Requests to modify a license must be submitted in writing, 30 working days in advance of any proposed changes, to the Director of the Office of Licensure and Certification.</p> <p>I. The license shall be returned to the OLC following a correction or reissuance when there has been a change in:</p> <ol style="list-style-type: none"> 1. Address; 2. Operator; 3. Name; or 4. Bed capacity. <p>J. Nursing facilities shall be exempt, for a period of no more than 30 days, from the requirement to obtain a license to add temporary beds when the commissioner has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a shortage of hospital or nursing home beds.</p> <p>K. The OLC will evaluate written information about any planned changes in operation which would affect either the terms of the license or the continuing eligibility for a license. A licensing representative may visit the facility during the process of evaluating a proposed modification.</p> <p>L. If a modification can be granted, the OLC shall respond in writing with a modified license. In the event a new application is needed, the licensee will receive written notification. When the modification cannot be granted, the licensee shall be advised by letter.</p> <p>M. The department shall send an application for renewal of the license to</p>	<p><u>1.</u> Application for initial license of a nursing facility shall include a statement of any agreement made with the commissioner as a condition for Certificate of Public Need approval to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care.</p> <p><u>2.</u> Any initial license issued to any nursing facility that made such agreement as a condition of its Certificate of Public Need approval shall not be renewed without demonstrating prior to or at the time of applying for renewal that it is substantially complying with its agreement.</p> <p>F. The renewal of a nursing facility license shall be conditioned upon the up-to-date payment of any civil penalties owed as a result of willful refusal, failure, or neglect to honor certain conditions established in their award of a Certificate of Public Need pursuant to § 32.1-102.4 F of the Code of Virginia.</p> <p>G. Prior to changes in operation which would affect the terms of the license, the licensee must secure a modification to the terms of the license from the OLC.</p> <p>H. Requests to modify a license must be submitted in writing, 30 working days in advance of any proposed changes, to the Director of the Office of Licensure and Certification.</p> <p>I. The license shall be returned to the OLC following a correction or reissuance when there has been a change in:</p> <ol style="list-style-type: none"> 1. Address; 2. Operator; 3. Name; or 4. Bed capacity. <p>J. G. Nursing facilities shall be exempt, for a period of no more than 30 days, from the requirement to obtain a license to add temporary beds when the commissioner has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a shortage of hospital or nursing home beds.</p>
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	<p>the licensee prior to the expiration date of the current license.</p> <p>N. The licensee shall submit the completed renewal application form along with any required attachments and the application fee by the date indicated in the cover letter.</p> <p>O. It is the licensee's responsibility to complete and return the application to assure timely processing. Should a current license expire before a new license is issued, the current license shall remain in effect provided the complete and accurate application was filed on time.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>K. The OLC will evaluate written information about any planned changes in operation which would affect either the terms of the license or the continuing eligibility for a license. A licensing representative may visit the facility during the process of evaluating a proposed modification.</p> <p>L. If a modification can be granted, the OLC shall respond in writing with a modified license. In the event a new application is needed, the licensee will receive written notification. When the modification cannot be granted, the licensee shall be advised by letter.</p> <p>M. The department shall send an application for renewal of the license to the licensee prior to the expiration date of the current license.</p> <p>N. H. The licensee shall submit the completed renewal application form along with any required attachments and the application fee by the date indicated in the cover letter.</p> <p>O. I. It is the licensee's responsibility to complete and return the application to assure timely processing. Should a current license expire before a new license is issued, the current license shall remain in effect provided the complete and accurate application was filed on time.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of the proposed changes is to remove duplicative notice requirements, clarify that a Certificate of Public Need is required prior to applying for a license, and to remove language about OLC providing forms upon request.</p> <p>RATIONALE: The rationale behind the proposed changes is that having multiple disparate sections discussing notice requirements is confusing for licensees and staff. The clarification that a Certificate of Public Need is required is to address confusion about the order of licensing and certification. Placing the onus on applicants to retrieve application forms is due to OLC's forms</p>
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			<p>being available online, negating the need for forms to be requested.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees and applicants.</p>
60	N/A	<p>12VAC5-371-60. On-site inspections.</p> <p>A. The licensing representative shall make unannounced on-site inspections of the nursing facility. The licensee shall be responsible for correcting any deficiencies found during any on-site inspection. Compliance with all standards will be determined by the OLC.</p> <p>B. The licensee shall make available to the licensing representative any necessary records.</p> <p>C. The licensee shall also allow the licensing representative to interview the agents, employees, residents, family members, and any person under its custody, control, direction or supervision.</p> <p>D. After the on-site inspection, the licensing representative shall discuss the findings of the inspection with the administrator of record or designee.</p> <p>E. As applicable, the administrator of record shall submit an acceptable plan for correcting any deficiencies found during an on-site inspection.</p> <p>F. The administrator of record will be notified whenever any item in the plan of correction is determined to be unacceptable.</p> <p>G. The administrator of record shall be responsible for assuring the plan of correction is implemented and monitored so that compliance is maintained.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-60. On-site inspections.</p> <p>A. The licensing representative shall make unannounced on-site inspections of the nursing facility. The licensee shall be responsible for correcting any deficiencies found during any on-site inspection. Compliance with all standards will be determined by the OLC.</p> <p>B. The licensee shall make available to the licensing representative any necessary records.</p> <p>C. The licensee shall also allow the licensing representative to interview the agents, employees, residents, family members, and any person under its custody, control, direction or supervision.</p> <p>D. After the on-site inspection, the licensing representative shall discuss the findings of the inspection with the administrator of record or designee.</p> <p>E. As applicable, the administrator of record shall submit an acceptable plan for correcting any deficiencies found during an on-site inspection.</p> <p>F. The administrator of record will be notified whenever any item in the plan of correction is determined to be unacceptable.</p> <p>G. The administrator of record shall be responsible for assuring the plan of correction is implemented and monitored so that compliance is maintained.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of</p>

			<p>undefined terms is disfavored when a defined term is available.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
70	N/A	<p>12VAC5-371-70. Complaint investigation.</p> <p>A. The OLC has the responsibility to investigate any complaints regarding alleged violations of the standards or statutes and complaints of the abuse or neglect of persons in care. The Department of Social Services and the State Ombudsman are notified of complaints received.</p> <p>B. Complaints may be received in written or oral form and may be anonymous.</p> <p>C. When the investigation is complete, the licensee and the complainant, if known, will be notified of the findings of the investigation.</p> <p>D. As applicable, the facility's administrator of record shall submit an acceptable plan for correcting any deficiencies found during a complaint investigation.</p> <p>E. The administrator of record will be notified whenever any item in the plan of correction is determined to be unacceptable.</p> <p>F. The administrator of record shall be responsible for assuring the plan of correction is implemented and monitored so that compliance is maintained.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-70. Complaint investigation.</p> <p>A. The OLC has the responsibility to investigate any complaints regarding alleged violations of the standards or statutes and complaints of the abuse or neglect of persons in care. The Department of Social Services and the State Ombudsman are notified of complaints received.</p> <p>B. Complaints may be received in written or oral form and may be anonymous.</p> <p>C. When the investigation is complete, the licensee and the complainant, if known, will be notified of the findings of the investigation.</p> <p>D. As applicable, the facility's administrator of record shall submit an acceptable plan for correcting any deficiencies found during a complaint investigation.</p> <p>E. The administrator of record will be notified whenever any item in the plan of correction is determined to be unacceptable.</p> <p>F. The administrator of record shall be responsible for assuring the plan of correction is implemented and monitored so that compliance is maintained.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p>

			<p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
<p>80</p>	<p>N/A</p>	<p>12VAC5-371-80. Variances.</p> <p>A. The OLC can authorize variances only to its own licensing standards, not to regulations of another agency or to any requirements in federal, state, or local laws.</p> <p>B. A nursing facility may request a variance to a particular standard or requirement contained in this chapter when the standard or requirement poses a special hardship and when a variance to it would not endanger the safety or well-being of residents, employees, or the public.</p> <p>C. Upon finding that the enforcement of one or more of the standards would be clearly impractical, the OLC shall have the authority to waive, either temporarily or permanently, the enforcement of one or more of these standards, provided safety, resident care and services are not adversely affected.</p> <p>D. The OLC may rescind or modify a variance if (i) conditions change; (ii) additional information becomes known which alters the basis for the original decision; (iii) the facility fails to meet any conditions attached to the variance; or (iv) results of the variance jeopardize the safety, comfort, or well-being of residents, employees and the public.</p> <p>E. Consideration of a variance is initiated when a written request is submitted to the Director of the Office of Licensure and Certification. The OLC may provide consultation in the development of the written request and throughout the variance process.</p> <p>F. The request for a variance must describe the special hardship to the existing program or to a planned innovative or pilot program caused by the enforcement of the requirements. When possible, the request should include proposed alternatives to meet the purpose of the requirements which will ensure the protection and well-being of residents, employees, and the public.</p> <p>G. The OLC shall notify the facility of the receipt of the request for a variance. The OLC may attach conditions to the</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-80. Variances.</p> <p>A. The OLC commissioner can <u>may</u> authorize variances only to its own licensing standards, not to regulations of another agency or to any requirements in federal, state, or local laws.</p> <p>B. A nursing facility may request a variance to a particular standard or requirement contained in this chapter when the standard or requirement poses a special hardship and when a variance to it would not endanger the safety or well-being of residents, employees, or the public.</p> <p>C. Upon finding that the enforcement of one or more of the standards would be clearly impractical, the OLC commissioner shall have the authority to waive, either temporarily or permanently, the enforcement of one or more of these standards, provided safety, resident care and services are not adversely affected.</p> <p>D. The OLC commissioner may rescind or modify a variance if (i) conditions change; (ii) additional information becomes known which alters the basis for the original decision; (iii) the <u>nursing</u> facility fails to meet any conditions attached to the variance; or (iv) results of the variance jeopardize the safety, comfort, or well-being of residents, employees and the public.</p> <p>E. Consideration of a variance is initiated when a written request is submitted to the Director <u>director</u> of the Office of Licensure and Certification <u>OLC</u>. The OLC may provide consultation in the development of the written request and throughout the variance process.</p> <p>F. The request for a variance must describe the special hardship to the existing program or to a planned innovative or pilot program caused by the enforcement of the requirements. When possible, the request should include proposed alternatives to meet the purpose of the requirements which</p>

		<p>granting of the variance in order to protect persons in care.</p> <p>H. When the decision is to deny a request for a variance, the reason shall be provided in writing to the licensee.</p> <p>I. When a variance is denied, expires, or is rescinded, routine enforcement of the standard or portion of the standard shall be resumed. The nursing facility may at any time withdraw a request for a variance.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>will ensure the protection and well-being of residents, employees, and the public.</p> <p>G. The OLC shall notify the <u>nursing facility</u> of the receipt of the request for a variance. The <u>OLC commissioner</u> may attach conditions to the granting of the variance in order to protect persons in care.</p> <p>H. When the decision is to deny a request for a variance, the reason shall be provided in writing to the licensee.</p> <p>I. When a variance is denied, expires, or is rescinded, routine enforcement of the standard or portion of the standard shall be resumed. The nursing facility may at any time withdraw a request for a variance.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10 and to clarify that the State Health Commissioner is responsible for the denial, suspension, or revocation of a nursing facility’s license.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available. Additionally, the Commissioner holds the statutory authority to deny, suspend, or revoke licenses and no written delegation of that authority to the OLC exists.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
110	N/A	<p>Part II Administrative Services 12VAC5-371-110. Management and administration.</p> <p>A. No person shall own, establish, conduct, maintain, manage, or operate any nursing facility, as defined in § 32.1-123 of the Code of Virginia, without having obtained a license.</p> <p>B. The nursing facility must comply with:</p> <ol style="list-style-type: none"> 1. These regulations (12VAC5-371); 	<p>CHANGE: The Board is proposing the following changes:</p> <p>Part II Administrative Services 12VAC5-371-110. Management and administration.</p> <p>A. No person shall own, establish, conduct, maintain, manage, or operate any nursing facility, as defined in § 32.1-123 of the Code of Virginia, without having obtained a license.</p> <p>B. The nursing facility must comply with:</p>

	<p>2. Other applicable federal, state or local laws and regulations; and</p> <p>3. Its own policies and procedures.</p> <p>C. The nursing facility shall submit, or make available, reports and information necessary to establish compliance with these regulations and applicable statutes.</p> <p>D. The nursing facility shall submit, in a timely manner as determined by the OLC, and implement a written plan of action to correct any noncompliance with these regulations identified during an inspection. The plan shall include:</p> <ol style="list-style-type: none"> 1. Description of the corrective action or actions to be taken; 2. Date of completion for each action; and 3. Signature of the person responsible for the operation. <p>E. The nursing facility shall permit representatives from the OLC to conduct inspections to:</p> <ol style="list-style-type: none"> 1. Verify application information; 2. Determine compliance with this chapter; 3. Review necessary records; and 4. Investigate complaints. <p>F. The current license from the department shall be posted in a place clearly visible to the general public.</p> <p>G. The nursing facility shall not operate more resident beds than the number for which it is licensed.</p> <p>H. The nursing facility shall fully disclose its admission policies, including any preferences given, to applicants for admission.</p> <p>I. The nursing facility shall identify its operating elements and programs, the internal relationship among these elements and programs, and the management or leadership structure.</p> <p>J. The facility shall provide, or arrange for, the administration to its residents of an annual influenza vaccination and a pneumonia vaccination according to the most recent recommendations for "Prevention and Control of Influenza" (www.cdc.gov/mmwr/preview/mmwrhtml/rr5306a1.htm), MMWR 53 (RR06), and</p>	<p>1. These regulations (12VAC5-371);</p> <p>2. Other applicable federal, state or local laws and regulations; and</p> <p>3. Its own policies and procedures.</p> <p>C. The nursing facility shall submit, or make available, reports and information necessary to establish compliance with these regulations and applicable statutes.</p> <p>D. The nursing facility shall submit, in a timely manner as determined by the OLC, and implement a written plan of action to correct any noncompliance with these regulations identified during an inspection. The plan shall include:</p> <ol style="list-style-type: none"> 1. Description of the corrective action or actions to be taken; 2. Date of completion for each action; and 3. Signature of the person responsible for the operation. <p>E. The nursing facility shall permit representatives from the OLC to conduct inspections to:</p> <ol style="list-style-type: none"> 1. Verify application information; 2. Determine compliance with this chapter; 3. Review necessary records; and 4. Investigate complaints. <p>F. The current license from the department shall be posted in a place clearly visible to the general public <u>A nursing facility shall give written notification 30 calendar days in advance of implementation of changes affecting the accuracy of the license. Changes affecting the accuracy of the license are:</u></p> <ol style="list-style-type: none"> <u>1. Address;</u> <u>2. Operator;</u> <u>3. Name of the nursing facility;</u> <u>4. Any proposed change in management contract or lease agreement to operate the nursing facility;</u> <u>5. Implementing any proposed addition, deletion, or change in nursing facility services whether or not licensure is required;</u> <u>6. A change in ownership; or</u> <u>7. Bed capacity.</u>
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	<p>"Guidelines for Preventing Health Care-Associated Pneumonia, 2003" (www.cdc.gov/mmwr/preview/mmwrhtml/rr5303a1.htm), MMWR 53 (RR03), of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, unless the vaccination is medically contraindicated or the resident declines the vaccination offer.</p> <p>K. Upon request of the facility's family council, the facility shall send notices and information about the family council mutually developed by the family council and the administration of the nursing home, and provided to the facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six times a year. Such notices may be included together with a monthly billing statement or other regular communication. Notices and information shall also be posted in a designated location within the nursing facility.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p><u>Notices shall be sent to the attention of the director of the OLC.</u></p> <p>G. The nursing facility shall not operate more resident beds than the number for which it is licensed. The current license from the commissioner shall be posted in a place clearly visible to the general public.</p> <p>H. The nursing facility shall fully disclose its admission policies, including any preferences given, to applicants for admission.</p> <p>I. The nursing facility shall identify its operating elements and programs, the internal relationship among these elements and programs, and the management or leadership structure.</p> <p>J. The <u>nursing</u> facility shall provide, or arrange for, the administration to its residents of an annual influenza vaccination and a pneumonia vaccination according to the most recent recommendations for "Prevention and Control of Influenza" <u>"Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2019–20 Influenza Season"</u>, and "Guidelines for Preventing Health Care-Associated Pneumonia, 2003" <u>(www.cdc.gov/mmwr/preview/mmwrhtml/rr5306a1.htm), MMWR 53 (RR06)</u>.</p> <p>"Guidelines for Preventing Health-Care-Associated Pneumonia" from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, unless the vaccination is medically contraindicated or the resident declines the vaccination offer.</p> <p>K. Upon request of the <u>nursing</u> facility's family council, the <u>nursing</u> facility shall send notices and information about the family council mutually developed by the family council and the administration of the <u>nursing home facility</u>, and provided to the <u>nursing</u> facility for such purpose, to the <u>listed responsible party legal representative</u> or a contact person of the resident's choice up to six times a year. Such notices may be included together</p>
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			<p>with a monthly billing statement or other regular communication. Notices and information shall also be posted in a designated location within the nursing facility.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia</p> <p>INTENT: The intent of the proposed changes is to consolidate duplicative notice requirements and update references to immunization guidelines.</p> <p>RATIONALE: The rationale behind the proposed changes is that having multiple disparate sections discussing notice requirements is confusing for licensees and staff. The citations to the Centers for Disease Control's MMWR documents were outdated.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees and applicants.</p>
120	N/A	<p>12VAC5-371-120. Governing body.</p> <p>A. The nursing facility shall have a governing body that is legally responsible for the management of the operation.</p> <p>B. The governing body shall adopt written bylaws that describe the organizational structure and establish authority and responsibility in accordance with applicable laws, including a:</p> <ol style="list-style-type: none"> 1. Statement of purpose; 2. Description of the functions of the governing body members, officers and committees; 3. Description of the method of adoption, implementation, and periodic review of policies and procedures; and 4. Description of the methods to be utilized to assure compliance with this chapter. <p>C. The governing body shall disclose the names and addresses of any individual or entity that holds 5.0% or more ownership interest in the operation of the nursing facility.</p> <p>D. When the governing body is not the owner of the physical plant, the</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-120. Governing body.</p> <p>A. The nursing facility shall have a governing body that is legally responsible for the management of the operation.</p> <p>B. The governing body shall adopt written bylaws that describe the organizational structure and establish authority and responsibility in accordance with applicable laws, including a:</p> <ol style="list-style-type: none"> 1. Statement of purpose; 2. Description of the functions of the governing body members, officers and committees; 3. Description of the method of adoption, implementation, and periodic review of policies and procedures; and 4. Description of the methods to be utilized to assure compliance with this chapter. <p>C. The governing body shall disclose the names and addresses of any individual or entity that holds 5.0%</p>

		<p>governing body shall disclose the name and address of the individual or entity responsible for the alterations, modifications, maintenance and repairs to the building.</p> <p>E. The governing body shall notify the OLC in writing 30 days in advance of changes affecting the accuracy of the license. Changes affecting the accuracy of the license are:</p> <ol style="list-style-type: none"> 1. Any proposed change in management contract or lease agreement to operate the nursing facility; 2. Implementing any proposed addition, deletion, or change in nursing facility services whether or not licensure is required; 3. Selling the facility; or 4. A change in ownership. <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>or more ownership interest in the operation of the nursing facility.</p> <p>D. When the governing body is not the owner of the physical plant, the governing body shall disclose the name and address of the individual or entity responsible for the alterations, modifications, maintenance and repairs to the building.</p> <p>E. The governing body shall notify the OLC in writing 30 days in advance of changes affecting the accuracy of the license. Changes affecting the accuracy of the license are:</p> <ol style="list-style-type: none"> 1. Any proposed change in management contract or lease agreement to operate the nursing facility; 2. Implementing any proposed addition, deletion, or change in nursing facility services whether or not licensure is required; 3. Selling the facility; or 4. A change in ownership. <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of the proposed changes is to remove duplicative notice requirements.</p> <p>RATIONALE: The rationale behind the proposed changes is that having multiple disparate sections discussing notice requirements is confusing for licensees and staff.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees and applicants.</p>
130	N/A	<p>12VAC5-371-130. Administrator.</p> <p>A. The governing body shall appoint an individual, on a full-time basis, to serve as its on-site agent, responsible for the day-to-day administration and management.</p> <p>B. The governing body shall provide the OLC with evidence that the individual appointed as administrator is:</p> <ol style="list-style-type: none"> 1. Currently licensed by the Virginia Board of Long-Term Care Administrators; or 	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-130. Administrator.</p> <p>A. The governing body shall appoint an individual, on a full-time basis, to serve as its on-site agent, responsible for the day-to-day administration and management.</p> <p>B. The governing body shall provide the OLC with evidence that the individual appointed as administrator is:</p>

	<p>2. Holds a current administrator's license in another state and has filed an application for license with the Virginia Board of Long-Term Care Administrators.</p> <p>C. Within five working days of the effective date of termination of the administrator's employment, the governing body shall notify the OLC, in writing, of the name and qualifications of the replacement administrator of record or the acting administrator.</p> <p>D. The governing body shall appoint a qualified administrator within 90 days of the effective date of the termination of the previously qualified administrator, and shall provide the OLC with written notification of the administrator's name, license number, and effective date of employment.</p> <p>An additional 30-day extension may be granted if a written request provides documentation that the individual designated as administrator is awaiting the final licensing decision of the Virginia Board of Long-Term Care Administrators.</p> <p>E. The governing body shall assure that administrative direction is provided at all times. The governing body, the administrator, or the chief executive officer shall designate, in writing, a qualified individual to act as the alternate nursing home administrator in the absence of the administrator of record.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>1. Currently licensed by the Virginia Board of Long-Term Care Administrators; or</p> <p>2. Holds a current administrator's license in another state and has filed an application for license with the Virginia Board of Long-Term Care Administrators.</p> <p>C. Within five working days of the effective date of termination of the administrator's employment, the governing body shall notify the OLC, in writing, of the name and qualifications of the replacement administrator of record or the acting administrator.</p> <p>D. The governing body shall appoint a qualified administrator within 90 days of the effective date of the termination of the previously qualified administrator, and shall provide the OLC with written notification of the administrator's name, license number, and effective date of employment.</p> <p>An additional 30-day extension may be granted if a written request provides documentation that the individual designated as administrator is awaiting the final licensing decision of the Virginia Board of Long-Term Care Administrators.</p> <p>E. The governing body shall assure that administrative direction is provided at all times. The governing body, the administrator, or the chief executive officer shall designate, in writing, a qualified individual to act as the alternate nursing home administrator in the absence of the administrator of record.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p>
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<p>140</p>	<p>N/A</p>	<p>12VAC5-371-140. Policies and procedures. A. The nursing facility shall implement written policies and procedures approved by the governing body. B. All policies and procedures shall be reviewed at least annually, with recommended changes submitted to the governing body for approval. C. A written record of the annual policy review, including at least the review dates, participants, recommendations and action dates of the governing body, shall be maintained. D. Administrative and operational policies and procedures shall include, but are not limited to: 1. Administrative records; 2. Admission, transfer and discharge; 3. Medical direction and physician services; 4. Nursing direction and nursing services; 5. Pharmaceutical services, including drugs purchased outside the nursing facility; 6. Dietary services; 7. Social services; 8. Activities services; 9. Restorative and rehabilitative resident services; 10. Contractual services; 11. Clinical records; 12. Resident rights and grievances; 13. Quality assurance and infection control and prevention; 14. Safety and emergency preparedness procedures; 15. Professional and clinical ethics, including: a. Confidentiality of resident information; b. Truthful communication with residents; c. Observance of appropriate standards of informed consent and refusal of treatment; and</p>	<p>CHANGE: The Board is proposing the following changes: 12VAC5-371-140. Policies and procedures. A. The nursing facility shall implement written policies and procedures approved by the governing body. B. All policies and procedures shall be reviewed at least annually, with recommended changes submitted to the governing body for approval. C. A written record of the annual policy review, including at least the review dates, participants, recommendations and action dates of the governing body, shall be maintained. D. Administrative and operational policies and procedures shall include, but are not limited to: 1. Administrative records; 2. Admission, transfer and discharge; 3. Medical direction and physician services; 4. Nursing direction and nursing services; 5. Pharmaceutical services, including drugs purchased outside the nursing facility; 6. Dietary services; 7. Social services; 8. Activities services; 9. Restorative and rehabilitative resident services; 10. Contractual services; 11. Clinical records; 12. Resident rights and grievances; 13. Quality assurance and infection control and prevention; 14. Safety and emergency preparedness procedures; 15. Professional and clinical ethics, including: a. Confidentiality of resident information; b. Truthful communication with residents; c. Observance of appropriate standards of</p>

		<p>d. Preservation of resident dignity, with special attention to the needs of the aged, the cognitively impaired, and the dying; and</p> <p>16. Facility security.</p> <p>E. Personnel policies and procedures shall include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Written job descriptions that specify authority, responsibility, and qualifications for each job classification; 2. An on-going plan for employee orientation, staff development, in-service training and continuing education; 3. An accurate and complete personnel record for each employee including: <ol style="list-style-type: none"> a. Verification of current professional license, registration, or certificate or completion of a required approved training course; b. Criminal record check; c. Verification that the employee has reviewed or received a copy of the job description; d. Orientation to the nursing facility, its policies and to the position and duties assigned; e. Completed continuing education program approved for the employee as determined by the outcome of the annual performance evaluation; f. Annual employee performance evaluations; and g. Disciplinary action taken; and 4. Employee health-related information retained in a file separate from personnel files. <p>F. Financial policies and procedures shall include, but not be limited to:</p> <ol style="list-style-type: none"> 1. Admission agreements; 2. Methods of billing: <ol style="list-style-type: none"> a. Services not included in the basic daily or monthly rate; 	<p>informed consent and refusal of treatment; and</p> <p>d. Preservation of resident dignity, with special attention to the needs of the aged, the cognitively impaired, and the dying; and</p> <p>16. Facility <u>Nursing facility</u> security.</p> <p>E. Personnel policies and procedures shall include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Written job descriptions that specify authority, responsibility, and qualifications for each job classification; 2. An on-going plan for employee orientation, staff development, in-service training and continuing education; 3. An accurate and complete personnel record for each employee including: <ol style="list-style-type: none"> a. Verification of current professional license, registration, or certificate or completion of a required approved training course; b. Criminal record check; c. Verification that the employee has reviewed or received a copy of the job description; d. Orientation to the nursing facility, its policies and to the position and duties assigned; e. Completed continuing education program approved for the employee as determined by the outcome of the annual performance evaluation; f. Annual employee performance evaluations; and g. Disciplinary action taken; and 4. Employee health-related information retained in a file separate from personnel files. <p>F. Financial policies and procedures shall include, but not be limited to:</p> <ol style="list-style-type: none"> 1. Admission agreements; 2. Methods of billing:
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		<p>b. Services delivered by contractors of the nursing facility; and c. Third party payers; 3. Resident or designated representative notification of changes in fees and charges; 4. Correction of billing errors and refund policy; 5. Collection of delinquent resident accounts; and 6. Handling of resident funds. G. Policies shall be made available for review, upon request, to residents and their designated representatives. H. Policies and procedures shall be readily available for staff use at all times.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>a. Services not included in the basic daily or monthly rate; b. Services delivered by contractors of the nursing facility; and c. Third party payers; 3. Resident or designated representative notification of changes in fees and charges; 4. Correction of billing errors and refund policy; 5. Collection of delinquent resident accounts; and 6. Handling of resident funds. G. Policies shall be made available for review, upon request, to residents and their designated representatives. H. Policies and procedures shall be readily available for staff use at all times.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
150	N/A	<p>12VAC5-371-150. Resident rights. A. The nursing facility shall develop and implement policies and procedures that ensure resident's rights as defined in §§ 32.1-138 and 32.1-138.1 of the Code of Virginia. B. The procedures shall: 1. Not restrict any right a resident has under law; 2. Provide staff training to implement resident's rights; and 3. Include grievance procedures. C. The name and telephone number of the complaint coordinator of the OLC, the Adult Protective Services toll-free telephone number, and the toll-free telephone number for the State</p>	<p>CHANGE: The Board is proposing the following changes: 12VAC5-371-150. Resident rights. A. The nursing facility shall develop and implement policies and procedures that ensure resident's rights as defined in §§ 32.1-138 and 32.1-138.1 of the Code of Virginia. B. The procedures shall: 1. Not restrict any right a resident has under law; 2. Provide staff training to implement resident's rights; and 3. Include grievance procedures. C. The name and telephone number of the complaint coordinator of the OLC, the Adult Protective Services toll-free</p>

	<p>Ombudsman shall be conspicuously posted in a public place.</p> <p>D. Copies of resident rights shall be given to residents upon admittance to the facility and made available to residents currently in residence, to any guardians, next of kin, or sponsoring agency or agencies, and to the public.</p> <p>E. The nursing facility shall have a plan to review resident rights with each resident annually, or with the responsible family member or responsible agent at least annually, and have a plan to advise each staff member at least annually.</p> <p>F. The nursing facility shall certify, in writing, that it is in compliance with the provisions of §§ 32.1-138 and 32.1-138.1 of the Code of Virginia, relative to resident rights, as a condition of license issuance or renewal.</p> <p>G. The nursing facility shall register with the Department of State Police to receive notice of the registration or reregistration of any sex offender within the same or a contiguous zip code area in which the facility is located pursuant to § 9.1-914 of the Code of Virginia.</p> <p>H. Prior to admission, each nursing facility shall determine if a potential resident is a registered sex offender when the potential resident is anticipated to have a length of stay:</p> <ol style="list-style-type: none"> 1. Greater than three days; or 2. In fact stays longer than three days. <p>I. The nursing facility shall not restrict the rights of a nursing home resident's family and resident's legal representative to meet in the facility with the families and legal representatives of other residents of the facility.</p> <p>Statutory Authority §§ 32.1-12, 32.1-127, and 32.1-162.12 of the Code of Virginia.</p>	<p>telephone number, and the toll-free telephone number for the State Ombudsman shall be conspicuously posted in a public place.</p> <p>D. Copies of resident rights shall be given to residents upon admittance to the <u>nursing</u> facility and made available to residents currently in residence, to any guardians <u>legal representatives</u>, next of kin, or sponsoring agency or agencies, and to the public.</p> <p>E. The nursing facility shall have a plan to review resident rights with each resident annually, or with the responsible family member or responsible agent <u>legal representative</u> at least annually, and have a plan to advise each staff member at least annually.</p> <p>F. The nursing facility shall certify, in writing, that it is in compliance with the provisions of §§ 32.1-138 and 32.1-138.1 of the Code of Virginia, relative to resident rights, as a condition of license issuance or renewal.</p> <p>G. The nursing facility shall register with the Department of State Police to receive notice of the registration or reregistration of any sex offender within the same or a contiguous zip code area in which the <u>nursing</u> facility is located pursuant to § 9.1-914 of the Code of Virginia.</p> <p>H. Prior to admission, each nursing facility shall determine if a potential resident is a registered sex offender when the potential resident is anticipated to have a length of stay:</p> <ol style="list-style-type: none"> 1. Greater than three days; or 2. In fact stays longer than three days. <p>I. The nursing facility shall not restrict the rights of a nursing home resident's family and resident's legal representative to meet in the <u>nursing</u> facility with the families and legal representatives of other residents of the facility.</p> <p>Statutory Authority §§ 32.1-12, 32.1-127, and 32.1-162.12 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p>
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160	N/A	<p>12VAC5-371-160. Financial controls and resident funds.</p> <p>A. All financial records, including resident funds, shall be kept according to generally accepted accounting principles (GAAP).</p> <p>B. Each nursing facility shall maintain liability insurance coverage in a minimum 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 facility. Failure to maintain minimum insurance shall result in revocation of the facility's license.</p> <p>C. Nursing facilities choosing to handle resident funds shall:</p> <ol style="list-style-type: none"> 1. Comply with § 32.1-138 A 7 of the Code of Virginia regarding resident funds; 2. Purchase a surety bond or otherwise provide assurance for the security of all personal funds deposited with the facility; and 3. Provide for separate accounting for resident funds. <p>D. In the event the facility is sold, the nursing facility shall provide written verification that all resident funds have been transferred and shall obtain a signed receipt from the new owner. Upon receipt, the new owner shall provide an accounting of resident funds.</p> <p>E. Each nursing facility shall be required to provide a full refund of any unexpended patient funds on deposit with the facility following the discharge or death of a patient, other than entrance related fees, within 30 days of a written request for such funds by the discharged patient or, in the case of the death of a patient, the person administering the patient's estate in</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-160. Financial controls and resident funds.</p> <p>A. All financial records, including resident funds, shall be kept according to generally accepted accounting principles (GAAP).</p> <p>B. Each nursing facility shall maintain liability insurance coverage in a minimum 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 <u>nursing</u> facility. Failure to maintain minimum insurance shall result in revocation of the <u>nursing</u> facility's license.</p> <p>C. Nursing facilities choosing to handle resident funds shall:</p> <ol style="list-style-type: none"> 1. Comply with § 32.1-138 A 7 of the Code of Virginia regarding resident funds; 2. Purchase a surety bond or otherwise provide assurance for the security of all personal funds deposited with the <u>nursing</u> facility; and 3. Provide for separate accounting for resident funds. <p>D. In the event the <u>nursing</u> facility is sold, the nursing facility shall provide written verification that all resident funds have been transferred and shall obtain a signed receipt from the new owner. Upon receipt, the new owner shall provide an accounting of resident funds.</p> <p>E. Each nursing facility shall be required to provide a full refund of any unexpended patient funds on deposit with the <u>nursing</u> facility following the discharge or death of a patient, other than entrance related fees, within 30</p>

		<p>accordance with the Virginia Small Estate Act (§ 64.2-600 et seq. of the Code of Virginia).</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>days of a written request for such funds by the discharged patient or, in the case of the death of a patient, the person administering the patient's estate in accordance with the Virginia Small Estate Act (§ 64.2-600 et seq. of the Code of Virginia).</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
170	N/A	<p>12VAC5-371-170. Quality assessment and assurance.</p> <p>A. The nursing facility shall maintain a quality assessment and assurance committee consisting of at least the following individuals:</p> <ol style="list-style-type: none"> 1. The director of nursing services; 2. A physician designated by the facility; and 3. At least three other members of the facility staff, one of whom demonstrates an ability to represent the rights and concerns of residents. <p>B. The quality assessment and assurance committee shall:</p> <ol style="list-style-type: none"> 1. Meet at least quarterly to identify issues which would improve quality of care and services provided to residents; and 2. Develop and implement appropriate plans of action to correct identified deficiencies. <p>C. The nursing facility shall document compliance with these requirements.</p> <p>Statutory Authority</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-170. Quality assessment and assurance.</p> <p>A. The nursing facility shall maintain a quality assessment and assurance committee consisting of at least the following individuals:</p> <ol style="list-style-type: none"> 1. The director of nursing services; 2. A physician designated by the <u>nursing</u> facility; and 3. At least three other members of the <u>nursing</u> facility staff, one of whom demonstrates an ability to represent the rights and concerns of residents. <p>B. The quality assessment and assurance committee shall:</p> <ol style="list-style-type: none"> 1. Meet at least quarterly to identify issues which would improve quality of care and services provided to residents; and 2. Develop and implement appropriate plans of action to correct identified deficiencies. <p>C. The nursing facility shall document compliance with these requirements.</p>

		<p>§§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
<p>180</p>	<p>N/A</p>	<p>12VAC5-371-180. Infection control. A. The nursing facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. B. The infection control program shall encompass the entire physical plant and all services. C. The infection control program addressing the surveillance, prevention and control of facility wide infections shall include: 1. Procedures to isolate the infecting organism; 2. Access to handwashing equipment for staff; 3. Training of staff in proper handwashing techniques, according to accepted professional standards, to prevent cross contamination; 4. Implementation of universal precautions by direct resident care staff; 5. Prohibiting employees with communicable diseases or infections from direct contact with residents or their food, if direct contact will transmit disease; 6. Monitoring staff performance of infection control practices; 7. Handling, storing, processing and transporting linens, supplies and equipment in a</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-180. Infection control. A. The nursing facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. B. The infection control program shall encompass the entire physical plant and all services. C. The infection control program addressing the surveillance, prevention and control of <u>facility-wide</u> infections <u>in the nursing facility</u> shall include: 1. Procedures to isolate the infecting organism; 2. Access to handwashing equipment for staff; 3. Training of staff in proper handwashing techniques, according to accepted professional standards, to prevent cross contamination; 4. Implementation of universal precautions by direct resident care staff; 5. Prohibiting employees with communicable diseases or infections from direct contact with residents or their food, if direct contact will transmit disease; 6. Monitoring staff performance of infection control practices;</p>

		<p>manner that prevents the spread of infection; 8. Handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations; 9. Maintaining an effective pest control program; and 10. Staff education regarding infection risk-reduction behavior.</p> <p>D. The nursing facility shall report promptly to its local health department diseases designated as "reportable" according to 12VAC5-90-80 when such cases are admitted to or are diagnosed in the facility and shall report any outbreak of infectious disease as required by 12VAC5-90. An outbreak is defined as an increase in incidence of any infectious disease above the usual incidence at the facility.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>7. Handling, storing, processing and transporting linens, supplies and equipment in a manner that prevents the spread of infection; 8. Handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations; 9. Maintaining an effective pest control program; and 10. Staff education regarding infection risk-reduction behavior.</p> <p>D. The nursing facility shall report promptly to its local health department diseases designated as "reportable" according to 12VAC5-90-80 when such cases are admitted to or are diagnosed in the <u>nursing</u> facility and shall report any outbreak of infectious disease as required by 12VAC5-90. An outbreak is defined as an increase in incidence of any infectious disease above the usual incidence at the <u>nursing</u> facility.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
190	N/A	<p>12VAC5-371-190. Safety and emergency procedures. A. A written emergency preparedness plan shall be developed, reviewed, and implemented when needed. The plan shall address responses to natural disasters, as well as fire or other emergency which disrupts the normal course of operations. The plan shall address provisions for relocating residents and also address staff responsibilities for:</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-190. Safety and emergency procedures. A. A written emergency preparedness plan shall be developed, reviewed, and implemented when needed. The plan shall address responses to natural disasters, as well as fire or other emergency which disrupts the normal course of operations. The plan shall address</p>

	<p>1. Alerting emergency personnel and sounding alarms;</p> <p>2. Implementing evacuation procedures including the evacuation of residents with special needs;</p> <p>3. Using, maintaining and operating emergency equipment;</p> <p>4. Accessing resident emergency medical information; and</p> <p>5. Utilizing community support services.</p> <p>B. All staff shall participate in periodic emergency preparedness training.</p> <p>C. Staff shall have documented knowledge of, and be prepared to implement, the emergency preparedness plan in the event of an emergency.</p> <p>D. At least one telephone shall be available in each area to which residents are admitted and additional telephones or extensions as are necessary to ensure availability in case of need.</p> <p>E. In the event of a disaster, fire, emergency or any other condition that may jeopardize the health, safety and well-being of residents, the organization shall notify the OLC of the conditions and status of the residents and the licensed facility as soon as possible.</p> <p>F. The nursing facility shall have a policy on smoking.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>provisions for relocating residents and also address staff responsibilities for:</p> <p>1. Alerting emergency personnel and sounding alarms;</p> <p>2. Implementing evacuation procedures including the evacuation of residents with special needs;</p> <p>3. Using, maintaining and operating emergency equipment;</p> <p>4. Accessing resident emergency medical information; and</p> <p>5. Utilizing community support services.</p> <p>B. All staff shall participate in periodic emergency preparedness training.</p> <p>C. Staff shall have documented knowledge of, and be prepared to implement, the emergency preparedness plan in the event of an emergency.</p> <p>D. At least one telephone shall be available in each area to which residents are admitted and additional telephones or extensions as are necessary to ensure availability in case of need.</p> <p>E. In the event of a disaster, fire, emergency or any other condition that may jeopardize the health, safety and well-being of residents, the organization <u>nursing facility</u> shall notify the OLC of the conditions and status of the residents and the licensed facility <u>physical plant</u> as soon as possible.</p> <p>F. The nursing facility shall have a policy on smoking.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p>
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<p>191</p>	<p>N/A</p>	<p>12VAC5-371-191. Electronic monitoring in resident rooms.</p> <p>A. All requests for electronic monitoring shall be made in writing and signed by the resident or the resident's responsible party if the resident has been properly assessed incapable of requesting and authorizing the monitoring.</p> <p>B. Only electronic monitoring in accordance with this section is permitted.</p> <p>C. A facility shall not refuse to admit an individual and shall not discharge or transfer a resident due to a request to conduct authorized electronic monitoring.</p> <p>D. Family members cannot obtain electronic monitoring over the objections of the resident, the resident's roommate, or the resident's responsible party. No equipment may be installed pursuant to subsection Q of this section over the objections of the resident, or if the resident is incapable, the resident's responsible party. Facilities shall not use monitoring equipment in violation of the law based solely on a family member's request or approval.</p> <p>E. Consent for electronic monitoring shall be kept in the resident's medical record.</p> <p>F. Facilities shall designate one staff person to be responsible for managing the electronic monitoring program.</p> <p>G. Facilities may designate custodial ownership of any recordings from monitoring devices to the resident or the resident's responsible party. Facility retained recordings shall be considered part of the resident's medical record and shall be retained for no less than two years or as required by state and federal laws.</p> <p>H. If a facility chooses to retain ownership of recordings, the facility shall not permit viewings of recordings without consent of the resident or the resident's responsible party except to the extent that disclosure is required by law through a court order or pursuant to a lawful subpoena duces tecum. Should</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-191. Electronic monitoring in resident rooms.</p> <p>A. All requests for electronic monitoring shall be made in writing and signed by the resident or the resident's responsible party <u>legal representative</u> if the resident has been properly assessed incapable of requesting and authorizing the monitoring.</p> <p>B. Only electronic monitoring in accordance with this section is permitted.</p> <p>C. A <u>nursing facility</u> shall not refuse to admit an individual and shall not discharge or transfer a resident due to a request to conduct authorized electronic monitoring.</p> <p>D. Family members cannot obtain electronic monitoring over the objections of the resident, the resident's roommate, or the resident's responsible party <u>legal representative</u>. No equipment may be installed pursuant to subsection Q of this section over the objections of the resident, or if the resident is incapable, the resident's responsible party or legal representative. <u>Facilities Nursing facilities</u> shall not use monitoring equipment in violation of the law based solely on a family member's request or approval.</p> <p>E. Consent for electronic monitoring shall be kept in the resident's medical record.</p> <p>F. Facilities <u>Nursing facilities</u> shall designate one staff person to be responsible for managing the electronic monitoring program.</p> <p>G. Facilities <u>Nursing facilities</u> may designate custodial ownership of any recordings from monitoring devices to the resident or the resident's responsible party <u>legal representative</u>. <u>Facility Nursing facility</u> retained recordings shall be considered part of the resident's medical record and shall be retained for no less than two years or as required by state and federal laws.</p>

	<p>a resident or a resident's responsible party approve viewing, the facility shall accommodate viewing of any recordings in a timely manner, including providing:</p> <ol style="list-style-type: none"> 1. Appropriate playing or viewing equipment; 2. Privacy during viewing; and 3. Viewing times convenient to the resident or the resident's responsible party. <p>If unauthorized viewing is discovered, the facility shall report any such violation to the Office of Long-Term Care Ombudsman and to OLC.</p> <p>I. A facility shall require its staff to report any incidents regarding safety or quality of care discovered as a result of viewing a recording immediately to the facility administrator and to the OLC. Facilities shall instruct the resident or the resident's responsible party of this reporting requirement and shall provide the resident or the resident's responsible party with the OLC's complaint hotline telephone number.</p> <p>J. A facility shall have no obligation to seek access to a recording in its possession or to have knowledge of a recording's content, unless the facility is aware of a recorded incident of suspected abuse, neglect, accident, or injury, or the resident, the resident's responsible party, or a government agency seeks to use a recording. Facilities shall immediately report suspected abuse and neglect discovered as a result of using monitoring devices, as required by law.</p> <p>K. A facility may require the resident or the resident's responsible party to be responsible for all aspects of the operation of the monitoring equipment, including the removal and replacement of recordings; adherence to local, state, and federal privacy laws; and for firewall protections to prevent images that would violate obscenity laws from being inadvertently shown on the Internet.</p> <p>L. A facility shall prohibit assigned staff from refusing to enter a resident's room solely because of electronic monitoring.</p> <p>M. Any electronic monitoring equipment shall be installed in a manner that is safe for residents, employees, or</p>	<p>H. If a <u>nursing</u> facility chooses to retain ownership of recordings, the <u>nursing</u> facility shall not permit viewings of recordings without consent of the resident or the resident's responsible party <u>legal representative</u> except to the extent that disclosure is required by law through a court order or pursuant to a lawful subpoena duces tecum. Should a the resident or a resident's responsible party <u>legal representative</u> approve viewing, the <u>nursing</u> facility shall accommodate viewing of any recordings in a timely manner, including providing:</p> <ol style="list-style-type: none"> 1. Appropriate playing or viewing equipment; 2. Privacy during viewing; and 3. Viewing times convenient to the resident or the resident's responsible <u>party legal representative</u>. <p>If unauthorized viewing is discovered, the <u>nursing</u> facility shall report any such violation to the Office of Long-Term Care Ombudsman and to OLC.</p> <p>I. A <u>nursing</u> facility shall require its staff to report any incidents regarding safety or quality of care discovered as a result of viewing a recording immediately to the facility administrator and to the OLC. Facilities <u>Nursing facilities</u> shall instruct the resident or the resident's responsible party <u>legal representative</u> of this reporting requirement and shall provide the resident or the resident's responsible party <u>legal representative</u> with the OLC's complaint hotline telephone number.</p> <p>J. A <u>nursing</u> facility shall have no obligation to seek access to a recording in its possession or to have knowledge of a recording's content, unless the <u>nursing</u> facility is aware of a recorded incident of suspected abuse, neglect, accident, or injury, or the resident, the resident's responsible party <u>legal representative</u>, or a government agency seeks to use a recording. Facilities <u>Nursing facilities</u> shall immediately report suspected abuse and neglect discovered as a result of using monitoring devices, as required by law.</p> <p>K. A <u>nursing</u> facility may require the resident or the resident's responsible party <u>legal representative</u> to be</p>
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	<p>visitors who may be moving about the resident's room.</p> <p>N. A facility shall make reasonable physical accommodation for monitoring equipment, including:</p> <ol style="list-style-type: none"> 1. Providing a reasonably secure place to mount the device; and 2. Providing access to power sources for the device. <p>O. A facility may require a resident or a resident's responsible party to pay for all costs, other than the cost of electricity, associated with installing electronic monitoring equipment. Such costs shall be reasonable and may include equipment, recording media and installation, compliance with life safety and building and electrical codes, maintenance or removal of the equipment, posting and removal of any public notices, or structural repairs to the building resulting from the removal of the equipment. Facilities shall give 45 days' notice of an increase in monthly monitoring fees.</p> <p>P. Any equipment installed for the purpose of monitoring a resident's room shall be fixed and unable to rotate.</p> <p>Q. The informed consent of all residents, or if a resident is incapable, a resident's responsible party, assigned to the monitored room shall be obtained prior to any electronic monitoring equipment being installed.</p> <p>R. A copy of any signed consent form shall be kept in the resident's medical record as well as on file with the facility's designated electronic monitoring coordinator.</p> <p>S. Any resident or the resident's responsible party of a monitored room may condition consent for use of monitoring devices. Such conditions may include pointing the camera away or limiting or prohibiting the use of certain devices. If conditions are placed on consent, then electronic monitoring shall be conducted according to those conditions.</p> <p>T. The facility shall conspicuously post and maintain a notice at the entrance to the resident's room stating that an electronic monitoring device is in operation.</p>	<p>responsible for all aspects of the operation of the monitoring equipment, including the removal and replacement of recordings; adherence to local, state, and federal privacy laws; and for firewall protections to prevent images that would violate obscenity laws from being inadvertently shown on the Internet.</p> <p>L. A <u>nursing</u> facility shall prohibit assigned staff from refusing to enter a resident's room solely because of electronic monitoring.</p> <p>M. Any electronic monitoring equipment shall be installed in a manner that is safe for residents, employees, or visitors who may be moving about the resident's room.</p> <p>N. A <u>nursing</u> facility shall make reasonable physical accommodation for monitoring equipment, including:</p> <ol style="list-style-type: none"> 1. Providing a reasonably secure place to mount the device; and 2. Providing access to power sources for the device. <p>O. A <u>nursing</u> facility may require a resident or a resident's responsible party <u>legal representative</u> to pay for all costs, other than the cost of electricity, associated with installing electronic monitoring equipment. Such costs shall be reasonable and may include equipment, recording media and installation, compliance with life safety and building and electrical codes, maintenance or removal of the equipment, posting and removal of any public notices, or structural repairs to the building resulting from the removal of the equipment. Facilities <u>Nursing facilities</u> shall give 45 days' notice of an increase in monthly monitoring fees.</p> <p>P. Any equipment installed for the purpose of monitoring a resident's room shall be fixed and unable to rotate.</p> <p>Q. The informed consent of all residents, or if a resident is incapable, a resident's responsible party, <u>or residents' legal representatives</u> assigned to the monitored room shall be obtained prior to any electronic monitoring equipment being installed.</p> <p>R. A copy of any signed consent form shall be kept in the resident's medical record as well as on file with the</p>
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	<p>U. Facilities shall notify all staff and their OLC Long-Term Care Supervisor that electronic monitoring is in use.</p> <p>V. A facility shall prohibit staff from covert monitoring in violation of this chapter. Facilities shall instruct the resident or the resident's responsible party of this prohibition and shall provide the resident or the resident's responsible party with the OLC's complaint hotline telephone number.</p> <p>W. If covert monitoring is discovered, the facility shall report any such violation to the Office of Long-Term Care Ombudsman and OLC, and the facility may require a resident or a resident's responsible party to meet all the requirements for authorized monitoring, if permitted by the facility.</p> <p>X. Each nursing facility, including those that choose not to offer electronic monitoring, shall adopt policies and procedures for electronic monitoring. These policies and procedures shall address all the elements of this section.</p> <p>Y. A facility shall prohibit staff from tampering with electronic monitoring in violation of this chapter. Facilities shall instruct the resident or the resident's responsible party of this prohibition and shall provide the resident or the resident's responsible party with the OLC's complaint hotline telephone number.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p><u>nursing</u> facility's designated electronic monitoring coordinator.</p> <p>S. Any resident or the resident's responsible party <u>legal representative of a resident</u> of a monitored room may condition consent for use of monitoring devices. Such conditions may include pointing the camera away or limiting or prohibiting the use of certain devices. If conditions are placed on consent, then electronic monitoring shall be conducted according to those conditions.</p> <p>T. The <u>nursing</u> facility shall conspicuously post and maintain a notice at the entrance to the resident's room stating that an electronic monitoring device is in operation.</p> <p>U. Facilities <u>Nursing facilities</u> shall notify all staff and their <u>the long-term care division of the OLC Long-Term Care Supervisor</u> that electronic monitoring is in use.</p> <p>V. A <u>nursing</u> facility shall prohibit staff from covert monitoring in violation of this chapter. Facilities <u>Nursing facilities</u> shall instruct the resident or the resident's responsible party <u>legal representative</u> of this prohibition and shall provide the resident or the resident's responsible party <u>legal representative</u> with the OLC's complaint hotline telephone number.</p> <p>W. If covert monitoring is discovered, the <u>nursing</u> facility shall report any such violation to the Office of Long-Term Care Ombudsman and OLC, and the <u>nursing</u> facility may require a resident or a resident's responsible party <u>legal representative</u> to meet all the requirements for authorized monitoring, if permitted by the <u>nursing</u> facility.</p> <p>X. Each nursing facility, including those that choose not to offer electronic monitoring, shall adopt policies and procedures for electronic monitoring. These policies and procedures shall address all the elements of this section.</p> <p>Y. A <u>nursing</u> facility shall prohibit staff from tampering with electronic monitoring in violation of this chapter. Facilities <u>Nursing facilities</u> shall instruct the resident or the resident's responsible party <u>legal representative</u> of this prohibition and shall provide the resident or the resident's responsible party <u>legal</u></p>
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			<p><u>representative</u> with the OLC's complaint hotline telephone number.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
210	N/A	<p>12VAC5-371-210. Nurse staffing.</p> <p>A. A nursing supervisor, designated by the director of nursing, shall be responsible for all nursing activities in the facility, or in the section to which assigned, including:</p> <ol style="list-style-type: none"> 1. Making daily visits to determine resident physical, mental, and emotional status and implementing any required nursing intervention; 2. Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherence to stop-order policies; 3. Reviewing resident plans of care for appropriate goals and approaches, and making revisions based on individual needs; 4. Assigning to the nursing staff responsibility for nursing care; 5. Supervising and evaluating performance of all nursing personnel on the unit; and 6. Keeping the director of nursing services, or director of nursing designee, informed of the status of residents and other related matters. <p>B. The nursing facility shall provide qualified nurses and certified nurse aides on all shifts, seven days per week, in sufficient number to meet the</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-210. Nurse staffing.</p> <p>A. A nursing supervisor, designated by the director of nursing, shall be responsible for all nursing activities in the <u>nursing</u> facility, or in the section to which assigned, including:</p> <ol style="list-style-type: none"> 1. Making daily visits to determine resident physical, mental, and emotional status and implementing any required nursing intervention; 2. Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherence to stop-order policies; 3. Reviewing resident plans of care for appropriate goals and approaches, and making revisions based on individual needs; 4. Assigning to the nursing staff responsibility for nursing care; 5. Supervising and evaluating performance of all nursing personnel on the unit; and 6. Keeping the director of nursing services, or director of nursing designee, informed of the status of residents and other related matters.

	<p>assessed nursing care needs of all residents.</p> <p>C. Nursing personnel, including registered nurses, licensed practical nurses, and certified nurse aides shall be assigned duties consistent with their education, training and experience.</p> <p>D. Weekly time schedules shall be maintained and shall indicate the number and classification of nursing personnel who worked on each unit for each shift. Schedules shall be retained for one year.</p> <p>E. 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 and with a plan developed and implemented by the facility.</p> <p>F. Before allowing a nurse aide to perform resident care duties, the nursing facility shall verify that the individual is:</p> <ol style="list-style-type: none"> 1. A certified nurse aide in good standing; 2. Enrolled full-time in a nurse aide education program approved by the Virginia Board of Nursing; or 3. Has completed a nurse aide education program or competency testing, but has not yet been placed on the nurse aide registry. <p>G. Any person employed to perform the duties of a nurse aide on a permanent full-time, part-time, hourly, or contractual basis must be registered as a certified nurse aide within 120 days of employment.</p> <p>H. Nurse aides employed or provided by a temporary personnel agency shall be certified to deliver nurse aide services.</p> <p>I. The services provided or arranged with a temporary personnel agency shall meet professional standards of practice and be provided by qualified staff according to each resident's comprehensive plan of care.</p> <p>Statutory Authority</p>	<p>B. The nursing facility shall provide qualified nurses and certified nurse aides on all shifts, seven days per week, in sufficient number to meet the assessed nursing care needs of all residents.</p> <p>C. Nursing personnel, including registered nurses, licensed practical nurses, and certified nurse aides shall be assigned duties consistent with their education, training and experience.</p> <p>D. Weekly time schedules shall be maintained and shall indicate the number and classification of nursing personnel who worked on each unit for each shift. Schedules shall be retained for one year.</p> <p>E. 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 and with a plan developed and implemented by the <u>nursing</u> facility.</p> <p>F. Before allowing a nurse aide to perform resident care duties, the nursing facility shall verify that the individual is:</p> <ol style="list-style-type: none"> 1. A certified nurse aide in good standing; 2. Enrolled full-time in a nurse aide education program approved by the Virginia Board of Nursing; or 3. Has completed a nurse aide education program or competency testing, but has not yet been placed on the nurse aide registry. <p>G. Any person employed to perform the duties of a nurse aide on a permanent full-time, part-time, hourly, or contractual basis must be registered as a certified nurse aide within 120 days of employment.</p> <p>H. Nurse aides employed or provided by a temporary personnel agency shall be certified to deliver nurse aide services.</p> <p>I. The services provided or arranged with a temporary personnel agency shall meet professional standards of practice and be provided by qualified staff</p>
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		<p>§§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>according to each resident's comprehensive plan of care.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
260	N/A	<p>12VAC5-371-260. Staff development and inservice training.</p> <p>A. All full-time, part-time and temporary personnel shall receive orientation to the facility commensurate with their function or job-specific responsibilities.</p> <p>B. All resident care staff shall receive annual inservice training commensurate with their function or job-specific responsibilities in at least the following:</p> <ol style="list-style-type: none"> 1. Special needs of residents as determined by the facility staff; 2. Prevention and control of infections; 3. Fire prevention or control and emergency preparedness; 4. Safety and accident prevention; 5. Restraint use, including alternatives to physical and chemical restraints; 6. Confidentiality of resident information; 7. Understanding the needs of the aged and disabled; 8. Resident rights, including personal rights, property rights and the protection of privacy, and procedures for handling complaints; 9. Care of the cognitively impaired; 10. Basic principles of cardiopulmonary resuscitation 	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-260. Staff development and inservice training.</p> <p>A. All full-time, part-time and temporary personnel shall receive orientation to the <u>nursing</u> facility commensurate with their function or job-specific responsibilities.</p> <p>B. All resident care staff shall receive annual inservice training commensurate with their function or job-specific responsibilities in at least the following:</p> <ol style="list-style-type: none"> 1. Special needs of residents as determined by the <u>nursing</u> facility staff; 2. Prevention and control of infections; 3. Fire prevention or control and emergency preparedness; 4. Safety and accident prevention; 5. Restraint use, including alternatives to physical and chemical restraints; 6. Confidentiality of resident information; 7. Understanding the needs of the aged and disabled; 8. Resident rights, including personal rights, property rights and the protection of privacy, and procedures for handling complaints;

	<p>for licensed nursing staff and the Heimlich maneuver for nurse aides; and</p> <p>11. Prevention and treatment of pressure sores.</p> <p>C. The nursing facility shall have an ongoing training program that is planned and conducted for the development and improvement of skills of all personnel.</p> <p>D. The nursing facility shall maintain written records indicating the content of and attendance at each orientation and inservice training program.</p> <p>E. The nursing facility shall provide inservice programs, based on the outcome of annual performance evaluations, for nurse aides.</p> <p>F. Nurse aide inservice training shall consist of at least 12 hours per anniversary year.</p> <p>G. The nursing facility shall provide training on the requirements for reporting adult abuse, neglect, or exploitation and the consequences for failing to make such a required report to all its employees who are licensed to practice medicine or any of the healing arts, serving as a hospital resident or intern, engaged in the nursing profession, working as a social worker, mental health professional or law-enforcement officer and any other individual working with residents of the nursing facility.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>9. Care of the cognitively impaired;</p> <p>10. Basic principles of cardiopulmonary resuscitation for licensed nursing staff and the Heimlich maneuver for nurse aides; and</p> <p>11. Prevention and treatment of pressure sores.</p> <p>C. The nursing facility shall have an ongoing training program that is planned and conducted for the development and improvement of skills of all personnel.</p> <p>D. The nursing facility shall maintain written records indicating the content of and attendance at each orientation and inservice training program.</p> <p>E. The nursing facility shall provide inservice programs, based on the outcome of annual performance evaluations, for nurse aides.</p> <p>F. Nurse aide inservice training shall consist of at least 12 hours per anniversary year.</p> <p>G. The nursing facility shall provide training on the requirements for reporting adult abuse, neglect, or exploitation and the consequences for failing to make such a required report to all its employees who are licensed to practice medicine or any of the healing arts, serving as a hospital resident or intern, engaged in the nursing profession, working as a social worker, mental health professional or law-enforcement officer and any other individual working with residents of the nursing facility.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
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<p>300</p>	<p>N/A</p>	<p>12VAC5-371-300. Pharmaceutical services.</p> <p>A. Provision shall be made for the procurement, storage, dispensing, and accounting of drugs and other pharmacy products in compliance with 18VAC110-20. This may be by arrangement with an off-site pharmacy, but must include provisions for 24-hour emergency service.</p> <p>B. Each nursing facility shall develop and implement policies and procedures for the handling of drugs and biologicals, including procurement, storage, administration, self-administration and disposal of drugs.</p> <p>C. Each nursing facility shall have a written agreement with a qualified pharmacist to provide consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>D. The consultant pharmacist shall make regularly scheduled visits, at least monthly, to the nursing facility for a sufficient number of hours to carry out the function of the agreement.</p> <p>E. No drug or medication shall be administered to any resident without a valid verbal order or a written, dated and signed order from a physician, dentist or podiatrist, nurse practitioner or physician assistant, licensed in Virginia.</p> <p>F. Verbal orders for drugs or medications shall only be given to a licensed nurse, pharmacist or physician.</p> <p>G. Drugs and medications not limited as to time or number of doses when ordered shall be automatically stopped, according to the written policies of the nursing facility, and the attending physician shall be notified.</p> <p>H. Each resident's medication regimen shall be reviewed by a pharmacist licensed by the Virginia Board of Pharmacy. Any irregularities identified by the pharmacist shall be reported to the physician and the director of nursing, and their response documented.</p> <p>I. Medication orders shall be reviewed at least every 60 days by the attending physician, nurse practitioner, or physician's assistant.</p> <p>J. Prescription and nonprescription drugs and medications may be brought</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-300. Pharmaceutical services.</p> <p>A. Provision shall be made for the procurement, storage, dispensing, and accounting of drugs and other pharmacy products in compliance with 18VAC110-20. This may be by arrangement with an off-site pharmacy, but must include provisions for 24-hour emergency service.</p> <p>B. Each nursing facility shall develop and implement policies and procedures for the handling of drugs and biologicals, including procurement, storage, administration, self-administration and disposal of drugs.</p> <p>C. Each nursing facility shall have a written agreement with a qualified pharmacist to provide consultation on all aspects of the provision of pharmacy services in the <u>nursing</u> facility.</p> <p>D. The consultant pharmacist shall make regularly scheduled visits, at least monthly, to the nursing facility for a sufficient number of hours to carry out the function of the agreement.</p> <p>E. No drug or medication shall be administered to any resident without a valid verbal order or a written, dated and signed order from a physician, dentist or podiatrist, nurse practitioner or physician assistant, licensed in Virginia.</p> <p>F. Verbal orders for drugs or medications shall only be given to a licensed nurse, pharmacist or physician.</p> <p>G. Drugs and medications not limited as to time or number of doses when ordered shall be automatically stopped, according to the written policies of the nursing facility, and the attending physician shall be notified.</p> <p>H. Each resident's medication regimen shall be reviewed by a pharmacist licensed by the Virginia Board of Pharmacy. Any irregularities identified by the pharmacist shall be reported to the physician and the director of nursing, and their response documented.</p> <p>I. Medication orders shall be reviewed at least every 60 days by the attending physician, nurse practitioner, or physician's assistant.</p>
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		<p>into the nursing facility by a resident's family, friend or other person provided:</p> <ol style="list-style-type: none"> 1. The individual delivering the drugs and medications assures timely delivery, in accordance with the nursing facility's written policies, so that the resident's prescribed treatment plan is not disrupted; 2. Each drug or medication is in an individual container; and 3. Delivery is not allowed directly to an individual resident. <p>In addition, prescription medications shall be obtained and labeled as required by law.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>J. Prescription and nonprescription drugs and medications may be brought into the nursing facility by a resident's family, friend or other person provided:</p> <ol style="list-style-type: none"> 1. The individual delivering the drugs and medications assures timely delivery, in accordance with the nursing facility's written policies, so that the resident's prescribed treatment plan is not disrupted; 2. Each drug or medication is in an individual container; and 3. Delivery is not allowed directly to an individual resident. <p>In addition, prescription medications shall be obtained and labeled as required by law.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
330	N/A	<p>12VAC5-371-330. Restraint usage.</p> <p>A. A resident shall be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>B. Restraints shall only be used:</p> <ol style="list-style-type: none"> 1. In accordance with the comprehensive assessment and plan of care, which includes a schedule or plan of rehabilitation training enabling the progressive removal or the progressive use of less restrictive restraints when appropriate; and 2. As a last resort, after completing, implementing, and evaluating the resident's comprehensive assessment 	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-330. Restraint usage.</p> <p>A. A resident shall be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>B. Restraints shall only be used:</p> <ol style="list-style-type: none"> 1. In accordance with the comprehensive assessment and plan of care, which includes a schedule or plan of rehabilitation training enabling the progressive removal or the progressive use of less restrictive restraints when appropriate; and

	<p>and plan of care, when the nursing facility has determined that less restrictive means have failed.</p> <p>C. If a restraint is used in a nonemergency, the nursing facility shall:</p> <ol style="list-style-type: none"> 1. Explain the use of the restraint, including potential negative outcomes of restraint use, to the resident or his legal representative, as appropriate; 2. Explain the resident's right to refuse the restraint; 3. Obtain written consent of the resident. If the resident has been legally declared incompetent, obtain written consent from the legal representative; and 4. Include the use of restraint in the plan of care. <p>D. Restraints shall not be ordered on a standing or PRN basis.</p> <p>E. Restraints shall be applied only by staff trained in their use.</p> <p>F. At a minimum, for a resident placed in a restraint, the nursing facility shall:</p> <ol style="list-style-type: none"> 1. Check the resident at least every 30 minutes; 2. Provide an opportunity for motion, exercise and elimination for not less than 10 minutes each hour in which a restraint is administered; and 3. Document restraint usage, including outcomes, in accordance with facility policy. <p>G. Emergency orders for restraints shall not be in effect for longer than 24 hours and must be confirmed by a physician within one hour of administration. Each application of emergency restraint shall be considered a single event and shall require a separate physician's order.</p> <p>H. Temporary restraints may be used for a brief period to allow a medical or surgical procedure, but shall not be used to impose a medical or surgical procedure which the resident has previously refused.</p> <p>I. The nursing facility shall notify a resident's legal representative, if any, or designated family member as soon as</p>	<ol style="list-style-type: none"> 2. As a last resort, after completing, implementing, and evaluating the resident's comprehensive assessment and plan of care, when the nursing facility has determined that less restrictive means have failed. <p>C. If a restraint is used in a nonemergency, the nursing facility shall:</p> <ol style="list-style-type: none"> 1. Explain the use of the restraint, including potential negative outcomes of restraint use, to the resident or his legal representative, as appropriate; 2. Explain the resident's right to refuse the restraint; 3. Obtain written consent of the resident. If the resident has been legally declared incompetent, obtain written consent from the legal representative; and 4. Include the use of restraint in the plan of care. <p>D. Restraints shall not be ordered on a standing or PRN basis.</p> <p>E. Restraints shall be applied only by staff trained in their use.</p> <p>F. At a minimum, for a resident placed in a restraint, the nursing facility shall:</p> <ol style="list-style-type: none"> 1. Check the resident at least every 30 minutes; 2. Provide an opportunity for motion, exercise and elimination for not less than 10 minutes each hour in which a restraint is administered; and 3. Document restraint usage, including outcomes, in accordance with <u>nursing</u> facility policy. <p>G. Emergency orders for restraints shall not be in effect for longer than 24 hours and must be confirmed by a physician within one hour of administration. Each application of emergency restraint shall be considered a single event and shall require a separate physician's order.</p> <p>H. Temporary restraints may be used for a brief period to allow a medical or surgical procedure, but shall not be used to impose a medical or surgical</p>
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	<p>practicable, but no later than 12 hours after administration of a restraint.</p> <p>J. Chemical restraint shall only be ordered in an emergency situation when necessary to ensure the physical safety of the resident or other individuals.</p> <p>K. Orders for chemical restraint shall be in writing, signed by a physician, specifying the dose, frequency, duration and circumstances under which the chemical restraint is to be used. Verbal orders for chemical restraints shall be implemented when an emergency necessitates parenteral administration of psychopharmacologic drugs, but only until a written order can reasonably be obtained.</p> <p>L. Emergency orders for chemical restraints shall:</p> <ol style="list-style-type: none"> 1. Not be in effect for more than 24 hours; and 2. Be administered only if the resident is monitored continually for the first 15 minutes after each parenteral administration (or 30 minutes for nonparenteral administration) and every 15 minutes thereafter, for the first hour, and hourly for the next eight hours to ensure that any adverse side effects will be noticed and appropriate action taken as soon as possible. <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>procedure which the resident has previously refused.</p> <p>I. The nursing facility shall notify a resident's legal representative, if any, or designated family member as soon as practicable, but no later than 12 hours after administration of a restraint.</p> <p>J. Chemical restraint shall only be ordered in an emergency situation when necessary to ensure the physical safety of the resident or other individuals.</p> <p>K. Orders for chemical restraint shall be in writing, signed by a physician, specifying the dose, frequency, duration and circumstances under which the chemical restraint is to be used. Verbal orders for chemical restraints shall be implemented when an emergency necessitates parenteral administration of psychopharmacologic drugs, but only until a written order can reasonably be obtained.</p> <p>L. Emergency orders for chemical restraints shall:</p> <ol style="list-style-type: none"> 1. Not be in effect for more than 24 hours; and 2. Be administered only if the resident is monitored continually for the first 15 minutes after each parenteral administration (or 30 minutes for nonparenteral administration) and every 15 minutes thereafter, for the first hour, and hourly for the next eight hours to ensure that any adverse side effects will be noticed and appropriate action taken as soon as possible. <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
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<p>360</p>	<p>N/A</p>	<p>12VAC5-371-360. Clinical records.</p> <p>A. The nursing facility shall maintain an organized clinical record system in accordance with recognized professional practices. Written policies and procedures shall be established specifying content and completion of clinical records.</p> <p>B. Clinical records shall be confidential. Only authorized personnel shall have access as specified in §§ 8.01-413 and 32.1-127.1:03 of the Code of Virginia.</p> <p>C. Records shall be safeguarded against destruction, fire, loss or unauthorized use.</p> <p>D. Overall supervisory responsibility for assuring that clinical records are maintained, completed and preserved shall be assigned to an employee of the nursing facility. The individual shall have work experience or training which is consistent with the nature and complexity of the record system and be capable of effectively carrying out the functions of the job.</p> <p>E. An accurate and complete clinical record shall be maintained for each resident and shall include, but not be limited to:</p> <ol style="list-style-type: none"> 1. Resident identification; 2. Designation of attending physician; 3. Admitting information, including resident medical history, physical examination and diagnosis; 4. Physician orders, including all medications, treatments, diets, restorative and special medical procedures required; 5. Progress notes written at the time of each visit; 6. Documented evidence of assessment of resident's needs, establishment of an appropriate treatment plan, and interdisciplinary plan of care; 7. Nurse's notes written in chronological order and signed by the individual making the entry; 8. All symptoms and other indications of illness or injury, including date, time, and action taken on each shift; 	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-360. Clinical records.</p> <p>A. The nursing facility shall maintain an organized clinical record system in accordance with recognized professional practices. Written policies and procedures shall be established specifying content and completion of clinical records.</p> <p>B. Clinical records shall be confidential. Only authorized personnel shall have access as specified in §§ 8.01-413 and 32.1-127.1:03 of the Code of Virginia.</p> <p>C. Records shall be safeguarded against destruction, fire, loss or unauthorized use.</p> <p>D. Overall supervisory responsibility for assuring that clinical records are maintained, completed and preserved shall be assigned to an employee of the nursing facility. The individual shall have work experience or training which is consistent with the nature and complexity of the record system and be capable of effectively carrying out the functions of the job.</p> <p>E. An accurate and complete clinical record shall be maintained for each resident and shall include, but not be limited to:</p> <ol style="list-style-type: none"> 1. Resident identification; 2. Designation of attending physician; 3. Admitting information, including resident medical history, physical examination and diagnosis; 4. Physician orders, including all medications, treatments, diets, restorative and special medical procedures required; 5. Progress notes written at the time of each visit; 6. Documented evidence of assessment of resident's needs, establishment of an appropriate treatment plan, and interdisciplinary plan of care; 7. Nurse's notes written in chronological order and signed by the individual making the entry;
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	<p>9. Medication and treatment record, including all medications, treatments and special procedures performed;</p> <p>10. Copies of radiology, laboratory and other consultant reports; and</p> <p>11. Discharge summary.</p> <p>F. Verbal orders shall be immediately documented in the clinical record by the individual authorized to accept the orders, and shall be countersigned.</p> <p>G. Clinical records of discharged residents shall be completed within 30 days of discharge.</p> <p>H. Clinical records shall be kept for a minimum of five years after discharge or death, unless otherwise specified by state or federal law.</p> <p>I. Permanent information kept on each resident shall include:</p> <ol style="list-style-type: none"> 1. Name; 2. Social security number; 3. Date of birth; 4. Date of admission and discharge; and 5. Name and address of guardian, if any. <p>J. Clinical records shall be available to residents and legal representatives, if they wish to see them.</p> <p>K. When a nursing facility closes, the owners shall make provisions for the safekeeping and confidentiality of all clinical records.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>8. All symptoms and other indications of illness or injury, including date, time, and action taken on each shift;</p> <p>9. Medication and treatment record, including all medications, treatments and special procedures performed;</p> <p>10. Copies of radiology, laboratory and other consultant reports; and</p> <p>11. Discharge summary.</p> <p>F. Verbal orders shall be immediately documented in the clinical record by the individual authorized to accept the orders, and shall be countersigned.</p> <p>G. Clinical records of discharged residents shall be completed within 30 days of discharge.</p> <p>H. Clinical records shall be kept for a minimum of five years after discharge or death, unless otherwise specified by state or federal law.</p> <p>I. Permanent information kept on each resident shall include:</p> <ol style="list-style-type: none"> 1. Name; 2. Social security number; 3. Date of birth; 4. Date of admission and discharge; and 5. Name and address of guardian <u>legal representative</u>, if any. <p>J. Clinical records shall be available to residents and legal representatives, if they wish to see them.</p> <p>K. When a nursing facility closes, the owners shall make provisions for the safekeeping and confidentiality of all clinical records.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p>
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			<p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
380	N/A	<p>12VAC5-371-380. Laundry services.</p> <p>A. A quantity of linens shall be available at all times to provide for proper care and comfort of residents.</p> <p>B. Linens and other laundry must be handled, stored and processed to control the spread of infection.</p> <p>C. Clean linen shall be stored in a clean and dry area accessible to the nursing unit.</p> <p>D. Soiled linen shall be stored in covered containers in separate, well ventilated areas and shall not accumulate in the facility.</p> <p>E. Soiled linen shall not be sorted, laundered, rinsed or stored in bathrooms, resident rooms, kitchens or food storage areas.</p> <p>F. Soiled linen shall not be placed on the floor.</p> <p>G. Arrangement for laundering resident's personal clothing shall be provided. If laundry facilities are not provided on premises, commercial laundry services shall be utilized.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-380. Laundry services.</p> <p>A. A quantity of linens shall be available at all times to provide for proper care and comfort of residents.</p> <p>B. Linens and other laundry must be handled, stored and processed to control the spread of infection.</p> <p>C. Clean linen shall be stored in a clean and dry area accessible to the nursing unit.</p> <p>D. Soiled linen shall be stored in covered containers in separate, well ventilated areas and shall not accumulate in the <u>nursing</u> facility.</p> <p>E. Soiled linen shall not be sorted, laundered, rinsed or stored in bathrooms, resident rooms, kitchens or food storage areas.</p> <p>F. Soiled linen shall not be placed on the floor.</p> <p>G. Arrangement for laundering resident's personal clothing shall be provided. If laundry facilities are not provided on premises, commercial laundry services shall be utilized.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
390	N/A	<p>12VAC5-371-390. Transportation.</p> <p>A. Provisions shall be made to obtain appropriate transportation in cases of emergency.</p> <p>B. The nursing facility shall assist in obtaining transportation when it is</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>12VAC5-371-390. Transportation.</p>

		<p>necessary to obtain medical, psychiatric, dental, diagnostic or other services outside the facility.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>A. Provisions shall be made to obtain appropriate transportation in cases of emergency.</p> <p>B. The nursing facility shall assist in obtaining transportation when it is necessary to obtain medical, psychiatric, dental, diagnostic or other services outside the <u>nursing</u> facility.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to align the terminology used with the defined terms in Section 10.</p> <p>RATIONALE: The rationale behind this proposed change is that use of undefined terms is disfavored when a defined term is available.</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
400	N/A	<p>12VAC5-371-400. Unique design solutions.</p> <p>A. All unique design solutions shall be described with outcome measures. This shall be reviewed in cooperation with the OLC.</p> <p>B. The description and outcome measures shall be a part of the material used to review the design solution at the time of the facility survey.</p> <p>C. All unique design solutions, unless specifically excluded by contract, shall comply with Parts II (12VAC5-371-110 et seq.) and III (12VAC5-371-200 et seq.) of this chapter.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p>	<p>CHANGE: The Board is proposing to repeal this section in its entirety:</p> <p>12VAC5-371-400. Unique design solutions. (Repealed.)</p> <p>A. All unique design solutions shall be described with outcome measures. This shall be reviewed in cooperation with the OLC.</p> <p>B. The description and outcome measures shall be a part of the material used to review the design solution at the time of the facility survey.</p> <p>C. All unique design solutions, unless specifically excluded by contract, shall comply with Parts II (12VAC5-371-110 et seq.) and III (12VAC5-371-200 et seq.) of this chapter.</p> <p>Statutory Authority §§ 32.1-12 and 32.1-127 of the Code of Virginia.</p> <p>INTENT: The intent of this proposed change is to eliminate irrelevant requirements.</p> <p>RATIONALE: The rationale behind this proposed change is that nursing facilities are already required to design</p>

			<p>and construct according to the Uniform Statewide Building Code, local zoning and building ordinances, and the guidelines issued by the Facilities Guidelines Institute (formerly the American Institute of Architects).</p> <p>LIKELY IMPACT: The likely impact of these proposed changes is reduced confusion for licensees.</p>
DIBR	N/A	<p>DOCUMENTS INCORPORATED BY REFERENCE (12VAC5-371) Guidelines for Design and Construction of Health Care Facilities, Facilities Guideline Institute (formerly of the American Institute of Architects Academy of Architecture), 2010 Edition. Guidelines for Preventing Health Care-Associated Pneumonia, 2003, MMWR 53 (RR03), Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention. Prevention and Control of Influenza, MMWR 53 (RR06), Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention.</p>	<p>CHANGE: The Board is proposing the following changes:</p> <p>DOCUMENTS INCORPORATED BY REFERENCE (12VAC5-371) Guidelines for Design and Construction of Health Care Facilities, Facilities Guideline Institute (formerly of the American Institute of Architects Academy of Architecture), 2010 Edition. Guidelines for Preventing Health Care-Associated Pneumonia, 2003, MMWR 53 (RR03), Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention. <u>Guidelines for Preventing Health-Care-Associated Pneumonia, 2003, MMWR 53 (RR-3), Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention.</u> Prevention and Control of Influenza, MMWR 53 (RR06), Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention. <u>Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2019–20 Influenza Season, 2019, MMWR 68 (RR-3), Centers for Disease Control and Prevention.</u></p> <p>INTENT: The intent of these proposed changes is to keep documents incorporated by reference current and accurate.</p> <p>RATIONALE: The rationale behind these proposed changes is that nursing facilities should be held to current standards and guidelines.</p>

			<p>LIKELY IMPACT: The likely impact of these proposed changes is improved resident health and safety at nursing facilities.</p>
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If a new regulation is being promulgated, that is not replacing an existing regulation, please use this chart:

New chapter-section number	New requirements	Other regulations and law that apply	Intent and likely impact of new requirements
75	<p><u>12VAC5-371-75. Criminal records check.</u></p> <p><u>A. A nursing facility shall:</u></p> <ol style="list-style-type: none"> <u>1. Obtain from an applicant for _____ compensated employment a sworn disclosure;</u> <u>2. Obtain a criminal record report on applicants for compensated employment from the Virginia Department of State Police no more than 30 calendar days after employment begins;</u> <u>3. File the sworn disclosure with the criminal record report.</u> <p><u>B. A nursing facility may not accept:</u></p> <ol style="list-style-type: none"> <u>1. A criminal record report dated more than 90 calendar days prior to the start date of employment;</u> <u>2. Duplicates or copies of the original criminal record report, except as provided in subsection D.</u> <p><u>C. A nursing facility may not hire for compensated employment a person who has been convicted of a barrier crime, unless:</u></p> <ol style="list-style-type: none"> <u>1. The person has been convicted of a single barrier crime punishable as a misdemeanor;</u> <u>2. The conviction does not involve abuse or neglect; and</u> <u>3. Five years have elapsed since the conviction.</u> <p><u>D. If a nursing facility uses a temporary staffing agency for</u></p>	N/A	<p>INTENT: The intent of this proposed change is to include relevant statutory requirements that were previously absent and to clarify how a facility can satisfy the criminal records check requirements when dealing with a temporary staffing agency.</p> <p>LIKELY IMPACT: The likely impact of this proposed change is improved understanding by licensees of how they can meet their statutory obligations for both staff they hire and for staff secured from a temporary staffing agency.</p>

	<p><u>substitute staff, a nursing facility shall obtain a letter from the temporary staffing agency that includes:</u></p> <ol style="list-style-type: none"><u>1. The name of the substitute staffing person;</u><u>2. The date of employment by the temporary staffing agency; and</u><u>3. A statement verifying that the criminal record report:</u><ol style="list-style-type: none"><u>a. Has been obtained within 30 calendar days of employment at the temporary staffing agency;</u><u>b. Is on file at the temporary staffing agency, and;</u><u>c. Does not contain a conviction for a barrier crime, or indicates the substitute staffing person has been convicted of a single barrier crime punishable as a misdemeanor that does not involve abuse or neglect and five years have elapsed since the conviction.</u> <p><u>E. A nursing facility may not permit a compensated employee to work in a position that involves direct contact with a patient until an original criminal record report has been received by the nursing facility or temporary staffing agency, unless the employee works under the direct supervision of another compensated employee for whom a background check has been completed in accordance with subsection B of this section.</u></p> <p><u>F. A nursing facility shall obtain a new criminal record report and a new sworn disclosure if an individual:</u></p> <ol style="list-style-type: none"><u>1. Terminates compensated employment at one nursing facility and begins compensated employment at another nursing facility, unless the nursing facilities are owned by the same entity. The employee's file shall contain a statement indicating the original</u>		
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	<p><u>criminal record report has been transferred or forward to the new work location; or</u> <u>2. Takes a leave of absence exceeding six consecutive months.</u></p> <p><u>G. A nursing facility shall provide a copy of the criminal record report to an applicant denied compensated employment because of convictions appearing on his criminal record report.</u></p> <p><u>H. A nursing facility shall maintain the confidentiality of criminal record reports and store criminal record reports in locked files accessible only to the administrator or designee.</u></p> <p><u>I. A nursing facility may not disseminate the criminal record report and sworn disclosure except to a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination.</u></p> <p>Statutory Authority <u>§§ 32.1-12, 32.1-126.01, and 32.1-127 of the Code of Virginia.</u></p>		
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1 Project 3404 - none

2 DEPARTMENT OF HEALTH
3 Amend Regulation after Periodic Review

4
5 Part I
6 Definitions and General Information

7 **12VAC5-371-10. Definitions.**

8 The following words and terms when used in this chapter shall have the following meanings
9 unless the context clearly indicates otherwise:

10 "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or
11 punishment with resulting physical harm, pain or mental anguish, or deprivation by an individual,
12 including caretaker, of goods or services that are necessary to attain or maintain physical, mental,
13 and psychosocial well-being. This includes verbal, sexual, physical or mental abuse.

14 "Administrator" means the individual licensed by the Virginia Board of Long-Term Care
15 Administrators and who has the necessary authority and responsibility for management of the
16 nursing facility.

17 "Admission" means the process of acceptance into a nursing facility, including orientation,
18 rules and requirements, and assignment to appropriate staff. Admission does not include
19 readmission to the facility after a temporary absence.

20 "Advance directive" means (i) a witnessed written document, voluntarily executed by the
21 declarant in accordance with the requirements of § 54.1-2983 of the Code of Virginia, or (ii) a
22 witnessed oral statement, made by the declarant subsequent to the time he is diagnosed as
23 suffering from a terminal condition and in accordance with the provision of § 54.1-2983 of the
24 Code of Virginia.

25 "Assessment" means the process of evaluating a resident for the purpose of developing a
26 profile on which to base services. Assessment includes information gathering, both initially and
27 on an ongoing basis, designed to assist the multi-disciplinary staff in determining the resident's
28 need for care, and the collection and review of resident-specific data.

29 "Attending physician" means a physician currently licensed by the Virginia Board of Medicine
30 and identified by the resident, or legal representative, as having the primary responsibility in
31 determining the delivery of the resident's medical care.

32 "Barrier crime" means any offense set forth in clause (i) of the definition of barrier crime in §
33 19.2-392.02 of the Code of Virginia.

34 "Board" means the Board of Health.

35 "Certified nurse aide" means the title that can only be used by individuals who have met the
36 requirements to be certified, as defined by the Virginia Board of Nursing, and who are listed in the
37 nurse aide registry.

38 "Chemical restraint" means a psychopharmacologic drug (a drug prescribed to control mood,
39 mental status, or behavior) that is used for discipline or convenience and not required to treat
40 medical symptoms or symptoms from mental illness or mental retardation that prohibit an
41 individual from reaching his highest level of functioning.

42 "Clinical record" means the documentation of health care services, whether physical or
43 mental, rendered by direct or indirect resident-provider interactions. An account compiled by
44 physicians and other health care professionals of a variety of resident health information, such as
45 assessments and care details, including testing results, medicines, and progress notes.

46 "Commissioner" means the State Health Commissioner.

47 "Complaint" means any allegation received by the Department of Health other than an incident
48 reported by the facility staff. Such allegations include abuse, neglect, exploitation, or violation of
49 state or federal laws or regulations.

50 "Comprehensive plan of care" means a written action plan, based on assessment data, that
51 identifies a resident's clinical and psychosocial needs, the interventions to meet those needs,
52 treatment goals that are measurable and that documents the resident's progress toward meeting
53 the stated goals.

54 "Construction" means the building of a new nursing facility or the expansion, remodeling, or
55 alteration of an existing nursing facility and includes the initial and subsequent equipping of the
56 facility.

57 "Criminal record report" means either the criminal record clearance with respect to convictions
58 for barrier crimes or the criminal history record from the Central Criminal Records Exchange of
59 the Virginia Department of State Police.

60 "Department" means the Virginia Department of Health.

61 "Dignity" means staff, in their interactions with residents, carry out activities which assist a
62 resident in maintaining and enhancing the resident's self-esteem and self-worth.

63 "Discharge" means the process by which the resident's services, delivered by the nursing
64 facility, are terminated.

65 "Discharge summary" means the final written summary of the services delivered, goals
66 achieved and post-discharge plan or final disposition at the time of discharge from the nursing
67 facility. The discharge summary becomes a part of the clinical record.

68 "Drug" means (i) articles or substances recognized in the official United States "Drug"
69 Pharmacopoeia National Formulary or official Homeopathic Pharmacopoeia of the United States,
70 or any supplement to any of them; (ii) articles or substances intended for the use in the diagnosis,
71 cure, mitigation, treatment, or prevention of disease in man or other animal; (iii) articles or
72 substances, other than food, intended to affect the structure or any function of the body of man
73 or other animal; and (iv) articles or substances intended for use as a component of any article
74 specified in clause (i), (ii), or (iii). This does not include devices or their components, parts or
75 accessories.

76 "Electronic monitoring" means an unmanned video recording system with or without audio
77 capability installed in the room of a resident.

78 "Emergency preparedness plan" means a component of a nursing facility's safety
79 management program designed to manage the consequences of natural disasters or other
80 emergencies that disrupt the nursing facility's ability to provide care.

81 "Employee" means a person who performs a specific job function for financial remuneration
82 on a full-time or part-time basis.

83 "Facility-managed" means an electronic monitoring system that is installed, controlled, and
84 maintained by the nursing facility with the knowledge of the resident or ~~resident's responsible~~
85 party legal representative in accordance with the facility's policies.

86 "Full-time" means a minimum of 35 hours or more worked per week in the nursing facility.

87 "~~Guardian~~" means ~~a person legally invested with the authority and charged with the duty of~~
88 ~~taking care of the resident, managing his property, and protecting the rights of the resident who~~
89 ~~has been declared by the circuit court to be incapacitated and incapable of administering his own~~
90 ~~affairs. The powers and duties of the guardian are defined by the court and are limited to matters~~
91 ~~within the areas where the resident in need of a guardian has been determined to be~~
92 ~~incapacitated.~~

93 "Legal representative" means a person legally responsible for representing or standing in the
94 place of the resident for the conduct of his affairs. This may include a guardian, conservator,
95 attorney-in-fact under durable power of attorney, trustee, or other person expressly named by a
96 court of competent jurisdiction or the resident as his agency in a legal document that specifies the
97 scope of the representative's authority to act. A legal representative may only represent or stand
98 in the place of a resident for the function or functions for which he has legal authority to act.

99 "Medication" means any substance, whether prescription or over-the-counter drug, that is
100 taken orally or injected, inserted, topically applied, or otherwise administered.

101 "Neglect" means a failure to provide timely and consistent services, treatment, or care to a
102 resident necessary to obtain or maintain the resident's health, safety, or comfort or a failure to
103 provide timely and consistent goods and services necessary to avoid physical harm, mental
104 anguish, or mental illness.

105 "Nursing facility" means any nursing home as defined in § 32.1-123 of the Code of Virginia.

106 "OLC" means the Office of Licensure and Certification of the Virginia Department of Health.

107 "Person" means any individual, corporation, partnership, association, trust, or other legal
108 entity, whether governmental or private, owning, managing, or operating a nursing facility.

109 "Physical restraint" means any manual method or physical or mechanical device, material, or
110 equipment attached or adjacent to the resident's body that the individual cannot remove easily
111 which restricts freedom of movement or normal access to one's own body.

112 "Policy" means a written statement that describes the principles and guides and governs the
113 activities, procedures and operations of the nursing facility.

114 "Procedures" means a series of activities designed to implement program goals or policy,
115 which may or may not be written, depending upon the specific requirements within this chapter.
116 For inspection purposes, there must be evidence that procedures are actually implemented.

117 "Progress note" means a written statement, signed and dated by the person delivering the
118 care, consisting of a pertinent, chronological report of the resident's care. A progress note is a
119 component of the clinical record.

120 "Qualified" means meeting current legal requirements of licensure, registration or certification
121 in Virginia; having appropriate training and experience commensurate with assigned
122 responsibilities; or, if referring to a professional, possessing an appropriate degree or having
123 documented equivalent education, training or experience.

124 "Quality assurance" means systematic activities performed to determine the extent to which
125 clinical practice meets specified standards and values with regard to such things as
126 appropriateness of service assignment and duration, appropriateness of facilities and resources
127 utilized, adequacy and clinical soundness of care given. Such activities should also assure
128 changes in practice that do not meet accepted standards. Examples of quality assurance activities
129 include the establishment of facility-wide goals for resident care, the assessment of the
130 procedures used to achieve the goals, and the proposal of solutions to problems in attaining those
131 goals.

132 "Readmission" means a planned return to the nursing facility following a temporary absence
133 for hospitalization, off-site visit or therapeutic leave, or a return stay or confinement following a
134 formal discharge terminating a previous admission.

135 "Resident" means the primary service recipient, admitted to the nursing facility, whether that
136 person is referred to as a client, consumer, patient, or other term.

137 "Resident-managed" means an electronic monitoring system that is installed, controlled, and
138 maintained by the resident with the knowledge of the nursing facility.

139 ~~"Responsible person or party" means an individual authorized by the resident to act for him~~
140 ~~as an official delegate or agent. The responsible person may be a guardian, payee, family member~~
141 ~~or any other individual who has arranged for the care of the resident and assumed this~~
142 ~~responsibility. The responsible person or party may or may not be related to the resident. A~~
143 ~~responsible person or party is not a guardian unless so appointed by the court.~~

144 "Supervision" means the ongoing process of monitoring the skills, competencies and
145 performance of the individual supervised and providing regular, face-to-face guidance and
146 instruction.

147 "Sworn disclosure" means a written statement or affirmation disclosing any criminal
148 convictions or any pending criminal charges, whether within or outside the Commonwealth, by an
149 applicant for compensated employment with a nursing facility.

150 "Volunteer" means a person who, without financial remuneration, provides services to the
151 nursing facility.

152 Statutory Authority

153 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

154 Historical Notes

155 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
156 Volume 23, Issue 10, eff. March 1, 2007; Volume 26, Issue 26, eff. September 30, 2010; Volume
157 35, Issue 5, eff. December 13, 2018.

158 **12VAC5-371-30. License.**

159 A. This chapter is not applicable to:

160 1. Those entities listed in § 32.1-124 of the Code of Virginia; and

161 2. Facilities established or operated for the practice of religious tenets pursuant to § 32.1-
162 128 of the Code of Virginia, except that such facilities shall comply with the statutes and
163 regulations on environmental protection and life safety.

164 B. A license to operate a nursing facility is issued to a person or organization. An organization
165 may be a partnership, association, corporation, or public entity.

166 B. C. Each license and renewal thereof shall be issued for one year. A nursing facility shall
167 operate within the terms of its license, which include the:

168 1. Name of the nursing facility;

169 2. Name of the operator;

170 3. Physical location of the nursing facility;

171 4. Maximum number of beds allowed; and

172 5. Date the license expires.

173 C. D. A separate license shall be required for nursing facilities maintained on separate
174 premises, even though they are owned or are operated under the same management.

175 D. E. Every nursing facility shall be designated by a permanent and appropriate unique name.
176 ~~The name shall not be changed without first notifying the OLC.~~

177 E. F. The number of resident beds allowed in a nursing facility shall be determined by the
178 department. Requests to increase beds must be made in writing and must include an approved
179 Certificate of Public Need, except as provided in 12VAC5-371-40 J.

180 F. G. Nursing facility units located in and operated by hospitals shall be licensed under
181 Regulations for the Licensure of Hospitals in Virginia (12VAC5-410). Approval for such units shall
182 be included on the annual license issued to each hospital.

183 ~~G. H.~~ Any person establishing, conducting, maintaining, or operating a nursing facility without
184 a license shall be guilty of a Class 6 felony.

185 Statutory Authority

186 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

187 Historical Notes

188 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
189 Volume 23, Issue 10, eff. March 1, 2007; Volume 35, Issue 24, eff. August 23, 2019.

190 **12VAC5-371-40. Licensing process.**

191 A. Upon request, the OLC will provide consultation to any person seeking information about
192 obtaining a license. The purpose of such consultation is to:

193 1. Explain the standards and the licensing process;

194 2. Provide assistance in locating other sources of information;

195 3. Review the potential applicant's proposed program plans, forms, and other documents,
196 as they relate to standards; and

197 4. Alert the potential applicant regarding the need to meet other state and local ordinances,
198 such as fire and building codes and environmental health standards, where applicable.

199 B. ~~Upon request, the OLC will provide an application form for a license to operate a nursing~~
200 ~~facility.~~ Licensees and applicants shall obtain licensure applications from the OLC.

201 C. The OLC shall consider the application complete when all requested information and the
202 application fee is submitted with the form required. If the OLC finds the application incomplete,
203 the applicant will be notified of receipt of the incomplete application.

204 D. The applicant shall complete and submit the initial application to the OLC at least 30 days
205 prior to a planned opening date to allow the OLC time to act on the application. An application for
206 a license may be withdrawn at any time.

207 E. A nursing facility may not be licensed without first complying with the requirements for a
208 Certificate of Public Need as required by Article 1.1. (§ 32.1-102.1 et seq.) of Chapter 4 of Title
209 32.1 of the Code of Virginia.

210 1. Application for initial license of a nursing facility shall include a statement of any
211 agreement made with the commissioner as a condition for Certificate of Public Need
212 approval to provide a level of care at a reduced rate to indigents or accept patients
213 requiring specialized care.

214 2. Any initial license issued to any nursing facility that made such agreement as a condition
215 of its Certificate of Public Need approval shall not be renewed without demonstrating prior
216 to or at the time of applying for renewal that it is substantially complying with its agreement.

217 F. The renewal of a nursing facility license shall be conditioned upon the up-to-date payment
218 of any civil penalties owed as a result of willful refusal, failure, or neglect to honor certain
219 conditions established in their award of a Certificate of Public Need pursuant to § 32.1-102.4 F of
220 the Code of Virginia.

221 ~~G. Prior to changes in operation which would affect the terms of the license, the licensee must~~
222 ~~secure a modification to the terms of the license from the OLC.~~

223 ~~H. Requests to modify a license must be submitted in writing, 30 working days in advance of~~
224 ~~any proposed changes, to the Director of the Office of Licensure and Certification.~~

225 ~~I. The license shall be returned to the OLC following a correction or reissuance when there~~
226 ~~has been a change in:~~

227 1. ~~Address;~~

228 2. ~~Operator;~~

229 ~~3. Name; or~~

230 ~~4. Bed capacity.~~

231 ~~J. G. Nursing facilities shall be exempt, for a period of no more than 30 days, from the~~
232 ~~requirement to obtain a license to add temporary beds when the commissioner has determined~~
233 ~~that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and~~
234 ~~that a public health emergency exists due to a shortage of hospital or nursing home beds.~~

235 ~~K. The OLC will evaluate written information about any planned changes in operation which~~
236 ~~would affect either the terms of the license or the continuing eligibility for a license. A licensing~~
237 ~~representative may visit the facility during the process of evaluating a proposed modification.~~

238 ~~L. If a modification can be granted, the OLC shall respond in writing with a modified license.~~
239 ~~In the event a new application is needed, the licensee will receive written notification. When the~~
240 ~~modification cannot be granted, the licensee shall be advised by letter.~~

241 ~~M. The department shall send an application for renewal of the license to the licensee prior to~~
242 ~~the expiration date of the current license.~~

243 ~~N. H. The licensee shall submit the completed renewal application form along with any~~
244 ~~required attachments and the application fee by the date indicated in the cover letter.~~

245 ~~O. I. It is the licensee's responsibility to complete and return the application to assure timely~~
246 ~~processing. Should a current license expire before a new license is issued, the current license~~
247 ~~shall remain in effect provided the complete and accurate application was filed on time.~~

248 Statutory Authority

249 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

250 Historical Notes

251 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
252 Volume 18, Issue 10, eff. February 28, 2002; Volume 23, Issue 10, eff. March 1, 2007; Volume
253 35, Issue 24, eff. August 23, 2019.

254 **12VAC5-371-60. On-site inspections.**

255 A. The licensing representative shall make unannounced on-site inspections of the nursing
256 facility. The licensee shall be responsible for correcting any deficiencies found during any on-site
257 inspection. Compliance with all standards will be determined by the OLC.

258 B. The licensee shall make available to the licensing representative any necessary records.

259 C. The licensee shall also allow the licensing representative to interview the agents,
260 employees, residents, family members, and any person under its custody, control, direction or
261 supervision.

262 D. After the on-site inspection, the licensing representative shall discuss the findings of the
263 inspection with the administrator ~~of record~~ or designee.

264 E. As applicable, the administrator ~~of record~~ shall submit an acceptable plan for correcting
265 any deficiencies found during an on-site inspection.

266 F. The administrator ~~of record~~ will be notified whenever any item in the plan of correction is
267 determined to be unacceptable.

268 G. The administrator ~~of record~~ shall be responsible for assuring the plan of correction is
269 implemented and monitored so that compliance is maintained.

270 Statutory Authority

271 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

272 Historical Notes

273 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
274 Volume 23, Issue 10, eff. March 1, 2007.

275 **12VAC5-371-70. Complaint investigation.**

276 A. The OLC has the responsibility to investigate any complaints regarding alleged violations
277 of the standards or statutes and complaints of the abuse or neglect of persons in care. The
278 Department of Social Services and the State Ombudsman are notified of complaints received.

279 B. Complaints may be received in written or oral form and may be anonymous.

280 C. When the investigation is complete, the licensee and the complainant, if known, will be
281 notified of the findings of the investigation.

282 D. As applicable, the ~~facility's~~ administrator ~~of record~~ shall submit an acceptable plan for
283 correcting any deficiencies found during a complaint investigation.

284 E. The administrator ~~of record~~ will be notified whenever any item in the plan of correction is
285 determined to be unacceptable.

286 F. The administrator ~~of record~~ shall be responsible for assuring the plan of correction is
287 implemented and monitored so that compliance is maintained.

288 Statutory Authority

289 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

290 Historical Notes

291 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
292 Volume 23, Issue 10, eff. March 1, 2007.

293 **12VAC5-371-75. Criminal records check.**

294 A. A nursing facility may not hire for compensated employment a person who has been
295 convicted of a barrier crime, unless:

- 296 1. The person has been convicted of a single barrier crime punishable as a misdemeanor;
297 2. The conviction does not involve abuse or neglect; and
298 3. Five years have elapsed since the conviction.

299 B. A nursing facility shall:

- 300 1. Obtain from an applicant for compensated employment a sworn disclosure; and
301 2. Attach the sworn disclosure to and file it with the criminal record report.
302 3. Obtain a criminal record report on applicants for compensated employment from the
303 Virginia Department of State Police no more than 30 calendar days after employment
304 begins.

305 C. A nursing facility may not accept:

- 306 1. A criminal record report dated more than 90 calendar days prior to the start date of
307 employment;
308 2. Duplicates or copies of the original criminal record report, except as provided in
309 subsection D.

310 D. If a nursing facility uses a temporary staffing agency for substitute staff, a nursing facility
311 shall obtain a letter from the temporary staffing agency that includes:

- 312 1. The name of the substitute staffing person;
313 2. The date of employment by the temporary staffing agency; and
314 3. A statement verifying that the criminal record report:
315 a. Has been obtained within 30 calendar days of employment at the temporary staffing
316 agency;

317 b. Is on file at the temporary staffing agency, and:
318 c. Does not contain a conviction for a barrier crime, or indicates the substitute staffing
319 person has been convicted of a single barrier crime punishable as a misdemeanor that
320 does not involve abuse or neglect and five years have elapsed since the conviction.

321 E. A nursing facility may not permit a compensated employee to work in a position that
322 involves direct contact with a patient until an original criminal record report has been received by
323 the nursing facility or temporary staffing agency, unless the employee works under the direct
324 supervision of another compensated employee for whom a background check has been
325 completed in accordance with subsection B of this section.

326 F. A nursing facility shall obtain a new criminal record report and a new sworn disclosure if an
327 individual:

328 1. Terminates compensated employment at one nursing facility and begins compensated
329 employment at another nursing facility, unless the nursing facilities are owned by the same
330 entity. The employee's file shall contain a statement indicating the original criminal record
331 report has been transferred or forwarded to the new work location; or

332 2. Takes a leave of absence exceeding six consecutive months.

333 G. A nursing facility shall provide a copy of the criminal record report to an applicant denied
334 compensated employment because of convictions appearing on his criminal record report.

335 H. A nursing facility shall maintain the confidentiality of criminal record reports and store
336 criminal record reports in locked files accessible only to the administrator or designee.

337 I. A nursing facility may not disseminate the criminal record report and sworn disclosure except
338 to a federal or state authority or court as may be required to comply with an express requirement
339 of law for such further dissemination.

340 Statutory Authority

341 §§ 32.1-12, 32.1-126.01, and 32.1-127 of the Code of Virginia.

342 Historical Notes

343 Derived from Virginia Register Volume , Issue , eff. Month dd, yyyy.

344 **12VAC5-371-80. Variances.**

345 A. The ~~OLC commissioner~~ can ~~may~~ authorize variances only to its own licensing standards,
346 not to regulations of another agency or to any requirements in federal, state, or local laws.

347 B. A nursing facility may request a variance to a particular standard or requirement contained
348 in this chapter when the standard or requirement poses a special hardship and when a variance
349 to it would not endanger the safety or well-being of residents, employees, or the public.

350 C. Upon finding that the enforcement of one or more of the standards would be clearly
351 impractical, the ~~OLC commissioner~~ shall have the authority to waive, either temporarily or
352 permanently, the enforcement of one or more of these standards, provided safety, resident care
353 and services are not adversely affected.

354 D. The ~~OLC commissioner~~ may rescind or modify a variance if (i) conditions change; (ii)
355 additional information becomes known which alters the basis for the original decision; (iii) the
356 nursing facility fails to meet any conditions attached to the variance; or (iv) results of the variance
357 jeopardize the safety, comfort, or well-being of residents, employees and the public.

358 E. Consideration of a variance is initiated when a written request is submitted to the ~~Director~~
359 director of the ~~Office of Licensure and Certification~~ OLC. The OLC may provide consultation in
360 the development of the written request and throughout the variance process.

361 F. The request for a variance must describe the special hardship to the existing program or to
362 a planned innovative or pilot program caused by the enforcement of the requirements. When

363 possible, the request should include proposed alternatives to meet the purpose of the
364 requirements which will ensure the protection and well-being of residents, employees, and the
365 public.

366 G. The OLC shall notify the nursing facility of the receipt of the request for a variance. The
367 ~~OLC commissioner~~ may attach conditions to the granting of the variance in order to protect
368 persons in care.

369 H. When the decision is to deny a request for a variance, the reason shall be provided in
370 writing to the licensee.

371 I. When a variance is denied, expires, or is rescinded, routine enforcement of the standard or
372 portion of the standard shall be resumed. The nursing facility may at any time withdraw a request
373 for a variance.

374 Statutory Authority

375 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

376 Historical Notes

377 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
378 Volume 23, Issue 10, eff. March 1, 2007.

379 Part II

380 Administrative Services

381 **12VAC5-371-110. Management and administration.**

382 A. No person shall own, establish, conduct, maintain, manage, or operate any nursing facility,
383 as defined in § 32.1-123 of the Code of Virginia, without having obtained a license.

384 B. The nursing facility must comply with:

- 385 1. These regulations (12VAC5-371);
- 386 2. Other applicable federal, state or local laws and regulations; and
- 387 3. Its own policies and procedures.

388 C. The nursing facility shall submit, or make available, reports and information necessary to
389 establish compliance with these regulations and applicable statutes.

390 D. The nursing facility shall submit, in a timely manner as determined by the OLC, and
391 implement a written plan of action to correct any noncompliance with these regulations identified
392 during an inspection. The plan shall include:

- 393 1. Description of the corrective action or actions to be taken;
- 394 2. Date of completion for each action; and
- 395 3. Signature of the person responsible for the operation.

396 E. The nursing facility shall permit representatives from the OLC to conduct inspections to:

- 397 1. Verify application information;
- 398 2. Determine compliance with this chapter;
- 399 3. Review necessary records; and
- 400 4. Investigate complaints.

401 ~~F. The current license from the department shall be posted in a place clearly visible to the~~
402 ~~general public~~ A nursing facility shall give written notification 30 calendar days in advance of
403 implementation of changes affecting the accuracy of the license. Changes affecting the accuracy
404 of the license are:

- 405 1. Address;
- 406 2. Operator;

- 407 3. Name of the nursing facility;
408 4. Any proposed change in management contract or lease agreement to operate the
409 nursing facility;
410 5. Implementing any proposed addition, deletion, or change in nursing facility services
411 whether or not licensure is required;
412 6. A change in ownership; or
413 7. Bed capacity.

414 Notices shall be sent to the attention of the director of the OLC.

415 ~~G. The nursing facility shall not operate more resident beds than the number for which it is~~
416 ~~licensed. The current license from the commissioner shall be posted in a place clearly visible to~~
417 ~~the general public.~~

418 H. The nursing facility shall fully disclose its admission policies, including any preferences
419 given, to applicants for admission.

420 I. The nursing facility shall identify its operating elements and programs, the internal
421 relationship among these elements and programs, and the management or leadership structure.

422 J. The nursing facility shall provide, or arrange for, the administration to its residents of an
423 annual influenza vaccination and a pneumonia vaccination according to the ~~most recent~~
424 ~~recommendations for "Prevention and Control of Influenza"~~
425 ~~(www.cdc.gov/mmwr/preview/mmwrhtml/rr5306a1.htm), MMWR 53 (RR06) "Prevention and~~
426 ~~Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on~~
427 ~~Immunization Practices — United States, 2019–20 Influenza Season"; and "Guidelines for~~
428 ~~Preventing Health Care-Associated Pneumonia, 2003"~~
429 ~~(www.cdc.gov/mmwr/preview/mmwrhtml/rr5303a1.htm), MMWR 53 (RR03), of "Guidelines for~~
430 ~~Preventing Health-Care-Associated Pneumonia" from the Advisory Committee on Immunization~~
431 ~~Practices of the Centers for Disease Control and Prevention, unless the vaccination is medically~~
432 ~~contraindicated or the resident declines the vaccination offer.~~

433 K. Upon request of the nursing facility's family council, the nursing facility shall send notices
434 and information about the family council mutually developed by the family council and the
435 administration of the nursing ~~home~~ facility, and provided to the nursing facility for such purpose,
436 to the ~~listed responsible party~~ legal representative or a contact person of the resident's choice up
437 to six times a year. Such notices may be included together with a monthly billing statement or
438 other regular communication. Notices and information shall also be posted in a designated
439 location within the nursing facility.

440 Statutory Authority

441 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

442 Historical Notes

443 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
444 Volume 20, Issue 26, eff. September 27, 2004; Volume 23, Issue 10, eff. March 1, 2007; Volume
445 27, Issue 24, eff. September 1, 2011.

446 **12VAC5-371-120. Governing body.**

447 A. The nursing facility shall have a governing body that is legally responsible for the
448 management of the operation.

449 B. The governing body shall adopt written bylaws that describe the organizational structure
450 and establish authority and responsibility in accordance with applicable laws, including a:

- 451 1. Statement of purpose;
452 2. Description of the functions of the governing body members, officers and committees;

453 3. Description of the method of adoption, implementation, and periodic review of policies
454 and procedures; and

455 4. Description of the methods to be utilized to assure compliance with this chapter.

456 C. The governing body shall disclose the names and addresses of any individual or entity that
457 holds 5.0% or more ownership interest in the operation of the nursing facility.

458 D. When the governing body is not the owner of the physical plant, the governing body shall
459 disclose the name and address of the individual or entity responsible for the alterations,
460 modifications, maintenance and repairs to the building.

461 ~~E. The governing body shall notify the OLC in writing 30 days in advance of changes affecting~~
462 ~~the accuracy of the license. Changes affecting the accuracy of the license are:~~

463 1. ~~Any proposed change in management contract or lease agreement to operate the~~
464 ~~nursing facility;~~

465 2. ~~Implementing any proposed addition, deletion, or change in nursing facility services~~
466 ~~whether or not licensure is required;~~

467 3. ~~Selling the facility; or~~

468 4. ~~A change in ownership.~~

469 Statutory Authority

470 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

471 Historical Notes

472 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
473 Volume 23, Issue 10, eff. March 1, 2007.

474 **12VAC5-371-130. Administrator.**

475 A. The governing body shall appoint an individual, on a full-time basis, to serve as its on-site
476 agent, responsible for the day-to-day administration and management.

477 B. The governing body shall provide the OLC with evidence that the individual appointed as
478 administrator is:

479 1. Currently licensed by the Virginia Board of Long-Term Care Administrators; or

480 2. Holds a current administrator's license in another state and has filed an application for
481 license with the Virginia Board of Long-Term Care Administrators.

482 C. Within five working days of the effective date of termination of the administrator's
483 employment, the governing body shall notify the OLC, in writing, of the name and qualifications
484 of the replacement administrator ~~of record~~ or the acting administrator.

485 D. The governing body shall appoint a qualified administrator within 90 days of the effective
486 date of the termination of the previously qualified administrator, and shall provide the OLC with
487 written notification of the administrator's name, license number, and effective date of employment.

488 An additional 30-day extension may be granted if a written request provides documentation
489 that the individual designated as administrator is awaiting the final licensing decision of the
490 Virginia Board of Long-Term Care Administrators.

491 E. The governing body shall assure that administrative direction is provided at all times. The
492 governing body, the administrator, or the chief executive officer shall designate, in writing, a
493 qualified individual to act as the alternate nursing home administrator in the absence of the
494 administrator ~~of record~~.

495 Statutory Authority

496 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

497 Historical Notes

498 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
499 Volume 23, Issue 10, eff. March 1, 2007.

500 **12VAC5-371-140. Policies and procedures.**

501 A. The nursing facility shall implement written policies and procedures approved by the
502 governing body.

503 B. All policies and procedures shall be reviewed at least annually, with recommended changes
504 submitted to the governing body for approval.

505 C. A written record of the annual policy review, including at least the review dates, participants,
506 recommendations and action dates of the governing body, shall be maintained.

507 D. Administrative and operational policies and procedures shall include, but are not limited to:

508 1. Administrative records;

509 2. Admission, transfer and discharge;

510 3. Medical direction and physician services;

511 4. Nursing direction and nursing services;

512 5. Pharmaceutical services, including drugs purchased outside the nursing facility;

513 6. Dietary services;

514 7. Social services;

515 8. Activities services;

516 9. Restorative and rehabilitative resident services;

517 10. Contractual services;

518 11. Clinical records;

519 12. Resident rights and grievances;

520 13. Quality assurance and infection control and prevention;

521 14. Safety and emergency preparedness procedures;

522 15. Professional and clinical ethics, including:

523 a. Confidentiality of resident information;

524 b. Truthful communication with residents;

525 c. Observance of appropriate standards of informed consent and refusal of treatment;
526 and

527 d. Preservation of resident dignity, with special attention to the needs of the aged, the
528 cognitively impaired, and the dying; and

529 16. ~~Facility~~ Nursing facility security.

530 E. Personnel policies and procedures shall include, but are not limited to:

531 1. Written job descriptions that specify authority, responsibility, and qualifications for each
532 job classification;

533 2. An on-going plan for employee orientation, staff development, in-service training and
534 continuing education;

535 3. An accurate and complete personnel record for each employee including:

536 a. Verification of current professional license, registration, or certificate or completion
537 of a required approved training course;

538 b. Criminal record check;

539 c. Verification that the employee has reviewed or received a copy of the job
540 description;

541 d. Orientation to the nursing facility, its policies and to the position and duties assigned;
542 e. Completed continuing education program approved for the employee as determined
543 by the outcome of the annual performance evaluation;
544 f. Annual employee performance evaluations; and
545 g. Disciplinary action taken; and
546 4. Employee health-related information retained in a file separate from personnel files.

547 F. Financial policies and procedures shall include, but not be limited to:
548 1. Admission agreements;
549 2. Methods of billing:
550 a. Services not included in the basic daily or monthly rate;
551 b. Services delivered by contractors of the nursing facility; and
552 c. Third party payers;
553 3. Resident or designated representative notification of changes in fees and charges;
554 4. Correction of billing errors and refund policy;
555 5. Collection of delinquent resident accounts; and
556 6. Handling of resident funds.

557 G. Policies shall be made available for review, upon request, to residents and their designated
558 representatives.

559 H. Policies and procedures shall be readily available for staff use at all times.

560 Statutory Authority
561 §§ 32.1-12 and 32.1-127 of the Code of Virginia.
562 Historical Notes
563 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
564 Volume 27, Issue 24, eff. September 1, 2011.

565 **12VAC5-371-150. Resident rights.**
566 A. The nursing facility shall develop and implement policies and procedures that ensure
567 resident's rights as defined in §§ 32.1-138 and 32.1-138.1 of the Code of Virginia.
568 B. The procedures shall:
569 1. Not restrict any right a resident has under law;
570 2. Provide staff training to implement resident's rights; and
571 3. Include grievance procedures.
572 C. The name and telephone number of the complaint coordinator of the OLC, the Adult
573 Protective Services toll-free telephone number, and the toll-free telephone number for the State
574 Ombudsman shall be conspicuously posted in a public place.
575 D. Copies of resident rights shall be given to residents upon admittance to the nursing facility
576 and made available to residents currently in residence, to ~~any guardians~~ legal representatives,
577 next of kin, or sponsoring agency or agencies, and to the public.
578 E. The nursing facility shall have a plan to review resident rights with each resident annually,
579 or with the ~~responsible family member or responsible agent~~ legal representative at least annually,
580 and have a plan to advise each staff member at least annually.
581 F. The nursing facility shall certify, in writing, that it is in compliance with the provisions of §§
582 32.1-138 and 32.1-138.1 of the Code of Virginia, relative to resident rights, as a condition of
583 license issuance or renewal.

584 G. The nursing facility shall register with the Department of State Police to receive notice of
585 the registration or reregistration of any sex offender within the same or a contiguous zip code area
586 in which the nursing facility is located pursuant to § 9.1-914 of the Code of Virginia.

587 H. Prior to admission, each nursing facility shall determine if a potential resident is a registered
588 sex offender when the potential resident is anticipated to have a length of stay:

- 589 1. Greater than three days; or
590 2. In fact stays longer than three days.

591 I. The nursing facility shall not restrict the rights of a ~~nursing home~~ resident's family and
592 ~~resident's~~ legal representative to meet in the nursing facility with the families and legal
593 representatives of other residents ~~of the facility~~.

594 Statutory Authority

595 §§ 32.1-12, 32.1-127, and 32.1-162.12 of the Code of Virginia.

596 Historical Notes

597 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
598 Volume 17, Issue 1, eff. October 27, 2000; Volume 23, Issue 10, eff. March 1, 2007; Volume 24,
599 Issue 11, eff. March 5, 2008; Volume 34, Issue 11, eff. February 21, 2018.

600 **12VAC5-371-160. Financial controls and resident funds.**

601 A. All financial records, including resident funds, shall be kept according to generally accepted
602 accounting principles (GAAP).

603 B. Each nursing facility shall maintain liability insurance coverage in a minimum of \$1 million
604 and professional liability coverage in an amount at least equal to the recovery limit set forth in
605 § 8.01-581.15 of the Code of Virginia to compensate residents or individuals for injuries and
606 losses resulting from the negligent or criminal acts of the nursing facility. Failure to maintain
607 minimum insurance shall result in revocation of the nursing facility's license.

608 C. Nursing facilities choosing to handle resident funds shall:

- 609 1. Comply with § 32.1-138 A 7 of the Code of Virginia regarding resident funds;
610 2. Purchase a surety bond or otherwise provide assurance for the security of all personal
611 funds deposited with the nursing facility; and
612 3. Provide for separate accounting for resident funds.

613 D. In the event the nursing facility is sold, the nursing facility shall provide written verification
614 that all resident funds have been transferred and shall obtain a signed receipt from the new owner.
615 Upon receipt, the new owner shall provide an accounting of resident funds.

616 E. Each nursing facility shall be required to provide a full refund of any unexpended patient
617 funds on deposit with the nursing facility following the discharge or death of a patient, other than
618 entrance related fees, within 30 days of a written request for such funds by the discharged patient
619 or, in the case of the death of a patient, the person administering the patient's estate in accordance
620 with the Virginia Small Estate Act (§ 64.2-600 et seq. of the Code of Virginia).

621 Statutory Authority

622 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

623 Historical Notes

624 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
625 Volume 23, Issue 10, eff. March 1, 2007; Volume 30, Issue 3, eff. November 8, 2013; Volume 34,
626 Issue 11, eff. February 21, 2018.

627 **12VAC5-371-170. Quality assessment and assurance.**

628 A. The nursing facility shall maintain a quality assessment and assurance committee
629 consisting of at least the following individuals:

- 630 1. The director of nursing services;
- 631 2. A physician designated by the nursing facility; and
- 632 3. At least three other members of the nursing facility staff, one of whom demonstrates an
633 ability to represent the rights and concerns of residents.

634 B. The quality assessment and assurance committee shall:

- 635 1. Meet at least quarterly to identify issues which would improve quality of care and
636 services provided to residents; and
- 637 2. Develop and implement appropriate plans of action to correct identified deficiencies.

638 C. The nursing facility shall document compliance with these requirements.

639 Statutory Authority

640 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

641 Historical Notes

642 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997.

643 **12VAC5-371-180. Infection control.**

644 A. The nursing facility shall establish and maintain an infection control program designed to
645 provide a safe, sanitary, and comfortable environment and to prevent the development and
646 transmission of disease and infection.

647 B. The infection control program shall encompass the entire physical plant and all services.

648 C. The infection control program addressing the surveillance, prevention and control of ~~facility~~
649 wide infections in the nursing facility shall include:

- 650 1. Procedures to isolate the infecting organism;
- 651 2. Access to handwashing equipment for staff;
- 652 3. Training of staff in proper handwashing techniques, according to accepted professional
653 standards, to prevent cross contamination;
- 654 4. Implementation of universal precautions by direct resident care staff;
- 655 5. Prohibiting employees with communicable diseases or infections from direct contact
656 with residents or their food, if direct contact will transmit disease;
- 657 6. Monitoring staff performance of infection control practices;
- 658 7. Handling, storing, processing and transporting linens, supplies and equipment in a
659 manner that prevents the spread of infection;
- 660 8. Handling, storing, processing and transporting regulated medical waste in accordance
661 with applicable regulations;
- 662 9. Maintaining an effective pest control program; and
- 663 10. Staff education regarding infection risk-reduction behavior.

664 D. The nursing facility shall report promptly to its local health department diseases designated
665 as "reportable" according to 12VAC5-90-80 when such cases are admitted to or are diagnosed in
666 the nursing facility and shall report any outbreak of infectious disease as required by 12VAC5-90.
667 An outbreak is defined as an increase in incidence of any infectious disease above the usual
668 incidence at the nursing facility.

669 Statutory Authority

670 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

671 Historical Notes

672 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
673 Volume 22, Issue 7, eff. January 11, 2006.

674 **12VAC5-371-190. Safety and emergency procedures.**

675 A. A written emergency preparedness plan shall be developed, reviewed, and implemented
676 when needed. The plan shall address responses to natural disasters, as well as fire or other
677 emergency which disrupts the normal course of operations. The plan shall address provisions for
678 relocating residents and also address staff responsibilities for:

- 679 1. Alerting emergency personnel and sounding alarms;
680 2. Implementing evacuation procedures including the evacuation of residents with special
681 needs;
682 3. Using, maintaining and operating emergency equipment;
683 4. Accessing resident emergency medical information; and
684 5. Utilizing community support services.

685 B. All staff shall participate in periodic emergency preparedness training.

686 C. Staff shall have documented knowledge of, and be prepared to implement, the emergency
687 preparedness plan in the event of an emergency.

688 D. At least one telephone shall be available in each area to which residents are admitted and
689 additional telephones or extensions as are necessary to ensure availability in case of need.

690 E. In the event of a disaster, fire, emergency or any other condition that may jeopardize the
691 health, safety and well-being of residents, the ~~organization~~ nursing facility shall notify the OLC of
692 the conditions and status of the residents and the ~~licensed facility~~ physical plant as soon as
693 possible.

694 F. The nursing facility shall have a policy on smoking.

695 Statutory Authority

696 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

697 Historical Notes

698 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
699 Volume 23, Issue 10, eff. March 1, 2007.

700 **12VAC5-371-191. Electronic monitoring in resident rooms.**

701 A. All requests for electronic monitoring shall be made in writing and signed by the resident or
702 ~~the resident's responsible party~~ legal representative if the resident has been properly assessed
703 incapable of requesting and authorizing the monitoring.

704 B. Only electronic monitoring in accordance with this section is permitted.

705 C. A nursing facility shall not refuse to admit an individual and shall not discharge or transfer
706 a resident due to a request to conduct authorized electronic monitoring.

707 D. Family members cannot obtain electronic monitoring over the objections of the resident,
708 the resident's roommate, or the resident's ~~responsible party~~ legal representative. No equipment
709 may be installed pursuant to subsection Q of this section over the objections of the resident, ~~or if~~
710 ~~the resident is incapable, the resident's responsible party~~ or legal representative. ~~Facilities~~
711 Nursing facilities shall not use monitoring equipment in violation of the law based solely on a
712 family member's request or approval.

713 E. Consent for electronic monitoring shall be kept in the resident's medical record.

714 F. ~~Facilities~~ Nursing facilities shall designate one staff person to be responsible for managing
715 the electronic monitoring program.

716 G. ~~Facilities~~ Nursing facilities may designate custodial ownership of any recordings from
717 monitoring devices to the resident or ~~the resident's responsible party~~ legal representative. ~~Facility~~
718 Nursing facility retained recordings shall be considered part of the resident's medical record and
719 shall be retained for no less than two years or as required by state and federal laws.

720 H. If a nursing facility chooses to retain ownership of recordings, the nursing facility shall not
721 permit viewings of recordings without consent of the resident or ~~the resident's responsible party~~
722 legal representative except to the extent that disclosure is required by law through a court order
723 or pursuant to a lawful subpoena duces tecum. Should a ~~the~~ resident or ~~a resident's responsible~~
724 ~~party~~ legal representative approve viewing, the nursing facility shall accommodate viewing of any
725 recordings in a timely manner, including providing:

- 726 1. Appropriate playing or viewing equipment;
- 727 2. Privacy during viewing; and
- 728 3. Viewing times convenient to the resident or ~~the resident's responsible party~~ legal
729 representative.

730 If unauthorized viewing is discovered, the nursing facility shall report any such violation to the
731 Office of Long-Term Care Ombudsman and to OLC.

732 I. A nursing facility shall require its staff to report any incidents regarding safety or quality of
733 care discovered as a result of viewing a recording immediately to the ~~facility~~ administrator and to
734 the OLC. ~~Facilities~~ Nursing facilities shall instruct the resident or ~~the resident's responsible party~~
735 legal representative of this reporting requirement and shall provide the resident or ~~the resident's~~
736 ~~responsible party~~ legal representative with the OLC's complaint hotline telephone number.

737 J. A nursing facility shall have no obligation to seek access to a recording in its possession or
738 to have knowledge of a recording's content, unless the nursing facility is aware of a recorded
739 incident of suspected abuse, neglect, accident, or injury, or the resident, ~~the resident's responsible~~
740 ~~party~~ legal representative, or a government agency seeks to use a recording. ~~Facilities~~ Nursing
741 facilities shall immediately report suspected abuse and neglect discovered as a result of using
742 monitoring devices, as required by law.

743 K. A nursing facility may require the resident or ~~the resident's responsible party~~ legal
744 representative to be responsible for all aspects of the operation of the monitoring equipment,
745 including the removal and replacement of recordings; adherence to local, state, and federal
746 privacy laws; and for firewall protections to prevent images that would violate obscenity laws from
747 being inadvertently shown on the Internet.

748 L. A nursing facility shall prohibit assigned staff from refusing to enter a resident's room solely
749 because of electronic monitoring.

750 M. Any electronic monitoring equipment shall be installed in a manner that is safe for
751 residents, employees, or visitors who may be moving about the resident's room.

752 N. A nursing facility shall make reasonable physical accommodation for monitoring
753 equipment, including:

- 754 1. Providing a reasonably secure place to mount the device; and
- 755 2. Providing access to power sources for the device.

756 O. A nursing facility may require a resident or ~~a resident's responsible party~~ legal
757 representative to pay for all costs, other than the cost of electricity, associated with installing
758 electronic monitoring equipment. Such costs shall be reasonable and may include equipment,
759 recording media and installation, compliance with life safety and building and electrical codes,
760 maintenance or removal of the equipment, posting and removal of any public notices, or structural
761 repairs to the building resulting from the removal of the equipment. ~~Facilities~~ Nursing facilities
762 shall give 45 days' notice of an increase in monthly monitoring fees.

763 P. Any equipment installed for the purpose of monitoring a resident's room shall be fixed and
764 unable to rotate.

765 Q. The informed consent of all residents, ~~or if a resident is incapable, a resident's responsible~~
766 ~~party, or residents' legal representatives~~ assigned to the monitored room shall be obtained prior
767 to any electronic monitoring equipment being installed.

768 R. A copy of any signed consent form shall be kept in the resident's medical record as well as
769 on file with the nursing facility's designated electronic monitoring coordinator.

770 S. Any resident or ~~the resident's responsible party~~ legal representative of a resident of a
771 monitored room may condition consent for use of monitoring devices. Such conditions may
772 include pointing the camera away or limiting or prohibiting the use of certain devices. If conditions
773 are placed on consent, then electronic monitoring shall be conducted according to those
774 conditions.

775 T. The nursing facility shall conspicuously post and maintain a notice at the entrance to the
776 resident's room stating that an electronic monitoring device is in operation.

777 U. ~~Facilities~~ Nursing facilities shall notify all staff and ~~their~~ the long-term care division of the
778 ~~OLC Long-Term Care Supervisor~~ that electronic monitoring is in use.

779 V. A nursing facility shall prohibit staff from covert monitoring in violation of this chapter.
780 ~~Facilities~~ Nursing facilities shall instruct the resident or ~~the resident's responsible party~~ legal
781 representative of this prohibition and shall provide the resident or ~~the resident's responsible party~~
782 legal representative with the OLC's complaint hotline telephone number.

783 W. If covert monitoring is discovered, the nursing facility shall report any such violation to the
784 Office of Long-Term Care Ombudsman and OLC, and the nursing facility may require a resident
785 or a ~~resident's responsible party~~ legal representative to meet all the requirements for authorized
786 monitoring, if permitted by the nursing facility.

787 X. Each nursing facility, including those that choose not to offer electronic monitoring, shall
788 adopt policies and procedures for electronic monitoring. These policies and procedures shall
789 address all the elements of this section.

790 Y. A nursing facility shall prohibit staff from tampering with electronic monitoring in violation of
791 this chapter. ~~Facilities~~ Nursing facilities shall instruct the resident or ~~the resident's responsible~~
792 ~~party~~ legal representative of this prohibition and shall provide the resident or ~~the resident's~~
793 ~~responsible party~~ legal representative with the OLC's complaint hotline telephone number.

794 Statutory Authority

795 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

796 Historical Notes

797 Derived from Virginia Register Volume 35, Issue 5, eff. December 13, 2018.

798 **12VAC5-371-210. Nurse staffing.**

799 A. A nursing supervisor, designated by the director of nursing, shall be responsible for all
800 nursing activities in the nursing facility, or in the section to which assigned, including:

801 1. Making daily visits to determine resident physical, mental, and emotional status and
802 implementing any required nursing intervention;

803 2. Reviewing medication records for completeness, accuracy in the transcription of
804 physician orders, and adherence to stop-order policies;

805 3. Reviewing resident plans of care for appropriate goals and approaches, and making
806 revisions based on individual needs;

807 4. Assigning to the nursing staff responsibility for nursing care;

808 5. Supervising and evaluating performance of all nursing personnel on the unit; and

809 6. Keeping the director of nursing services, or director of nursing designee, informed of
810 the status of residents and other related matters.

811 B. The nursing facility shall provide qualified nurses and certified nurse aides on all shifts,
812 seven days per week, in sufficient number to meet the assessed nursing care needs of all
813 residents.

814 C. Nursing personnel, including registered nurses, licensed practical nurses, and certified
815 nurse aides shall be assigned duties consistent with their education, training and experience.

816 D. Weekly time schedules shall be maintained and shall indicate the number and classification
817 of nursing personnel who worked on each unit for each shift. Schedules shall be retained for one
818 year.

819 E. All nursing services shall be directly provided by an appropriately qualified registered nurse
820 or licensed practical nurse, except for those nursing tasks that may be delegated by a registered
821 nurse according to 18VAC90-20-420 through 18VAC90-20-460 of the regulation of the Virginia
822 Board of Nursing and with a plan developed and implemented by the nursing facility.

823 F. Before allowing a nurse aide to perform resident care duties, the nursing facility shall verify
824 that the individual is:

825 1. A certified nurse aide in good standing;

826 2. Enrolled full-time in a nurse aide education program approved by the Virginia Board of
827 Nursing; or

828 3. Has completed a nurse aide education program or competency testing, but has not yet
829 been placed on the nurse aide registry.

830 G. Any person employed to perform the duties of a nurse aide on a permanent full-time, part-
831 time, hourly, or contractual basis must be registered as a certified nurse aide within 120 days of
832 employment.

833 H. Nurse aides employed or provided by a temporary personnel agency shall be certified to
834 deliver nurse aide services.

835 I. The services provided or arranged with a temporary personnel agency shall meet
836 professional standards of practice and be provided by qualified staff according to each resident's
837 comprehensive plan of care.

838 Statutory Authority

839 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

840 Historical Notes

841 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
842 Volume 22, Issue 7, eff. January 11, 2006.

843 **12VAC5-371-260. Staff development and inservice training.**

844 A. All full-time, part-time and temporary personnel shall receive orientation to the nursing
845 facility commensurate with their function or job-specific responsibilities.

846 B. All resident care staff shall receive annual inservice training commensurate with their
847 function or job-specific responsibilities in at least the following:

848 1. Special needs of residents as determined by the nursing facility staff;

849 2. Prevention and control of infections;

850 3. Fire prevention or control and emergency preparedness;

851 4. Safety and accident prevention;

852 5. Restraint use, including alternatives to physical and chemical restraints;

853 6. Confidentiality of resident information;

- 854 7. Understanding the needs of the aged and disabled;
855 8. Resident rights, including personal rights, property rights and the protection of privacy,
856 and procedures for handling complaints;
857 9. Care of the cognitively impaired;
858 10. Basic principles of cardiopulmonary resuscitation for licensed nursing staff and the
859 Heimlich maneuver for nurse aides; and
860 11. Prevention and treatment of pressure sores.

861 C. The nursing facility shall have an ongoing training program that is planned and conducted
862 for the development and improvement of skills of all personnel.

863 D. The nursing facility shall maintain written records indicating the content of and attendance
864 at each orientation and inservice training program.

865 E. The nursing facility shall provide inservice programs, based on the outcome of annual
866 performance evaluations, for nurse aides.

867 F. Nurse aide inservice training shall consist of at least 12 hours per anniversary year.

868 G. The nursing facility shall provide training on the requirements for reporting adult abuse,
869 neglect, or exploitation and the consequences for failing to make such a required report to all its
870 employees who are licensed to practice medicine or any of the healing arts, serving as a hospital
871 resident or intern, engaged in the nursing profession, working as a social worker, mental health
872 professional or law-enforcement officer and any other individual working with residents of the
873 nursing facility.

874 Statutory Authority

875 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

876 Historical Notes

877 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
878 Volume 17, Issue 1, eff. October 27, 2000.

879 **12VAC5-371-300. Pharmaceutical services.**

880 A. Provision shall be made for the procurement, storage, dispensing, and accounting of drugs
881 and other pharmacy products in compliance with 18VAC110-20. This may be by arrangement
882 with an off-site pharmacy, but must include provisions for 24-hour emergency service.

883 B. Each nursing facility shall develop and implement policies and procedures for the handling
884 of drugs and biologicals, including procurement, storage, administration, self-administration and
885 disposal of drugs.

886 C. Each nursing facility shall have a written agreement with a qualified pharmacist to provide
887 consultation on all aspects of the provision of pharmacy services in the nursing facility.

888 D. The consultant pharmacist shall make regularly scheduled visits, at least monthly, to the
889 nursing facility for a sufficient number of hours to carry out the function of the agreement.

890 E. No drug or medication shall be administered to any resident without a valid verbal order or
891 a written, dated and signed order from a physician, dentist or podiatrist, nurse practitioner or
892 physician assistant, licensed in Virginia.

893 F. Verbal orders for drugs or medications shall only be given to a licensed nurse, pharmacist
894 or physician.

895 G. Drugs and medications not limited as to time or number of doses when ordered shall be
896 automatically stopped, according to the written policies of the nursing facility, and the attending
897 physician shall be notified.

898 H. Each resident's medication regimen shall be reviewed by a pharmacist licensed by the
899 Virginia Board of Pharmacy. Any irregularities identified by the pharmacist shall be reported to
900 the physician and the director of nursing, and their response documented.

901 I. Medication orders shall be reviewed at least every 60 days by the attending physician, nurse
902 practitioner, or physician's assistant.

903 J. Prescription and nonprescription drugs and medications may be brought into the nursing
904 facility by a resident's family, friend or other person provided:

905 1. The individual delivering the drugs and medications assures timely delivery, in
906 accordance with the nursing facility's written policies, so that the resident's prescribed
907 treatment plan is not disrupted;

908 2. Each drug or medication is in an individual container; and

909 3. Delivery is not allowed directly to an individual resident.

910 In addition, prescription medications shall be obtained and labeled as required by law.

911 Statutory Authority

912 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

913 Historical Notes

914 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
915 Volume 22, Issue 7, eff. January 11, 2006.

916 **12VAC5-371-330. Restraint usage.**

917 A. A resident shall be free from any physical or chemical restraints imposed for purposes of
918 discipline or convenience, and not required to treat the resident's medical symptoms.

919 B. Restraints shall only be used:

920 1. In accordance with the comprehensive assessment and plan of care, which includes a
921 schedule or plan of rehabilitation training enabling the progressive removal or the
922 progressive use of less restrictive restraints when appropriate; and

923 2. As a last resort, after completing, implementing, and evaluating the resident's
924 comprehensive assessment and plan of care, when the nursing facility has determined
925 that less restrictive means have failed.

926 C. If a restraint is used in a nonemergency, the nursing facility shall:

927 1. Explain the use of the restraint, including potential negative outcomes of restraint use,
928 to the resident or his legal representative, as appropriate;

929 2. Explain the resident's right to refuse the restraint;

930 3. Obtain written consent of the resident. If the resident has been legally declared
931 incompetent, obtain written consent from the legal representative; and

932 4. Include the use of restraint in the plan of care.

933 D. Restraints shall not be ordered on a standing or PRN basis.

934 E. Restraints shall be applied only by staff trained in their use.

935 F. At a minimum, for a resident placed in a restraint, the nursing facility shall:

936 1. Check the resident at least every 30 minutes;

937 2. Provide an opportunity for motion, exercise and elimination for not less than 10 minutes
938 each hour in which a restraint is administered; and

939 3. Document restraint usage, including outcomes, in accordance with nursing facility
940 policy.

941 G. Emergency orders for restraints shall not be in effect for longer than 24 hours and must be
942 confirmed by a physician within one hour of administration. Each application of emergency
943 restraint shall be considered a single event and shall require a separate physician's order.

944 H. Temporary restraints may be used for a brief period to allow a medical or surgical
945 procedure, but shall not be used to impose a medical or surgical procedure which the resident
946 has previously refused.

947 I. The nursing facility shall notify a resident's legal representative, if any, or designated family
948 member as soon as practicable, but no later than 12 hours after administration of a restraint.

949 J. Chemical restraint shall only be ordered in an emergency situation when necessary to
950 ensure the physical safety of the resident or other individuals.

951 K. Orders for chemical restraint shall be in writing, signed by a physician, specifying the dose,
952 frequency, duration and circumstances under which the chemical restraint is to be used. Verbal
953 orders for chemical restraints shall be implemented when an emergency necessitates parenteral
954 administration of psychopharmacologic drugs, but only until a written order can reasonably be
955 obtained.

956 L. Emergency orders for chemical restraints shall:

957 1. Not be in effect for more than 24 hours; and

958 2. Be administered only if the resident is monitored continually for the first 15 minutes after
959 each parenteral administration (or 30 minutes for nonparenteral administration) and every
960 15 minutes thereafter, for the first hour, and hourly for the next eight hours to ensure that
961 any adverse side effects will be noticed and appropriate action taken as soon as possible.

962 Statutory Authority

963 §§ 32.1-12 and 32.1-127 of the Code of Virginia.

964 Historical Notes

965 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997.

966 **12VAC5-371-360. Clinical records.**

967 A. The nursing facility shall maintain an organized clinical record system in accordance with
968 recognized professional practices. Written policies and procedures shall be established specifying
969 content and completion of clinical records.

970 B. Clinical records shall be confidential. Only authorized personnel shall have access as
971 specified in §§ 8.01-413 and 32.1-127.1:03 of the Code of Virginia.

972 C. Records shall be safeguarded against destruction, fire, loss or unauthorized use.

973 D. Overall supervisory responsibility for assuring that clinical records are maintained,
974 completed and preserved shall be assigned to an employee of the nursing facility. The individual
975 shall have work experience or training which is consistent with the nature and complexity of the
976 record system and be capable of effectively carrying out the functions of the job.

977 E. An accurate and complete clinical record shall be maintained for each resident and shall
978 include, but not be limited to:

979 1. Resident identification;

980 2. Designation of attending physician;

981 3. Admitting information, including resident medical history, physical examination and
982 diagnosis;

983 4. Physician orders, including all medications, treatments, diets, restorative and special
984 medical procedures required;

985 5. Progress notes written at the time of each visit;

- 986 6. Documented evidence of assessment of resident's needs, establishment of an
987 appropriate treatment plan, and interdisciplinary plan of care;
- 988 7. Nurse's notes written in chronological order and signed by the individual making the
989 entry;
- 990 8. All symptoms and other indications of illness or injury, including date, time, and action
991 taken on each shift;
- 992 9. Medication and treatment record, including all medications, treatments and special
993 procedures performed;
- 994 10. Copies of radiology, laboratory and other consultant reports; and
995 11. Discharge summary.
- 996 F. Verbal orders shall be immediately documented in the clinical record by the individual
997 authorized to accept the orders, and shall be countersigned.
- 998 G. Clinical records of discharged residents shall be completed within 30 days of discharge.
- 999 H. Clinical records shall be kept for a minimum of five years after discharge or death, unless
1000 otherwise specified by state or federal law.
- 1001 I. Permanent information kept on each resident shall include:
- 1002 1. Name;
- 1003 2. Social security number;
- 1004 3. Date of birth;
- 1005 4. Date of admission and discharge; and
1006 5. Name and address of ~~guardian~~ legal representative, if any.
- 1007 J. Clinical records shall be available to residents and legal representatives, if they wish to see
1008 them.
- 1009 K. When a nursing facility closes, the owners shall make provisions for the safekeeping and
1010 confidentiality of all clinical records.
- 1011 Statutory Authority
- 1012 §§ 32.1-12 and 32.1-127 of the Code of Virginia.
- 1013 Historical Notes
- 1014 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
1015 Volume 22, Issue 7, eff. January 11, 2006.
- 1016 **12VAC5-371-380. Laundry services.**
- 1017 A. A quantity of linens shall be available at all times to provide for proper care and comfort of
1018 residents.
- 1019 B. Linens and other laundry must be handled, stored and processed to control the spread of
1020 infection.
- 1021 C. Clean linen shall be stored in a clean and dry area accessible to the nursing unit.
- 1022 D. Soiled linen shall be stored in covered containers in separate, well ventilated areas and
1023 shall not accumulate in the nursing facility.
- 1024 E. Soiled linen shall not be sorted, laundered, rinsed or stored in bathrooms, resident rooms,
1025 kitchens or food storage areas.
- 1026 F. Soiled linen shall not be placed on the floor.
- 1027 G. Arrangement for laundering resident's personal clothing shall be provided. If laundry
1028 facilities are not provided on premises, commercial laundry services shall be utilized.
- 1029 Statutory Authority

- 1030 §§ 32.1-12 and 32.1-127 of the Code of Virginia.
- 1031 Historical Notes
- 1032 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997.
- 1033 **12VAC5-371-390. Transportation.**
- 1034 A. Provisions shall be made to obtain appropriate transportation in cases of emergency.
- 1035 B. The nursing facility shall assist in obtaining transportation when it is necessary to obtain
- 1036 medical, psychiatric, dental, diagnostic or other services outside the nursing facility.
- 1037 Statutory Authority
- 1038 §§ 32.1-12 and 32.1-127 of the Code of Virginia.
- 1039 Historical Notes
- 1040 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997.
- 1041 **12VAC5-371-400. Unique design solutions. (Repealed.)**
- 1042 ~~A. All unique design solutions shall be described with outcome measures. This shall be~~
- 1043 ~~reviewed in cooperation with the OLC.~~
- 1044 ~~B. The description and outcome measures shall be a part of the material used to review the~~
- 1045 ~~design solution at the time of the facility survey.~~
- 1046 ~~C. All unique design solutions, unless specifically excluded by contract, shall comply with~~
- 1047 ~~Parts II (12VAC5-371-110 et seq.) and III (12VAC5-371-200 et seq.) of this chapter.~~
- 1048 ~~Statutory Authority~~
- 1049 ~~§§ 32.1-12 and 32.1-127 of the Code of Virginia.~~
- 1050 Historical Notes
- 1051 Derived from Virginia Register Volume 13, Issue 17, eff. July 1, 1997; amended, Virginia Register
- 1052 Volume 23, Issue 10, eff. March 1, 2007.
- 1053 FORMS (12VAC5-371)
- 1054 Application for License Renewal: Nursing Homes (rev. 9/06).
- 1055 Application for License Renewal: Nursing Homes; Mid Year, Initial and Changes (rev. 9/06).
- 1056 DOCUMENTS INCORPORATED BY REFERENCE (12VAC5-371)
- 1057 Guidelines for Design and Construction of Health Care Facilities, Facilities Guideline Institute
- 1058 (formerly of the American Institute of Architects Academy of Architecture), 2010 Edition.
- 1059 ~~Guidelines for Preventing Health Care-Associated Pneumonia, 2003, MMWR 53 (RR03),~~
- 1060 ~~Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention.~~
- 1061 [Guidelines for Preventing Health-Care-Associated Pneumonia, 2003, MMWR 53 \(RR-3\),](#)
- 1062 [Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention.](#)
- 1063 ~~Prevention and Control of Influenza, MMWR 53 (RR06), Advisory Committee on Immunization~~
- 1064 ~~Practices, Centers for Disease Control and Prevention.~~
- 1065 [Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the](#)
- 1066 [Advisory Committee on Immunization Practices — United States, 2019–20 Influenza Season,](#)
- 1067 [2019, MMWR 68 \(RR-3\), Centers for Disease Control and Prevention.](#)



COMMONWEALTH of VIRGINIA

Department of Health

P O BOX 2448

RICHMOND, VA 23218

M. NORMAN OLIVER, MD, MA
STATE HEALTH COMMISSIONER

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

MEMORANDUM

DATE: February 13, 2020

TO: Virginia State Board of Health

FROM: Heather Board, Acting Director, Office of Family Health Services

SUBJECT: Proposed Stage – Regulations Governing Virginia Newborn Screening Services

The Virginia Newborn Screening Program has initiated the proposed stage to amend the existing newborn screening regulation to add spinal muscular atrophy (SMA) and X-linked adrenoleukodystrophy (X-ALD) to the newborn screening panel. Approval of this regulatory action would result in amending 12VAC5-71 to revise Section 30, which lists the specific disorders and genetic diseases that must be screened in Virginia. All Virginia newborns would be screened for SMA and X-ALD at birth. The Virginia Department of Health works in partnership with the Department of General Services' Division of Consolidated Services to provide blood spot newborn screening services.

Upon approval by the Board, the proposed amendments will be submitted to the Regulatory Town Hall to begin Executive Branch Review Process. Following approval by the Governor, it will be published in the Virginia Register of Regulations for a 60-day public comment period.



townhall.virginia.gov

Proposed Regulation Agency Background Document

Agency name	Virginia Department of Health
Virginia Administrative Code (VAC) citation(s)	12 VAC5-71
Regulation title(s)	Regulations Governing Virginia Newborn Screening Services
Action title	Amend regulations to add SMA and X-ALD to the Virginia Newborn Screening System core panel of heritable disorders and genetic diseases.
Date this document prepared	January 29, 2020

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1 VAC7-10), and the *Virginia Register Form, Style, and Procedure Manual for Publication of Virginia Regulations*.

Brief Summary

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

The proposed regulatory action would amend the existing newborn screening regulation to add spinal muscular atrophy (SMA) and X-linked adrenoleukodystrophy (X-ALD) to the newborn screening panel. Blood spot newborn screening services are provided by the Department of General Services' Division of Consolidated Laboratory Services (DCLS) in partnership with the Virginia Department of Health (VDH). SMA is a genetic disorder that is estimated to occur in approximately 9.1 out of every 100,000 live births. X-ALD is a genetic disorder that is estimated to occur in approximately 6 out of every 100,000 live births. Treatment for both X-ALD and SMA is available if detected early. Screening is necessary, as these disorders cannot be detected at birth through physical examinations. The additions of SMA and X-ALD to the newborn screening panel have been recommended by the Virginia Genetics Advisory Committee. On the national level, these disorders have been added to the core panel of 35 genetic disorders included in the Recommended Uniform Screening Panel (RUSP) of the U.S. Secretary of Health and Human Services' (HHS) Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC).

Acronyms and Definitions

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the “Definition” section of the regulations.

ACHDNC – Advisory Committee on Heritable Disorders in Newborns and Children

DCLS – Division of Consolidated Laboratory Services

HHS – Health and Human Services

RUSP – Recommended Uniform Screening Panel

SMA – spinal muscular atrophy

VDH – Virginia Department of Health

VNSP – Virginia Newborn Screening Program

X-ALD – X-linked adrenoleukodystrophy

Mandate and Impetus

Please 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, board decision, etc.). For purposes of executive branch review, “mandate” has the same meaning as defined in Executive Order 14 (as amended, July 16, 2018), “a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part.”

The State Board of Health is initiating this regulatory action in response to a recommendation received from the Virginia Genetics Advisory Committee. On the national level, these disorders have been added to the core panel of 35 genetic disorders included in the RUSP of the U.S. Secretary of HHS ACHDNC.

Legal Basis

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

The State Board of Health is authorized to make, adopt, promulgate and enforce regulations by Section 32.1-12 of the Code of Virginia.

Section 32.1-65 of the Code of Virginia requires newborn screening to be conducted on every infant born in the Commonwealth of Virginia.

Section 32.1-67 of the Code of Virginia requires the Board of Health to promulgate regulations as necessary to implement Newborn Screening Services. The regulations are required to include a list of newborn screening tests pursuant to Section 32.1-65.

Purpose

Please 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's intended to solve.

Spinal muscular atrophy is a genetic disorder characterized by weakness and wasting (atrophy) in muscles used for movement (skeletal muscles). SMA is caused by a loss of specialized nerve cells, called motor neurons, which control muscle movement. SMA affects 9.1 out of every 100,000 births and there are five classification types. Type 0 often leads to fetal loss or newborns with significant involvement and death in early infancy; this is the rarest and most severe form of the condition. Type I, the most common form, leads to progressive weakness in the first six months of life and, without targeted intervention, death prior to two years of age. Type II is associated with progressive weakness by 15 months of life and, without targeted intervention, respiratory failure and death after the third decade of life. Types III and IV are associated with progressive weakness that develops after one year of life or in adulthood, and most individuals have a normal lifespan. Treatment for SMA generally includes a disease-modifying therapy that uses FDA-approved Spinraza, as well as clinical care support therapies such as nutritional support, respiratory support, pulmonary care, orthopedic and rehabilitation care, and palliative care.

X-linked adrenoleukodystrophy is a genetic disorder that occurs primarily in males, mainly affecting the nervous system and the adrenal glands. In the United States, X-ALD affects 6 out of every 100,000 births, regardless of sex. There are three distinct types of X-ALD: a childhood cerebral form, an adrenomyeloneuropathy type, and a form called Addison disease only. Childhood cerebral X-ALD is the most serious form of X-ALD and it usually presents between 2.5 and 10 years of age. It is associated with rapid neurologic decline and death or disability an average three years after onset. Signs and symptoms of the adrenomyeloneuropathy type appear between early adulthood and middle age. People with X-ALD whose only symptom is adrenocortical insufficiency are said to have the Addison disease only form, which is the mildest form of the three types. In these individuals, adrenocortical insufficiency can begin anytime between childhood and adulthood. Treatment for X-ALD is difficult to predict since symptom onset varies and, in many cases, might not occur until after infancy. Treatment options include hormone therapy and hematopoietic stem cell transplantation (HSCT), depending on the severity of the disorder.

All newborns in Virginia would be screened for SMA and X-ALD as a result of this proposed regulatory action. Screening for SMA and X-ALD can provide affected infants the benefit of early diagnosis and treatment. Screening is an effective diagnostic tool since these disorders cannot be detected at birth through a physical examination. Laboratory screening is available at a cost.

The addition of SMA and X-ALD to the core panel will result in an increase to the newborn screening fee. The VDH Office of Family Health Services has a longstanding partnership with DCLS to provide blood spot newborn screening services. The Virginia Newborn Screening Program is solely funded through Enterprise Funding, which is generated from the collection of fees from dried blood spot specimen kits sold to submitting birthing facilities and health care providers statewide. As of October 1, 2019, the newborn screening fee is \$138 per card. To implement these two screenings statewide, DCLS will require infrastructure investment that includes additional laboratory equipment; programmatic staff; application development to incorporate screening results; incorporation of new education modules; identification of specialized medical support systems for infants and their families; and family support and case management services for infants diagnosed with SMA or X-ALD. An estimated fee increase of \$1.86 for SMA and an increase between \$4.62 - \$6.92 for X-ALD would need to occur at least twelve months prior to implementation to cover the cost of adding these screenings.

Substance

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

The proposed changes to 12 VAC 5-71 will revise Section 30, which lists the specific disorders and genetic diseases that must be screened in Virginia, by adding SMA and X-ALD to the state's core panel. Currently, DCLS analyzes biological markers that may be indicative of 31 certain disorders that constitute the core panel. Section 32.1-67 of the Code of Virginia requires that this list of screened disorders be in the regulation. Section 32.1-65 of the Code requires that Virginia's screening tests are consistent with the panel recommended by the U.S. Secretary of HHS ACHDNC.

Issues

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

The primary advantage of the proposed regulatory action to the public is that screening for SMA and X-ALD can provide affected infants the benefit of early diagnosis and treatment. Screening is an effective diagnostic tool since these disorders cannot be detected at birth through a physical examination. The primary disadvantage to the public is that adding these two screenings to the panel results in a cost increase.

A primary advantage of the proposed regulatory action to the agency is that the action aligns with the recommendation from the Virginia Genetics Advisory Committee to add SMA and X-ALD to the state's core panel. This also aligns with the panel recommended by the U.S. Secretary of HHS ACHDNC.

A disadvantage to the regulated community, government officials and the public is the projected increase in the cost of the two screenings. Newborn screening is a fee-for-service program, and the fee is paid by hospitals and other screeners who must purchase the filter paper kits used for blood spot collection. Most screening is performed in hospitals, with about 10-15% of screening performed by private physicians and military facilities. Hospitals do not generally pass on these costs to patients because third party payers usually pay a negotiated bundled amount per delivery, and Medicaid reimbursed delivery payment is set by the state. Self-pay patients may be responsible to pay the screening fee themselves if they have the resources to do so.

Requirements More Restrictive than Federal

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

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

Agencies, Localities, and Other Entities Particularly Affected

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

Other State Agencies Particularly Affected

The Department of General Services' DCLS is particularly affected by this regulatory change. The Department of Medical Assistance Services may also be affected since they may have to negotiate new reimbursement rates for the increased fee.

Localities Particularly Affected

No locality will be particularly affected by the proposed amendment.

Other Entities Particularly Affected

Hospitals, birthing centers and regional genetic centers within the Commonwealth will be affected by the proposed amendment.

Economic Impact

Pursuant to § 2.2-4007.04 of the Code of Virginia, please 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. Please keep in mind that this is change versus the status quo.

Impact on State Agencies

<p><i>For your agency:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources</p>	<p>VDH costs are included in the newborn screening fee, which include one full-time employee for follow-up activities and education and outreach costs.</p>
<p><i>For other state agencies:</i> projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.</p>	<p>Projected costs to add SMA and X-ALD to the newborn screening panel will be incurred by DCLS. Costs related to capital equipment, staff, application development and education modules to conduct SMA screenings are estimated at \$389,631 start-up costs and \$192,262 annually. Costs related to capital equipment, staff, application development and education modules to conduct X-ALD screenings are estimated at \$1,101,568 start-up costs and \$1,073,422 annually. The projected costs will be funded through the fee increase for the blood spot screening panel resulting from the addition of SMA and X-ALD to the core panel.</p>

<p><i>For all agencies:</i> Benefits the regulatory change is designed to produce.</p>	<p>SMA and X-ALD are genetic disorders affecting newborns that can result in death if not treated early. These amendments will assure that all newborns born in Virginia hospitals and birthing centers will be screened for SMA and X-ALD prior to their discharge. Better health outcomes and higher infant survival rates are the intended impacts.</p>
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Impact on Localities

<p>Projected costs, savings, fees or revenues resulting from the regulatory change.</p>	<p>There is no projected fiscal impact on localities.</p>
<p>Benefits the regulatory change is designed to produce.</p>	<p>These amendments will assure that all newborns born in Virginia hospitals and birth centers will be screened for SMA and X-ALD prior to their discharge. Better health outcomes and higher infant survival rates are the intended impacts.</p>

Impact on Other Entities

<p>Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.</p>	<p>Hospitals, birthing centers, midwives and infants born in Virginia hospitals and birth centers will likely be affected.</p>
<p>Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million.</p>	<p>Hospitals: 58 Birth centers: Approximately 10-15 Midwives: Unknown Infants born in these facilities annually: 99,000</p>
<p>All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Please 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.</p>	<p>The current cost of the newborn screening panel is \$138. It is estimated that adding SMA to the newborn screening panel will result in an increase of \$1.86, and adding X-ALD to the newborn screening panel will result in an increase between \$4.62 - \$6.92 per sample. a) \$0 b) \$0 c) \$8.78 increase per sample (estimated maximum) d) Start-up equipment cost is \$389,631 for SMA and \$1,101,568 for X-ALD. e) The fee increase needs to go into effect 12 months prior to implementation to accrue start-up costs.</p>
<p>Benefits the regulatory change is designed to produce.</p>	<p>SMA and X-ALD are genetic disorders affecting newborns that can result in death if not treated early. These amendments will assure that all newborns born in Virginia hospitals and birth centers will be screened for SMA and X-ALD prior to their discharge. Better health outcomes</p>

	and higher infant survival rates are the intended impacts.
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Alternatives

Please 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.

The alternative to this proposed regulatory action is to not add SMA and X-ALD to the core panel of disorders for which newborns are screened. However, this option would be in direct conflict with both the national RUSP and the recommendation of the Virginia Genetics Advisory Committee.

Regulatory Flexibility Analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, please 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.

VDH staff convened SMA and X-ALD workgroups comprised of internal and external stakeholders including medical experts in the field of pediatric SMA and X-ALD diagnosis and treatment, professionals from major medical and higher education institutions within the Commonwealth, parent advocates and staff from DCLS to evaluate and consider this regulatory change and its cost effectiveness. The alternative regulatory methods are not applicable. There are no other applicable regulations to consolidate which impact newborn screening. Small businesses may not be exempted as a category because screening for all infants must be managed equitably by their providers, regardless of business size, to assure optimal outcomes. There are no viable alternatives to the proposed regulatory action to achieve the necessary regulatory changes determined to be appropriate.

Periodic Review and Small Business Impact Review Report of Findings

If you are using this form to report the result of a periodic review/small business impact review that is being conducted as part of this regulatory action, and was announced during the NOIRA stage, please indicate whether the regulatory change meets the criteria set out in Executive Order 14 (as amended, July 16, 2018), e.g., is necessary for the protection of public health, safety, and welfare; minimizes the economic impact on small businesses consistent with the stated objectives of applicable law; and is clearly written and easily understandable.

In addition, as required by § 2.2-4007.1 E and F of the Code of Virginia, include a discussion of the agency’s consideration of: (1) the continued need for the regulation; (2) the nature of complaints or comments received concerning the regulation from the public; (3) the complexity of the regulation; (4) the extent to which the regulation overlaps, duplicates, or conflicts with federal or state law or regulation; and (5) the length of time since the regulation has been evaluated or the degree to which technology, economic conditions, or other factors have changed in the area affected by the regulation.

The regulation meets the criteria set out in Executive Order 14 and is necessary for the protection of public health, safety and welfare.

There is a continued need for the regulations, as the provision of newborn screening services to babies born in the Commonwealth of Virginia are required by legislation. The amendment to add SMA and X-ALD to the Virginia Newborn Screening System’s core panel of heritable disorders and genetic diseases is consistent with the RUSP. SMA and X-ALD were recommended to be added to the RUSP in July 2018 and February 2016, respectively.

Two public comments were received in June 2019 in support of adding SMA to the newborn screening panel. The comments were received during the public comment period.

The regulations are clearly written and easily understandable. The regulations do not overlap, duplicate or conflict with any known federal or state law or regulation. Regulations are evaluated on an ongoing basis and these regulations were last amended in January 2019.

Public Comment

Please summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Ensure to include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency or board. If no comment was received, enter a specific statement to that effect.

Commenter	Comment	Agency response
Debra Schaefer, Virginia Chapter Cure SMA	<p>I can’t express strongly enough the importance and urgency of adding Spinal Muscular Atrophy (SMA) to Virginia’s Newborn Screening Panel as expeditiously as possible.</p> <p>My family has experienced the heartbreaking loss of my first granddaughter 7 years ago to SMA, at the tender age of 7 months. At that time, there was no treatment and no cure. We are now experiencing the joy of seeing my second granddaughter live and thrive with SMA since her participation from the time she was 3 months of age in the clinical trial that resulted in the first FDA approved treatment for SMA. She had already lost most of her ability to move. Although still medically fragile, she is 5 1/2 years old and able to do things previously unheard of for a Type 1 baby, including holding up her head and propelling her own manual wheelchair.</p> <p>We have seen firsthand the profoundly improved outcomes for the Type 1 babies who are diagnosed and treated PRIOR to exhibiting symptoms. PLEASE expedite implementation of Newborn Screening for SMA in Virginia</p>	VDH notes the support of the proposed amendments. No response is required.

	<p>so that approximately 9 families per year will never know the struggles we will face every day.</p>	
<p>Jaimie Vickery, Cure SMA</p>	<p>On behalf of the largest nonprofit organization dedicated to finding a cure for spinal muscular atrophy (SMA), we ask that Virginia adopt newborn screening for SMA as soon as possible.</p> <p>SMA is the most common genetic cause of death in infants in the United States, affecting approximately 1 in 11,000 newborns. The condition is caused by a mutation in the survival motor neuron gene 1 (<i>SMN1</i>) that causes nerve cells to malfunction, leading to debilitating and often fatal muscle weakness. In Virginia, 9 babies are born with SMA every year, and roughly 155,000 individuals are genetic carriers of the condition.</p> <p>Fortunately, there are two FDA-approved treatments for the disease, but they cannot repair motor neuron damage that has already happened, only slow down or prevent further damage. Because of this, treatment must happen as soon as possible for it to be most effective. In some cases, this may be before a child shows any symptoms of the disease. It is critical, therefore, that newborns with SMA be identified and receive treatment as soon as possible.</p> <p>Given the importance of newborn screening in effectively treating SMA, Health and Human Services Secretary Alex Azar added SMA to the Recommended Uniform Screening Panel in July of 2018, and Virginia’s Advisory Council voted to add it in November 2018. More than twenty other states have approved adding SMA to their newborn testing program, and seven states have already begun testing. Already, several infants have been identified and are receiving life-saving treatment.</p> <p>Therefore, we ask that Virginia adopt this screening as soon as possible</p>	<p>VDH notes the support of the proposed amendments. No response is required.</p>

Public Participation

Please include a statement that in addition to any other comments on the regulatory change, the agency is seeking comments on the costs and benefits of the regulatory change and the impacts of the regulated community. Also, indicate whether a public hearing will be held to receive comments.

In addition to any other comments, the Board of Health is seeking comments on the costs, benefits and potential impacts of this regulatory proposal. Also, the agency/board is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include: 1) projected reporting, recordkeeping and other administrative costs; 2) probable effect of the regulation on affected small businesses; and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

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>. Written comments must include the name and address of the commenter. Comments may also be submitted by mail, email or fax to Robin Buskey, Virginia Department of Health, 109 Governor Street, Richmond, Virginia 23219, robin.buskey@vdh.virginia.gov, (804) 864-7652. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will not be held following the publication of this stage of this regulatory action.

Detail of Changes

Please 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.

If the regulatory change will be a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory change. Delete inapplicable tables.

If the regulatory change is intended to replace an emergency regulation, please follow the instructions in the text following the three chart templates below. Please include citations to the specific section(s) of the regulation that are changing.

For changes to existing regulation(s), please use the following chart:

Current section number	New section number, if applicable	Current requirement	Change, intent, rationale, and likely impact of new requirements
12VAC5-71-30		The Virginia Newborn Screening System’s core panel of heritable disorders and genetic diseases.	<p>This section lists the conditions of the core panel of heritable disorders and genetic diseases for which the newborn dried blood spot testing is conducted. The proposed change would add SMA and X-ALD to the core panel.</p> <p>Intent: Align Virginia Newborn screening panel with the recommendations of the Virginia Genetics Advisory Committee and the U.S. Secretary of HHS ACHDNC.</p> <p>Rationale: Screening for these two additional disorders can provide affected infants the benefit of early diagnosis and treatment.</p> <p>Likely Impact: Better health outcomes and higher infant survival rates.</p>

1 RIS Project 5996

2 12VAC5-71-30. Core panel of heritable disorders and genetic diseases.

3 A. The Virginia Newborn Screening System, which includes the Virginia Newborn
4 Screening Program, the Virginia Early Hearing Detection and Intervention Program, and
5 the Virginia critical congenital heart disease screening, shall ensure that the core panel
6 of heritable disorders and genetic diseases for which newborn screening is conducted is
7 consistent with but not necessarily identical to the U.S. Department of Health and Human
8 Services Secretary's Recommended Uniform Screening Panel.

9 B. The department shall review, at least biennially, national recommendations and
10 guidelines and may propose changes to the core panel of heritable disorders and genetic
11 diseases for which newborn dried-blood-spot screening tests are conducted.

12 C. The Virginia Genetics Advisory Committee may be consulted and provide advice
13 to the commissioner on proposed changes to the core panel of heritable disorders and
14 genetic diseases for which newborn dried-blood-spot screening tests are conducted.

15 D. Infants under six months of age who are born in Virginia shall be screened in
16 accordance with the provisions set forth in this chapter for the following heritable disorders
17 and genetic diseases, which are identified through newborn dried-blood-spot screening
18 tests:

- 19 1. Argininosuccinic aciduria (ASA);
- 20 2. Beta-Ketothiolase deficiency (BKT);
- 21 3. Biotinidase deficiency (BIOT);
- 22 4. Carnitine uptake defect (CUD);
- 23 5. Classical galactosemia (galactose-1-phosphate uridylyltransferase deficiency)
24 (GALT);
- 25 6. Citrullinemia type I (CIT-I);

- 26 7. Congenital adrenal hyperplasia (CAH);
- 27 8. Cystic fibrosis (CF);
- 28 9. Glutaric acidemia type I (GA I);
- 29 10. Hb S beta-thalassemia (Hb F,S,A);
- 30 11. Hb SC-disease (Hb F,S,C);
- 31 12. Hb SS-disease (sickle cell anemia) (Hb F, S);
- 32 13. Homocystinuria (HCY);
- 33 14. Isovaleric acidemia (IVA);
- 34 15. Long chain L-3-Hydroxy acyl-CoA dehydrogenase deficiency (LCHAD);
- 35 16. Maple syrup urine disease (MSUD);
- 36 17. Medium-chain acyl-CoA dehydrogenase deficiency (MCAD);
- 37 18. Methylmalonic acidemia (Methylmalonyl-CoA mutase deficiency) (MUT);
- 38 19. Methylmalonic acidemia (Adenosylcobalamin synthesis deficiency) (CBL A,
- 39 CBL B);
- 40 20. Multiple carboxylase deficiency (MCD);
- 41 21. Phenylketonuria (PKU);
- 42 22. Primary congenital hypothyroidism (CH);
- 43 23. Propionic acidemia (PROP);
- 44 24. Severe combined immunodeficiency (SCID);
- 45 25. Tyrosinemia type I (TYR I);
- 46 26. Trifunctional protein deficiency (TFP);
- 47 27. Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD);
- 48 28. 3-hydroxy 3-methyl glutaric aciduria (HMG);
- 49 29. 3-Methylcrotonyl-CoA carboxylase deficiency (3-MCC);

- 50 30. Pompe disease; and
51 31. Mucopolysaccharidosis type I (MPS I);
52 32. Spinal muscular atrophy (SMA); and
53 33. X-linked adrenoleukodystrophy (X-ALD).

54 E. Infants born in Virginia shall be screened for hearing loss in accordance with
55 provisions set forth in §§ 32.1-64.1 and 32.1-64.2 of the Code of Virginia and as governed
56 by 12VAC5-80.

57 F. Newborns born in Virginia shall be screened for critical congenital heart disease in
58 accordance with provisions set forth in §§ 32.1-65.1 and 32.1-67 of the Code of Virginia
59 and as governed by 12VAC5-71-210 through 12VAC5-71-260.

60 Statutory Authority

61 §§ 32.1-12 and 32.1-67 of the Code of Virginia.

62 Historical Notes

63 Derived from Virginia Register Volume 23, Issue 13, eff. April 4, 2007; amended, Virginia
64 Register Volume 30, Issue 7, eff. January 24, 2014; amended Volume 31, Issue 18, eff.
65 June 4, 2015; Errata, 31:22 VA.R. 2082 June 29, 2015; amended, Virginia Register
66 Volume 33, Issue 2, eff. October 20, 2016; Volume 35, Issue 2, eff. January 1, 2019.



COMMONWEALTH of VIRGINIA

M. Norman Oliver, MD, MA
State Health Commissioner

Department of Health
P O BOX 2448
RICHMOND, VA 23218

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

February 25, 2020

The Honorable Faye O. Pritchard, Chair
Virginia State Board of Health
109 Governor Street
Richmond, VA 23219

Dear Chair Pritchard:

Section 32.1-111.3 of the Code of Virginia requires the development of a comprehensive, coordinated, statewide emergency medical services plan, heretofore referred to as “The Plan” by the Virginia Office of EMS (OEMS). The Board of Health must review, update, and publish the plan triennially, making such revisions as may be necessary to improve the effectiveness and efficiency of the Commonwealth’s emergency care system. The objectives of the plan shall include, but not be limited to the nineteen objectives outlined in Section 32.1-111.3.

The OEMS, in coordination with the Executive Committee of the State EMS Advisory Board, the Legislation and Planning (L&P) Committee, and the chairs of all the standing committees of the State EMS Advisory Board submitted planning templates created by OEMS; pertaining to each aspect of the EMS system that committee is tasked with. Much of the information included in each planning template, as well as information in many EMS review reports, namely the Joint Legislative Audit and Review Commission (JLARC) report “Review of Emergency Medical Services in Virginia”, the Institute of Medicine (IOM) Report “EMS at the Crossroads”, as well as the Five Year Strategic Plan of the Federal Interagency Committee on EMS (FICEMS) were included in the development and the draft version of the plan.

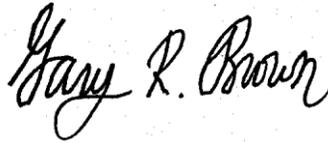
Attached to this document is the current version of the Strategic and Operational State EMS plan. It is comprised of four main core strategies, with each core strategy having several key strategic initiatives. This plan was unanimously approved by the State EMS Advisory Board at their November 6, 2019 meeting.

As the Code of Virginia mandates, this plan must be reviewed, updated, and published by the Virginia State Board of Health. Progress on achieving the objectives of each strategic initiative in the state EMS Plan will be reported to the state EMS Advisory Board on an annual basis, and to the Board of Health upon request.

Chair Pritchard
February 25, 2020
Page 2

The OEMS appreciates the opportunity to present this document to the Board, and values any input that the Board provides, as well as the input of any other stakeholder, or interested party. Any questions related to this document can be forwarded to Chris Vernovai, EMS Systems Planner, at (804) 888-9100, or chris.vernovai@vdh.virginia.gov.

Sincerely,

A handwritten signature in black ink that reads "Gary R. Brown". The signature is written in a cursive style with a large, prominent "G" and "B".

Gary R. Brown, Director
Office of Emergency Medical Services
Virginia Department of Health

Virginia's State EMS Plan

Reviewing the Plan

What is the State EMS Plan?

- Three year strategic and operational plan.
- Designed to utilize core strategies and strategic initiatives to outline and address the needs of the EMS System over a three year span.
- Goal is to make improvements to EMS System in Virginia, and not necessarily the delivery of EMS care.
- Build on the past efforts made in previous versions of the State EMS Plan.

Why was the State EMS Plan created?

- §32.1-111.3 of the Code of Virginia requires the development of a comprehensive, coordinated, statewide EMS plan by the Virginia Department of Health's Office of EMS (OEMS).
- Support delivery of EMS care in Virginia
- Support existing and new initiatives designed to improve all aspects of the EMS system in Virginia.
- Most recent version of the State EMS Plan approved by Board of Health on March 16, 2017.

How was the Plan created?

- In the spring of 2019, OEMS, in conjunction with the EMS Advisory Board and its 13 subcommittees, reviewed the existing plan to determine the needs of the EMS system.
 - Plan divided into four core strategies:
 - Develop Partnerships
 - Create Tools and Resources
 - Develop Infrastructure
 - Assure Quality and Evaluation

Plan Creation – 2019

- OEMS staff evaluated information submitted by subcommittees, and integrated that information into the draft plan.
- Plan approved by the EMS Advisory Board on November 6, 2019.
- Plan submitted for approval by the State Board of Health on March 26, 2020.

Highlights of the State EMS Plan

- Use of technology and social media to provide accurate and timely information.
- Maintenance and expansion of EMS Agency and Provider Portal
- Maintenance and expansion of Virginia Pre-hospital Information Bridge (VPHIB)
- Continued focus on EMS Provider health and safety.

Why is a revision to the State EMS Plan necessary?

- Revision is required by the Code of Virginia to be revised triennially.
- The current plan is nearly three years old.
- Many of the strategic initiatives and action steps have been met or have made significant progress.
- EMS is a dynamic field, and the plan must also remain dynamic to address the needs of a changing system.

What happens to the current plan?

- Unfinished initiatives carry over to the new version of the plan.
- Summary information is provided as requested.
- Lessons learned help shape the new version of the plan.

For more information:

<http://www.vdh.virginia.gov/emergency-medical-services/state-strategic-and-operational-ems-plan/>

**VIRGINIA OFFICE OF
EMERGENCY MEDICAL SERVICES
STATE STRATEGIC AND OPERATIONAL PLAN**



2020 – 2022

VIRGINIA OFFICE OF EMS STATE STRATEGIC AND OPERATIONAL PLAN

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VIRGINIA OFFICE OF EMS STATE STRATEGIC AND OPERATIONAL PLAN

INTRODUCTION

Section 32.1-111.3 of the Code of Virginia requires the development of a comprehensive, coordinated, statewide emergency medical services plan by the Virginia Office of EMS (OEMS) which shall incorporate, but not be limited to, the plans prepared by the regional emergency medical services councils. The Board of Health must review, update, and publish the plan triennially, making such revisions as may be necessary to improve the effectiveness and efficiency of the Commonwealth's emergency care system. The objectives of the plan shall include, but not be limited to the nineteen objectives outlined in Section 32.1-111.3.

Over the past few years, much attention has been paid to the development of the plan. Some of this is due to review reports, namely the Joint Legislative Audit and Review Commission (JLARC) report "Review of Emergency Medical Services in Virginia, EMS Agenda 2050, and the Institute of Medicine (IOM) Report "EMS at the Crossroads". The recommendations made in these documents have assisted in driving the planning process forward.

As the Code of Virginia mandates, this plan must be reviewed, updated, and published triennially by the Board of Health. The Office of EMS appreciates the opportunity to present this document to the Board, and values any input that the Board provides, as well as the input of any other stakeholder, or interested party. Additionally, OEMS is prepared to report on the progress of the plan to the Board of Health or other interested parties upon request, and through the OEMS Annual Reports, and Service Area Plans as required by VDH, and the Code of Virginia.

This operational plan identifies the specific initiatives required of the OEMS staff in executing the 2020-2022 Strategic Plan. Each objective and action step is intended to accomplish those items most critical to the Strategic Plan in the given fiscal year. The Strategic Plan is designed to improve priority areas of performance and initiate new programs. Therefore, much of the routine, but important work of the OEMS staff is not included in the Operational Plan.

No later than three (3) months prior to the end of each fiscal year the OEMS staff will evaluate progress on the plan and begin the process of creating the Operational Plan for the next fiscal year.

In most cases "accountability" should be the name of a person, division, or entity that has the lead responsibility for the implementation of the objective or action step. The plan will be reviewed quarterly, and only those objectives and items relevant to the time frame will be a part of the review. Any changes in the objective or action steps should be noted in writing on the form at that time.

Definitions of acronyms included in the plan can be found on **pages 5 and 6**.

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Virginia Office of Emergency Medical Services Mission Statement

To reduce death and disability resulting from sudden, serious, and/or chronic injury or illness in the Commonwealth through planning and development of a comprehensive and coordinated EMS system; and provision of technical assistance and support to enable the EMS community to collaborate, integrate, and enhance the delivery of the highest quality medical care to those in need.

Virginia Office of Emergency Medical Services Vision Statement

To establish a unified, comprehensive and effective EMS system for the Commonwealth of Virginia that provides for the health and safety of its citizens and visitors.

What is the Emergency Medical Services system in Virginia?

The Virginia EMS system is very large and complex, involving a wide variety of EMS agencies and personnel, including volunteer and career providers functioning in volunteer rescue squads, municipal fire departments, commercial ambulance services, hospitals, and a number of other settings to enable the EMS community to provide the highest quality emergency medical care possible to those in need. Every person living in or traveling through the state is a potential recipient of emergency medical care.

The Virginia Department of Health, Office of Emergency Medical Service (OEMS) is responsible for development of an efficient and effective statewide EMS system. The EMS System in Virginia is designed to respond to any and all situations where emergency medical care is necessary. This is accomplished through a coordinated system of over 36,000 trained, prepared and certified providers, nearly 4,300 permitted EMS vehicles, and nearly 600 licensed EMS agencies, to provide ground and air emergency medical care to all people in the Commonwealth of Virginia.

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Glossary of Commonly Used Acronyms

AHA	American Heart Association
AMS	Air Medical Services
COOP	Continuity Of Operations Plan
DGS	Virginia Department of General Services
DBDHS	Virginia Department of Behavioral Health and Developmental Services
DW	VDH Data Warehouse
DMV	Virginia Department of Motor Vehicles
EMSC	EMS For Children
FARC	Financial Assistance Review Committee (Subcommittee of state EMS Advisory Board)
FCC	Federal Communications Commission
FICEMS	Federal Interagency Committee on EMS
HMERT	Health and Medical Emergency Response Team
LZ	Landing Zone
MCI	Mass Casualty Incident
MDC	Medical Direction Committee (Subcommittee of state EMS Advisory Board)
NASEMSO	National Association of State EMS Officials
NEMSIS	National EMS Information System
NFFF	National Fallen Firefighters Foundation
OEMS	Virginia Department of Health, Office of EMS
OMD	Operational Medical Director
OHE	Virginia Department of Health, Office of Health Equity
PDC	Professional Development Committee (Subcommittee of state EMS Advisory Board)
PSAP	Public Service Answering Point
PSHS	Secretary of Public Safety and Homeland Security
RC	Virginia's Regional EMS Councils
RSAF	Rescue Squad Assistance Fund
SIC	System Improvement Committee (Trauma System Committee)
TCC	Training and Certification Committee
TSC's	Trauma System Committees
VAGEMSA	Virginia Association of Governmental EMS Administrators
VAVRS	Virginia Association of Volunteer Rescue Squads
VDEM	Virginia Department of Emergency Management
VDFP	Virginia Department of Fire Programs
VDH	Virginia Department of Health

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Appendix A - Glossary of Commonly Used Acronyms (Cont.)

VDOT	Virginia Department of Transportation
VFCA	Virginia Fire Chiefs Association
VHAC	Virginia Heart Attack Coalition
VHHA	Virginia Hospital and Healthcare Association
VPFF	Virginia Professional Firefighters
VPHIB	Virginia Pre Hospital Information Bridge
VSP	Virginia State Police
VSTR	Virginia State Trauma Registry
WDC	Workforce Development Committee (Subcommittee of state EMS Advisory Board)

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VIRGINIA OFFICE OF EMS STATE STRATEGIC AND OPERATIONAL PLAN

Strategic Initiative 1.1- Promote Collaborative Approaches			
Objectives	Accountability	Action Steps	
Core Strategy 1: Develop Partnerships	1.1.1 Use technology to provide accurate and timely communication within the Virginia EMS System	OEMS, RC	1.1.1.1 Develop and promote timely and appropriate communications and pertinent information through social media, websites and other platforms of communications by OEMS and Regional EMS Councils. 1.1.1.2 Track and report on amount, and general content of material posted to OEMS websites and social media on a monthly and quarterly basis. 1.1.1.3 Track and report on amount, and general content of material posted to Regional EMS Council websites and social media on a monthly and quarterly basis.
	1.1.2 Promote collaborative activities between local government, EMS agencies, hospitals & health systems, healthcare coalitions, and other related entities, to increase recruitment and retention of certified EMS providers.	OEMS, RC, System stakeholders	1.1.2.1. Develop a method to measure the number of new EMS providers recruited via recruitment and retention programs and activities. 1.1.2.2. Revise “Keeping The Best!” programs for online access. 1.1.2.3. Maintain informational items regarding benefits and incentives for local governments to provide to volunteer fire and EMS providers. 1.1.2.4. Educate and familiarize local government officials on the importance of taking a greater role in EMS planning and coordination in their locality and/or region. 1.1.2.5. Promote participation with other state, national and regional organizations and associations. 1.1.2.6 Develop a method to measure the EMS workforce demographics and statistics i.e. length of service, affiliation history and agency status.
	1.1.3 Provide a platform for clear, accurate, and concise information sharing and improved interagency communications between the OEMS, state agencies and EMS system stakeholders in Virginia.	OEMS, VDEM, Secretary of Public Safety and Homeland Security (PSHS), VSP, VDFP, RC, System Stakeholders.	1.1.3.1. Encourage, develop and promote information sharing opportunities for improved communication between EMS system stakeholders in Virginia. 1.1.3.2. Encourage agencies and providers to visit OEMS web page regularly, subscribe to OEMS e-mail list, access OEMS social media sites, and complete customer service surveys. 1.1.3.3. Educate providers and agency officials in the proper use of OEMS Provider and Agency Portals.

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Strategic Initiative 1.1- Promote Collaborative Approaches (Cont.)			
	Objectives	Accountability	Action Steps
Core Strategy 1: Develop Partnerships	1.1.4 Identify resources and/or opportunities to work collaboratively with other state agencies, organizations, and associations to improve processes and patient outcomes.	OEMS	1.1.4.1. Attend meetings of, and exchange knowledge with the National Association of State EMS Officials (NASEMSO) and other organizations generally recognized by the EMS community. 1.1.4.2. Encourage appropriate state agencies and organizations to participate in meetings and activities hosted or sponsored by OEMS.
	1.1.5 Promote data sharing which benefit internal and external projects for improved patient outcomes.	OEMS, VHHA	1.1.5.1. Further data sharing, including the most recent version of National EMS Information System (NEMSIS), among the highway safety community, and internal and external stakeholders. 1.1.5.2 Utilize the national EMS database to monitor national data trends. 1.1.5.3 Provide a means for VDH bio-surveillance programs to utilize Virginia Pre-Hospital Information Bridge (VPHIB) data. 1.1.5.4. Explore and promote patient data sharing with approved entities as permitted under applicable law.
	1.1.6 Promote collaboration between OEMS and VDOT and DMV safety officials through activities to promote traffic incident management and safety.	OEMS, VDOT, DMV, VSP	1.1.6.1 Develop and promote collaborative relationships with national highway safety-related organizations and federal partners. 1.1.6.2 Promote the linkage of EMS data with crash data reports. 1.1.6.3 Promote National Traffic Incident Management (TIM) responder training in Virginia.

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Strategic Initiative 1.2 –Coordinate response to natural, man-made, and public health emergencies.			
	Objectives	Accountability	Action Steps
Core Strategy 1: Develop Partnerships	1.2.1 Support, coordinate and maintain deployable emergency response resources.	OEMS, VDEM	1.2.1.1. Create recruiting and selection process for resource management team. 1.2.1.2. Work with partner agencies to develop mission ready packages and the process for implementation and use.
	1.2.2 Increase knowledge of Emergency Operations capabilities with Emergency Managers, leaders, and supervisors on a local, regional, and state level.	OEMS	1.2.2.1. Promote emergency operations training courses, technical assistance, and other emergency operations capabilities to localities across the Commonwealth.
	1.2.3 Assist EMS agencies to prepare and respond to natural and man-made emergencies (including pandemic diseases) by incorporating strategies to develop emergency response plans (the plan) that address the four phases of an emergency (preparedness, mitigation, response, and recovery) and to exercise the plan.	OEMS, VDEM	1.2.3.1. Create and promote planning templates aimed at EMS agencies, specifically related to COOP, Emergency Preparedness, and response concerns (MCI, Surge Planning, etc.)
	1.2.4 Assist hospitals & health systems, hospital regions, and local governments to increase their ability to care for medically vulnerable populations, (pediatric, geriatric, etc.) during disasters and multiple-patient emergency events.	OEMS, EMSC, EMS Emergency Management Committee, TSC	1.2.4.1 Create and promote planning resources for hospitals and local governments specifically related to pediatric disaster preparedness and management of multiple-patient pediatric emergency events. 1.2.4.2. Create and promote planning resources for hospitals and local governments specifically related to disaster preparedness and management of other medically vulnerable populations.
	1.2.5 Identify and support resources and/or opportunities to improve patient outcomes in relation to the opioid crisis.	OEMS, VDH	1.2.5.1. Continue to support funding opportunities for licensed EMS agencies to obtain naloxone to reverse the effects of opioid related drug overdoses. 1.2.5.2. Utilize VPHIB data to track opioid related statistics and the effect of prehospital care by EMS, fire department, law enforcement and citizens. 1.2.5.3. Promote and collaborate with other entities to educate and prevent the opioid crisis in Virginia.

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Strategic Initiative 2.1 - Sponsor EMS related research and education.			
	Objectives	Accountability	Action Steps
Core Strategy 2: Create Tools and Resources	2.1.1 Encourage research and other projects that contribute to high quality EMS and improve patient outcomes utilizing data collected by the EMS Registries.	OEMS	2.1.1.1. Provide state and regional EMS data summaries, and compare with other similar state EMS data. 2.1.1.2. Develop VSTR and VPHIB research data set to be available for entities upon request and that have obtained institutional review board approval. 2.1.1.3. Support the development, implementation, and evaluation of evidence-based guidelines (EBGs) according to the National Prehospital EBG Model Process 2.1.1.4. Promote standardization and quality improvement of prehospital EMS data by supporting the adoption and implementation of NEMSIS-compliant systems 2.1.1.5. Improve linkages between NEMSIS data, VDH data warehouse and other databases, registries, or other sources to measure system effectiveness and improve clinical outcomes 2.1.1.6 Utilizing VPHIB and VSTR data, OEMS epidemiology staff will collaborate with stakeholders to conduct and publish research to improve prehospital and trauma care. 2.1.1.7. Review regional data and pilot projects to enhance patient care. 2.1.1.8 Promote the availability of undergraduate, graduate, and fellowship opportunities in EMS data analytics to promote an interest and culture in EMS based research opportunities.
	2.1.2 Determine quality of EMS service and conduct analysis of trauma triage effectiveness.	OEMS, Designated Trauma Centers, Advisory Board, RC	2.1.2.1. Develop and provide quarterly reports that identify the rate of over and under triage events. OEMS staff will submit this information for inclusion in the EMS Quarterly Report to the EMS Advisory Board according to applicable laws. 2.1.2.2. Provide agency-wide access to EMS data to be used in other public health efforts.
	2.1.3 Evaluate challenges that impact the workforce on service provision around the State.	OEMS, Workforce Development Committee, VAGEMSA, VAVRS	2.1.3.1. Assess demographic and profile characteristics of EMS Providers in Virginia through EMS Provider Portal. 2.1.3.2. Utilize EMS databases to evaluate information related to challenges that impact the workforce in the provision of EMS service. 2.1.3.3 Utilize demographic data to promote diversity in the EMS workforce.

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Strategic Initiative 2.2 - Supply quality education and certification of EMS personnel.			
	Objectives	Accountability	Action Steps
Core Strategy 2: Create Tools and Resources	2.2.1 Ensure adequate, accessible, affordable, and quality EMS provider training and continuing education exists in Virginia.	OEMS, TCC, Regional EMS Councils	2.2.1.1. Widely publicize the availability of and ensure adequate, accessible, and quality EMS provider training and continuing education through course offerings held across the state. 2.2.1.2. Review student disposition on a bi-annual basis, identifying areas of concern for Training and Certification Committee (TCC) input and possible corrective action. 2.2.1.3 Provide continued support for an annual multi-disciplinary EMS Symposium (i.e. Virginia EMS Symposium) as a primary statewide EMS system continuing education event. 2.2.1.4. Seek out an educator to deliver dynamic continuing education (CE) programs based on assessed needs on statewide basis to include a monthly continuing education webcast with a live Q & A session.
	2.2.2 Enhance competency based EMS training programs.	OEMS, TCC, MDC	2.2.2.1. Compare and contrast traditional versus competency based programs. 2.2.2.2 Identify and document aspects from competency based programs that may enhance training programs as compared to the traditional approach. 2.2.2.3 Provide guidance through research to identify key components of competency based education.

VIRGINIA OFFICE OF EMS STATE STRATEGIC AND OPERATIONAL PLAN

Strategic Initiative 2.2 - Supply quality education and certification of EMS personnel. (cont.)

<i>Objectives</i>	<i>Accountability</i>	<i>Action Steps</i>
<p>2.2.3 Align all initial EMS education programs to that of other allied health professions to promote professionalism of EMS.</p>	<p>OEMS, TCC, MDC, Board of Health Professions</p>	<p>2.2.3.1. Promote Advanced Level EMS Training including Advanced EMT (AEMT), Paramedic, Critical Care, Flight, Mobile Integrated Healthcare/Community Paramedicine, and Tactical Paramedicine. 2.2.3.2. Review the benefits of and barriers to the various models of EMS education within Virginia. 2.2.3.3. Evaluate the need for standardized EMT education related to aeromedical services including utilization, safety and landing zones. 2.2.3.4. Evaluate and/or develop resources to aid training programs in offering scenarios and tracking mechanisms to ensure skills and competencies are met to satisfy accreditation requirements. 2.2.3.5. Support OEMS staff in implementing technological resources to streamline the EMS education program processes.</p>
<p>2.2.4 Assure an adequate amount and quality of pediatric training and educational resources for EMS providers and emergency department staff in Virginia.</p>	<p>OEMS, EMSC Committee, Virginia Hospital and Healthcare Association (VHHA)</p>	<p>2.2.4.1. Acquire and distribute pediatric training equipment for EMS agencies. 2.2.4.2. Sponsor pediatric training related instructor courses. 2.2.4.3. Provide support for speakers and topics at the annual VA EMS Symposium. 2.2.4.4 Participate in the National Pediatric Readiness Project. 2.2.4.5 Provide resources, training and support for EMS agency Pediatric Champions.</p>
<p>2.2.5 Assure an adequate amount and quality of geriatric training and educational resources for EMS providers and emergency department staff in Virginia.</p>	<p>OEMS, TCC, MDC</p>	<p>2.2.5.1. Sponsor geriatric training related instructor courses. 2.2.5.2. Provide support for speakers and topics at the annual VA EMS Symposium.</p>

**Core Strategy 2:
Create Tools and Resources**

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Strategic Initiative 2.2 - Supply quality education and certification of EMS personnel. (cont.)

Strategic Initiative 2.2 - Supply quality education and certification of EMS personnel. (cont.)			
	Objectives	Accountability	Action Steps
Core Strategy 2: Create Tools and Resources	2.2.6. Assure an adequate amount and quality of crisis/behavioral health training and educational resources for EMS providers.	OEMS, TCC, MDC, RC, Provider Health and Safety, Virginia Department of Behavioral Health and Developmental Services (VBHDS)	2.2.6.1 Coordinate and sponsor crisis/behavioral health courses for instructors and students throughout the Commonwealth. 2.2.6.2 Provide support for speakers and topics at the annual VA EMS Symposium. 2.2.6.3 Continue to promote and support health and safety programs for provider mental health through programs such as; the peer support CISM team accreditation program, suicide prevention, and other similar mental health initiatives.
	2.2.7 Assure an adequate amount and quality of trauma training and education for EMS providers and emergency department staff in Virginia.	OEMS, TSC's, MDC, RC	2.2.7.1 Use the VPHIB and VSTR databases to identify opportunities for improvement, and design education to target those areas. 2.2.7.2 Provide support for speakers and topics at the annual VA EMS Symposium.
	2.2.8. Assure an adequate amount and quality of medically vulnerable populations health training and educational resources for EMS providers.	OEMS, MDC, RC,	2.2.8.1. Sponsor medically vulnerable populations training related instructor courses. 2.2.8.2. Provide support for speakers and topics at the annual VA EMS Symposium.

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Strategic Initiative 3.1 - EMS Regulations, Protocols, Policies, and Standards			
<i>Objectives</i>	<i>Accountability</i>	<i>Action Steps</i>	
Core Strategy 3: Develop Infrastructure	3.1.1 Review and assess state and federal legislation related to the EMS system.	OEMS, Rules and Regulations Committee, Legislation and Planning Committee	3.1.1.1. Review legislation to determine its impact on the state EMS system. 3.1.1.2. Gather legislative news and interest items from NASEMSO, and National Association of EMS Physicians (NAEMSP), Federal Interagency Committee on EMS (FICEMS), and related organizations.
	3.1.2 Establish statewide Air/Ground Safety Standards.	OEMS, State Medevac Committee	3.1.2.1. Identify and adopt universal safety standards. 3.1.2.2. Maintain weather turn down system. 3.1.2.3. The development of training criteria for EMS field personnel and telecommunications personnel regarding the use of Medevac services. 3.1.2.4. Standardize air/ground safety standards. 3.1.2.5. Review current policies/procedures related to quality improvement and safety standards. 3.1.2.6. Standardize Landing Zone procedures. 3.1.2.7. Maintain process for consistent use of air to air communication.
	3.1.3 Develop criteria for a voluntary Virginia Standards of Excellence recognition program for EMS Agencies.	OEMS, WDC	3.1.3.1. Promote and incentivize voluntary accreditation standards. 3.1.3.2. Implement and market program to interested agencies. 3.1.3.3. Evaluate efficacy of program based on feedback of EMS agency officials and site reviewers.
	3.1.4 Maintain and enhance the Trauma Center designation process.	OEMS, TSC's, EMSC	3.1.4.1. Maintain the trauma designation criteria to include American College of Surgeons (ACS) Trauma Center standards. 3.1.4.2. Develop a Trauma Center Consultation program that hospitals (designated and non-designated) can use as a resource to assist with programmatic implementation and operational issues.

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Strategic Initiative 3.1 - EMS Regulations, Protocols, Policies, and Standards (Cont.)			
Objectives		Accountability	Action Steps
Core Strategy 3: Develop Infrastructure	3.1.5 Maintain and enhance the Regional EMS Council designation process.	OEMS, RC	3.1.5.1. Evaluate the structure of the designation process. 3.1.5.2. Incorporate input of applicants and evaluators into next round of designations. 3.1.5.3. Conduct re-designation process for councils every 3 years.
	3.1.6 Establish standardized methods and procedures for the inspection and licensing and/or permitting of all EMS agencies and vehicles, including equipment and supply requirements.	OEMS, Transportation Committee	3.1.6.1. Development of standard inspection checklist, to include all aspects of agency and EMS vehicle inspection.
	3.1.7 Through a consensus process, develop a recommendation for evidence-based patient care guidelines and formulary.	OEMS, State EMS Medical Director, MDC, Board of Pharmacy.	3.1.7.1. Develop and maintain a resource document to assist regional medical directors, agency medical directors, and agency personnel as patient care guidelines and protocols are produced.

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VIRGINIA OFFICE OF EMS STATE STRATEGIC AND OPERATIONAL PLAN

Strategic Initiative 3.2 - Focus recruitment and retention efforts			
	Objectives	Accountability	Action Steps
Core Strategy 3: Develop Infrastructure	3.2.1 Develop, implement, and promote a comprehensive recruitment and retention campaign for EMS personnel and physicians, supporting the needs of the EMS system.	OEMS, State EMS Medical Director, MDC, WDC, FARC, RC	3.2.1.1. Continue to support “VA EMS Jobs” website. 3.2.1.2. Maintain a voluntary Standards of Excellence program for EMS agencies. 3.2.1.3. Develop, promote and maintain an EMS agency resiliency program for EMS agencies can utilize tools such as self-evaluations to identify potential agency vulnerabilities and offer tools to support agency resiliency. 3.2.1.4. Maintain Leadership & Management track at the VA EMS Symposium, and recommend topics and presenters. 3.2.1.5. Continue to promote and support special Rescue Squad Assistance Fund (RSAF) applications related to recruitment and retention of EMS providers. 3.2.1.6. Review and promote the Operational Medical Director (OMD) workshop curriculum. 3.2.1.7. Support the transition of military EMS providers to civilian practice.
	3.2.2 Support and expand the Virginia Recruitment and Retention Network.	OEMS, WDC	3.2.2.1. Continue to support the distribution of information and education related to recruitment and retention. 3.2.2.2. Seek new avenues for EMS recruitment outreach. 3.2.2.3. Recommend strategies for expansion of existing programs.
	3.2.3 Develop, implement, and promote EMS leadership programs, utilizing best practices.	OEMS, WDC	3.2.3.1. Develop and promote leadership programs to assist EMS agencies to provide high quality leadership to include all levels of the EMS Officer training program. 3.2.3.2. Develop and/or review leadership criteria and qualifications for managing an EMS agency. 3.2.3.3. Develop model job descriptions for EMS Officers.

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Strategic Initiative 3.3 – Upgrade technology and communication systems			
	Objectives	Accountability	Action Steps
Core Strategy 3: Develop Infrastructure	3.3.1 Assist with, and promote, the compliance of all emergency medical communications systems with state and federal regulations for interoperability.	OEMS, Communications Committee	3.3.1.1. Continue to ensure that all emergency medical communications systems meet state and federal regulations.
	3.3.2 Promote emergency medical dispatch standards and accreditation among 911 Public Safety Answering Points (PSAPs) in Virginia.	OEMS, Communications Committee	3.3.2.1. Support concept of accredited PSAPs, operating with emergency medical dispatch (EMD) standards, and assist agencies in achieving accreditation, and/or adopting EMD as standard operating procedure.
	3.3.3 Provide technical assistance on communication products available for use in the emergency medical community.	OEMS, Communications Committee	3.3.3.1. Support new products and technologies, state and federal interoperability initiatives, including First Net, and serve as information conduit to entities. 3.3.3.2. Review the feasibility of additional statewide mutual aid radio frequencies for ground to air communications.
	3.3.4 Develop and maintain policies and programs for the Office of EMS to become fully paperless.	OEMS, OIM	3.3.4.1 Develop a program to make the EMS candidate psychomotor examination process a paperless process. This would include a searchable database for the availability of Consolidated Test Site locations throughout multiple regions, candidate pre-registration eligibility confirmation, examination testing history all accessible and completed through electronic submission. 3.3.4.2 Develop a program that allows State Certification Examiners the ability to electronically record the psychomotor certification examination process. This would also include the on-site candidate check-in, identification verification of testing candidate, candidate testing documentation, testing results and maintenance of candidate records.

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Strategic Initiative 3.4 – EMS Funding			
	Objectives	Accountability	Action Steps
Core Strategy 3: Develop Infrastructure	3.4.1 Establish roles, expectations, qualifications, and training for FARC committee members.	OEMS, FARC	3.4.1.1. Review and compare FARC training policies and procedures to current scope of work to determine relevance. 3.4.1.2. Develop FARC member job descriptions, to include qualifications, experience, and position expectations. 3.4.1.3. Utilize online LMS (Learning Management System) to create course modules, training plans, and onboarding materials for FARC. 3.4.1.4. Implement annual conflict of interest disclosures for FARC members.
	3.4.2 Enhance RSAF application to capture high-level, decision-oriented data and compelling narrative information.	OEMS, FARC	3.4.2.1. Survey FARC, OEMS Graders, and Regional EMS Councils to determine data and information that drives decision-making. 3.4.2.2. Present recommendations from survey to OEMS IT Committee to make necessary changes to RSAF application. 3.4.2.3. Update E-GIFT User Guides, technical assistance training, and application guidance documents to include changes.
	3.4.3 Explore cost-saving measures to expand RSAF impact and provide greater assistance to critical programs, equipment, and vehicles.	OEMS, FARC, Transportation Committee, VDH Office of Purchasing and General Services	3.4.3.1. Continue to produce annual OEMS Consolidated Grants Product Price List. 3.4.3.2. Engage discussion with EMS equipment and vehicle manufacturers and subject-matter experts to further knowledge base for RSAF application review and OEMS Consolidated Grants Products Price List. 3.4.3.3. Continue to seek additional grant sources to improve the statewide EMS System. 3.4.3.4. Develop and maintain list of eligible equipment and vehicles that agencies are eligible to purchase using state grant funds.
	3.4.4 Streamline RSAF administration to ensure effective, efficient, equitable and transparent administration of state funding.	OEMS, Office of Internal Audit	3.4.4.1. Explore options to enhance efficiency by adjusting grant period, funding levels, and reporting requirements. 3.4.4.2. Solicit contracted audit firms to assist with grant monitoring and reporting. 3.4.4.3. Update RSAF policies and procedures documents.
	3.4.5 Provide outreach, technical assistance, and training opportunities for prospective applicants, grantees, and stakeholders.	OEMS	3.4.5.1. Continue to promote RSAF program through Regional EMS Councils. 3.4.5.2. Continue to provide technical assistance webinars for each RSAF application cycle. 3.4.5.3 Identify grant opportunities that EMS agencies may be eligible for, and distribute information to EMS system.

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Strategic Initiative 3.4 – EMS Funding (cont.)			
	Objectives	Accountability	Action Steps
Core Strategy 3: Develop Infrastructure	3.4.6 Provide funding opportunities to support special initiatives identified by OEMS and the EMS Advisory Board.	OEMS, FARC, Transportation Committee, TCC, EMSC, MDC, TSCs	3.4.6.1. Collaboratively develop special initiative grant opportunities with EMS Advisory Board subcommittees. 3.4.6.2. Determine needs and make adjustments to special initiative application form.
	3.4.7 Standardize EMS grant review and grading process by graders at regional and state level.	OEMS, FARC	3.4.7.1. Develop RSAF decision making matrix. 3.4.7.2. Revise RSAF grant review sheet developed by FARC and OEMS staff, and continue to evaluate for efficacy. 3.4.7.3. Solicit feedback from Regional EMS Councils and stakeholders regarding the review process. 3.4.7.4. Provide education and outreach to explain reviewer roles and grading process. 3.4.7.5 Incorporate VPHIB data (submission compliance, quality scoring, call volume and type etc.) into the evaluation process. 3.4.7.6. Review the utilization of the Return to Localities (RTL) data such as carryover balances in the evaluation process.

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Strategic Initiative 3.5 – Enhance regional and local EMS efficiencies			
	Objectives	Accountability	Action Steps
Core Strategy 3: Develop Infrastructure	3.5.1 Standardize performance and outcome based service contracts with designated Regional EMS Councils and other qualified entities.	OEMS, RC	3.5.1.1. Maintain annual service contracts with Regional EMS Councils. 3.5.1.2. Provide standard contracts, plan templates, and other reference documents to Regional EMS Councils in each fiscal year. 3.5.1.3. Provide input on contract deliverables to Regional EMS Councils on a quarterly basis. 3.5.1.4. Review and update contract and or memorandums of understanding (MOUs) deliverables to maintain relevance and functional importance to EMS system stakeholders within the regional EMS service areas.
	3.5.2 Improve regulation and oversight of air medical services (AMS) statewide.	OEMS, State Medevac Committee, Rules & Regulations Committee, MDC	3.5.2.1. Revise/implement state AMS regulations. 3.5.2.2. More clearly define licensure requirements for AMS agencies. 3.5.2.3. Establish response areas for AMS agencies. 3.5.2.4. Develop criteria for ongoing AMS PI program.
	3.5.3 Educate local government officials and communities about the value of a high quality EMS system to promote development in economically depressed communities and the importance of assuming a greater responsibility in the planning, development, implementation, and evaluation of its emergency medical services system.	OEMS, WDC, Virginia Office of Minority Health and Health Equity (OMHHE)	3.5.3.1. Give presentations at Virginia Association of Counties (VACO) and Virginia Municipal League (VML) meetings, to educate local government officials about EMS. 3.5.3.2. Contribute EMS related articles and news items to periodic publications of VACO and VML.

VIRGINIA OFFICE OF EMS STATE STRATEGIC AND OPERATIONAL PLAN

Strategic Initiative 4.1 – Assess compliance with EMS performance driven standards.			
	Objectives	Accountability	Action Steps
Core Strategy 4: Assure Quality and Evaluation	4.1.1 Maintain statewide data-driven performance improvement process.	OEMS, MDC	4.1.1.1. Utilize VDH resources to conduct risk adjusted data analysis of patients in cooperation with our stakeholders. 4.1.1.2. Develop an EMS performance improvement program. 4.1.1.3. Evaluate the need for performance improvement programs for specific care populations (e.g. stroke, sepsis, STEMI).
	4.1.2 Maintain statewide pre-hospital and inter-hospital triage/patient management plans.	OEMS, TAG, State EMS Medical Director, MDC, RC, EMSC	4.1.2.1. Maintain statewide stroke triage, and trauma triage plans to include regional plan development and maintenance by regional EMS councils. 4.1.2.2. Supply state level data to assist with monitoring individual regional performance compared to state and national benchmarks. 4.1.2.3. Actively participate with organizations, such as American Heart Association (AHA) that addresses pre-hospital and inter-hospital triage/patient management. 4.1.2.4 Encourage hospitals & health systems to develop written interfacility emergency transfer guidelines and agreements that specifically include pediatric patients.
	4.1.3 Review and evaluate data collection and submission efforts.	OEMS, MDC	4.1.3.1. Develop standard reports within VPHIB that will allow individual EMS agencies to view the quality of data being submitted. 4.1.3.2. Provide quality “dashboards” where education can improve data quality and update validity rules within the application when education alone cannot correct poor data. 4.1.3.3. Provide quarterly compliance reports to the OEMS, Division of Regulation and Compliance and Executive Management. 4.1.3.4. Promote initiatives for the ability to review near real-time insights for patient care utilizing data from the Virginia and NEMSIS data points while ensuring the security of protected health information (PHI).
	4.1.4 Review functional adequacy and design features of EMS vehicles utilized in Virginia and recommend changes to improve EMS provider safety, unit efficiency and quality of patient care.	OEMS, Rules & Regulations Committee, Transportation Committee, Health & Safety Committee	4.1.4.1. Evaluation of national/international documents and information related to vehicle and provider safety, with potential incorporation into EMS regulation and inspection procedure.

VIRGINIA OFFICE OF EMS STATE STRATEGIC AND OPERATIONAL PLAN

Strategic Initiative 4.1 – Assess compliance with EMS performance driven standards. (cont.)		
<i>Objectives</i>	<i>Accountability</i>	<i>Action Steps</i>
4.1.5 Measure EMS system compliance utilizing national EMS for Children (EMSC) performance measures.	OEMS, EMSC	4.1.5.1. Continue to assess the pediatric emergency care readiness of Virginia’s Emergency Departments. 4.1.5.2 Continue to assess components of pediatric emergency care readiness of Virginia EMS agencies. 4.1.5.3 Encourage EMS agencies (or in some cases groups of EMS agencies) to appoint a Pediatric Champion.

Strategic Initiative 4.2 – Assess and enhance quality of education for EMS providers.		
<i>Objectives</i>	<i>Accountability</i>	<i>Action Steps</i>
Core Strategy 4: Assure Quality and Evaluation	4.2.1 Update the certification process to assure certification examinations continue to be valid, psychometrically sound, and legally defensible.	OEMS, TCC 4.2.1.1. Review and revision of psychomotor examination by TCC as needed. 4.2.1.2. Review statistical data and make recommendations for the EC recertification exam.
	4.2.2 Assure adequate and appropriate education of EMS students.	OEMS, TCC 4.2.2.1. Review state statistics for certification rates and assist in determining avenues to improve outcomes and implement new processes. 4.2.2.2. Improve instructor compliance with student registration process. 4.2.2.3. Review funding mechanisms provided by the Commonwealth of Virginia to ensure efficiency in providing funding assistance to individuals seeking EMS certification.
	4.2.3 Explore substitution of practical examination with successful completion of a recognized competency based training program conducted by accredited training sites and using computer based technology for written examinations.	OEMS, TCC 4.2.3.1. Review the program summative practical examination process in EMT education. 4.2.3.2. Modify the process according to the outcomes of the review.

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Strategic Initiative 4.3 – Pursue initiatives that support EMS			
	Objectives	Accountability	Action Steps
Core Strategy 4: Assure Quality and Evaluation	4.3.1 Engage the EMS system in unintentional injury, illness, and violence prevention efforts.	OEMS, Provider Health & Safety Committee, VDH – Div. of Injury and Violence Prevention	4.3.1.1. Participate in intentional and unintentional injury and illness prevention initiatives, and facilitate involvement for EMS agencies and providers. 4.3.1.2. Review VPHIB statistics regarding Line of Duty Death (LODD) and Line of Duty Injury (LODI), and develop prevention materials.
	4.3.2 Develop, implement, and promote programs that emphasize safety, health and wellness of first responders.	OEMS, TCC, MDC, Virginia Department of Behavioral Health and Developmental Services (DBHDS), VDFP, VFCA, VAVRS, VAGEMSA, VPFF, NFFF, RC	4.3.2.1. Maintain OEMS staff support of quarterly meetings of the Health and Safety Committee of the state EMS Advisory Board. 4.3.2.2. Identify, develop, and distribute safety, health and wellness programs aimed at first responders, such as Traffic Incident Management, and suicide prevention, and EMS fatigue. 4.3.2.3. Ensure Health, Safety, and wellness training is available at stakeholder conferences, and recommend topics and presenters. 4.3.2.4. Maintain Governor’s EMS Award category for contribution to the EMS system related to the health and safety of EMS providers.
	4.3.3. Research and disseminate information on best practices as it relates to EMS response to active shooter and hostile environment incidents.	OEMS, Health & Safety Committee, State EMS Medical Director, VSP, VDFP, RC, EMSC	4.3.3.1 Develop and maintain website providing information on best practices related to response procedures, policies, team equipment, and other issues related to EMS involvement in active shooter/hostile environment response. 4.3.3.2. Work with partner agencies to encourage public safety relationships at the local level to enhance response to active shooter/hostile environment incidents. 4.3.3.3. Host online component of “Stop the Bleed Toolkit” developed for school nurses in Virginia.
	4.3.4. Research and disseminate information on best practices as it relates to community risk reduction programs targeted toward improving population health.	All EMS Stakeholder groups	4.3.4.1 Develop partnerships with public and private entities to expand opportunities to improve population health. 4.3.4.2 Develop and promote programs, such as mobile integrated healthcare, targeted toward improving population health.
	4.3.5 Engage in evidence-based practices to improve EMS care in the Commonwealth of Virginia.	TCC, OEMS, EMSC, MDC, RC	4.3.5.1. Review research and disseminate information to educators and agencies based on valid, credible studies. 4.3.5.2. Review the rules and regulations of OEMS to ensure current alignment with educational theory and practices.

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Appendix A – Sample Planning Matrix

Strategic Initiative			
<i>Objectives</i>		<i>Accountability</i>	<i>Action Steps</i>
Core Strategy			

Appendix B – Glossary of Terms

Glossary of Terms

Action Step: A specific action required to carry out an objective.

Core Strategy: A main thrust or action that will move the organization towards accomplishing your vision and mission.

Operational Plan: This is the plan that implements the strategic intent of the organization on an annual basis.

Objective: A specific, realistic and measurable statement under a strategic initiative.

Strategic Initiative: An action that will address areas needing improvement or set forth new initiatives under the core strategy. This is the planning part of strategy that when combined with the vision, the mission and core strategies complete the strategic effort.

SWOT Analysis: An assessment of the internal strengths and weaknesses of the organization and the organization’s external opportunities and threats.

Template: A guide and/or format that assists the user in accomplishing a task efficiently in a uniform and consistent manner.

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Appendix C - Resources

Resources

In developing this plan several resources were used in addition to meetings and interviews with OEMS staff and many system stakeholders.

- Code of Virginia: § 32.1-111.3. Statewide emergency medical care system. Requires a comprehensive, coordinated EMS system in the Commonwealth and identifies specific objectives that must be addressed.
- EMS Agenda 2050: EMS Agenda 2050 document is the result of a collaborative and inclusive two-year effort to create a bold plan for the next several decades. The new Agenda for the Future envisions people-centered innovative possibilities to advance EMS systems.
- EMS Agenda for the Future: A document created by the National Highway Traffic and Safety Administration (NHTSA) that outlines a vision and objectives for the future of EMS. August 1996
- OEMS 3-Year Plan: 2017-2019
- Service Area Strategic Plan State Office of Emergency Medical Services (601 402 04) which describes the statutory authority and expectations for OEMS and identifies the growing EMS needs of the citizens and visitors of Virginia.
- Service Area Strategic Plan Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (601 402 03) This service area includes Virginia Rescue Squads Assistance Fund grants program, Financial Assistance to Localities to support Non Profit Emergency Medical Service (EMS) agencies, and funding provided to support Virginia Association of Volunteer Rescue Squads (VAVRS).
- State Emergency Medical Services Systems: A Model: National Association of State EMS Officials – July 2008
- EMS at the Crossroads: Institute of Medicine – 2006
- Agency Planning Handbook: A Guide for Strategic Planning and Service Area Planning Linking to Performance-Based Budgeting: Department of Planning and Budget 2018-2020 Biennium, Release Date August 9, 2018
- Joint Legislative Action Review Commission (JLARC) Report – House Document 37, Review of Emergency Medical Services in Virginia. 2004.

VIRGINIA OFFICE OF EMS STATE STRATEGIC AND OPERATIONAL PLAN

Resources (Cont.)

- EMS Advisory Board Committee Planning Templates – Revised 2016
- Regional EMS Council Process Action Team (PAT) Retreat Report - November 2008.
- Five-Year Strategic Plan – Federal Interagency Committee on EMS – November 2014

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**Virginia Department of Health 2020
Policy Research, Analysis, and Development Plan**



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Introduction

The mission of the Virginia Department of Health (VDH) is to protect the health and promote the well-being of all people in Virginia. VDH's vision is to help Virginia become the healthiest state in the nation. To achieve both its mission and vision, it is critical that VDH utilize an equity lens in its development, implementation, and evaluation of public health programs and policies. This will work toward eliminating disparities across the Commonwealth and ensure that the goals of Public Health 1.0, Public Health 2.0, Public Health 3.0, and Virginia's Plan for Well-Being are met.

Public Health 1.0

- During the late 19th century through much of the 20th century, governments assumed the responsibility for public health through systematized sanitation; improved food and water safety; expanded understanding of diseases; development of powerful prevention and treatment tools, such as vaccines and antibiotics; and expanded capability in epidemiology and laboratory science.¹
- Public Health 1.0 programs and goals are still essential to VDH today. They are successfully delivered through many of our environmental and family health services, such as restaurant inspections, epidemiology efforts, and immunizations.

Public Health 2.0

- Public Health 2.0 emerged in the second half of the 20th century and was shaped by the 1988 Institute of Medicine's report, *The Future of Public Health*, which posited that public health authorities were encumbered by the demands of providing safety-net clinical care and were unprepared to address the rising burden of chronic diseases and emerging threats like HIV and AIDS.¹
- Some core VDH programs that continue to encompass the goals of Public Health 2.0 are family planning, chronic disease prevention, health promotion campaigns, sexually transmitted disease (STD) treatment, and dental sealants.

Public Health 3.0

- In this new era of enhanced and broadened public health practices, Public Health 3.0 expands traditional public health functions and programs by tasking public health leaders to serve as "Chief Health Strategists" by engaging multiple sectors and community partners in an effort to create collective impact and eliminate disparities in the social determinants of health.¹
- As outlined in Virginia's Plan for Well-Being goals below, VDH emphasizes the importance of community collaborations and social determinants of health through its programs like Women, Infants, and Children (WIC).

Virginia's Plan for Well-Being²

- Healthy, Connected Communities
 - Virginia's families maintain economic stability
 - Virginia's communities collaborate to improve the population's health
- Strong Start for Children
 - Virginians plan their pregnancies
 - Virginia's children are prepared to succeed in kindergarten
 - The racial disparity in Virginia's infant mortality rate is eliminated
- Preventive Actions
 - Virginians follow a healthy diet and live actively
 - Virginia prevents nicotine dependency
 - Virginians are protected against vaccine-preventable diseases
 - Cancers are prevented or diagnosed at the earliest stage possible
 - Virginians have life-long wellness
- System of Health Care

¹ https://www.cdc.gov/pcd/issues/2017/17_0017.htm

² <http://virginiawellbeing.com/wp-content/uploads/2016/06/Virginias-Plan-for-Well-Being.pdf>

- Virginia has a strong primary care system linked to behavioral health care, oral health care, and community support systems
- Virginia’s health IT system connects people, services, and information to support optimal health outcomes
- Health care-associated infections are prevented and controlled in Virginia

The Commonwealth has already taken steps to improve its performance as evaluated in several national studies (i.e. America’s Health Rankings,³ the Robert Wood Johnson Foundation’s County Health Rankings,⁴ Trust for America’s Health’s Public Health Emergency Preparedness Program Rankings,⁵ and the National Health Security Preparedness Index⁶) and other statewide health system performance indicators through significant investments in Virginia’s Medicaid program, substance abuse disorder treatment infrastructure, health information technology, emergency preparedness, and health surveillance. In its role as Chief Health Strategist, VDH must supplement the existing public health system by developing evidence-based, proactive public policy decisions. Such decisions can be achieved through legislative proposals, regulatory actions, budget amendment requests, program and grant proposals, and strategic partnerships. Regardless of the method by which it is achieved, any decision should strive to align public health and Virginia’s Plan for Well-Being by following these guiding principles:

- All policy proposals and strategic decisions are equity-driven to ensure Virginia’s most vulnerable populations will be identified and disparities are eliminated.
 - VDH staff within the Office of Family Health Services and the Office of Health Equity will be developing a tool to evaluate the impact of legislative proposals on equity to be included in this document by the completion of the 2021 iteration of the Plan.
- Timely, accurate, and transparent data serve as the backbone to policy development.
- Policy development aligns with agency strategic documents, such as the Virginia Plan for Well-Being and VDH’s Strategic Plan.⁷
- External partners are included in policy planning and implementation.
- Past, present, and emerging public health challenges and successes are thoughtfully considered.
- VDH staff are involved in policy planning and development.
- Community voice is critical to policy development. If the public identifies an issue as a public health priority area, it is carefully considered.
- Policy planning reflects the Administration’s strategic priorities. In the case of the Northam Administration, strategic priorities include:⁸
 - Medicaid expansion;
 - Behavioral health and development services;
 - Substance use disorder treatment and prevention;
 - Women’s health; and
 - Children’s health and services.

³ <https://www.americashealthrankings.org/explore/annual/measure/Overall/state/VA>

⁴ <http://www.countyhealthrankings.org/rankings/data/va>

⁵ # <https://www.tfah.org/report-details/ready-or-not-protecting-the-publics-health-from-diseases-disasters-and-bioterrorism-2019/>

⁶ <https://nhspi.org/#by-state>

⁷ <http://www.vdh.virginia.gov/commissioner/core-of-the-strategic-plan/>

⁸ <http://jchc.virginia.gov/meetings2018.asp>

VDH's Policy Research and Analysis Plan (Plan) will assess the adherence of public health policy decisions to these guiding principles and will be updated annually with a similar analysis of external driving forces and internal guiding principles. The updated Plan will reflect changes in VDH strategic initiatives and the evolving political landscape. Since policy development is most successful when priorities are measurable, feasible, and aligned with those of internal and external stakeholders, the Plan will be developed as a product of ongoing collaboration between the agency's Office of the Commissioner; other VDH offices and divisions; local health districts; the VDH Policy Analysis Roundtable; the Commissioner's Public Health Policy Advisory Council; state agencies; external partners, including health systems and local providers; and residents of the Commonwealth. The initial implementation of the Plan will also help to establish the infrastructure for future policy development in to-be-identified focus areas, thus fostering within the agency a culture of ongoing, impactful policy analysis. The Plan is not intended to supersede programmatic or operational priorities within VDH offices or local health districts; rather, the Plan will guide opportunities to address public health priorities that are statewide priorities or anticipated to be public health challenges in the future.

VDH 2020 Public Health Policy Priorities

Following Dr. M. Norman Oliver's appointment as State Health Commissioner in June 2018, VDH leadership has engaged in numerous strategic initiatives:

- State Health Commissioner's 2018 Listening Tour;⁹
- "Partnering for a Healthy Virginia" Initiative with the Virginia Hospital and Healthcare Association (VHHA);¹⁰
- Governor's Challenge to Prevent Suicide among Service Members, Veterans, and their Families (SMVF);¹¹
- Active supervision of the Ballad Health Cooperative Agreement;¹²
- Partnership with the Virginia Community Health Worker Association and Advisory Committee;^{13,14}
- Association of State and Territorial Health Officials (ASTHO) Learning Community: Behavioral Health and Public Health Interconnection;¹⁵
- Maternal and Child Health Policy Innovation Program (MCH PIP) Policy Academy conducted by the National Academy for State Health Policy and funded by the federal Health Resources and Services Administration;¹⁶
- Response to Governor Northam's goal to eliminate racial disparity in Virginia maternal mortality rate by 2025;¹⁷
- Response to local and national illness and deaths attributed to vaping;¹⁸
- Responses to Governor Northam's *Executive Order 24*, which instructed state agencies to increase statewide resilience to sea level rise and natural hazards¹⁹; *Executive Order 29*, which established the

⁹ <http://www.vdh.virginia.gov/news/m-norman-oliver-md-ma/health-commissioner-2018-listening-tour/>

¹⁰ <https://www.vhha.com/communications/virginia-hospitals-virginia-department-of-health-partner-on-new-population-health-effort/>

¹¹ <https://www.blogs.va.gov/VAntage/55707/va-health-human-services-announce-governors-challenge-prevent-suicide/>

¹² <http://www.vdh.virginia.gov/licensure-and-certification/cooperative-agreement/active-supervision-of-the-cooperative-agreement/>

¹³ <https://www.institutephi.org/our-work-in-action/community-health-worker-initiatives/>

¹⁴ <https://www.institutephi.org/regional-update-chw-workforce-development-certification/>

¹⁵ <https://www.astho.org/generickey/GenericKeyDetails.aspx?contentid=20363&folderid=5156&catid=7203>

¹⁶ <https://mchb.hrsa.gov/sites/default/files/mchb/AboutMCHB/mch-pip-factsheet.pdf>

¹⁷ <https://www.governor.virginia.gov/newsroom/all-releases/2019/june/headline-840941-en.html>

¹⁸ <http://www.vdh.virginia.gov/news/2019-news-releases/virginia-department-of-health-warns-of-new-danger-of-vaping/>

¹⁹ <https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/ED-24-Increasing-Virginias-Resilience-To-Sea-Level-Rise-And-Natural-Hazards.pdf>

Virginia Council on Environmental Justice²⁰; and *Executive Order 22*, which established the Governor's Conservation Cabinet²¹;

- Virginia Commissioner's Public Health Policy Advisory Council (see roster in attachments);
- Initiation of Virginia's State Health Assessment;
- Development of the Title V Maternal Child Health Needs Assessment;
- Initiation of Virginia's Updated State Rural Health Plan;
- VDH Policy Analysis Roundtable (see roster in attachments); and
- In accordance with Virginia Code § 32.1-13.1, intentionally and proactively engaging the State Board of Health in meaningful policy development (see State Board of Health roster in attachments).²²

Across these initiatives and partnerships, VDH collected valuable information from residents of the Commonwealth, health system leadership, the Governor's leadership team, community providers and navigators, the Virginia Department of Medical Assistance Services (DMAS), the Virginia Department of Behavioral Health and Developmental Services (DBHDS), the Virginia Department of Environmental Quality (DEQ), Virginia's masters of public health programs, VDH staff, and many others. VDH leadership has determined that through research, analysis, and policy development, the agency should prioritize serving as Chief Health Strategist in the following public health areas:

- Addiction and substance abuse;
- Data interoperability and transparency;
- Early childhood development and resilience;
- Environmental health hazards and climate change;
- Impacts of e-cigarettes and tobacco;
- Maternal and infant health;
- Prevention of the spread of infectious disease;
- Social isolation and connectedness; and
- Suicide prevention and firearm safety.

To develop meaningful policy recommendations or identify gaps in data required for policy development, it is critical to approach the above focus areas through a population health lens with the following parameters:

- Overview: What is this health/social outcome and why is it critical to population health?
- Vulnerable Populations: What populations are most vulnerable to poor health outcomes?
- VDH Program Alignment: What relevant programs and initiatives is the agency involved in?
- Best Practices & Approaches: What are other states/entities effectively doing to improve outcomes?
- Agency Leads and Points of Contact
- Relevant Stakeholders: Who are the relevant stakeholders VDH must engage for policy development to be successful?
- Recommendations: Legislative Proposals/Periodic Regulatory Review/Funding/Partnerships/Program Activities

²⁰ <https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-29-Establishment-Of-The-Virginia-Council-On-Environmental-Justice.pdf>

²¹ <https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-22-Establishment-of-the-Governors-Conservation-Cabinet---A-United-Effort-to-Protect-and-Conserve-Virginias-Natural-Resources.pdf>

²² <https://law.lis.virginia.gov/vacode/title32.1/chapter1/section32.1-13.1/>

Recommended Public Health Priority Focus Areas for Research, Analysis, and/or Policy Development

Addiction and Substance Abuse

Overview

- Addiction is defined as a chronic, relapsing disorder characterized by compulsive drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain. It is considered both a complex brain disorder and a mental illness.²³
- Addiction is the most severe form of a full spectrum of substance use disorders, and is a medical illness caused by repeated misuse of a substance or substances.²³
- Use of and addiction to alcohol, nicotine, and illicit drugs cost the nation more than \$740 billion a year related to healthcare, crime, and lost productivity.
- In 2016, drug overdoses killed over 63,000 people in the U.S., while 88,000 died from excessive alcohol use.²³
- As of October 2019 in Virginia, there were an estimated 5,832 emergency department visits and 650 deaths attributed to opioid overdoses.²⁴
- As of 2019, 16.9% of Virginians have reported as either a binge drinker (having four or more [women] or five or more [men] drinks on one occasion in the past 30 days) or chronic drinker (having eight or more [women] or 15 or more [men] drinks per week).²⁵

Vulnerable Populations

- Virginians aged 25 to 34 experience the highest rates of emergency department visits for all drugs.²⁶
- Virginians aged 25 to 44 are at higher risk for death attributable to any opioid.²⁶
- The rates of Neonatal Abstinence Syndrome (NAS) is higher in far Southwest Virginia than other regions of the state.²⁷
- Families and partners of people who use drugs are at higher risks for being drug users.²⁸
- Excessive drinking occurs most in adults ages 18-44, college graduates, and those that are white or multiracial.²⁹
- Children of parents of those who suffer from substance abuse.³⁰

VDH Program Alignment

- The Comprehensive Harm Reduction (CHR) program provides safe needle exchanges in select local health districts across the Commonwealth.
- Local health districts and the Office of Family Health Services provides education, outreach, and treatment of viral hepatitis and HIV
- VDH provides Naloxone education and distribution
- Funding mental health and substance use disorder treatment for people living with HIV through the Ryan White Part B grant

²³ <https://www.drugabuse.gov/publications/media-guide/science-drug-use-addiction-basics>

²⁴ <http://www.vdh.virginia.gov/opioid-data/>

²⁵ <https://www.americashealthrankings.org/explore/annual/measure/ExcessDrink/state/VA>

²⁶ <http://www.vdh.virginia.gov/opioid-data/deaths/>

²⁷ <http://www.vdh.virginia.gov/opioid-data/neonatal-abstinence-syndrome-nas/>

²⁸ <https://www.ncbi.nlm.nih.gov/books/NBK64258/>

²⁹ <https://www.americashealthrankings.org/explore/annual/measure/ExcessDrink/state/VA>

³⁰ https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.html

- The Office of Health Equity operates the State Loan Repayment Program, which can also be used to recruit Mental Health providers, Psychiatrists, and other allied health personnel to address patients with substance abuse disorders.
- Various local health districts provide enhanced HIV services for justice-involved individuals
- Project ECHO is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best-practice specialty care and reduce health disparities.³¹
 - The heart of the ECHO model is its hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers. In this way, primary care doctors, nurses, and other clinicians learn to provide excellent specialty care to patients in their own communities.²⁷

Best Practices & Approaches

- Provide Medication Assisted Treatment (MAT) in jails for those either on it when they enter the facility, and/or for those willing to begin it in the facility to potentially prevent both recidivism and substance use associated death.
- Expand CHR programs across the Commonwealth.
- Expand access to HIV and hepatitis testing and treatment.
- Increase enrollment in Medicaid to improve access to substance use disorder treatment.
- Increase access to pre- and post-exposure prophylaxis to prevent transmission of HIV .
- Increasing the number of providers trained in MAT increases access to services for populations suffering from substance use disorders.

Agency Leads and Points of Contact

- Diana Jordan; Director, Division of Disease Prevention, Office of Epidemiology
- Elaine Martin; Director HIV Hepatitis Prevention Services, Division of Disease Prevention, Office of Epidemiology
- Bruce Taylor; Drug User Health Coordinator, Division of Disease Prevention, Office of Epidemiology
- Kimberly Scott; Director, HIV Care Services, Division of Disease Prevention, Office of Epidemiology
- Bob Mauskapf; Director, Office of Emergency Preparedness
- Heather Board; Director, Division of Prevention and Health Promotion
- Jonathan Kiser; Assistant State Planning Coordinator, Office of Emergency Preparedness
- Shameera Carr; Chief of Staff; Community Health Services
- Kim Beazley; Acting Director, Office of Licensure and Certification

Relevant Stakeholders

- VHHA
- DBHDS
- DMAS
- Virginia Association of Free and Charitable Clinics
- Virginia Department of Social Services (DSS)
- Virginia Department of Corrections (VADOC)
- Virginia Department of Criminal Justice Services (DCJS)
- Virginia Community Healthcare Association
- Virginia Association of Health Plans (VAHP)

³¹ <http://www.vdh.virginia.gov/project-echo/>

- Virginia Association of Counties
- Virginia Health Workforce Development Authority
- Virginia Health Workforce Foundation
- United States Department of Agriculture
- Virginia Department of Agriculture and Consumer Services
- Virginia Farm Bureau

Recommendations

Legislative Proposals

- Develop a legislative proposal that allows for the implementation of CHR programs in any local health district across the Commonwealth.
- Explore legislation with DBHDS that expands oversight of residential addiction facilities to include those that are not certified by DBHDS.

Periodic Regulatory Review

Funding (Budget Amendment Requests and/or Grant Proposals)

- Secure grant funds and/or general funds to expand VDH and community partner access to Narcan.

Strategic Partnerships

- Partner with VADOC to explore opportunities to pilot and fund MAT in select corrections facilities across the Commonwealth.
- Continue to engage localities, per Virginia code, to ensure that all eligible localities offer CHR programs
- Continue working with DBHDS to ensure the Curb the Crisis website effectively provides Virginians suffering with substance use disorders the resources to receive the appropriate care.
- Convene workgroup comprised of leadership from DMAS, DBHDS, the Virginia Workforce Development Authority, the VHHA, MSV, and others to increase the number of providers trained in MAT.

Program Activities

Data Interoperability and Transparency

Overview

- Interoperability is the ability of different information systems, devices and applications ('systems') to access, exchange, integrate and cooperatively use data in a coordinated manner, within and across organizational, regional and national boundaries, to provide timely and seamless portability of information and optimize the health of individuals and populations globally.³²
- Integrated data sets that promote real-time data exchange, increase public data transparency, and allow for the exchange of data between health care providers and community-based organizations support the effective care coordination and value-based payment infrastructure needed for population health improvements.³³

VDH Program Alignment

- Implementation of an agency-wide, fully functional Electronic Health Record (EHR)
- Oversight of the Virginia Emergency Department Care Coordination Program (EDCC)³⁴
- Oversight of the Virginia All Payer Claims Database (APCD)³⁵
- Oversight of the Patient Level Data System³⁶

Agency Leads and Points of Contact

- Mona Bector; Deputy Commissioner for Administration
- Suresh Soundararajan; Acting Chief Information Officer, Office of Information Management
- Dr. Parham Jaber; Chief Deputy Commissioner for Public Health and Preparedness
- Dr. Laurie Forlano; Deputy Commissioner for Population Health
- Gary Brown; Director, Virginia Office of Emergency Medical Services

Relevant Stakeholders

- Virginia Health Information (VHI)
- DMAS
- VAHP
- VHHA
- Virginia Community Healthcare Association

Recommendations

Legislative Proposals

Periodic Regulatory Review

Funding (Budget Amendment Requests and/or Grant Proposals)

Strategic Partnerships

- Develop communication strategy, in partnership with VHI, to recruit self-insured employers to submit claims data to the APCD.

³² <https://www.himss.org/library/interoperability-standards/what-is-interoperability>

³³ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.W5.10>

³⁴ <https://connectvirginia.org/services/edccp/>

³⁵ <https://www.vhi.org/apcd/>

³⁶ <https://law.lis.virginia.gov/admincodeexpand/title12/agency5/chapter217/>

- Explore opportunities to increase the connection to, and utilization of, the EDCC program by local health districts and other community-based organizations.

Program Activities

- Develop and distribute a data catalog outlining what data sources are available to VDH staff, how to access data sets, and who are the points of contact.

Early Childhood Development and Resilience

Overview

- Adverse Childhood Experiences (ACEs) have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity.³⁷
- ACEs describe all types of abuse, neglect, and other potentially traumatic experiences that may impact people under the age of 18 and have been linked to:³⁸
 - risky health behaviors;
 - chronic health conditions;
 - low life potential; and
 - early death.
- Children who experience four or more ACEs are:³⁴
 - 4 times more likely to be a high-risk drinker;
 - 6 times more likely to have had or caused unintended teenage pregnancy;
 - 6 times more likely to smoke e-cigarettes or tobacco;
 - 6 times more likely to have had sex under the age of 16 years;
 - 11 times more likely to have smoked cannabis;
 - 14 times more likely to have been a victim of violence over the previous 12 months;
 - 15 times more likely to have committed violence against another person in the past 12 months;
 - 16 times more likely to have used crack cocaine or heroin; and
 - 20 times more likely to have been incarcerated at any point in their lifetime.
- 1 in 6 adults experience four or more types of ACEs.³⁵
- At least 5 of the top 10 leading causes of death are associated with ACEs.³⁵
- Preventing ACEs could reduce the number of adults with depression by as much as 44%.³⁹
- Children’s positive experiences or protective factors can prevent them from experiencing adversity and can build resilience against many negative health and life outcomes even after adversity has occurred.
- 1 in 5 children who have experienced four or more ACEs have a diagnosable mental disorder and 1 in 10 suffers from a serious mental health problem.³⁴
 - Approximately 50% of psychiatric illnesses begin by age 15 and 75% begin by age 24.
- Over 65% of pediatricians reported to the American Board of Pediatrics they lacked mental and behavioral health knowledge and skills.⁴⁰
- Virginia ranks 42nd in the nation for the number of psychiatrists, psychologists, licensed social workers, counselors, therapists and advanced practice nurses specializing in mental health care per population.
 - Only two counties have sufficient numbers of child and adolescent psychiatrists, which represents only 23,086 of the 1.86 million children in Virginia.
 - Results from the 2017 Virginia Youth Survey showed that among middle and high school students, 1 in 5 females and 1 in 10 males have seriously contemplated suicide in the preceding twelve months.⁴¹
- In the State of Mental Health in America 2020 report:⁴²
 - 13.22% of Virginia children have had at least one major depressive episode (MDE).

³⁷ <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html>

³⁸ <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/aboutace.html>

³⁹ <https://www.cdc.gov/vitalsigns/ACEs/>

⁴⁰ <https://www.abp.org/sites/abp/files/pdf/abpf-nasem-presentations-2018.pdf>

⁴¹ http://www.vdh.virginia.gov/content/uploads/sites/69/2019/09/vys-2017-copy_28905401.pdf

⁴² <https://www.mhanational.org/issues/mental-health-america-all-data>

- 51.3% of Virginia children who had an MDE have not received not receiving mental health services.
- Only 28.3% of Virginia children with severe MDE received some consistent treatment.
- Virginia ranks 37th in the nation for access to mental health care.
- Virginia has the 7th highest rate for youth with alcohol dependence, 10th highest for youth reporting marijuana use, 8th highest for youth reporting cocaine use.

Vulnerable Populations

- Children are more likely to experience multiple ACEs if they live in poverty and/or if a parent was exposed to ACEs as children.⁴³
- Black children and children in urban and large rural areas are at highest risk for exposure to ACEs.⁴⁰

VDH Program Alignment

- The Maternal, Infant, and Early Childhood Home Visiting program supports pregnant women, families, and at-risk parents of children (birth to age five) to access resources and develop the skills needed to rear children who are physically, socially, and emotionally healthy and ready to learn. The program develops and implements voluntary, evidence-based home visiting programs that utilize models such as Healthy Families America, Nurse Family Partnership, and Parents as Teachers.⁴⁴
- Virginia's Healthy Start initiative, the Loving Steps home visiting program, is for pregnant women and children (birth to 24 months), which focuses on parent education and support to develop skills to build nurturing relationships to enhance social and emotional wellbeing of children. The program also focuses on reducing maternal and infant mortality by providing clinical consultation with high risk moms and local resources to reduce those risks.⁴⁵
- Many of VDH's Local Health Districts participate in the BabyCare program, a Medicaid-sponsored home visiting program for pregnant women and mothers of infants and children (birth to age two). Baby Care will help mothers and families learn about the child's growth and development, and help them find regular medical care.
- The Resource Mothers program is designed to decrease infant mortality and low birth weight rates among Virginia's teen mothers. The resource mother is a community health worker who develops a supportive mentoring relationship with the teen and her family. From the prenatal period through the infant's first birthday, the resource mother provides health education, discusses ways to prevent infant injury, models daily living skills, encourages constructive decision making and life-planning, connects the teen to community resources, and provides guidance to assist the teen in making a successful transition to parenthood. The resource mother has weekly contact with the teen and her family.⁴⁶
- Title V Developmental Screening Initiative⁴⁷
- Project funded by the federal Health Resources and Services Administration and the Virginia Mental Health Access Program, in partnership with DBHDS and the Virginia Chapter, American Academy of Pediatrics (AAP).

⁴³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6678738/>

⁴⁴ <http://www.vdh.virginia.gov/family-home-visiting/maternal-infant-and-early-childhood-home-visiting-program-miechv/>

⁴⁵ <http://www.vdh.virginia.gov/family-home-visiting/healthy-start-loving-steps/>

⁴⁶ <http://www.vdh.virginia.gov/family-home-visiting/resource-mothers-program/>

⁴⁷ <http://www.vdh.virginia.gov/content/uploads/sites/16/2018/09/Title-V-MCH-Block-Grant-AY19-AR17-for-Public-Comment.pdf>

- VDH is actively supervising the Ballard Health Cooperative Agreement. Ballard Health has proposed aligning community resources to build strong families and children, with the goal of improving population health outcomes immediately and over the next 10 plus years. VDH will be closely monitoring Ballard’s activities to learn Best Practices & Approaches that can be replicated across the Commonwealth.
- VDH’s Office of Health Equity (OHE) has launched an updated version of the Virginia Health Opportunity Index (HOI), an online mapping tool of community health influences that allows advocates, citizens, and providers to view factors affecting Virginians’ health.
- VDH is supporting the Community Health Worker Advisory Group to ensure that Community Health Workers are properly trained to identify and address ACEs and protective factors in Virginia’s most vulnerable communities.
- The Domestic and Sexual Violence Prevention program coordinates efforts to prevent rape, sexual domestic violence, and dating violence. The program provides training, education, and outreach, as well as funding and technical assistance for primary prevention programming in local communities.

Best Practices & Approaches

- ACEs can be prevented and resilience can be fostered by:⁴⁸
 - Strengthening economic support to families;
 - Changing social norms to support parents and positive parenting;
 - Providing quality care and education early in life;
 - Enhancing parenting skills to promote healthy childhood development; and
 - Intervening to lessen harms and prevent future risk.
- Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child abuse and neglect.
- Identifying children who have been exposed to ACEs or are at risk for exposure, screening tools can be leveraged in clinical, educational, and other social settings:
 - Ages and Stages Questionnaire 3 and Social Emotional (ASQ-3 and SE-2) screenings are widely used to assess infant and children’s development and social emotional development.
 - Bright Futures is AAP’s standard reference book on children’s health information for pediatricians.
- Coordinate and manage partnerships with other child abuse and neglect prevention organizations and non-traditional partners, both of whom are involved in assuring safe, stable, nurturing relationships and environments for children.
- Expand opportunities to identify ACEs and provide trauma-informed treatment in the most appropriate setting where children and families feel safe.
- Leverage home visiting programs to provide trauma-informed coaching and mentoring in homes.

Agency Leads and Points of Contact

- Dr. Vanessa Walker-Harris; Director, Office of Family Health Services (OFHS)
- TBD; Director, OHE
- Justin Crowe; Director, Division of Social Epidemiology
- Valerie McAllister; Community Clinical Linkages Coordinator, OFHS
- Kim Beazley; Acting Director, Office of Licensure and Certification
- Dr. Nancy Welch; Director, Chesapeake Health District
- Dr. Karen Shelton; Director, Mount Rogers Health District
- Jeannine Uzel; Director of Public Health Nursing, Community Health Services

⁴⁸ <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-graphics.html>

Relevant Stakeholders

- Virginia Chapter, AAP
- Early Childhood Mental Health Virginia
- Early Impact Virginia
- DOE
- DMAS
- DSS
- VHHA
- Virginia Community Health Worker Advisory Group
- VAHP
- Early Impact Virginia
- Virginia Health Care Foundation
- Families Forward
- Family and Children's Trust Fund
- Children's Services Act (Community Policy and Management Team/Family Assessment and Planning Team)
- DBHDS
- Governor's Children's Cabinet
- Virginia Chamber of Commerce
- U.S. Department of Housing and Urban Development (HUD)
- Virginia Department of Housing and Community Development (DHCD)
- VADOC
- Virginia Department of Conservation and Recreation
- Virginia Health Workforce Development Authority
- Virginia Health Workforce Foundation
- The United Way

Recommendations

Legislative Proposals

Periodic Regulatory Review

- Explore revisions to the network adequacy provisions in the Managed Care Health Insurance Plan (MCHIP) regulations that would include explicit behavioral health requirements, to be part of an existing collaboration with the Secretary of Health and Human Resources (SHHR), DBHDS, the Centers for Medicare and Medicaid Services, the Virginia Bureau of Insurance (BOI), and DMAS for mental health parity.

Funding (Budget Amendment Requests and/or Grant Proposals)

- Secure grant funds and/or general funds to support community discussions around ACEs that will promote screening and identification of ACEs at the community level and provide education on trauma-informed care, similar to Crater Health District's Beyond ACEs Summit.⁴⁹

Strategic Partnerships

- Develop and promote the utilization of an ACEs screening tool by all Virginia providers with the VHHA; Virginia Community Healthcare Association; Medical Society of Virginia; and Virginia Chapter, AAP.

⁴⁹ <http://www.vdh.virginia.gov/blog/2019/07/03/beyond-aces-summit-the-impact-of-race-culture-and-poverty/>

Program Activities

- Continue discussions to further integrate VDH's data sources with the Virginia Longitudinal Data System to evaluate early interventions and investments on Virginians educational attainment and employment.

Environmental Health Hazards, Disasters, and Climate Change

Overview

- Virginians are exposed to numerous environmental risks, including:
 - Transmission of disease through food, milk, shellfish, water, and sewage;
 - Exposure to contaminated water;
 - Lead in drinking water as a result of lead pipes, plumbing fixtures that contain lead, and lead solder in private homes and waterworks' distribution systems;
 - Injury and death from natural and human-caused disasters;
 - Temperature extremes;
 - Poor air quality; and
 - Exposure to vector-borne diseases.
- Changing and unpredictable weather patterns, severe weather events, poor air quality, and climate factors, such as sea level rise, extreme heat, and drought, can exacerbate chronic illnesses and intensify the impact of environmental and health risks.
- Individuals with access and functional needs are more at risk for natural and human caused disasters due to reduced ability to evacuate or take other protective measures. These individuals include persons who:
 - Are from diverse cultures, races, and nations of origin;
 - Don't read, have limited English proficiency, or are non-English speaking;
 - Are transportation disadvantaged;
 - Are experiencing homelessness;
 - Are economically disadvantaged;
 - Have a pharmacological dependency;
 - Have physical, sensory, behavioral, mental health, intellectual, developmental, and cognitive disabilities;
 - Are Pregnant;
 - Are infants or children;
 - Have chronic medical conditions
- All Virginians are at risk of experiencing emergencies and disaster situations, with little or no warning to prepare. Since 1953 there have been 67 major disasters declared in Virginia.
- Per- and polyfluoroalkyl substances (PFAS), a group of man-made chemicals that includes PFOA, PFOS, GenX, and many other chemicals, are very persistent in the environment and in the human body--meaning that these chemicals do not break down and can accumulate over time. There is evidence that exposure can lead to adverse human health effects.⁵⁰
 - While certain PFAS chemicals are no longer manufactured in the U.S., PFAS have infiltrated groundwater and soil at three military facilities, a firefighter training facility, and a chemical manufacturing plant in Virginia, posing potential risk to drinking water and agriculture.^{51,52}
 - Currently, the EPA has set a lifetime health advisory of 70 parts per trillion (ppt) combined PFOS and PFOA for drinking water, though this level is not enforceable.⁵³

⁵⁰ <https://www.epa.gov/pfas/basic-information-pfas>

⁵¹ <https://www.deq.virginia.gov/ConnectWithDEQ/EnvironmentalInformation/PFAS.aspx>

⁵² https://www.atsdr.cdc.gov/pfas/atsdr_sites_involvement.html

⁵³ <http://www.vdh.virginia.gov/epidemiology/epidemiology-fact-sheets/perfluoroalkyl-substances-pfas/>

- Exposure to indoor radon is the second leading cause of lung cancer . Many regions and communities in Virginia face high risks of consistent exposure to radon in the home.^{54,55}

Vulnerable Populations

- Populations that lack transportation.
- Individuals living in poverty.
- Individuals living in public housing.
- Populations that are highly susceptible to foodborne illness.
- Children aged one to four years old (drowning).
- Populations in historically underserved neighborhoods.
- Shellfish farmers and consumers.
- Residents of low-lying coastal regions.
- Consumers.
- Migrant laborers.
- Athletes.
- Individuals with chronic illnesses and/or medical device dependency or pharmacological dependency.
- Residents of communities that receive water from waterworks that lack the technical, managerial, or financial capability to produce water that consistently and reliably meets water quality standards.

VDH Program Alignment

- Permitting, inspection, and surveillance of public water supply systems (waterworks) under the Public Water Supplies Law and Waterworks Regulations.⁵⁶
- The Office of Drinking Water (ODW) manages the Drinking Water State Revolving Fund (DWSRF) Program, which combines federal and state funds to offer a mix of loan, grant and refinancing opportunities for waterworks to upgrade, rehabilitate, or expand treatment facilities and capabilities.⁵⁷
- The Lead Testing in School and Child Care Program Drinking Water Grant creates a program to assist with voluntary testing for lead in drinking water at schools and child care programs.⁵⁸ Virginia is scheduled to receive \$757,000 in grant funding, which ODW will administer. ODW is working with the Office of Epidemiology, OHE, the Virginia Department of Education (VDOE), and DSS on the work plan.
- The Division of Food and General Environmental Services is responsible for public policy updates, training, and standardization of oversight for restaurant and food establishment inspections, which include hospitals, nursing homes, restaurants, mobile food units, caterers, and temporary food establishments.
- Continue to partner with VDOE on the U.S. Department of Agriculture (USDA) Summer Food Service Program. This program ensures low-income children continue to receive nutritious meals when school is not in session.

⁵⁴ <http://www.vdh.virginia.gov/radiological-health/indoor-radon-program/>

⁵⁵ <http://www.vdh.virginia.gov/radiological-health/indoor-radon-program/epa-radon-risk-map-for-virginia/>

⁵⁶ <http://www.vdh.virginia.gov/drinking-water/about-us/>

⁵⁷ <http://www.vdh.virginia.gov/drinking-water/financial-construction-assistance-programs/>

⁵⁸ <https://www.epa.gov/dwcapacity/wiin-2107-lead-testing-school-and-child-care-program-drinking-water-state-grant-program>

- The Division of Shellfish Safety and Waterborne Hazards Control conducts routine water sampling and analysis of shellfish growing areas; surveys shorelines at properties in watersheds to identify potential pollution sources; and closes shellfish growing areas in response to pollution events, weather, and outbreaks associated with Vibrios, Norovirus, and harmful bacteria.
- The Division of Shellfish Safety and Waterborne Hazards Control oversees harmful algae bloom monitoring and response and coordinates the marine beach monitoring and swimming advisories in local health districts.
- Onsite Sewage and Water Services, Environmental Engineering, and Marina Programs oversee the regulation of onsite sewage treatment and disposal (conventional and alternative onsite sewage systems), private wells, and marinas in Virginia.
- Inspection and permitting of the construction and operation of Migrant Labor Camps, Hotels/Motels, Bed and Breakfasts, Public Swimming Pools, Marinas and other facilities.
- The Office of Emergency Preparedness collaborates with state, regional, and local emergency response partners to enhance readiness for responses to all hazards, including natural and human-caused disasters, bioterrorism, infectious disease outbreaks, and other public health emergencies.
- The Radioactive Materials Program is responsible for the licensing and inspections of persons using radioactive materials in such areas as industrial, medical, educational and research applications.
- The VDH Climate Change Committee (C-3) is developing strategies to more effectively identify and mitigate the public health risks associated with climate change.

Best Practices & Approaches

- Leveraging the Safe Drinking Water Information System (SDWIS), a database for logging and tracking water quality/monitoring results for the more than 2,800 waterworks in Virginia.
- Maintenance of an Environmental Health Database (EHD) of Environmental Health Programs used to generate hypothesis; guide planning, implementation, and evaluation of programs; and characterize trends.
- Ensuring the uniform application of Environmental Health regulations and policies by providing a standardized training program for local health district Environmental Health staff; auditing Environmental Health programs; tracking enforcement measures taken by local health districts; and conducting analysis of enforcement.
- Expansion of strategic partnerships with state and federal entities to explore documented effects of climate change.
- Partnerships with the Department of Education to protect athletes by limiting practices/activities in extreme heat.
- Developing local community partnerships to create cooling and warming stations in extreme temperatures.
- Conducting Hazard Vulnerability Assessments to focus planning, training and exercise resources on most likely and most dangerous hazards, partner with other local and state government agencies and private sector partners, and ensure persons with access and functional needs are considered and involved in all planning processes.
- Providing targeted education to populations at risk for increased radon exposure and distributing testing kits free of charge.

Agency Leads and Points of Contact

- Climate Change Committee: Brenden Rivenbark; Office of the Commissioner
- Nelson Daniel; Policy and Program Director, Office of Drinking Water
- Julie Henderson; Director, Division of Food and General Environmental Services
- TBD; Director, Office of Environmental Health Services
- Lance Gregory; Director, Division of Onsite Sewage and Technical Services
- TBD; Director, Division of Shellfish Safety and Waterborne Hazards Control
- Sonal Iyer; Director, Division of Data Analysis and Process Improvement
- Dwight Flammia; State Toxicologist
- Heather Board; Director, Division of Prevention and Health Promotion
- Bob Mauskapf; Director, Office of Emergency Preparedness
- TBD; Director, Virginia Radioactive Materials Program
- Kim Beazley; Acting Director, Office of Licensure and Certification

Relevant Stakeholders

- Virginia Tech and the University of Virginia (related to lead in drinking water)
- VDOE
- DSS
- U.S. Environmental Protection Agency
- Virginia Department of Agriculture and Consumer Services (VDACS)
- DEQ
- HUD
- DHCD
- Virginia Marine Resources Commission
- Virginia Institute of Marine Science
- Old Dominion University
- Virginia Tech Area Research and Cooperative Extension (Seafood Extension in Hampton)
- Shellfish Growers of Virginia
- Virginia Seafood Council
- Virginia Employment Commission
- Virginia Association of Counties
- VHHA
- Virginia Department of Emergency Management
- Virginia Department of Transportation
- The Federal Reserve Bank of Richmond
- The Southeast Rural Community Assistance Project, Inc.

Recommendations

Legislative Proposals

- Explore legislative proposal to broaden the scope of the Department of Health's authority as it relates to public swimming pools and drowning prevention.
- Explore options for alternative sources of drinking water supply, including harvested rainwater.
- Convene all VDH stakeholders to initiate policy discussions on effective enforcements and protections around human and animal exposure to PFAS and PFOS.

Periodic Regulatory Review

- Similar to Massachusetts' approach, explore opportunities to revise Virginia's licensure regulations to require that new hospitals and nursing homes as well as major renovations within hospitals and nursing homes must meet established national green (LEED Silver requirements) building standards.⁵⁹

Funding (Budget Amendment Requests and/or Grant Proposals)

- Explore grant and other funding opportunities applicable to supporting repair/upgrade of onsite sewage systems to mitigate potential adverse impact to public health and the environment.
- Continue conversations with SHHR to explore staffing to support VDH's Climate Change Committee.

Strategic Partnerships

- Convene roundtable with VDH, VDEM, the VHHA, local health districts, local emergency management agencies, and others to develop plans to better leverage trusted community resources (i.e. Community Health Workers) as the points of contact and communicators of environmental and emergency threats.
- Partner with the Department of Professions and Occupations to explore opportunities to ensure that real estate developers and consumers are aware of areas at risk from sea level rise.

Program Activities

- Develop a data management tool for the Lead Testing in School and Child Care Program Drinking Water Grant. ODW will use the data management tool to track schools and child care programs that perform testing under the Grant and compile sample results.
- Implement the Center for Disease Control's National Environmental Assessment Reporting System (NEARS) surveillance system for outbreak response in local health districts. System enables ongoing, systematic collection, management, analysis, interpretation, and dissemination of foodborne illness outbreak environmental assessment data.
- In partnership with local health districts, develop strategic communication strategies for communities with high risk of exposure to radon in homes and explore funding through grants or general funds to provide free radon tests to communities with high risk of exposure.
- Engage local health district Environmental Health staff on climate change specific to Environmental Health Programs (private wells, onsite sewage, marinas, campgrounds, migrant labor camps, summer camps, restaurants, etc.).

⁵⁹ <https://nashp.org/states-take-the-lead-to-address-climate-change/>

Impacts of E-Cigarettes and Tobacco

Overview

- E-cigarettes are battery-operated devices that contain nicotine in combination with other chemicals and additives. Users have been known to add illegal tetrahydrocannabinol (THC) or cannabinoid (CBD) oils post-production.⁶⁰
- E-cigs are primarily used by youth ages 17-24. Using e-cigarettes is linked to use of other tobacco products.⁶¹
- Tobacco is linked to an estimated 480,000 deaths per year.
- Virginia is the third leading state for producing tobacco.⁶²
- In Virginia, 10,300 adults per year die due to smoking. Of these, 9,200 are smokers and 1,600 are persons exposed to secondhand smoke.⁶³
- Recently, injuries related to vaping devices have swept the national news cycle. With nearly 1,500 injuries reported from all states except Alaska and more than 33 deaths confirmed in 35 states, there is increased attention and movement to take action on regulating these devices.⁶⁴
- Virginia currently has laws on product packaging of e-cigarettes and to restrict access for youth but has no laws related to taxation for e-cigarettes or licensing for retail sales (for any tobacco products).⁶⁵

Vulnerable Populations

- Among non-smokers, exposure to secondhand smoke was highest among black non-Hispanics, those living with a smoker, renters, those living in poverty, and children aged 3-11.⁶⁶
- In Virginia, the Southwest region had the highest percentage of youth using cigarettes or other tobacco product.
- Vaping injuries have primarily occurred among young males.

VDH Program Alignment

- Tobacco Free Living⁶⁷
- The Tobacco Control Program worked in partnership with other stakeholders to create a Tobacco Free Strategic Plan which includes the following 5 goals:⁶⁸
 - Prevent initiation of tobacco use among youth and young adults
 - Promote tobacco cessation among adults and youths
 - Eliminate exposure to secondhand smoke
 - Identify and eliminate tobacco-related disparities
 - Development of a statewide infrastructure for tobacco use, prevention, and control
- The Tobacco Control Program has operated a tobacco cessation hotline since 2005.

⁶⁰ What is Vaping? Center on Addiction. October 2018. Available at: <https://www.centeronaddiction.org/e-cigarettes/recreational-vaping/what-vaping>

⁶¹ https://www.cdc.gov/tobacco/data_statistics/sgr/e-cigarettes/pdfs/2016_sgr_entire_report_508.pdf

⁶² <http://www.virginaliving.com/culture/bright-leaf-legacy/>

⁶³ <http://www.vdh.virginia.gov/tobacco-free-living/>

⁶⁴ https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html

⁶⁵ <https://www.publichealthlawcenter.org/resources/us-e-cigarette-regulations-50-state-review>

⁶⁶ Tsai J, Homa DM, Gentzke AS, et al. Exposure to Secondhand Smoke Among Nonsmokers — United States, 1988–2014. *MMWR Morb Mortal Wkly Rep* 2018;67:1342–1346. DOI: <http://dx.doi.org/10.15585/mmwr.mm6748a3>.

⁶⁷ <http://www.vdh.virginia.gov/tobacco-free-living/>

⁶⁸ <http://www.vdh.virginia.gov/content/uploads/sites/29/2017/06/2017-Tobacco-Free-Alliance-Strategic-PlanFINAL2.pdf>

- Other VDH programs, such as those related to child and maternal health programs as well as chronic disease, are also linked to this topic.

Best Practices & Approaches

- The CDC recommends Virginia allocate a minimum of \$63.9 million for tobacco cessation and prevention programming.⁶⁹
- State and Community interventions focus on cessation interventions, surveillance and evaluation, infrastructure, administration, and management.”
- Mass-reach Health Communication Interventions to help mitigate the effects of tobacco advertising (resources available in the CDC’s Media Campaign Resource Center database).⁷⁰
- Increase tax on cigarettes and tobacco products.
- Expanding insurance plan coverage to include cessation programs.
- Develop smoke free policies to cover workplaces, multi-unit housing, restaurants, recreation and public spaces to protect adults and children.

Agency Leads and Points of Contact

- Dr. Vanessa Walker-Harris; Director, OFHS
- Heather Board; Director, Division of Prevention and Health Promotion
- VDH Tobacco Control Program
 - Jayne Flowers - Program Manager
 - Will Hockaday - Policy/Outreach Coordinator
 - Rita Miller - Cessation Services Coordinator
 - Gina Roberts - Lead Regional Coordinator
 - Sally Goodquist - Region 1 Coordinator
 - Shannon Raines - Region 2 Coordinator
 - Gina Roberts - Region 3 Coordinator
 - Sarah Birkhead - Region 4 Coordinator
 - Nicole Mayaen - Region 5 Coordinator

Relevant Stakeholders

- Virginia Foundation for Healthy Youth
- Tobacco Free Alliance of Virginia
- Virginia Healthcare and Hospital Association
- DBHDS
- VDOE
- DCJS
- DMAS
- VDACS
- Virginia Alcohol and Beverage Control Authority – Underage Buyer Program
- Altria
- American Lung Association, Virginia Chapter

⁶⁹ Page 124, https://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/comprehensive.pdf

⁷⁰ <https://nccd.cdc.gov/mcrc/index.aspx>

Recommendations

Legislative Proposals

- Explore legislation that would define and prevent the sale of all flavored tobacco products in any venue that sells tobacco products.

Periodic Regulatory Review

Funding (Budget Amendment Requests and/or Grant Proposals)

- Increase funding allocation to Quit Now Virginia tobacco cessation program and local health districts to provide nicotine replacement therapy (NRT) to users:
 - Provide clinically recommended NRT dosage for 12 week period.
 - Consider offering sliding scale fee through local health districts.
 - Work with DMAS to promote provision of NRT to Medicaid-eligible individuals.
- Allocate additional funds to increase education through digital and social media campaign targeting adults via the VDH Tobacco Control Program (TCP).

Strategic Partnerships

- Convene work group with the Virginia Foundation for Healthy Youth (VFHY) to expand education through digital and social media campaign targeting youth.
- Consult with the Public Health Law Center, which is available to provide free legal technical assistance to explore both short- and long-term solutions.

Program Activities

- Reactivate the VFHY's Vaping Advisory Council to monitor trends and develop recommendations regarding youth vaping, including the development and implementation of an enforcement plan for retailers (TCP currently serves on this Council).

Maternal and Infant Health

Overview

- Infant mortality is the death of an infant before his or her first birthday with such rates serving as an important marker of the overall health of a society.⁷¹
- In 2017, the five leading causes of infant death in the U.S. were birth defects, preterm birth and low birth rate, maternal pregnancy complications, sudden infant death syndrome, and injuries.⁷²
- In 2017, the infant mortality rate in the U.S. was 5.8 deaths per 1,000 live births. The infant mortality rate in Virginia was 5.9 per 1,000 live births, ranking the Commonwealth 23rd in the nation.⁷³
- A pregnancy-related death is defined as the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.⁷⁴
- Pregnancy-associated deaths include all deaths that have a temporal relationship to pregnancy but not necessarily a causal relationship to pregnancy and occur from any cause during pregnancy or within one year of the end of pregnancy.⁷⁵
- Two out of three pregnancy-related deaths in the U.S. are preventable.⁷⁶
- In 2019, Virginia received a Preterm Birth Rate grade of “C+” from the March of Dimes, with a preterm birth rate of 9.4%.⁷⁷
- Data collected from Virginia’s Pregnancy-Associated Mortality Surveillance System (PAMSS) indicated that from 2004 to 2013, the majority of pregnancy-associated deaths (54.8%) occurred 43 or more days after the pregnancy ended⁷⁸ and were correlated with a woman’s health coverage benefits. The leading causes of death were cardiac disorders (12.9%), accidental overdoses (12.9%), motor vehicle accidents (11.8%), homicide (11.5%), and suicide (7.5%).
 - The number of reported pregnancy-associated deaths in the United States has steadily increased from 7.2 deaths per 100,000 live births in 1987 to 17.2 deaths per 100,000 live births in 2015.
- The leading causes of pregnancy-related deaths between 2011 and 2016 in the U.S. were hemorrhage, infection or sepsis, amniotic fluid embolism, thrombotic pulmonary or other embolism, hypertensive disorders of pregnancy, anesthesia complications, cerebrovascular accidents, cardiomyopathy, and other cardiovascular and noncardiovascular conditions.⁷⁹
- Virginia currently ranks 14th in the nation for maternal mortality, with a rate of 15.6.⁸⁰

⁷¹ <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>

⁷² <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>

⁷³ https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm

⁷⁴ <https://www.cdc.gov/reproductivehealth/maternal-mortality/preventing-pregnancy-related-deaths.html>

⁷⁵ <https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/mmr-data-brief.html>

⁷⁶ <https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/mmr-data-brief.html>

⁷⁷ https://www.marchofdimes.org/materials/US_REPORTCARD_FINAL.pdf

⁷⁸ http://www.vdh.virginia.gov/content/uploads/sites/18/2016/04/PAMSS-Ten-Year-Trends-Report-2004-2013_final.pdf

⁷⁹ <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm#trends>

⁸⁰ https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality/state/VA

- Virginia currently ranks 23rd in the nation for infant mortality, with a rate of 5.9; 23rd in the nation in neonatal mortality with a rate of 3.9; and 21st in preterm birth with 9.5% of births occurring preterm.⁸¹
- In a recent report on chronic disease and pregnancy-associated deaths (1999-2012) by the VDH Office of the Chief Medical Examiner (OCME), facility, community, and provider related factors can contribute to these deaths. Among women with a chronic condition:⁸²
 - 19% had at least one facility-related factor contribute to their death, such as a facility's infrastructure, policies, or availability of personnel, equipment or technology.
 - 31% had at least one community-related factor contribute to their death, such as lack of community outreach or inadequate subsidy of care.
 - 44% had at least one provider-related factor contribute to their death, such as delay in or lack of diagnosis, treatment or follow-up or failure to refer or seek consultation.
- In rural areas, the leading causes of pregnancy-associated death included motor vehicle accidents (21%), homicides (14%), accidental overdoses (11.4%) and cardiac disorders (11.4%).⁸³
- The most significant contributors to mortality in rural areas are community services being unavailable (14%) or inaccessible (10%), provider related delay in or lack of diagnosis or treatment (24%), a lack of continuity of care (15%) and facility policies that led to delays in care (8%). Environmental hazards, substance abuse and mental illness were also found to be significant contributors to mortality in rural areas.⁸⁴

Vulnerable Populations

- In Virginia, black mothers are at least twice as likely to die postpartum as compared to other mothers.⁸⁵
- The preterm birth rate among black women is 49% higher than the rate among other women.⁸⁶
- Research shows that the impact of stress due to experiences of racism have negative health outcomes, including those that can impact pregnancy.^{87,88}
- Virginia Pregnancy Risk Assessment Monitoring System (PRAMS) data mirrors national trends in that black mothers experienced more stress in every category assessed and were more likely to experience three or more stressors and to report experiencing racial bias in pregnancy.⁸⁹
- Native American women also experience disparate pregnancy and birth outcomes, which are related to the legacies of historic trauma, discrimination and under resourcing that Native communities have endured.⁹⁰

⁸¹ https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm

⁸² <http://www.vdh.virginia.gov/content/uploads/sites/18/2019/08/MMRT-Chronic-Disease-Report-FINAL-VERSION.pdf>

⁸³ <https://docs.house.gov/meetings/WM/WM00/20190516/109496/HHRG-116-WM00-Wstate-RouseM-20190516.pdf>

⁸⁴ <https://docs.house.gov/meetings/WM/WM00/20190516/109496/HHRG-116-WM00-Wstate-RouseM-20190516.pdf>

⁸⁵ <http://www.vdh.virginia.gov/content/uploads/sites/18/2019/08/MMRT-Chronic-Disease-Report-FINAL-VERSION.pdf>

⁸⁶ https://www.marchofdimes.org/materials/US_REPORTCARD_FINAL.pdf

⁸⁷ <https://www.ncbi.nlm.nih.gov/pubmed/18377138>

⁸⁸ <https://www.ncbi.nlm.nih.gov/pubmed/16380565>

⁸⁹ <http://www.vdh.virginia.gov/prams/data/>

⁹⁰ http://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf

- Women who experience intimate partner violence (IPV) are also at increased risk for negative maternal and neonatal outcomes. Such outcomes include inadequate or inconsistent prenatal care, poor nutrition, substance use, maternal death, low birth weight, preterm birth, and neonatal death. The impact of IPV is largely preventable.⁹¹
- Infants whose mothers are between the ages of 15 and 24 and over 40 are more negatively impacted than those with mothers between the ages of 25 and 39.⁹²
- Of the 1,652 infants who resided and died in Virginia from 2014 to 2016, 1,313 died of natural causes (79.5%) and 339 died of non-natural causes (20.5%).⁹³
- Males presented higher natural and non-natural infant mortality rates (4.76 and 1.30 per 1,000 live births) compared to females (3.76 and 0.90).⁹¹
- Despite having a lower number of fatalities, black (6.93 and 1.75) and other race (4.89 and 1.19) infants died at a higher rate of both natural and non-natural causes than white infants (3.08 and 0.84).⁹¹
- Hispanic infants were at higher risk of death due to natural causes (3.53) compared to non-natural causes (0.64).⁹¹
- The Eastern and Central Health Planning Regions (HPR) reported the highest natural infant mortality rates (5.83 and 5.55, respectively), while Southwest and Eastern Virginia reported the highest nonnatural rates (2.01 and 1.60, respectively).⁹¹
- Pregnant women residing in obstetric provider shortage areas.

VDH Program Alignment

- The Maternal, Infant, and Early Childhood Home Visiting program supports pregnant women, families and at-risk parents of children (birth to age five) access resources and develop the skills needed to raise children who are physically, socially and emotionally healthy and ready to learn. The program develops and implements voluntary, evidence-based home visiting programs utilizing models such as Healthy Families America, Nurse Family Partnership, and Parents as Teachers.
- VDH's Title X Family Planning Program includes approximately 140 clinics that provide contraception, STI testing, and other reproductive health services on a sliding scale
- The Virginia Healthy Start/Loving Steps Initiative, provides home visiting services for pregnant women and children (birth to 18 months) with a focus on African American women who are at-risk. The program focuses on maternal health during and after pregnancy as well as infant health. It uses the Growing Great Kids evidenced based curriculum for parent education, provides the services of a nurse for high risk mothers and provides a variety of child and maternal health and wellness screenings to participants.
- OFHS administers the state Title V program, a federal-state partnership program to improve the health of mothers and children, including children and youth with special health care needs.
- The Baby Care program is a fee-for-service Medicaid-sponsored home visiting program for eligible pregnant women and mothers of infants and children up to the age of two. When a baby is born and until he/she is two years old, Baby Care will help mothers and families learn

⁹¹ Alhusen JL. Intimate Partner Violence During Pregnancy: Maternal and Neonatal Outcomes. *Journal of Women's Health*. 2015; 24: 100-106. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4361157/>

⁹² https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/IMR_MCH/state/VA

⁹³ <http://www.vdh.virginia.gov/content/uploads/sites/18/2018/05/Infant-Mortality-Trends-in-Virginia-2014-2016.pdf>

about the child's growth and development, and help them find regular medical care. The BabyCare Program is currently in operation in multiple local health districts.

- The Virginia PAMSS is a maternal mortality surveillance system operated by OCME and OFHS to identify and study pregnancy-associated death in Virginia so that public health prevention and intervention strategies can be developed.
- The Maternal Mortality Review Information Application (MMRIA) used by the Virginia Maternal Mortality Review Team is designed to support and standardize data abstraction, case narrative development, documentation of committee decisions, and routine analysis.⁹⁴
- The Virginia Maternal Mortality Review Team is a program of OCME dedicated to the prevention through the epidemiological surveillance and review of all pregnancy-associated deaths in the Commonwealth that drives the development of recommendations by the team to reduce preventable deaths.
- The Resource Mothers Program is designed to decrease infant mortality and low birth weight rates among Virginia's teen mothers. The resource mother is a community health worker who develops a supportive mentoring relationship with the teen and her family. From the prenatal period through the infant's first birthday, the resource mother provides health education, discusses ways to prevent infant injury, models daily living skills, encourages constructive decision making and life-planning, connects the teen to community resources and provides guidance to assist the teen in making a successful transition to parenthood. The resource mother has weekly contact with the teen and her family.
- The Office of Epidemiology supports maternal and infant health and prevents infant mortality by preventing and controlling infection through surveillance/investigation, education related to disease transmission, interventions that may include treatment for some infections, and vaccines.
- Local Health Districts across the Commonwealth implement a variety of support programs, from maternal and post-partum clinics, tobacco cessation for pregnant and parenting women, safe sleep education/training, car seat safety checkpoints, and dental preventive services.
- VDH is currently providing long-acting reversible contraception (LARCs) to 18 eligible providers across the Commonwealth.⁹⁵
- Perinatal HIV/STD reviews and active surveillance.

Best Practices & Approaches

- Preventing pregnancy-associated deaths requires assuring that women enter pregnancy as safe and healthy as possible. This requires that chronic conditions are well-managed and quality care is received during pregnancy and after. The causes of pregnancy-associated deaths differ before, throughout, and after pregnancy, and therefore interventions must be appropriately tailored to those leading causes.
- Ensure that systems of care address social and medical needs.
- Hospitals and health systems should aim to standardize coordination of care and response to emergencies in order to improve outcomes. Implementation of AIM (Alliance for Innovation on Maternal Health) patient safety bundles is a recommended practice.
- Hospitals and health systems should develop policies and implement tools to ensure women are cared for at hospitals with an appropriate level of maternal care.

⁹⁴ <https://reviewtoaction.org/implement/mmria#collapseOne-mmria>

⁹⁵ <http://www.vdh.virginia.gov/family-planning/larc-initiative/>

- Assure high quality care through one year following delivery, communicate clearly about warning signs of common complications, and ensure care coordination to provide timely referrals to needed care. Implementation of AIM patient safety bundles focused on Postpartum Care Basics and Wellwoman Visit are recommended. Expanding access to patient navigators, case managers, community health workers, and peer support are suggested strategies.
- Policymakers and relevant stakeholders across state agencies and communities should address health related social needs including unstable housing by prioritizing pregnant and postpartum women for temporary or permanent supportive housing.
- Policymakers and relevant stakeholders across state agencies and communities should address the lack of or inadequate transportation options.
- Public health and relevant stakeholders across state agencies and communities should address food insecurity by optimizing participation in community nutrition programs such as the Special Supplemental Program for Women, Infants and Children (WIC) and the Child and Adult Food Program (CACFP) through streamlined enrollment for applicants eligible for multiple safety net programs (i.e. TANF, SNAP, Medicaid, etc.).
- Develop strategies to identify pregnant women not receiving prenatal care and ensure screening for communicable diseases (e.g. syphilis, HIV, etc.) to prevent transmission from mother to baby.
- HIV and syphilis testing of pregnant women in both the first and third trimesters.
- Addressing infant health necessitates a focus on the continuum of reproductive health, inclusive of preconception, pregnancy, labor and delivery and baby's first year of life; attaining data to identify points in the care continuum that require system level improvements.
- To improve infant health outcomes, seven core recommendations should be advanced, which include implementing health promotion efforts; ensuring quality care for all women and infants; improving maternal risk screening among women of reproductive age; enhancing service integration for women and infants; improving access to care for women across the life course; developing data to drive program planning; and promoting social equity.
- Promote developmental screening for early childhood social, emotional, behavioral, and developmental health, including autism (i.e. Bright Futures)

Agency Leads and Points of Contact

- Dr. Vanessa Walker- Harris; Director, OFHS
- TBD; Director, Division of Child and Family Health
- Dr. Nancy Welch; Director, Chesapeake Health District
- Dr. Karen Shelton; Director, Mount Rogers Health District
- Dr. Lillian Peake; State Epidemiologist
- Christy Gray; Director, Division of Immunization
- Diana Jordan; Director, Division of Disease Prevention
- Seth Levine; Acting Director, Division of Clinical Epidemiology
- Dr. Caroline Holsinger; Director, Division of Surveillance and Investigation
- Dr. Melanie Rouse, PhD; Maternal Mortality Projects Coordinator, OCME
- Dr. Ryan Diduk-Smith; Director of Division of Death Prevention, OCME
- TBD; Director, OHE
- Kim Beazley; Acting Director, Office of Licensure and Certification

Relevant Stakeholders

- Early Childhood Mental Health Virginia
- Early Impact Virginia
- DMAS
- DSS
- Virginia Breastfeeding Advisory Committee
- VHHA
- Virginia Neonatal Perinatal Collaborative
- VAHP
- Virginia Health Care Foundation
- Families Forward
- Family and Children's Trust Fund
- Health Hearts Plus II
- Birth in Color
- Urban Baby Beginnings
- Virginia Sexual and Domestic Violence Action Alliance
- Virginia Section of the American College of Obstetricians and Gynecologists
- Virginia Chapter, AAP
- Virginia Health Workforce Development Authority
- Virginia Health Workforce Foundation
- Virginia Doula Association

Recommendations

Legislative Proposals

- Initiate discussions to submit a legislative proposal that would allow for the prescribing of birth control by pharmacists.

Periodic Regulatory Review

Funding (Budget Amendment Requests and/or Grant Proposals)

- Expand eligible home visiting programs to be reimbursed by Medicaid to include, but not limited to:
 - Nurse-Family Partnership
 - Parents as Teachers
 - Healthy Families
- Align Medicaid reimbursement rates for eligible home visiting programs to better reflect the cost, value, and return on investment of such programs.
- Explore opportunities to provide Medicaid reimbursement mechanisms for community health workers and doulas.
- Secure funding to support the integration of Virginia's vital records with the Virginia Longitudinal Data System to assess the correlation of expanding home visiting services to at-risk populations with educational attainment, a key determinant of lifelong wellness.
- Study the feasibility of developing and implementing a statewide e-referral system that connects vulnerable populations with necessary medical, behavioral health, oral health, and social services.

- Reestablish the Virginia Fetal and Infant Mortality Review Team to assess infant mortality using a framework that works backward from infant death to the immediate determinants, including birth outcomes (i.e. low birth weight, preterm); labor and delivery risk indicators (i.e. uninsured, inappropriate level of care); pregnancy risk indicators (i.e. substance use, lack of social support); preconception risk indicators (i.e. lack of housing, poor health status).
- To increase opportunities to enroll pregnant women or young families in needs-based programs (i.e. Medicaid, WIC, SNAP, etc.), secure grant funding or request general funds to support piloting a real-time needs based screening tool to be tested at Virginia's local health districts and/or social services agencies.
- Expand access to LARCs and other contraceptive methods.

Strategic Partnerships

- Convene local health districts implementing Baby Care, VHI, Community Health Services, OFHS, Old Dominion University, and other potential researchers to outline next steps in promoting Baby Care as an evidence-based program.
- Meet with the Virginia Tobacco Region Revitalization Commission to discuss grant funding opportunities for Quit Now.
- Partner with Medicaid and Quit Now to authorize Quit Now as a DMAS Approved Providers for Tobacco Cessation Counseling for Pregnant Women

Program Activities

- Study program structure, capacity, and infrastructure of black women led maternal infant health focused community based organizations to better inform future requests for the expansion of non-traditional home visiting programs.
- Conduct a study with VHI to analyze the costs of care for children and families who receive Baby Care services versus those who do not.
- Study the feasibility of establishing a Virginia Pay for Success Trust Fund, a Virginia Pay for Success Advisory Commission, and mechanisms for appropriating funds to such a Trust Fund.

Prevention of the Spread of Sexually Transmitted Infectious Disease

Overview

- There are five reportable STDs in Virginia.⁹⁶ Chlamydia (*Chlamydia trachomatis*), gonorrhea (*Neisseria gonorrhoeae*), and syphilis (*Treponema pallidum*) comprise the majority of STD reports. Chancroid (*Haemophilus ducreyi*) and granuloma inguinale (*Klebsiella granulomatis*) are rarely reported.
- STD rates continue to increase in Virginia⁹⁷, as well as nationally⁹⁸, to levels not seen in decades.
- Hepatitis, HIV, and STDs are often asymptomatic, so routine screening is critical for detection.
- Syphilis infection during pregnancy may be transmitted from mother to baby. Congenital syphilis (CS) cases have also increased significantly in recent years.
 - ⁹⁹CS is a sentinel event suggesting failure of the public health and healthcare systems
 - CS can lead to miscarriage, stillbirth, or fetal abnormalities
- Untreated syphilis infections may result in blindness, major organ damage and death. Syphilis can affect many organ systems, including the heart, blood vessels, brain and nervous system.
- Untreated chlamydia and gonorrhea infections can lead to a variety of health issues, including pelvic inflammatory disease in women that can cause infertility or ectopic pregnancies, ophthalmia in newborns, and male infertility.¹⁰⁰
- Gonorrhea has developed resistance to nearly all of the antibiotics used for its treatment. One recommended and effective class of antibiotics, cephalosporins, exists to treat this infection.¹⁰¹
- Individuals infected with STDs are more likely to acquire or transmit human immunodeficiency virus (HIV) than those without an STD.¹⁰²
- Significant health disparities exist in HIV and STD diagnoses. Populations disproportionately affected are Blacks/African-Americans, Hispanics, men who have sex with men (MSM), young age groups (15-24).¹⁰³
 - Rates of HIV and STD diagnoses are significantly higher in areas with lower health opportunity and higher poverty.¹⁰⁴

Vulnerable Populations

- Pregnant women
- Women of reproductive age
- Men who have sex with men (MSM)
- Transgender women who have sex with men
- Adolescents and young adults age 15-24
- Persons living with HIV
- People of color, specifically Blacks/African Americans and Hispanics/Latinos
- People who use drugs

⁹⁶ <https://law.lis.virginia.gov/admincode/title12/agency5/chapter90/section80/>

⁹⁷ <http://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-aids-sexually-transmitted-disease-std-hepatitis-reports/>

⁹⁸ <https://www.cdc.gov/std/stats18/STDSurveillance2018-full-report.pdf>

⁹⁹ <http://www.vdh.virginia.gov/content/uploads/sites/10/2018/12/Syphilis-Fact-Sheet.pdf>

¹⁰⁰ <http://www.vdh.virginia.gov/disease-prevention/std/>

¹⁰¹ <https://www.cdc.gov/std/gonorrhea/arg/basic.htm>

¹⁰² <https://www.cdc.gov/std/hiv/stdfact-std-hiv-detailed.htm>

¹⁰³ <https://www.cdc.gov/std/health-disparities/default.htm>

¹⁰⁴ <http://www.vdh.virginia.gov/health-equity/virginia-health-opportunity-index-hoi/>

- Sex and needle sharing partners of people with an infection
- Justice-involved populations

VDH Program Alignment

- VDH's Title X Family Planning Program includes approximately 140 clinics that provide contraception, STI testing, and other reproductive health services on a sliding scale
- Condom distribution program
- Pre-exposure prophylaxis (PrEP) post exposure prophylaxis (PEP) for HIV prevention program
 - Individuals on PrEP should be screened for chlamydia, gonorrhea, and syphilis at three month intervals as best practice, presenting an opportunity to diagnose and treat STDs more efficiently
- Partner services provided by disease intervention specialists (DIS)¹⁰⁵
- HIV, STD, hepatitis testing offered at local health departments
- HIV, STD, hepatitis testing supported by VDH at select community health centers, community based organizations, pharmacies and correctional facilities
- Extra genital testing at pharyngeal and rectal sites offered through the current laboratory provider under state contract
- CHR services
- HIV care and treatment including the Virginia Medication Assistance Program (formerly known as the AIDS Drug Assistance Program or ADAP)
- Hepatitis C treatment pilot and clinician training
- Disease Prevention Hotline
- Re-entry services such as HIV Care Coordination and Comprehensive
- Routine and enhanced HIV, STD investigation and surveillance
- Ensure workforce is trained to address social determinants of health and stigma (e.g. sexual diversity training, Undoing Racism training, Anti-racism Dialogue Group)

Best Practices & Approaches

- Taking a holistic sexual health approach to STD prevention, including the integration of STD prevention into primary health care and other healthcare services
- Providing specific services for populations at increased risk
- Comprehensive case management
- Sexual health education
- Expedited partner therapy (EPT)
 - Currently explicitly legal for clinicians employed by VDH only
 - VDH clinicians can dispense or prescribe medication to patients infected with chlamydia or gonorrhea to then give to their partner(s), without the partner receiving an examination by the clinician
- Centers for Disease Control and Prevention (CDC)-recommended screening, diagnosis, and treatment practices
- Extra genital screening at pharyngeal and rectal sites identifies significantly more instances of chlamydia and gonorrhea than urine-based screening alone
- Improving access to curative HCV treatment by building clinician capacity
- Improving access to PrEP and HIV

¹⁰⁵ <http://www.vdh.virginia.gov/content/uploads/sites/10/2018/12/DIS-Fact-Sheet.pdf>

- Linkage to care and initiation of anti-retroviral therapy for individuals within 30 days of diagnosis and improvements to ensure rapid access to HIV treatment, ideally within 7 days.
- Address social determinants of health and develop strategies to reduce stigma
- Provision of sterile syringes and proper disposal of used syringes as part of CHR Services.
- Use of surveillance data to identify people with HIV who are not in care or not virally suppressed in order to re-engage them in care and to assist them with treatment adherence.

Agency Leads and Points of Contact

- Dr. Vanessa Walker-Harris; Director, Office of Family Health Services
- Jen Macdonald; Acting Director, Division of Child and Family Health
- Emily Yeattes; Reproductive Health Unit Supervisor, Division of Child and Family Health
- Janelle Anthony; Family Planning Quality Assurance Nurse Supervisor, Division of Child and Family Health
- Diana Jordan; Director, Division of Disease Prevention, Office of Epidemiology
- Diana Prat; Director of STD Prevention and Surveillance, Division of Disease Prevention, Office of Epidemiology
- Oana Vasiliu; STD Epidemiology and Surveillance Manager, Division of Disease Prevention, Office of Epidemiology
- Kendra Weindling; STD Field Operations and Training Coordinator, Division of Disease Prevention, Office of Epidemiology
- Celestine Buyu; Director, HIV Surveillance, Division of Disease Prevention, Office of Epidemiology
- Kimberly Scott; Director, HIV Care Services, Division of Disease Prevention, Office of Epidemiology
- Elaine Martin; Director, HIV Hepatitis Prevention Services, Division of Disease Prevention, Office of Epidemiology
- Chelsea Canan; Lead HIV Epidemiologist, Division of Disease Prevention, Office of Epidemiology
- Bob Mauskapf; Director, Office of Emergency Preparedness

Relevant Stakeholders

- Clinicians serving the vulnerable populations listed above
 - Especially those specializing in OB/GYN, Family Medicine, Emergency Medicine/Urgent Care, Dermatology, Urology, Infectious Disease
- HIV, STD, hepatitis service providers
- Persons living with HIV
- Community health centers and other community-based organizations providing services
- Community HIV Planning Group
- ADAP Advisory Committee
- Quality Management Advisory Committee
- Virginia Quality of Care Consumer Advisory Committee
- Pharmaceutical manufacturers
- VAHP
- Ryan White Part A planning councils
- Virginia Department of Corrections

Recommendations

Legislative Proposals

- Expand EPT to non-VDH clinicians statewide.
- Increase the number of CHR sites.

Periodic Regulatory Review

Funding (Budget Amendment Requests and/or Grant Proposals)

- Secure funding for PrEP expenses that cannot be paid for with federal funds including medical appointments, required laboratory tests and medication.

Strategic Partnerships

- Expand partnerships with other agencies/organizations to increase HIV, STD, hepatitis testing.
- Expand routine HIV testing in medical settings including urgent care, private providers and federally qualified community health centers.
- Ensure availability of testing in non-clinical settings and during non-business hours including outreach, pharmacies, and through community-based organizations.
- Expand use of PrEP through engagement and education of private health care providers.

Program Activities

- Improve outreach to private providers related to Best Practices & Approaches for the prevention and treatment of HIV, STDs, hepatitis.
- Replicate successful models (e.g. integrated sexual health clinics, Men's Health Clinic, Rainbow Tuesdays Clinic, Test and Go) that reduce barriers to care.
- Support enrollment to health insurance including Medicaid to improve access to care and ensure current programs are sustainable.

Social Connectedness and Social Isolation

Overview

- There two forms of social isolation: social disconnectedness and perceived isolation:¹⁰⁶
 - Social disconnectedness is characterized by a lack of contact with others, indicated by situational factors, like a small social network, infrequent social interaction, and lack of participation in social activities and groups..
 - Perceived isolation refers to the subjective experience of a shortfall in one's social resources such as companionship and support. Feelings of loneliness and not belonging,.
- According to a 2018 survey, loneliness levels have reached an all-time high, with nearly half of survey participants reporting they sometimes or always feel alone.¹⁰⁷
- Over 40% of survey participants also reported they sometimes or always feel that their relationships are not meaningful and that they feel isolated.¹⁰⁵
- Lack of social connection heightens health risks as much as smoking 15 cigarettes a day or having alcohol use disorder. Loneliness and social disconnection are twice as harmful to physical and mental health as obesity.¹⁰⁸
- Perceived social isolation is linked with adverse health consequences including depression, poor sleep quality, impaired executive function, accelerated cognitive decline, poor cardiovascular function and impaired immunity at every stage of life.¹⁰⁵
- Particularly among youth, social isolation is correlated with lower self-esteem, higher depressive symptoms, and an increased risk for suicide attempts. There are also gender differences across the lifespan; more intimate connections (such as family) for adolescent girls is as protective as frequent or more superficial social contact (seeing friends at school) is for adolescent boys.¹⁰⁹
- Among adolescents, the type of feedback or lack thereof on social media networks helps determine if the use of technology to connect youths to others is beneficial or harmful.¹¹⁰
- A 2019 study by the CDC found that youth who feel connected at school and at home were found to be as much as 66% less likely to experience health risk behaviors related to sexual health, substance use, violence, and mental health in adulthood.¹¹¹
- A 2018 study found loneliness is associated with a 40% increase in a person's risk of dementia, with little evidence that the association varied across demographic groups.¹¹²
- The areas of highest levels of social isolation and disconnectedness among adults aged 65 and older are far southwest Virginia and Southern Central Virginia.¹¹³
- School connectedness in youth can provide protective effects through adulthood related to mental health, violence as a victim and perpetrator, and illicit drug use.¹¹⁴

¹⁰⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2756979/pdf/nihms-133647.pdf>

¹⁰⁷ <https://www.cigna.com/assets/docs/newsroom/loneliness-survey-2018-full-report.pdf>

¹⁰⁸ <https://www.apa.org/monitor/2019/05/ce-corner-isolation>

¹⁰⁹ Hall-Lande, Eisenberg, Chrestenson, Newmark-Sztainer. "Social Isolation, Psychological Health, and Protective Factors in Adolescence.

¹¹⁰ https://pediatrics.aappublications.org/content/pediatrics/140/Supplement_2/S71.full.pdf

¹¹¹ <https://www.cdc.gov/healthyouth/protective/youth-connectedness-important-protective-factor-for-health-well-being.htm>

¹¹² <https://academic.oup.com/psychsocgerontology/advance-article/doi/10.1093/geronb/gby112/5133324>

¹¹³ <https://assets.americashealthrankings.org/app/uploads/virginia-senior-socialisolation-2019.pdf>

¹¹⁴ <https://pediatrics.aappublications.org/content/pediatrics/144/1/e20183766.full.pdf>

Vulnerable Populations

- Social isolation increases the risk of premature death from every cause for every race.¹¹⁵
- For black populations, social isolation can double the risk of early death, while increasing the risk among white participants by 60 to 84 percent.¹¹³
- Older populations are becoming increasingly at risk of suffering from isolation and its associated effects.¹¹⁶
- Victims of intimate partner violence
- School-aged youths
- Virginians that live in rural regions¹¹⁷
- Veterans, especially those residing in rural areas or behavioral health provider shortage areas.

VDH Program Alignment

- The Project Radar program focuses on prevention and resources for intimate partner violence, which can include social isolation.
- The VDH and DBHDS suicide prevention program discusses social withdrawing as a possible sign of depression and a risk factor for suicide attempts.¹¹⁸
- VDH is currently participating on the Governor's Challenge to Prevent Suicide among Service Members, Veterans, and their Families (SMVF)

Best Practices & Approaches

- Consider both the presence of systems and networks to connect to, as well as perceptions of connectedness when developing prevention and engagement activities.
- Interventions that focus inward and address the negative thoughts underlying loneliness in the first place seem to help combat loneliness more than those designed to improve social skills, enhance social support or increase opportunities for social interaction.⁶⁹
- Engaging older adults in community and social groups can lead to positive mental health effects and reduce feelings of loneliness.⁶⁹
- Older adults who take part in social groups such as book clubs or church groups have a lower risk of death.⁶⁹
- Technology and social media groups can be used to help socially connect and form networks among youth with less common interests or youths with disabilities.⁷¹
- Youth may be more engaged in social connections and feel able to explore deeper relationships through social media networks than in face-to-face communications.⁷¹

Agency Leads and Points of Contact

- Dr. Vanessa Walker-Harris; Director, OFHSs
- Lisa Wooten; Injury and Violence Prevention Program Supervisor, OFHS
- Heather Board; Director, Division of Prevention and Health Promotion
- Carole Pratt; Senior Policy Advisor, Office of the Commissioner

Relevant Stakeholders

- Virginia Department of Aging and Rehabilitative Services
- DSS

¹¹⁵ <https://www.apa.org/monitor/2019/05/ce-corner-isolation>

¹¹⁶ <https://www.nia.nih.gov/news/social-isolation-loneliness-older-people-pose-health-risks>

¹¹⁷ <https://wvutoday.wvu.edu/stories/2019/09/09/wvu-researcher-finds-link-between-deprivation-and-rural-suicide-rates>

¹¹⁸ <http://www.vdh.virginia.gov/suicide-prevention/>

- VHHA
- VAHP
- AARP Virginia
- Virginia Association of Area Agencies on Aging
- Virginia’s local area agencies on aging

Recommendations

Legislative Proposals

Periodic Regulatory Review

Funding (Budget Amendment Requests and/or Grant Proposals)

- Explore the opportunities to develop a Gen2Gen campaign.¹¹⁹

Strategic Partnerships

- Convene relevant stakeholders to initiate discussions outlining the public and population health impacts associated with social isolation and connectedness.

Program Activities

- Explore opportunities to include social isolation in VDH’s HOI.

¹¹⁹ <https://generationtogenation.org/local-gen2gen-campaigns/>

Suicide Prevention and Firearm Safety

Overview

- Firearm violence is any violence against one's self or another using a firearm. In 2017, 60% of fatal gun incidents were suicide deaths.¹²⁰
- Suicide is death caused by injuring oneself with the intent to die and is the 10th leading cause of death in the United States. It was responsible for more than 47,000 deaths in 2017, resulting in about one death every 11 minutes. In 2017, 10.6 million American adults seriously thought about suicide, 3.2 million made a plan, and 1.4 million attempted suicide.¹²¹
- For every suicide death, it is estimated there are 25 non-fatal attempts.¹²²
- In addition to the number of people who are injured or die, suicide also affects the health of others and the community. The economic toll of suicide on society is immense as well. Suicides and suicide attempts cost the nation almost \$70 billion per year in lifetime medical and work-loss costs alone.¹⁰³
- People who are interrupted during a suicide attempt are unlikely to go on to die by suicide.¹²³
- Suicide deaths in Virginia have increased from 10.8 per 100,000 (2003) to 13.4 per 100,000 (2017).¹²⁴
- Firearms are the top mechanism of injury each year for suicide deaths.¹⁰⁴
- Virginia was ranked 32nd for firearm suicides in the United States in 2017.¹²⁵

Vulnerable Populations

- Suicide is the tenth leading cause across all ages. It is the second leading cause of death for people 10 to 34 years of age, the fourth leading cause among people 35 to 54 years of age, and the eighth leading cause among people 55 to 64 years of age.¹⁰⁴
- In 2017, the highest rates of suicide deaths among Virginians were white males aged 55-64 and aged 85 and older.¹²⁶ These are consistently the highest risk age groups.
- Suicide rates vary by race/ethnicity, age, and other population characteristics, with the highest rates across the life span occurring among non-Hispanic American Indian/Alaska Native and non-Hispanic white populations. Other Americans disproportionately impacted by suicide include veterans and other military personnel and workers in certain occupational groups like males in the construction field and women in the arts, design, entertainment, sports, and media field. Sexual minority youth bear a large burden as well, and experience increased suicidal ideation and behavior compared to their non-sexual minority peers.

¹²⁰ <https://www.pewresearch.org/fact-tank/2019/08/16/what-the-data-says-about-gun-deaths-in-the-u-s/>

¹²¹ <https://www.cdc.gov/violenceprevention/suicide/fastfact.html>

¹²² <https://suicidology.org/facts-and-statistics/>

¹²³ Owens, D., Horrocks, J., & House, A. (2002). Fatal and non-fatal repetition of self-harm: Systematic review. *British Journal of Psychiatry*, 181(3), 193-199. doi:10.1192/bjp.181.3.193

¹²⁴ <https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm>

¹²⁵ https://suicidology.org/wp-content/uploads/2019/04/2017States_Total_Firearms_TABLE.pdf

¹²⁶ <http://www.vdh.virginia.gov/content/uploads/sites/18/2019/04/Annual-Report-2017.pdf>

- Residing in rural areas (such as Appalachian counties in far Southwest Virginia) coupled with lower labor force involvement and lack of community connections were strong contributors to the rising suicide rates among middle-aged white men.^{127, 109}
- Additional stressors involve a lack of access to health insurance/care and education. Further in all counties except rural, more gun shops correlated to a higher suicide rate.¹²⁸
- It is estimated that one third of households with children (aged 0-17) have a firearm. Of those, fewer than 1 in 3 follow AAP's recommendations to store all firearms locked and unloaded.¹²⁹
- Virginians that live in rural regions¹³⁰
- Veterans, especially those residing in rural areas or behavioral health provider shortage areas.

VDH Program Alignment

- OCME investigates a subset of deaths in Virginia, including suicides. They publish an annual report that highlights suicide deaths, among others. Data is also available through the Virginia Medical Examiner Data System (VMEDs).
- OCME also operates the Virginia Violent Death Reporting System (VVDRS), the Virginia operation of the National Violent Death Reporting System (NVDRS). This program is a public health data collection system designed to better understand the breadth and scope of fatal violence and its victims, and to support data-driven violence prevention efforts. Beyond the information captured in VMEDs, VVDRS also captures information related to circumstances that contributed to the suicide death.
- VDH can access data for suicide and firearm treatment through analyzing data from hospital inpatient discharge data in the Office of Epidemiology.
- The Division of Vital Records collects information on death certificates which can be used to inform suicide prevention efforts.
- The VDH Division of Violence Prevention collects data and provides educational materials and training to prevent domestic and sexual violence, youth violence and bullying, and suicide.
- The Division of Violence Prevention co-leads the Suicide Prevention Interagency Advisory Group with DBHDS. This group, which includes several other state agencies and non-profits, promotes awareness of and access to suicide prevention resources in their respective communities and addresses suicide prevention across the lifespan on a statewide level.
- Starting in late summer/early fall 2019, the Division of Violence Prevention will be working on a year-long suicide prevention campaign with VDOE focused on school-aged children.
- In 2018, the Rappahannock-Rapidan Health District handed out 2,000 gun locks.¹³¹
- VDH is also part of the Mayor's Challenge and Governor's Challenge to Prevent Suicide among SMVF.

Best Practices & Approaches

- Provision of gun locks and medication lockboxes with concurrent education about lethal means safety

¹²⁷ <https://www.pnas.org/content/112/49/15078>

¹²⁸ [https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2749451?utm_source=For The Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=090619](https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2749451?utm_source=For%20The%20Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=090619)

¹²⁹ <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2733158>

¹³⁰ <https://wvutoday.wvu.edu/stories/2019/09/09/wvu-researcher-finds-link-between-deprivation-and-rural-suicide-rates>

¹³¹ <http://www.vdh.virginia.gov/news/2018-regional-news-releases/rappahannock-rapidan-health-district-offers-gun-locks-for-safety/>

- Peer support services
- Same-day access to behavioral health and crisis intervention services
- Suicide prevention hotlines
- Screening for suicide risk, e.g. Ask the Question campaign (related to veteran initiatives), Columbia screener

Agency Leads and Points of Contact

- Lisa Wooten; Injury and Violence Prevention Program Supervisor, OFHS
- Heather Board; Director, Division of Prevention and Health Promotion
- Rosie Hobron; Statewide Forensic Epidemiologist, Office of the Chief Medical Examiner
- Carole Pratt; Senior Policy Advisor, Office of the Commissioner
- Alex Jansson; Policy Analyst, Office of the Commissioner
- Dr. Ryan Diduk-Smith; Director of Division of Death Prevention, Office of the Chief Medical Examiner
- Bob Mauskapf; Director, Office of Emergency Preparedness
- Kim Beazley; Acting Director, Office of Licensure and Certification

Relevant Stakeholders

- DBHDS
- VDOE
- Governor’s Challenge to Prevent Suicide among SMVF
- Mayor’s Challenge to Prevent Suicide among SMVF
- DSS
- VHHA
- Virginia Army, Navy, Air Force, and Coast Guard Bases
- Virginia Department of Veterans Services (and National Guard)
- American Foundation for Suicide Prevention Virginia Chapter
- Moms Demand Action
- Be Smart
- National Alliance for Mental Illness
- National Rifle Association
- Virginia Chamber of Commerce

Recommendations

Legislative Proposals

Periodic Regulatory Review

- Explore revisions to the network adequacy provisions in the MCHIP regulations that would include explicit behavioral health requirements, to be part of an existing collaboration with SHHR, DBHDS, CMS, BOI and DMAS for mental health parity.

Funding (Budget Amendment Requests and/or Grant Proposals)

- Explore budget proposals and/or grant funds to expand Virginia’s Lock and Talk to more community based organizations across the Commonwealth.

Strategic Partnerships

- Develop an educational campaign with the Virginia Chamber of Commerce for Virginian employers on firearm safety and access to crisis intervention and behavioral health services.

- Incorporate protective factor training in peer/home based services such as Community Health Workers, public health nurses, peer recovery specialists, etc.

Program Activities

Review of VDH Systems for Public Health Policy Development

Legislative Proposals

- In May, the Deputy Commissioner for Governmental and Regulatory Affairs will distribute the Statement of Need document (attached) to Office Directors to develop legislative proposals for consideration by agency leadership, SHHR, and the Governor.
- In early July, agency leadership will vet proposals for submission to SHHR.
- In early fall, SHHR will inform the Commissioner which proposals are approved for inclusion in the Governor's legislative agenda.
- While the process is seasonal and driven by strict timelines, it is never too early to begin developing and discussing potential legislative proposals in preparation for upcoming General Assembly sessions.

Periodic Review of Regulations

- Guidelines for the Development and Review of State Agency Regulations, per *Executive Order 14(2018)* are attached below.

Budget Amendment Requests

- During May and June of each year, Office Directors begin to develop and justify budget amendment requests for consideration by the Governor and upcoming General Assembly.
- Budget amendment request development must begin early and the agency must put only the most carefully considered and documented requests forward.
- The requests must address critical needs essential for the provision of public health services.
- Each proposal is submitted on the attached template, limited to one page, with the following information:
 - The problem or opportunity;
 - The justification or rationale (what is driving the need); and
 - The required resources (including FTEs) as well as the existing resources that can be contributed by the office or district.
- Timeline
 - Mid-July - Offices email requests to the Office of Financial Management (OFM) for review and copy their respective deputy commissioner and operations director.
 - July - OFM meets with each deputy commissioner and senior leadership reviews requests supported by each deputy. If approved, offices are notified to develop a Decision Package.
 - August/September - Proposed amendments are submitted to SHHR and offices submit final details to OFM for submission via Performance Budgeting System.
 - September - Projected date that OFM submits final budget amendment requests to the Department of Planning and Budget.

Grant Proposals

- It has become increasingly apparent that a more intentional system for tracking grant opportunities and prioritizing which grant opportunities are pursued is needed., The Governmental and Regulatory Affairs team is soliciting feedback from the Commissioner's Leadership Team and the Roundtable to accomplish this task.

Strategic Partnerships

- Partnerships, from informal to contractual, are critical to accomplishing VDH's Strategic Plan and the Virginia Plan for Well-Being. All population health improvement efforts require

intentional partnerships with cross-sector partners; strategic partnerships are often challenging, slow to develop, and even slower to bear results. VDH must ensure that all policy and operational plans and executions involve with as many external partners as appropriate and required. Further, VDH staff must be thoughtful and patient in seeking and developing partnerships as population health improvement often requires creative and uncomfortable assessments of previously established roles and responsibilities.

Roles of Local Health Districts in Strategic Policy Development

In addition to communicating with state leadership regarding local and regional population health needs, Virginia's localities are uniquely positioned to lead local efforts that are beyond the scope of state leadership. As well as serving as conveners and advocates for local leaders and elected officials, local health districts can inform localities decisions to levy taxes or provide tax incentives for various commodities that directly or indirectly impact public health, including:

- Tax Incentives for Green Roofing
 - <https://law.lis.virginia.gov/vacode/title58.1/chapter38/section58.1-3852/>
- Taxes on Food and Beverages, Including Alcohol
 - <https://law.lis.virginia.gov/vacode/title58.1/chapter38/section58.1-3833/>
- Taxes on Cigarettes
 - <https://law.lis.virginia.gov/vacode/title58.1/chapter38/section58.1-3832/>
 - <https://law.lis.virginia.gov/vacode/title58.1/chapter38/section58.1-3830/>
- Incentives for Green Development Zones
 - <https://law.lis.virginia.gov/vacode/title58.1/chapter38/section58.1-3854/>

Equity Tool

OHE is in the process of developing a tool and guidance document for evaluating internal and external policy proposals as such developments impact equity and potentially present unintended consequences. This tool will be included in this document following its development.

Attachments

Legislative Proposal Statement of Need



Governor's Confidential Working Papers

Statement of Need

Complete a Statement of Need for each legislative proposal.

1. **Proposal Title**
2. **Proposal Short Description.**
3. **What is the purpose of the proposed legislation? What problem does it solve?**
4. **What is the relevant history regarding this proposal?**
5. **Does this legislation impact other state agencies? If so, please explain the impact and the reaction of the impacted agency.**
6. **What are the relevant stakeholders and what is the potential impact on them?**
7. **Who is likely to oppose this legislation and why?**
8. **What are the fiscal implications of this proposal and how were they calculated?**
9. **Has this or similar legislation been proposed before?**
10. **Will enactment of this legislation require or result in the promulgation of any rulemaking actions, including any revisions or amendments to existing regulations or the creation of new regulations? If so, please describe the anticipated amendments or new regulations.**

Executive Order Number Fourteen: Development and Review of State Agency Regulations



Commonwealth of Virginia
Office of the Governor

Executive Order

NUMBER FOURTEEN (2018) (AMENDED)

DEVELOPMENT AND REVIEW OF STATE AGENCY REGULATIONS

Importance of the Initiative

By virtue of the authority vested in me as Governor under Article V of the Constitution of the Commonwealth of Virginia and under the laws of the Commonwealth, including, but not limited to, §§ 2.2-4013 and 2.2-4017 of the *Code of Virginia*, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby establish policies and procedures for the review of all new regulations and changes to existing regulations proposed by state agencies, which shall include all agencies, boards, commissions, and other entities of the Commonwealth within the executive branch authorized to promulgate regulations. Nothing in this Executive Order shall be construed to limit my authority under the *Code of Virginia*, including to require an additional 30-day public comment period, file a formal objection to a regulation, suspend the effective date of a regulation with the concurrence of the applicable body of the General Assembly, or to exercise any other rights and prerogatives existing under Virginia law.

Definitions

The following acronyms and definitions are set out for ease of use and represent only a summary of terms and acronyms related to the regulatory review process. More detailed descriptions and definitions appear in the Administrative Process Act (APA), § 2.2-4000, *et seq.* of the *Code of Virginia*.

“Agency Background Document” (ABD) refers to a form completed by agencies and uploaded on the Virginia Regulatory Town Hall website for each regulatory stage in order to describe and explain the regulatory action. The form for each stage is available on the Town Hall.

“Administrative Process Act” (APA) refers to § 2.2-4000, *et seq.* of the *Code of Virginia*, which contains provisions setting forth the process for promulgating regulations in Virginia.

“Day” means a calendar day.

“Virginia Department of Planning and Budget” (DPB) refers to the state entity that reviews regulatory proposals for economic and policy impact and manages the Virginia Regulatory Town Hall website.

“Economic Impact Analysis” (EIA) refers to a report prepared by DPB that evaluates the estimated costs and benefits of a regulatory proposal.

“Emergency rulemaking process” refers to the process used (1) when there is an emergency situation as determined by the agency and affirmed by the Governor that an emergency regulation is necessary, or (2) when a Virginia statutory law, Acts of Assembly (such as the appropriation act), federal law, or federal regulation requires that a state regulation be effective in 280 days or fewer from its enactment.

“Executive Branch Review” refers to the review of a regulatory proposal at various stages by the executive branch before the regulatory proposal is published in the *Virginia Register of Regulations* and is available for public comment.

“Exempt rulemaking process” refers to the process by which agency actions exempt from the promulgation requirements of Article 2 of the APA can be adopted and filed directly with the Office of the Registrar of Regulations (Registrar) and are not subject to Executive Branch Review outlined in this executive order. Agencies should consult with their respective cabinet secretary prior to promulgating a regulation under the exempt process.

“Fast-track rulemaking process” refers to the process utilized for rules that are expected to be noncontroversial.

“Mandate” refers to 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.

“Notice of Intended Regulatory Action” (NOIRA) refers to the first stage in the standard rulemaking process under Article 2 of the APA.

“Office of the Attorney General” (OAG) refers to the state agency headed by the Attorney General. The OAG reviews regulatory proposals at the emergency stage, the fast-track stage, and the proposed stage. In addition, the OAG must review a proposal at the final stage if changes with substantial impact, as determined by either the promulgating agency or DPB, have been made since the proposed stage.

“The *Virginia Register of Regulations*” (*Register*) refers to an official legal publication that provides information about proposed and final changes to Virginia’s regulations.

“Rulemaking or regulatory process” refers to the four types of rulemaking processes in Virginia: (1) emergency, (2) fast-track, (3) standard, and (4) exempt.

“Standard rulemaking process” refers to the default rulemaking process in Virginia. If a regulatory proposal does not meet the criteria for exempt, fast-track, or emergency rulemaking, it goes through the standard rulemaking process, generally consisting of three stages: NOIRA, proposed, and final.

“The Virginia Regulatory Town Hall website” (Town Hall) refers to the website managed by DPB and used by agencies to post regulatory proposals and to facilitate the regulatory review process.

“*Virginia Administrative Code*” (VAC) refers to Virginia’s official legal publication for regulations.

Policy and Principles

The executive branch agencies of the Commonwealth must consider, review, and promulgate numerous regulations each year. This Executive Order sets out procedures and requirements to ensure the efficiency and quality of Virginia’s regulatory process. All state employees who draft, provide policy analysis for, or review regulations shall carefully consider and apply the principles outlined below during the regulatory development and review process.

General

- A. All regulatory activity should be undertaken with the least possible intrusion into the lives of the citizens of the Commonwealth and be necessary to protect the public health, safety, and welfare. Accordingly, agencies shall consider:
 - 1. The use of user fees or permits;
 - 2. The use of information disclosure requirements, rather than regulatory mandates, so that the public can make more informed choices;
 - 3. The use of performance standards in place of required techniques or behavior; and
 - 4. The consideration of reasonably available alternatives in lieu of regulation.
- B. Where applicable, and to the extent permitted by law, it shall be the policy of the Commonwealth that only regulations necessary to interpret the law or to protect the public health, safety, or welfare shall be promulgated. These principles shall be considered when an agency performs its periodic review of regulations pursuant to § 2.2-4017 and this Executive Order.
- C. Regulations shall be clearly written and easily understandable.
- D. Regulations shall be designed to achieve their intended objective in the most efficient, cost effective manner.

Regulatory Development

- A. Regulatory development shall be based on the best reasonably available and reliable scientific, economic, and other information concerning the need for, and consequences of, the intended regulation. Agencies shall specifically cite the best reasonably available and reliable scientific, economic, or statistical data as well as any other information in support of regulatory proposals.
- B. Regulatory development shall be conducted in accordance with the statutory provisions related to impact on small businesses. DPB shall work with state agencies to address these requirements during the regulatory review process, including notifications, as appropriate, to the Joint Commission on Administrative Rules.
- C. During regulatory development, agencies shall consider the impact on existing and potential Virginia employers and their ability to maintain and increase the number of jobs in the Commonwealth, as well as the cost of compliance to the general public.

Public Participation

- A. Agencies shall actively seek input for proposed regulations from interested parties, stakeholders, citizens, and members of the General Assembly.
- B. In addition to requirements established in Article 2 of the APA, agencies shall post all rulemaking actions on Town Hall to ensure that the public is adequately informed of rulemaking activities.
- C. All legal requirements and guidelines related to public participation shall be strictly followed to ensure that citizens have reasonable access and opportunity to present comments and concerns. Agencies shall inform interested persons of (1) Town Hall's email notification service that can send information regarding specific regulations, regulatory actions, and meetings about which citizens are interested, and (2) the process to submit comments in Town Hall public comment forums. Agencies shall establish procedures that provide for a timely written response to all comments and the inclusion of suggested changes that would improve the quality of the regulation.

Other

- A. Agencies, as well as reviewing entities, shall perform their tasks in the regulatory process as expeditiously as possible and shall adhere to the timeframes set out in this Executive Order.
- B. Regulations are subject to periodic evaluation, review, and modification, as appropriate, in accordance with the APA, policy initiatives of the Governor, and legislation.

- C. Each agency head will be held accountable for ensuring that the policies and objectives specified in this Executive Order are followed. Agency heads shall ensure that information requested by DPB, a Cabinet Secretary, or the Office of the Governor, in connection with this Executive Order, is provided on a timely basis. Incomplete regulatory packages may be returned to the appropriate agency by DPB.

Applicability

The review process in this Executive Order applies to rulemakings initiated by agencies of the Commonwealth of Virginia in accordance with Article 2 of the APA.

With the exception of the requirements governing the periodic review of existing regulations, the posting of meeting agenda and minutes, and the posting of guidance documents, agencies and agency regulatory action exempt from Article 2 of the APA are not subject to the requirements of this Executive Order. Nonetheless, the Governor, a Cabinet Secretary, or the Chief of Staff to the Governor may request in writing that an agency comply with all or part of the requirements of this Executive Order for regulations exempt from Article 2 of the APA. Copies of such requests shall be forwarded to the Governor's Policy Office and DPB. In addition, a Cabinet Secretary may request in writing that certain Article 2 exempt regulations be further exempted from all or part of the requirements of this Executive Order.

These procedures shall apply in addition to those already specified in the APA, the agencies' public participation guidelines, and the agencies' basic authorizing statutes. As of July 16, 2018, these procedures shall apply to all regulatory actions and stages that have been submitted to DPB for any stage of Executive Branch Review.

Any failure to comply with the requirements set forth herein shall in no way affect the validity of a regulation, create any cause of action or provide standing for any person under Article 5 of the APA (§ 2.2-4025 *et seq.* of the *Code of Virginia*), or otherwise challenge the actions of a government entity responsible for adopting or reviewing regulations.

Regulatory Review Process

Regulations shall be subject to Executive Branch Review as specified herein. All agency regulatory packages shall be submitted via Town Hall. For each stage of the regulatory development process, agencies shall complete and post the applicable ABD on Town Hall to describe the regulatory action and inform the public about the substance and reasons for the rulemaking. Agencies shall ensure that the correct regulatory text is synchronized with the appropriate stage information page on Town Hall.

If a regulatory package is submitted to DPB, and DPB determines that the package is not substantially complete, then DPB shall notify the agency within 10 days. At that time, the agency must withdraw the package from Town Hall and resubmit the package after all missing elements identified by DPB have been added. Agencies shall submit regulatory packages to the Registrar for publication on Town Hall within 14 days of being authorized to do so.

In rulemakings where there are two or more stages, the filing of each stage shall be submitted on Town Hall as expeditiously as the subject matter allows and no later than 180 days after the conclusion of the public comment period for the prior stage.

A. Standard Rulemaking Process

1. NOIRA Stage

The NOIRA shall include the nature and scope of the regulatory changes being considered and the relevant sections of the VAC. This package shall include draft regulatory text if it is available.

DPB shall review the NOIRA to determine whether it complies with all requirements of this Executive Order and applicable statutes, and whether the contemplated regulatory action comports with the policy of the Commonwealth as set forth herein. Within 14 days of receiving a complete NOIRA review package from the agency, the Director of DPB or his designee shall advise the appropriate Cabinet Secretary and the Governor of DPB's determination.

If the Director of DPB or his designee advises the appropriate Cabinet Secretary and the Governor that the NOIRA presents issues requiring further review, the NOIRA shall be forwarded to the Cabinet Secretary. The Cabinet Secretary shall review the NOIRA within 14 days and forward a recommendation to the Governor. If DPB does not find issues requiring further review, the agency shall be authorized to submit the NOIRA to the *Register* for publication after the Governor approves the NOIRA.

The Chief of Staff to the Governor or his designee is hereby authorized to approve or disapprove NOIRAs on behalf of the Governor.

Public comments received following publication of the NOIRA should be encouraged and carefully considered in developing the proposed stage of a regulatory proposal.

2. Proposed Stage

Following the initial public comment period required by § 2.2-4007.01 of the *Code of Virginia*, and taking into account the comments received, the agency shall prepare a regulatory review package.

At this stage, the proposed regulation and regulatory review package shall be in as close to final form as possible, including completed review by all appropriate regulatory advisory panels or negotiated rulemaking panels. New issues that were not disclosed to the public when the NOIRA was published shall not be addressed at the proposed stage.

The order of Executive Branch Review shall be as follows:

- a. OAG. The OAG will conduct a review of the proposed regulation and produce a memorandum assessing the agency's legal authority to promulgate the regulation and determining whether the content of the proposed regulation conflicts with existing law. The OAG may also provide any advice, recommendations, or other comments for consideration by the Governor with respect to the proposed regulation. After the OAG has completed its review, the package will be submitted to DPB.
- b. DPB. DPB shall review the proposed regulatory package to determine whether it complies with all requirements of this Executive Order, applicable statutes, and other policies of the Commonwealth. Consistent with § 2.2-4007.04 of the *Code of Virginia*, within 45 days of receiving a complete regulatory review package, the Director of DPB or his designee shall prepare a policy analysis and EIA, and advise the appropriate Cabinet Secretary and the Governor of the results of the review.
- c. Cabinet Secretary. The Cabinet Secretary shall review the proposed regulation package within 14 days and forward a recommendation to the Governor.
- d. Governor. The Chief of Staff to the Governor or his designee is hereby authorized to approve or disapprove proposed regulations on behalf of the Governor.

3. Revised Proposed Stage (Optional)

Following the public comment period of the proposed stage, required by § 2.2-4007.03 of the *Code of Virginia*, the agency may wish to make additional changes and/or receive additional public comment by publishing a revised proposed regulation (as allowed by § 2.2-4007.03 of the *Code of Virginia*). The order of Executive Branch Review for the revised proposed stage shall be the same as for the Proposed Stage, with the exception that DPB will perform its duties within 21 days.

4. Final Stage

Following the approval of the proposed regulation package or the revised proposed regulation package, and taking into account all comments received during the prior stage, the rulemaking entity shall revise the proposed regulation.

If any change with substantial impact—as determined by DPB—has been made to the regulatory text between the proposed and final stages, the agency shall obtain a letter from the OAG certifying that the agency has authority to make the additional changes.

The order of Executive Branch Review shall be as follows:

- a. **DPB.** DPB shall review the final stage package to determine whether it complies with all requirements of this Executive Order, applicable statutes, and other policies of the Commonwealth. In particular, DPB shall assess the effect of any substantive changes made since the publication of the proposed regulation and the responsiveness of the agency to public comment. Within 21 days of receiving a complete final regulation package from the agency, the Director of DPB or his designee shall prepare a policy analysis advising the appropriate Cabinet Secretary and the Governor of the results of the review.
- b. **Cabinet Secretary.** The Cabinet Secretary shall review the final stage regulation package within 14 days and forward a recommendation to the Governor.
- c. **Governor.** The Chief of Staff to the Governor or his designee is hereby authorized to approve or disapprove proposed final regulations on behalf of the Governor.

B. Fast-Track Rulemaking Process

The fast-track rulemaking process is for rules that are expected to be noncontroversial.

DPB shall review the fast-track regulation to determine whether it complies with all other requirements of this Executive Order and applicable statutes, and whether the contemplated regulatory action comports with the policies of the Commonwealth as set forth herein. DPB shall request the Governor's Office to determine if the fast-track process is appropriate when there is any question as to whether a package should be allowed to proceed in this manner. The Governor or his designee retains sole discretion to disapprove use of the fast-track rulemaking process when the Governor or his designee determines it is not in the public interest.

After a fast-track regulation has been submitted on Town Hall, Executive Branch Review will proceed as follows:

1. **OAG.** The OAG will conduct a review of the proposed fast-track regulation and produce a memorandum assessing the agency's legal authority to promulgate the regulation and determining that the content of the proposed regulation does not conflict with existing law. The OAG may also provide any advice, recommendations, or other comments for consideration by the Governor with respect to the fast-track regulation. After the OAG has completed its review, the package will be submitted to DPB.
2. **DPB.** DPB shall determine within 10 days or less whether the regulatory package is appropriate for the fast-track rulemaking process and communicate

this decision to the agency. After a package has been determined to be appropriate for the fast-track process, the Director of DPB or his designee shall have 30 days to prepare a policy analysis and EIA, and advise the appropriate Cabinet Secretary and the Governor of the results of the review.

3. Cabinet Secretary. The Cabinet Secretary shall review the fast-track regulation package within 14 days and forward a recommendation to the Governor.
4. Governor. The Chief of Staff to the Governor or his designee is hereby authorized to approve or disapprove fast-track regulations on behalf of the Governor.

C. Emergency Rulemaking Process

Emergency regulations may be promulgated by an agency if it determines there is an emergency situation, consults with the OAG, and obtains the approval of the Governor or his designee. Emergency regulations may also be promulgated where Virginia statutory law, an Act of Assembly such as the appropriation act, federal law, or federal regulation requires that a state regulation be effective in 280 days or fewer from its enactment and the regulation is not exempt from the APA.

If the agency plans to replace the emergency regulation with a permanent regulation, it should file an Emergency/NOIRA stage. The order of Executive Branch Review shall be as follows:

1. OAG. The OAG will conduct a review of the proposed emergency regulation and produce a memorandum assessing the agency's legal authority to promulgate the regulation and determining that the content of the proposed regulation does not conflict with existing law. The OAG may also provide any advice, recommendations, or other comments for consideration by the Governor with respect to the proposed emergency regulation. After the OAG has completed its review, the package will be submitted to DPB.
2. DPB. DPB shall review the proposed emergency regulatory package to determine whether it complies with all requirements of this Executive Order, applicable statutes, and other policies of the Commonwealth. Within 14 days of receiving a complete emergency regulation package from the agency, the Director of DPB or his designee shall prepare a policy analysis, and advise the appropriate Secretary and the Governor of the results of the review.
3. Cabinet Secretary. The Cabinet Secretary shall review the proposed emergency regulation package within 10 days and forward a recommendation to the Governor.
4. Governor. The Chief of Staff to the Governor or his designee is hereby authorized to approve or disapprove emergency regulations on behalf of the

Governor.

An emergency regulation shall be effective for up to 18 months and may be extended for up to an additional six months if, despite the rulemaking entity's best efforts, a permanent replacement regulation cannot become effective before the emergency regulation expires. If an agency wishes to extend an emergency regulation beyond its initial effective period, the agency shall submit an emergency extension request to the Governor's Office via Town Hall as soon as the need for the extension is known, but no later than 30 days before the emergency regulation is set to expire. The emergency extension request must be granted prior to the expiration date of the emergency regulation, pursuant to § 2.2-4011(D) of the *Code of Virginia*.

D. Periodic Review of Existing Regulations

Existing state regulations shall be reviewed every four years to determine whether they should be continued without change or be amended or repealed, consistent with the stated objectives of applicable law, to minimize the economic impact on small businesses in a manner consistent with the stated objectives of applicable law, as regarding § 2.2-4007.1 of the *Code of Virginia*.

The regulatory review shall include: (1) the continued need for the rule; (2) the nature and complaints or comments received concerning the regulation from the public; (3) the complexity of the regulation; (4) the extent to which the regulation overlaps, duplicates, or conflicts with federal or state law or regulation; and (5) the length of time since the regulation has been evaluated or the degree to which technology, economic conditions, or other factors have changed in the area affected by the regulation.

Prior to commencement of the periodic regulatory review, the agency shall publish a notice of the review in the *Register* and post the notice on Town Hall. The agency shall provide a minimum of 21 days for public comment after publication of the notice. No later than 120 days after close of the public comment period, the agency shall publish a report of the findings of the regulatory review in the *Register* and post the report on Town Hall.

The periodic review shall include (1) a review by the Attorney General or his designee to ensure statutory authority for regulations, and (2) a determination by the Governor or his designee, whether the regulations are (a) necessary for the protection of public health, safety and welfare and (b) clearly written and easily understandable.

The periodic review must be conducted on Town Hall and may be accomplished either during the course of a comprehensive regulatory action using the standard rulemaking process, or by using the periodic review feature as follows:

1. If during the course of a comprehensive rulemaking, using the standard regulatory process, the agency plans to undertake a standard regulatory action, then the agency can fulfill the periodic review requirement by including a notice of a periodic review in the NOIRA. When the proposed stage is submitted for Executive Branch Review, the ABD shall include the result of

the periodic review. When a regulation has undergone a comprehensive review as part of a regulatory action and when the agency has solicited public comment on the regulation, a periodic review shall not be required until four years after the effective date of the regulatory action.

2. Using the periodic review feature. If, at the time of the periodic review, the agency has no plans to begin a comprehensive rulemaking using the standard rulemaking process, then the agency shall use the periodic review feature to announce and report the result of a periodic review using the appropriate Town Hall form. If the result of the periodic review is to amend or repeal the regulation, the agency shall link the periodic review with the subsequent action to amend or repeal the regulation.

Electronic Availability of Petitions and Documents

Agencies shall post petitions for rulemaking and decisions to grant or deny the petitions on Town Hall, in accordance with the timeframes established in § 2.2-4007 of the *Code of Virginia*.

Executive branch agencies shall post the notice of, and agenda for, a public regulatory meeting on Town Hall at least seven days prior to the date of the meeting, except if it is necessary to hold an emergency meeting in which case the agenda shall be posted as soon as possible.

In addition, agencies that promulgate regulations and keep minutes of regulatory meetings shall post such minutes of those meetings on Town Hall in accordance with the timeframes established in §§ 2.2-3707 and 2.2-3707.1 of the *Code of Virginia*.

Agencies shall post all guidance documents or a link to each agency guidance document, as defined by § 2.2-4101 of the *Code of Virginia* on Town Hall. Any changes to a guidance document or a guidance document link shall be reflected on Town Hall within 10 days of the change.

Effective Date of the Executive Order

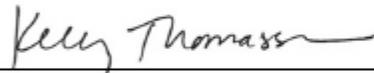
This Executive Order amends Executive Order No. 14 (2018) issued by Governor Ralph S. Northam and rescinds Executive Order No. 58 (1999) issued by Governor James S. Gilmore, III. This Executive Order shall become effective on July 16, 2018, and shall remain in full force and effect until June 30, 2022, unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia on this 16th day of July, 2018.




Ralph S. Northam, Governor

Attest:


Kelly Thomasson, Secretary of Commonwealth

**2021- 2022 Budget Development
Budget Amendment Request Brief**

Decision Package Title: _____

Description: *What do you need/want?*

Justification: *What is the underlying need that this request addresses?*

Resource Requirements:

FY2021		FY2022		FTE	
GF	NGF	GF	NGF	GF	NGF

Office/District: _____ **Date Prepared:** _____

Preparer: _____ **Phone Number:** _____

Director Approval: _____ **Date:** _____

VDH Health Policy Analysis Roundtable Roster

Name	Title	Office
Joe Hilbert	Deputy Commissioner for Governmental and Regulatory Affairs	Office of the Commissioner
Alexander Samuel, MD	Director	Chesterfield Health District
Alison Ansher, MD	Director	Prince William Health District
Anne Rhodes	Deputy Director, Division of Disease Prevention	Office of Epidemiology
Carole Pratt	Senior Advisor and Confidential Assistant	Office of the Commissioner
Demetria Lindsay, MD	Director	Norfolk City Health District
Denise Bonds, MD	Director	Thomas Jefferson Health District
Jeannine Uzel	Director of Public Health Nursing	Office of Community Health Services
John Ringer	Director of Public Health Planning and Evaluation	Office of the Commissioner
Keshia Singleton	Statewide Project Manager	Office of the Chief Medical Examiner
Khalida Willoughby	Training Coordinator	Office of Epidemiology
Kristin Clay	Senior Policy Analyst	Office of Environmental Health Services
Kristin Collins	Policy Analyst	Office of Administration
Mike Magner	Central Region Coordinator	Office of Emergency Preparedness
Nelson Daniel	Director of Hearings & Legal Services	Office of Drinking Water
Richard Williams, MD	Director	Three Rivers Health District
Robin Buskey	Policy Analyst	Office of Family Health Services
Ron Passmore	Regulations and Compliance Manager	Office of Emergency Medical Services
Sarah Lineberger	Healthcare-Associated Infection Epidemiologist	Office of Epidemiology
Stephanie Gilliam	Budget Operations Manager	Office of Financial Management
Stephanie Norris	Health Economist	Office of Health Equity
Beth Cox	HR Policy Deputy	Office of Human Resources
Brenden Rivenbark	Senior Policy Analyst	Office of the Commissioner
Alton Hart, Jr., MD, MPH	Director	Crater District Health Departments
Tiffany Cox	Public Information Officer	Crater District Health Departments
Rebekah Allen	Senior Policy Analyst	Office of Licensure and Certification
Clay Aschliman	Senior Policy Analyst	Community Health Services
Mylam Ly	Policy Analyst/Project Coordinator	Office of Information Management
Alexandra Jansson	Policy Analyst	Office of the Commissioner

Virginia Public Health Policy Advisory Council Roster

Name	Organization	Title
Joseph Hilbert	Virginia Department of Health	Deputy Commissioner for Governmental and Regulatory Affairs
Brian Martin, PhD, MBA	Eastern Virginia Medical School	Associate Dean, Administration of MPH Program
Lisa Anderson, MPH	Virginia Commonwealth University	MPH Director of Educational Programs, Professor
Robert Weiler, PhD, MPH	George Mason University	Chair, Department of Global and Community Health
Ruth Bernheim, J.D., MPH	University of Virginia	Professor and Chair, Department of Public Health Sciences
Dr. Laura Hungerford	Virginia Tech	Professor of Public Health
Norman Oliver, MD, MPH	Virginia Department of Health	Commissioner
John Ringer	Virginia Department of Health	Director of Public Health Planning and Evaluation
Carole Pratt	Virginia Department of Health	Senior Advisor and Confidential Assistant in the Office of the Commissioner
Brenden Rivenbark	Virginia Department of Health	Senior Policy Advisor in the Office of the Commissioner
Dr. Bethesda O'Connell	Liberty University	Assistant Professor
Dr. Anna Jeng	Virginia Board of Health	Board of Health and Advisory Council Liason
Jim Edmondson	Virginia Board of Health	Board of Health and Advisory Council Liason
Muge Akpinar-Elci, MD, MPH	Old Dominion University	Professor and Chair, School of Community & Environmental Health, Director, Center for Global Health
Alexandra Jansson	Virginia Department of Health	Policy Analyst in the Office of the Commissioner

Virginia State Board of Health Roster

Name/Location	Affiliation
The Honorable Faye O. Prichard Chair Ashland, Virginia	Local Government

Gary P. Critzer, NRP, CCEMTP Waynesboro, Virginia	EMS
Tommy East Roanoke, Virginia	Nursing Home Industry
James H. Edmondson, Jr. Executive Committee McLean, Virginia	Corporate Purchaser of Health Care
Elizabeth Ruffin Harrison N. Prince George, Virginia	Consumer
Linda Hines, RN Vice Chair Richmond, Virginia	Managed Care Health Insurance Plans
Anna Jeng, ScD Norfolk, Virginia	Public Environmental Health
Patricia Anne Kinser, PhD, WHNP-BC, RN Richmond, Virginia	Virginia Nurses Association
Wendy Klein, MD, MACP Richmond, Virginia	Medical Society of Virginia
Benita Miller, DDS Richmond, Virginia	Virginia Dental Association
Holly S. Puritz, MD, FACOG Norfolk, Virginia	Medical Society of Virginia
Jim Shuler, DVM Executive Committee Blacksburg, Virginia	Virginia Veterinary Medical Association
Stacey Swartz, PharmD Alexandria, Virginia	Virginia Pharmacists Association
Katherine B. Waddell Richmond, Virginia	Consumer
Mary Margaret Whipple Glen Allen, Virginia	Hospital Industry