CHAPTER 320

An Act to amend and reenact §§ 8.01-225.01, 8.01-581.16, 8.01-581.17, 23-77.3, 32.1-111.3, 32.1-125.1, and 32.1-127 of the Code of Virginia, relating to national accrediting organizations; Joint Commission on Accreditation of Healthcare Organizations.

[H 391]

Approved March 27, 2014

Be it enacted by the General Assembly of Virginia:

1. That §§ 8.01-225.01, 8.01-581.16, 8.01-581.17, 23-77.3, 32.1-111.3, 32.1-125.1, and 32.1-127 of the Code of Virginia are amended and reenacted as follows:

§ 8.01-225.01. Certain immunity for health care providers during disasters under specific circumstances.

A. In the absence of gross negligence or willful misconduct, any health care provider who responds to a disaster by delivering health care to persons injured in such disaster shall be immune from civil liability for any injury or wrongful death arising from abandonment by such health care provider of any person to whom such health care provider owes a duty to provide health care when (i) a state or local emergency has been or is subsequently declared; and (ii) the provider was unable to provide the requisite health care to the person to whom he owed such duty of care as a result of the provider's voluntary or mandatory response to the relevant disaster.

B. In the absence of gross negligence or willful misconduct, any hospital or other entity credentialing health care providers to deliver health care in response to a disaster shall be immune from civil liability for any cause of action arising out of such credentialing or granting of practice privileges if (i) a state or local emergency has been or is subsequently declared~~;~~ and (ii) the hospital has followed procedures for such credentialing and granting of practice privileges that are consistent with the ~~Joint Commission on Accreditation of Healthcare Organizations'~~ *applicable* standards *of an approved national accrediting organization* for granting emergency practice privileges.

C. For the purposes of this section:

"Approved national accrediting organization" means an organization granted authority by the Centers for Medicare and Medicaid Services to ensure compliance with Medicare conditions of participation pursuant to § 1865 of Title XVIII of the Social Security Act (42 U.S.C. § 1395bb).

"Disaster" means any "disaster," "emergency," or "major disaster" as those terms are used and defined in § 44-146.16; and

"Health care provider" means those professions defined as such in § 8.01-581.1.

D. The immunity provided by this section shall be in addition to, and shall not be in lieu of, any immunities provided in other state or federal law, including, but not limited to, §§ 8.01-225 and 44-146.23.

§ 8.01-581.16. Civil immunity for members of or consultants to certain boards or committees.

Every member of, or health care professional consultant to, any committee, board, group, commission or other entity shall be immune from civil liability for any act, decision, omission, or utterance done or made in performance of his duties while serving as a member of or consultant to such committee, board, group, commission or other entity, which functions primarily to review, evaluate, or make recommendations on (i) the duration of patient stays in health care facilities, (ii) the professional services furnished with respect to the medical, dental, psychological, podiatric, chiropractic, veterinary or optometric necessity for such services, (iii) the purpose of promoting the most efficient use or monitoring the quality of care of available health care facilities and services, or of emergency medical services agencies and services, (iv) the adequacy or quality of professional services, (v) the competency and qualifications for professional staff privileges, (vi) the reasonableness or appropriateness of charges made by or on behalf of health care facilities or (vii) patient safety, including entering into contracts with patient safety organizations~~;~~, provided that such committee, board, group, commission or other entity has been established pursuant to federal or state law or regulation, or pursuant to ~~Joint Commission on Accreditation of Healthcare Organizations~~ *the* requirements *of a national accrediting organization granted authority by the Centers for Medicare and Medicaid Services to ensure compliance with Medicare conditions of participation pursuant to § 1865 of Title XVIII of the Social Security Act (42 U.S.C. § 1395bb)*, or established and duly constituted by one or more public or licensed private hospitals, community services boards, or behavioral health authorities, or with a governmental agency and provided further that such act, decision, omission, or utterance is not done or made in bad faith or with malicious intent.

§ 8.01-581.17. Privileged communications of certain committees and entities.

A. For the purposes of this section:

"Centralized credentialing service" means (i) gathering information relating to applications for professional staff privileges at any public or licensed private hospital or for participation as a provider in any health maintenance organization, preferred provider organization or any similar organization and (ii) providing such information to those hospitals and organizations that utilize the service.

"Patient safety data" means reports made to patient safety organizations together with all health care data, interviews, memoranda, analyses, root cause analyses, products of quality assurance or quality improvement processes, corrective action plans or information collected or created by a health care provider as a result of an occurrence related to the provision of health care services.

"Patient safety organization" means any organization, group, or other entity that collects and analyzes patient safety data for the purpose of improving patient safety and health care outcomes and that is independent and not under the control of the entity that reports patient safety data.

B. The proceedings, minutes, records, and reports of any (i) medical staff committee, utilization review committee, or other committee, board, group, commission or other entity as specified in § 8.01-581.16; (ii) nonprofit entity that provides a centralized credentialing service; or (iii) quality assurance, quality of care, or peer review committee established pursuant to guidelines approved or adopted by (a) a national or state physician peer review entity, (b) a national or state physician accreditation entity, (c) a national professional association of health care providers or Virginia chapter of a national professional association of health care providers, (d) a licensee of a managed care health insurance plan (MCHIP) as defined in § 38.2-5800, (e) the Office of Emergency Medical Services or any regional emergency medical services council, or (f) a statewide or local association representing health care providers licensed in the Commonwealth, together with all communications, both oral and written, originating in or provided to such committees or entities, are privileged communications which may not be disclosed or obtained by legal discovery proceedings unless a circuit court, after a hearing and for good cause arising from extraordinary circumstances being shown, orders the disclosure of such proceedings, minutes, records, reports, or communications. Additionally, for the purposes of this section, accreditation and peer review records of the American College of Radiology and the Medical Society of Virginia are considered privileged communications. Oral communications regarding a specific medical incident involving patient care, made to a quality assurance, quality of care, or peer review committee established pursuant to clause (iii), shall be privileged only to the extent made more than 24 hours after the occurrence of the medical incident. Nothing in this section shall be construed as providing any privilege to any health care provider, emergency medical services agency, community services board, or behavioral health authority with respect to any factual information regarding specific patient health care or treatment, including patient health care incidents, whether oral, electronic, or written. However, the analysis, findings, conclusions, recommendations, and the deliberative process of any medical staff committee, utilization review committee, or other committee, board, group, commission, or other entity specified in § 8.01-581.16, as well as the proceedings, minutes, records, and reports, including the opinions and reports of experts, of such entities shall be privileged in their entirety under this section. Information known by a witness with knowledge of the facts or treating health care provider is not privileged or protected from discovery merely because it is provided to a committee, board, group, commission, or other entity specified in § 8.01-581.16, and may be discovered by deposition or otherwise in the course of discovery. A person involved in the work of the entities referenced in this subsection shall not be made a witness with knowledge of the facts by virtue of his involvement in the quality assurance, peer review, or credentialing process.

C. Nothing in this section shall be construed as providing any privilege to health care provider, emergency medical services agency, community services board, or behavioral health authority medical records kept with respect to a patient, whose treatment is at issue, in the ordinary course of business of operating a hospital, emergency medical services agency, community services board, or behavioral health authority nor to any facts or information contained in medical records, nor shall this section preclude or affect discovery of or production of evidence relating to hospitalization or treatment of such patient in the ordinary course of the patient's hospitalization or treatment. However, the proceedings, minutes, records, reports, analysis, findings, conclusions, recommendations, and the deliberative process, including opinions and reports of experts, of any medical staff committee, utilization review committee, or other committee, board, group, commission, or other entity specified in § 8.01-581.16 shall not constitute medical records, are privileged in their entirety, and are not discoverable.

D. Notwithstanding any other provision of this section, reports or patient safety data in possession of a patient safety organization, together with the identity of the reporter and all related correspondence, documentation, analysis, results or recommendations, shall be privileged and confidential and shall not be subject to a civil, criminal, or administrative subpoena or admitted as evidence in any civil, criminal, or administrative proceeding. Nothing in this subsection shall affect the discoverability or admissibility of facts, information or records referenced in subsection C as related to patient care from a source other than a patient safety organization.

E. Any patient safety organization shall promptly remove all patient-identifying information after receipt of a complete patient safety data report unless such organization is otherwise permitted by state or federal law to maintain such information. Patient safety organizations shall maintain the

confidentiality of all patient-identifying information and shall not disseminate such information except as permitted by state or federal law.

F. Exchange of (i) patient safety data among health care providers or patient safety organizations that does not identify any patient or (ii) information privileged pursuant to subsection B between committees, boards, groups, commissions, or other entities specified in § 8.01-581.16 shall not constitute a waiver of any privilege established in this section.

G. Reports of patient safety data to patient safety organizations shall not abrogate obligations to make reports to health regulatory boards or other agencies as required by state or federal law.

H. No employer shall take retaliatory action against an employee who in good faith makes a report of patient safety data to a patient safety organization.

I. Reports produced solely for purposes of self-assessment of compliance with requirements or standards of ~~the Joint Commission on Accreditation of Healthcare Organizations~~ *a national accrediting organization granted authority by the Centers for Medicare and Medicaid Services to ensure compliance with Medicare conditions of participation pursuant to § 1865 of Title XVIII of the Social Security Act (42 U.S.C. § 1395bb)* shall be privileged and confidential and shall not be subject to subpoena or admitted as evidence in a civil or administrative proceeding. Nothing in this subsection shall affect the discoverability or admissibility of facts, information, or records referenced in subsection C as related to patient care from a source other than such accreditation body. A health care provider's release of such reports to such accreditation body shall not constitute a waiver of any privilege provided under this section.

§ 23-77.3. Operations of Medical Center.

A. In enacting this section, the General Assembly recognizes that the ability of the University of Virginia to provide medical and health sciences education and related research is dependent upon the maintenance of high quality teaching hospitals and related health care and health maintenance facilities, collectively referred to in this section as the Medical Center, and that the maintenance of a Medical Center serving such purposes requires specialized management and operation that permit the Medical Center to remain economically viable and to participate in cooperative arrangements reflective of changes in health care delivery.

B. Notwithstanding the provisions of § 32.1-124 exempting hospitals and nursing homes owned or operated by an agency of the Commonwealth from state licensure, the Medical Center shall be, for so long as the Medical Center maintains its accreditation by ~~the Joint Commission on Accreditation of Health Care Organizations or any successor in interest thereof~~ *a national accrediting organization granted authority by the Centers for Medicare and Medicaid Services to ensure compliance with Medicare conditions of participation pursuant to § 1865 of Title XVIII of the Social Security Act (42 U.S.C. § 1395bb)*, deemed to be licensed as a hospital for purposes of other law relating to the operation of hospitals licensed by the Board of Health. The Medical Center shall not, however, be deemed to be a licensed hospital to the extent any law relating to licensure of hospitals specifically excludes the Commonwealth or its agencies. As an agency of the Commonwealth, the Medical Center shall, in addition, remain (i) exempt from licensure by the Board of Health pursuant to § 32.1-124 and (ii) subject to the Virginia Tort Claims Act (§ 8.01-195.1 et seq.). Further, this subsection shall not be construed as a waiver of the Commonwealth's sovereign immunity.

C. Without limiting the powers provided in this chapter, the University of Virginia may create, own in whole or in part or otherwise control corporations, partnerships, insurers or other entities whose activities will promote the operations of the Medical Center and its mission, may cooperate or enter into joint ventures with such entities and government bodies and may enter into contracts in connection therewith. Without limiting the power of the University of Virginia to issue bonds, notes, guarantees, or other evidence of indebtedness under subsection D in connection with such activities, no such creation, ownership or control shall create any responsibility of the University, the Commonwealth or any other agency thereof for the operations or obligations of any such entity or in any way make the University, the Commonwealth, or any other agency thereof responsible for the payment of debt or other obligations of such entity. All such interests shall be reflected on the financial statements of the Medical Center.

D. Notwithstanding the provisions of Chapter 3 (§ 23-14 et seq.) of this title, the University of Virginia may issue bonds, notes, guarantees, or other evidence of indebtedness without the approval of any other governmental body subject to the following provisions:

1. Such debt is used solely for the purpose of paying not more than 50 percent of the cost of capital improvements in connection with the operation of the Medical Center or related issuance costs, reserve funds, and other financing expenses, including interest during construction or acquisitions and for up to one year thereafter;

2. The only revenues of the University pledged to the payment of such debt are those derived from the operation of the Medical Center and related health care and educational activities, and there are pledged therefor no general fund appropriation and special Medicaid disproportionate share payments for indigent and medically indigent patients who are not eligible for the Virginia Medicaid Program;

3. Such debt states that it does not constitute a debt of the Commonwealth or a pledge of the faith and credit of the Commonwealth;

4. Such debt is not sold to the public;

5. The total principal amount of such debt outstanding at any one time does not exceed $25 million;

6. The Treasury Board has approved the terms and structure of such debt;

7. The purpose, terms, and structure of such debt are promptly communicated to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees; and

8. All such indebtedness is reflected on the financial statements of the Medical Center.

Subject to meeting the conditions set forth above, such debt may be in such form and have such terms as the board of visitors may provide and shall be in all respects debt of the University for the purposes of §§ 23-23, 23-25, and 23-26.

§ 32.1-111.3. Statewide emergency medical care system.

A. The Board of Health shall develop a comprehensive, coordinated, emergency medical care system in the Commonwealth and prepare a Statewide Emergency Medical Services Plan which shall incorporate, but not be limited to, the plans prepared by the regional emergency medical services councils. The Board shall 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 medical care system. Publishing through electronic means and posting on the Department website shall satisfy the publication requirement. The objectives of such Plan and the system shall include, but not be limited to, the following:

1. Establishing a comprehensive statewide emergency medical care system, incorporating facilities, transportation, manpower, communications, and other components as integral parts of a unified system that will serve to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality;

2. Reducing the time period between the identification of an acutely ill or injured patient and the definitive treatment;

3. Increasing the accessibility of high quality emergency medical services to all citizens of Virginia;

4. Promoting continuing improvement in system components including ground, water and air transportation, communications, hospital emergency departments and other emergency medical care facilities, consumer health information and education, and health manpower and manpower training;

5. Ensuring performance improvement of the Emergency Medical Services system and emergency medical care delivered on scene, in transit, in hospital emergency departments and within the hospital environment;

6. Working with professional medical organizations, hospitals, and other public and private agencies in developing approaches whereby the many persons who are presently using the existing emergency department for routine, nonurgent, primary medical care will be served more appropriately and economically;

7. Conducting, promoting, and encouraging programs of education and training designed to upgrade the knowledge and skills of health manpower involved in emergency medical services, including expanding the availability of paramedic and advanced life support training throughout the Commonwealth with particular emphasis on regions underserved by personnel having such skills and training;

8. Consulting with and reviewing, with agencies and organizations, the development of applications to governmental or other sources for grants or other funding to support emergency medical services programs;

9. Establishing a statewide air medical evacuation system which shall be developed by the Department of Health in coordination with the Department of State Police and other appropriate state agencies;

10. Establishing and maintaining a process for designation of appropriate hospitals as trauma centers and specialty care centers based on an applicable national evaluation system;

11. Maintaining a comprehensive emergency medical services patient care data collection and performance improvement system pursuant to Article 3.1 (§ 32.1-116.1 et seq.);

12. Collecting data and information and preparing reports for the sole purpose of the designation and verification of trauma centers and other specialty care centers pursuant to this section. All data and information collected shall remain confidential and shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.);

13. Establishing and maintaining a process for crisis intervention and peer support services for emergency medical services and public safety personnel, including statewide availability and accreditation of critical incident stress management teams;

14. Establishing a statewide emergency medical services for children program to provide coordination and support for emergency pediatric care, availability of pediatric emergency medical care equipment, and pediatric training of medical care providers;

15. Establishing and supporting a statewide system of health and medical emergency response teams, including emergency medical services disaster task forces, coordination teams, disaster medical assistance teams, and other support teams that shall assist local emergency medical services at their request during mass casualty, disaster, or whenever local resources are overwhelmed;

16. Establishing and maintaining a program to improve dispatching of emergency medical services including establishment of and support for emergency medical dispatch training, accreditation of 911 dispatch centers, and public safety answering points;

17. Identifying and establishing best practices for managing and operating agencies, improving and managing emergency medical response times, and disseminating such information to the appropriate persons and entities;

18. Ensuring that the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund shall be contacted immediately to deploy assistance in the event there are victims as defined in § 19.2-11.01, and that the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund become the lead coordinating agencies for those individuals determined to be victims; and

19. Maintaining current contact information for both the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund.

B. The Board of Health shall also develop and maintain as a component of the Emergency Medical Services Plan a statewide prehospital and interhospital Trauma Triage Plan designed to promote rapid access for pediatric and adult trauma patients to appropriate, organized trauma care through the publication and regular updating of information on resources for trauma care and generally accepted criteria for trauma triage and appropriate transfer. The Trauma Triage Plan shall include:

1. A strategy for maintaining the statewide Trauma Triage Plan through formal regional trauma triage plans that incorporate each region's geographic variations and trauma care capabilities and resources, including hospitals designated as trauma centers pursuant to subsection A. The regional trauma triage plans shall be reviewed triennially. Plans should ensure that the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund shall be contacted immediately to deploy assistance in the event there are victims as defined in § 19.2-11.01, and that the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund become the lead coordinating agencies for those individuals determined to be victims; and maintain current contact information for both the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund.

2. A uniform set of proposed criteria for prehospital and interhospital triage and transport of trauma patients developed by the Emergency Medical Services Advisory Board, in consultation with the Virginia Chapter of the American College of Surgeons, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, and prehospital care providers. The Emergency Medical Services Advisory Board may revise such criteria from time to time to incorporate accepted changes in medical practice or to respond to needs indicated by analyses of data on patient outcomes. Such criteria shall be used as a guide and resource for health care providers and are not intended to establish, in and of themselves, standards of care or to abrogate the requirements of § 8.01-581.20. A decision by a health care provider to deviate from the criteria shall not constitute negligence per se.

3. A performance improvement program for monitoring the quality of care, consistent with other components of the Emergency Medical Services Plan. The program shall provide for collection and analysis of data on emergency medical and trauma services from existing validated sources, including but not limited to the emergency medical services patient care information system, pursuant to Article 3.1 (§ 32.1-116.1 et seq.), the Patient Level Data System, and mortality data. The Emergency Medical Services Advisory Board shall review and analyze such data on a quarterly basis and report its findings to the Commissioner. The Emergency Medical Services Advisory Board may execute these duties through a committee composed of persons having expertise in critical care issues and representatives of emergency medical services providers. The program for monitoring and reporting the results of emergency medical and trauma services data analysis shall be the sole means of encouraging and promoting compliance with the trauma triage criteria.

The Commissioner shall report aggregate findings of the analysis annually to each regional emergency medical services council. The report shall be available to the public and shall identify, minimally, as defined in the statewide plan, the frequency of (i) incorrect triage in comparison to the total number of trauma patients delivered to a hospital prior to pronouncement of death and (ii) incorrect interfacility transfer for each region.

The Emergency Medical Services Advisory Board or its designee shall ensure that each hospital or emergency medical services director is informed of any incorrect interfacility transfer or triage, as defined in the statewide plan, specific to the provider and shall give the provider an opportunity to correct any facts on which such determination is based, if the provider asserts that such facts are inaccurate. The findings of the report shall be used to improve the Trauma Triage Plan, including triage, and transport and trauma center designation criteria.

The Commissioner shall ensure the confidentiality of patient information, in accordance with § 32.1-116.2. Such data or information in the possession of or transmitted to the Commissioner, the Emergency Medical Services Advisory Board, any committee acting on behalf of the Emergency Medical Services Advisory Board, any hospital or prehospital care provider, any regional emergency medical services council, licensed emergency medical services agency, or group or committee established to monitor the quality of care pursuant to this subdivision, or any other person shall be

privileged and shall not be disclosed or obtained by legal discovery proceedings, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.

C. The Board of Health shall also develop and maintain as a component of the Emergency Medical Services Plan a statewide prehospital and interhospital Stroke Triage Plan designed to promote rapid access for stroke patients to appropriate, organized stroke care through the publication and regular updating of information on resources for stroke care and generally accepted criteria for stroke triage and appropriate transfer. The Stroke Triage Plan shall include:

1. A strategy for maintaining the statewide Stroke Triage Plan through formal regional stroke triage plans that incorporate each region's geographic variations and stroke care capabilities and resources, including hospitals designated as "primary stroke centers" through certification by the Joint Commission, *DNV Healthcare*, or a comparable process consistent with the recommendations of the Brain Attack Coalition. The regional stroke triage plans shall be reviewed triennially.

2. A uniform set of proposed criteria for prehospital and interhospital triage and transport of stroke patients developed by the Emergency Medical Services Advisory Board, in consultation with the American Stroke Association, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, and prehospital care providers. The Board of Health may revise such criteria from time to time to incorporate accepted changes in medical practice or to respond to needs indicated by analyses of data on patient outcomes. Such criteria shall be used as a guide and resource for health care providers and are not intended to establish, in and of themselves, standards of care or to abrogate the requirements of § 8.01-581.20. A decision by a health care provider to deviate from the criteria shall not constitute negligence per se.

D. Whenever any state-owned aircraft, vehicle, or other form of conveyance is utilized under the provisions of this section, an appropriate amount not to exceed the actual costs of operation may be charged by the agency having administrative control of such aircraft, vehicle or other form of conveyance.

§ 32.1-125.1. Inspection of hospitals by state agencies generally.

As used in this section unless the context requires a different meaning, "hospital" means a hospital as defined in § 32.1-123 or 37.2-100.

State agencies shall make or cause to be made only such inspections of hospitals as are necessary to carry out the various obligations imposed on each agency by applicable state and federal laws and regulations. Any on-site inspection by a state agency or a division or unit thereof that substantially complies with the inspection requirements of any other state agency or any other division or unit of the inspecting agency charged with making similar inspections shall be accepted as an equivalent inspection in lieu of an on-site inspection by said agency or by a division or unit of the inspecting agency. A state agency shall coordinate its hospital inspections both internally and with those required by other state agencies so as to ensure that the requirements of this section are met.

Notwithstanding any provision of law to the contrary, all hospitals licensed by the Department of Health or Department of Behavioral Health and Developmental Services ~~which~~ *that* have been certified under the provisions of Title XVIII of the Social Security Act for hospital or psychiatric services or ~~which~~ *that* have obtained accreditation from ~~the~~ ~~Joint~~ ~~Commission~~ ~~on~~ ~~Accreditation~~ ~~of~~ ~~Healthcare~~ ~~Organizations~~ *a national accrediting organization granted authority by the Centers for Medicare and Medicaid Services to ensure compliance with Medicare conditions of participation pursuant to § 1865 of Title XVIII of the Social Security Act (42 U.S.C. § 1395bb)* may be subject to inspections so long as such certification or accreditation is maintained but only to the extent necessary to ensure the public health and safety.

§ 32.1-127. Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to ~~assure~~ *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. For purposes of this paragraph, facilities in which five or more first trimester abortions per month are performed shall be classified as a category of "hospital";

2. Shall provide that at least one physician who is licensed to practice medicine in this

Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at each hospital which operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Centers for Medicare ~~&~~ *and* Medicaid Services (CMS), particularly 42 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS regulations for routine contact, whereby the provider's designated organ procurement organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer of the hospital or his designee knows of such opposition, and no donor card or other relevant document, such as an advance directive, can be found;

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

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

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

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be ~~based on Joint Commission on Accreditation of Healthcare Organizations' standards~~ *consistent with applicable federal law and regulations of the Centers for Medicare and Medicaid Services*;

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

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

11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable

period of time not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital policies and procedures, by the person giving the order, or, when such person is not available within the period of time specified, co-signed by another physician or other person authorized to give the order;

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

13. Shall require that each nursing home and certified nursing facility 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 home or facility is located, pursuant to § 9.1-914;

14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission, whether a potential patient is a registered sex offender, if the home or facility anticipates the potential patient will have a length of stay greater than three days or in fact stays longer than three days;

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

16. Shall require that each nursing home and certified nursing facility shall, upon the request of the facility's family council, send notices and information about the family council mutually developed by the family council and the administration of the nursing home or certified nursing facility, 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 per 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 home or certified nursing facility; and

17. Shall require that each nursing home and certified nursing facility maintain liability insurance coverage in a minimum amount of $1 million, and professional liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15, to compensate patients or individuals for injuries and losses resulting from the negligent or criminal acts of the facility. Failure to maintain such minimum insurance shall result in revocation of the facility's license.

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

D. All facilities licensed by the Board pursuant to this article which provide treatment or care for hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot which is known to be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each recipient who received treatment from a known contaminated lot at the individual's last known address.