COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Kara Johnson-Hufford, Interim Deputy Division Director; Jo Tansey, Acute Care & Nursing Facilities Branch Chief; Dr. Steve Cox, Home & Community Facilities Branch Chief; Health Facilities and Emergency Medical Services Division

Through: Elaine McManis, Division Director

Date: February 15, 2023

Subject: Emergency Rulemaking Hearing concerning 6 CCR 1011-1, Chapter 2, General Licensure Standards

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The Colorado legislature passed House Bill (HB) 22-1401, *Hospital Nurse Staffing Standards*, during the 2022 legislative session. This new law seeks to ensure hospitals are prepared for a public health emergency or staffing shortage, and includes a provision, found at Section 25-3-128(11), C.R.S., allowing the Department to establish regulations regarding infection control and prevention practices in licensed health facilities.

This particular requirement mirrors a requirement that has been contained in Public Health Order (PHO) 20-20, which sets forth specific infection control guidance for the following residential care facilities: Assisted Living Residences, Nursing Care Facilities, and Facilities for Persons with Intellectual and Developmental Disabilities. It became clear during the height of the COVID-19 pandemic that these facilities were at-risk for infectious disease outbreaks, due to the congregate living arrangements. The original PHO 20-20 was put into place on March 12, 2020, and facilities have been held to this infection control guidance since then.

With the shift from an emergency to a long term response by the Department, PHO 20-20 is expected to lapse without renewal at the end of February 2023. The Department is requesting the Board of Health pass emergency rules to ensure existing infection control requirements, as required by the PHO, do not lapse while the Health Facilities and Emergency Medical Services Division (Division) continues its stakeholder engagement process for permanent rulemaking related to infection control requirements in Section 25-3-128(11),C.R.S.

As such, the proposed emergency rules incorporate the requirements of the aforementioned guidance. The new rule language includes the following:

- Facilities will make vaccines for communicable diseases and vaccine information available to staff and residents; and
- Facilities will appoint an Infection Control Officer, responsible for the Facility's Infection Control & Prevention Program, who will be tasked with the following requirements:
    - Complete initial and continuing education; and
    - Maintain and implement supplies, information, training, and policies related to the management of infectious diseases.
- All licensed health facilities will establish and maintain infectious disease mitigation, vaccine, and treatment plan. This plan will address:

- Identification of staff to coordinate vaccine information, and tracking of vaccination status of staff and, if applicable, residents

- Name and location of vaccine and treatment providers to be used by the facility

- How the facility will assess and address the vaccination of new staff, and if applicable, residents

This emergency rulemaking also includes:

- Remedying the accidental removal of a definition reference in Influenza Immunization Documentation. The Division updated this reference during the emergency rulemakings related to COVID-19 vaccination for healthcare workers in licensed facilities. When those emergency regulations ultimately expired in July 2022, the entire regulatory requirement was inadvertently struck from the Chapter 2 regulations.

Although emergency rulemaking does not require stakeholder engagement, the Division has nevertheless engaged stakeholders with two (2) town-hall meetings, held January 24th and February 2nd, as well as including stakeholders of the 1294 forum, a standing stakeholder group which comprises all licensed health facilities.

In the attached rule language, all new proposed language changes are in red or stricken. The Division will continue to work with stakeholders to craft permanent regulations. The Division is requesting an emergency rulemaking for 6 CCR 1011-1 Chapter 2, General Licensure Standards in February 2023, and hopes to bring those regulations before the Board of Health for permanent rulemaking in April 2023.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
6 CCR 1011-1, Chapter 2, General Licensure Standards

Basis and Purpose.

The Colorado legislature passed House Bill (HB) 22-1401, *Hospital Nurse Staffing Standards*, during the 2022 legislative session. This new law seeks to ensure hospitals are prepared for a public health emergency or staffing shortage, and includes a provision, found at Section 25-3-128(11), C.R.S., allowing the Department to establish regulations regarding infection control and prevention practices in licensed health facilities.

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Emergency Rulemaking Finding and Justification.
An emergency rulemaking, which waives the initial Administrative Procedure Act noticing requirements, is necessary to comply with state law. Emergency rulemaking is authorized pursuant to Section 24-4-103(6), C.R.S., as HB 22-1401 allows the Department to establish infection control & prevention and staffing and policy requirements, through rules approved by the Board of Health. Currently, infection control & prevention requirements are found in Public Health Order 20-20, which is expected to expire in February 2023. Because of the high risk of the spread of infectious disease in congregate care settings, the Department seeks to codify the Public Health Order 20-20 requirements in regulations on an emergency basis to ensure resident safety and maintain the status quo while undertaking a stakeholder engagement process for permanent rulemaking.

This emergency rule shall become effective upon adoption. It will be effective for no more than one hundred twenty (120) days after its adoption unless made permanent through a rulemaking that satisfies the Administrative Procedure Act noticing requirements.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:
Section 25-3-128, C.R.S.

Other relevant statutes:
Section 25-1-120, C.R.S.
Section 25-1.5-103, C.R.S

Is this rulemaking due to a change in state statute?

__X__ Yes, the bill number is House Bill 22-1401. Rules are __X__ authorized
____ required.
_____ No

Does this rulemaking include proposed rule language that incorporate materials by reference?

_____ Yes ___ URL
__X__ No

Does this rulemaking include proposed rule language to create or modify fines or fees?

_____ Yes

__X__ No

Does the proposed rule language create (or increase) a state mandate on local government?

__X__ No.

- The proposed rule does not require a local government to perform or increase a specific activity for which the local government will not be reimbursed;
- The proposed rule requires a local government to perform or increase a specific activity because the local government has opted to perform an activity, or;
- The proposed rule reduces or eliminates a state mandate on local government.

REGULATORY ANALYSIS
for Amendments to
6 CCR 1011-1, Chapter 2, General Licensure Standards

1. A description of the classes of persons affected by the proposed rule, including the classes that will bear the costs and the classes that will benefit from the proposed rule.

Group of persons/entities Affected by the Proposed Rule	Size of the Group	Relationship to the Proposed Rule Select category: C/S/B
Licensed Assisted Living Residences	691	C
Licensed Skilled Nursing Facilities	216	C
Licensed Facilities for Persons with Intellectual and Developmental Disabilities	106	C
Residents receiving care at aforementioned licensed facilities	appx 42,000	B
Acute Care Facilities	117	B

While all are stakeholders, groups of persons/entities connect to the rule and the problem being solved by the rule in different ways. To better understand those different relationships, please use this relationship categorization key:

C = individuals/entities that implement or apply the rule.
S = individuals/entities that do not implement or apply the rule but are interested in others applying the rule.
B = the individuals that are ultimately served, including the customers of our customers. These individuals may benefit, be harmed by or be at-risk because of the standard communicated in the rule or the manner in which the rule is implemented.

More than one category may be appropriate for some stakeholders.

2. To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

Impact on Customers (C):

Economic: The impact to each facility should be minimal, as these requirements already exist, and have been in place since 2020 pursuant to Public Health Order (PHO) 20-20. Any administrative costs have already been incurred by facilities.

Non-economic: PHO 20-20 requires facilities to maintain infection control and mitigation policies that have been in effect since 2020. This emergency rulemaking maintains the status quo while also simplifying the requirements.

Impact on Beneficiaries (B):

Economic: Possible economic benefits for beneficiaries are decreased care costs, as residents are not transferred as often to an acute setting for isolation, which is typically more expensive than residential setting. There should be no new economic impact from these rules, as this incorporates requirements which have been in effect since 2020.

Non-economic: The intention of the bill is to ensure facilities are prepared for an

outbreak of infectious disease. The non-economic impacts will be greater patient safety, security, and improved care while in the facility which will lead to improved health outcomes for residents. This provision will also reduce patient load on the state's healthcare systems overall.

3. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   A. Anticipated CDPHE personal services, operating costs or other expenditures:

      The proposed rules may add some administrative and survey costs to the Department, in that facilities which do not comply with the new rules would be subject to revisit and further enforcement as appropriate. However, the Department expects to absorb these costs.

   B. Anticipated personal services, operating costs or other expenditures by another state agency:

      Anticipated Revenues for another state agency: N/A

4. A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Along with the costs and benefits discussed above, the proposed revisions:

   _X_ Comply with a statutory mandate to promulgate rules.
   ___ Comply with federal or state statutory mandates, federal or state regulations, and department funding obligations.
   ___ Maintain alignment with other states or national standards.
   ___ Implement a Regulatory Efficiency Review (rule review) result
   _X_ Improve public and environmental health practice.
   _X_ Implement stakeholder feedback.

   Advance the following CDPHE Strategic Plan priorities (select all that apply):

1. Reduce Greenhouse Gas (GHG) emissions economy-wide from 125.716 million metric tons of CO2e (carbon dioxide equivalent) per year to 119.430 million metric tons of CO2e per year by June 30, 2020 and to 113.144 million metric tons of CO2e by June 30, 2023. ___ Contributes to the blueprint for pollution reduction ___ Reduces carbon dioxide from transportation ___ Reduces methane emissions from oil and gas industry ___ Reduces carbon dioxide emissions from electricity sector
2. Reduce ozone from 83 parts per billion (ppb) to 80 ppb by June 30, 2020 and 75 ppb by June 30, 2023. ___ Reduces volatile organic compounds (VOC) and oxides of nitrogen (NOx) from the oil and gas industry. ___ Supports local agencies and COGCC in oil and gas regulations. ___ Reduces VOC and NOx emissions from non-oil and gas contributors

3. Decrease the number of Colorado adults who have obesity by 2,838 by June 30, 2020 and by 12,207 by June 30, 2023.

___ Increases the consumption of healthy food and beverages through education, policy, practice and environmental changes.
___ Increases physical activity by promoting local and state policies to improve active transportation and access to recreation.
___ Increases the reach of the National Diabetes Prevention Program and Diabetes Self-Management Education and Support by collaborating with the Department of Health Care Policy and Financing.

4. Decrease the number of Colorado children (age 2-4 years) who participate in the WIC Program and have obesity from 2120 to 2115 by June 30, 2020 and to 2100 by June 30, 2023.

___ Ensures access to breastfeeding-friendly environments.

5. Reverse the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023.

___ Reverses the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023.
___ Performs targeted programming to increase immunization rates.
___ Supports legislation and policies that promote complete immunization and exemption data in the Colorado Immunization Information System (CIIS).

6. Colorado will reduce the suicide death rate by 5% by June 30, 2020 and 15% by June 30, 2023.

___ Creates a roadmap to address suicide in Colorado.
___ Improves youth connections to school, positive peers and caring adults, and promotes healthy behaviors and positive school climate.
___ Decreases stigma associated with mental health and suicide, and increases help-seeking behaviors among working-age males, particularly within high-risk industries.
___ Saves health care costs by reducing reliance on emergency departments and connects to responsive community-based resources.

7. The Office of Emergency Preparedness and Response (OEPR) will identify 100% of jurisdictional gaps to inform the required work of the Operational Readiness Review by June 30, 2020.

___ Conducts a gap assessment.
___ Updates existing plans to address identified gaps.
___ Develops and conducts various exercises to close gaps.

8. For each identified threat, increase the competency rating from 0% to 54% for outbreak/incident investigation steps by June 30, 2020 and increase to 92% competency rating by June 30, 2023.

___ Uses an assessment tool to measure competency for CDPHE's response to an outbreak or environmental incident. ___ Works cross-departmentally to update and draft plans to address identified gaps noted in the assessment. ___ Conducts exercises to measure and increase performance related to identified gaps in the outbreak or incident response plan.
9. 100% of new technology applications will be virtually available to customers, anytime and anywhere, by June 20, 2020 and 90 of the existing applications by June 30, 2023. ___ Implements the CDPHE Digital Transformation Plan. ___ Optimizes processes prior to digitizing them. ___ Improves data dissemination and interoperability methods and timeliness.
10. Reduce CDPHE's Scope 1 & 2 Greenhouse Gas emissions (GHG) from 6,561 metric tons (in FY2015) to 5,249 metric tons (20% reduction) by June 30, 2020 and 4,593 tons (30% reduction) by June 30, 2023. ___ Reduces emissions from employee commuting ___ Reduces emissions from CDPHE operations
11. Fully implement the roadmap to create and pilot using a budget equity assessment by June 30, 2020 and increase the percent of selected budgets using the equity assessment from 0% to 50% by June 30, 2023. ___ Used a budget equity assessment

__ Advance CDPHE Division-level strategic priorities.

The costs and benefits of the proposed rule will not be incurred if inaction is chosen. Costs and benefits of inaction not previously discussed include:

This particular requirement mirrors a requirement that has been contained in PHO 20-20. Because of the shift in pandemic response, PHO 20-20 is expected to lapse without renewal, necessitating this emergency rulemaking. The Department recognizes the importance of maintaining these minimum infection control standards while the Health Facilities and Emergency Medical Services Division ("Division") continues its stakeholder engagement process for permanent rulemaking. As such, the proposed emergency rules incorporate the requirements of the aforementioned guidance.

5. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

Rulemaking is proposed when it is the least costly method or the only statutorily allowable method for achieving the purpose of the statute. The specific revisions proposed in this emergency rulemaking were developed in alignment with the requirements of PHO 20-20 and in coordination with the Department's Disease Control and Public Health Response Division (DCPHR). The proposed regulations are the minimum necessary to maintain the comprehensive infection control requirements in residential care settings, while the Department works with stakeholders to draft

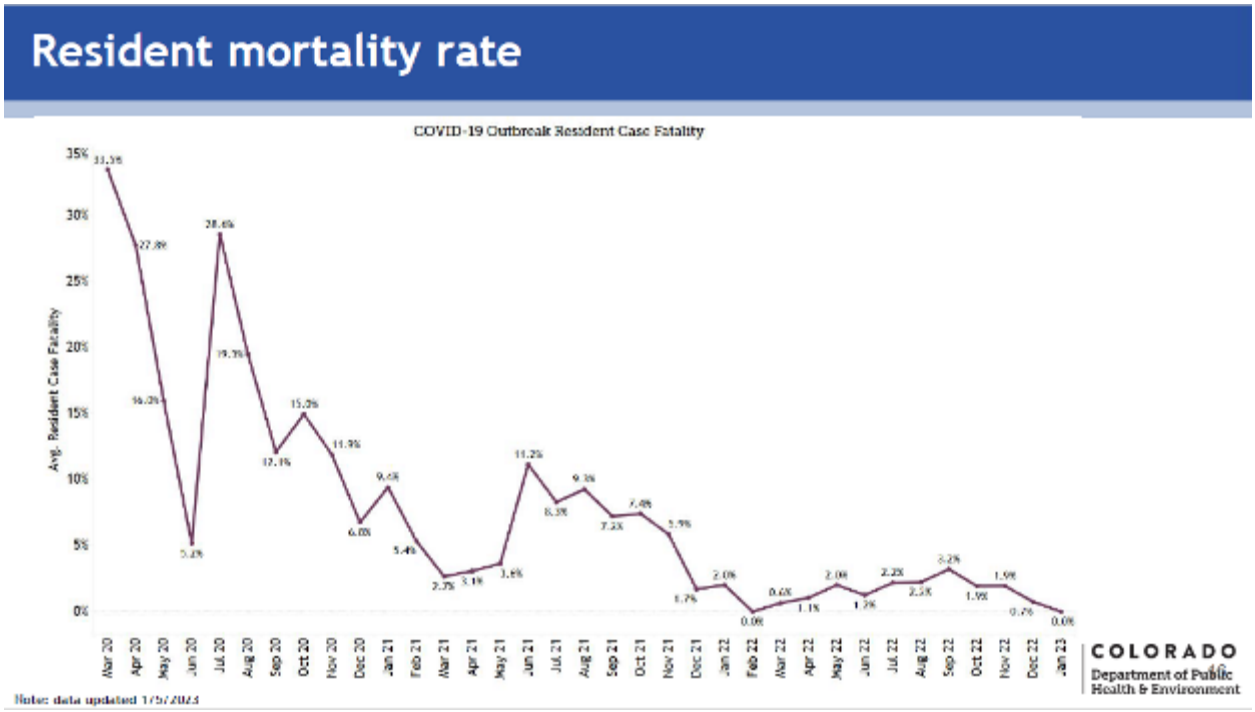
permanent regulations.

6. Alternative Rules or Alternatives to Rulemaking Considered and Why Rejected.

The expected lapse of PHO 20-20 creates the need for these necessary minimum requirements to be maintained until a permanent rulemaking can occur.

7. To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.

Residents of long term care facilities were impacted greatly by the COVID-19 virus. During the early months of the COVID pandemic some facilities did not have access to routine supplies such as personal protective equipment (e.g. gloves, masks, and gowns) due to supply chain issues. Many facilities did not have protocols or processes in place to respond to an infectious disease outbreak including how to separate sick persons from others, how to properly disinfect surfaces and equipment, and how to use personal protective equipment to prevent staff and resident illness. Deaths among cases have decreased significantly following the implementation of strategies aimed at preventing morbidity and mortality in these settings (see chart below). Important interventions included access to testing, vaccination, treatments, source control, personal protective equipment for staff, and staff education.



HOUSE BILL 22-1401

BY REPRESENTATIVE(S) Mullica, Amabile, Bernett, Caraveo, Duran, Esgar, Herod, Hooton, Jodeh, Lindsay, Lontine, Ortiz, Sirota, Valdez A.; also SENATOR(S) Moreno, Buckner, Fields, Gonzales, Hinrichsen, Jaquez Lewis, Lee, Pettersen, Story, Winter, Fenberg.

CONCERNING THE PREPAREDNESS OF HEALTH FACILITIES TO MEET PATIENT NEEDS, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** 25-3-128 and 25-3-129 as follows:

25-3-128. Hospitals - nurses, nurse aides, and EMS providers - staffing requirements - enforcement - waiver - rules - definitions. (1) AS USED IN THIS SECTION:

(a) "CLINICAL STAFF NURSE" MEANS A PRACTICAL NURSE OR REGISTERED PROFESSIONAL NURSE LICENSED PURSUANT TO ARTICLE 255 OF TITLE 12 WHO PROVIDES DIRECT CARE TO PATIENTS.

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

(b) "EMS PROVIDER" MEANS AN INDIVIDUAL WHO HOLDS A VALID CERTIFICATE OR LICENSE ISSUED BY THE DEPARTMENT AS PROVIDED IN ARTICLE 3.5 OF THIS TITLE 25.

(c) "NURSE AIDE" MEANS A PERSON CERTIFIED PURSUANT TO ARTICLE 255 OF TITLE 12 TO PRACTICE AS A NURSE AIDE WHO PROVIDES DIRECT CARE TO PATIENTS OR WHO WORKS IN AN AUXILIARY CAPACITY UNDER THE SUPERVISION OF A REGISTERED NURSE.

(d) "STAFFING PLAN" MEANS THE MASTER NURSE STAFFING PLAN DEVELOPED FOR A HOSPITAL PURSUANT TO SUBSECTION (2)(b) OF THIS SECTION.

(2) (a) ON OR BEFORE SEPTEMBER 1, 2022, EACH HOSPITAL SHALL ESTABLISH A NURSE STAFFING COMMITTEE PURSUANT TO RULES PROMULGATED BY THE STATE BOARD OF HEALTH, EITHER BY CREATING A NEW COMMITTEE OR ASSIGNING THE NURSE STAFFING FUNCTIONS TO AN EXISTING HOSPITAL STAFFING COMMITTEE. THE NURSE STAFFING COMMITTEE MUST HAVE AT LEAST SIXTY PERCENT OR GREATER PARTICIPATION BY CLINICAL STAFF NURSES, IN ADDITION TO AUXILIARY PERSONNEL AND NURSE MANAGERS. THE NURSE STAFFING COMMITTEE MUST INCLUDE A DESIGNATED LEADER OF WORKPLACE VIOLENCE PREVENTION AND REDUCTION EFFORTS.

(b) THE NURSE STAFFING COMMITTEE:

(I) SHALL ANNUALLY DEVELOP AND OVERSEE A MASTER NURSE STAFFING PLAN FOR THE HOSPITAL THAT:

(A) IS VOTED ON AND RECOMMENDED BY AT LEAST SIXTY PERCENT OF THE NURSE STAFFING COMMITTEE;

(B) INCLUDES MINIMUM STAFFING REQUIREMENTS AS ESTABLISHED IN RULES PROMULGATED BY THE STATE BOARD OF HEALTH FOR EACH INPATIENT UNIT AND EMERGENCY DEPARTMENT THAT ARE ALIGNED WITH NATIONALLY RECOGNIZED STANDARDS AND GUIDELINES;

(C) INCLUDES STRATEGIES THAT PROMOTE THE HEALTH, SAFETY, AND WELFARE OF THE HOSPITAL'S EMPLOYEES AND PATIENTS;

(D) INCLUDES GUIDANCE AND A PROCESS FOR REDUCING

NURSE-TO-PATIENT ASSIGNMENTS TO ALIGN WITH THE DEMAND BASED ON PATIENT ACUITY; AND

(E) MAY INCLUDE INNOVATIVE STAFFING MODELS;

(II) (A) SHALL SUBMIT THE RECOMMENDED STAFFING PLAN TO THE HOSPITAL'S SENIOR NURSE EXECUTIVE AND THE HOSPITAL'S GOVERNING BODY FOR APPROVAL. IF THE FINAL PLAN APPROVED BY THE HOSPITAL CHANGES MATERIALLY FROM THE RECOMMENDATIONS PUT FORTH BY THE STAFFING COMMITTEE, THE SENIOR NURSE EXECUTIVE SHALL PROVIDE THE NURSE STAFFING COMMITTEE WITH AN EXPLANATION FOR THE CHANGES.

(B) IF, AFTER RECEIVING THE EXPLANATION REFERENCED IN SUBSECTION (2)(b)(II)(A) OF THIS SECTION, THE STAFFING COMMITTEE BELIEVES THE FINAL PLAN DOES NOT MEET NURSE STAFFING STANDARDS ESTABLISHED IN RULES PROMULGATED BY THE STATE BOARD OF HEALTH, THE STAFFING COMMITTEE, WITH A VOTE OF SIXTY PERCENT OR MORE OF THE MEMBERS, MAY REQUEST THE DEPARTMENT REVIEW THE FINAL ADOPTED STAFFING PLAN FOR COMPLIANCE WITH RULES PROMULGATED BY THE STATE BOARD OF HEALTH.

(III) MAY PUBLISH A REPORT THAT IS RESPONSIVE TO THE CHANGES MADE TO THE RECOMMENDED PLAN PURSUANT TO SUBSECTION (2)(b)(II) OF THIS SECTION, IF ANY;

(IV) SHALL DESCRIBE IN WRITING THE PROCESS FOR RECEIVING, TRACKING, AND RESOLVING COMPLAINTS AND RECEIVING FEEDBACK ON THE STAFFING PLAN FROM CLINICAL STAFF NURSES AND OTHER STAFF; AND

(V) SHALL MAKE THE COMPLAINT AND FEEDBACK PROCESS AVAILABLE TO ALL PROVIDERS, INCLUDING CLINICAL STAFF NURSES, NURSE AIDES, AND EMS PROVIDERS.

(c) THE DEPARTMENT IS AUTHORIZED TO AND SHALL ENTER, SURVEY, AND INVESTIGATE EACH HOSPITAL AS NECESSARY TO ENSURE COMPLIANCE WITH THE NURSING STAFFING STANDARDS ESTABLISHED IN RULES PROMULGATED BY THE STATE BOARD OF HEALTH.

(3) A HOSPITAL SHALL:

(a) SUBMIT THE FINAL, APPROVED NURSE STAFFING PLAN TO THE DEPARTMENT ON AN ANNUAL BASIS;

(b) ON A QUARTERLY BASIS, EVALUATE THE STAFFING PLAN AND PREPARE A REPORT FOR INTERNAL REVIEW BY THE STAFFING COMMITTEE;

(c) PROVIDE THE RELEVANT UNIT-BASED STAFFING PLAN TO:

(I) EACH APPLICANT FOR A NURSING POSITION ON A GIVEN UNIT UPON AN OFFER OF EMPLOYMENT; AND

(II) A PATIENT UPON REQUEST; AND

(d) PREPARE AN ANNUAL REPORT CONTAINING THE DETAILS OF THE EVALUATION REQUIRED IN SUBSECTION (3)(b) OF THIS SECTION AND SUBMIT THE REPORT TO THE DEPARTMENT, IN A FORM AND MANNER DETERMINED BY RULES PROMULGATED BY THE STATE BOARD OF HEALTH.

(4) A HOSPITAL SHALL NOT ASSIGN A CLINICAL STAFF NURSE, NURSE AIDE, OR EMS PROVIDER TO A HOSPITAL UNIT UNLESS, CONSISTENT WITH THE CONDITIONS OF PARTICIPATION ADOPTED FOR FEDERAL MEDICARE AND MEDICAID PROGRAMS, HOSPITAL PERSONNEL RECORDS INCLUDE DOCUMENTATION THAT THE TRAINING AND DEMONSTRATION OF COMPETENCY WERE SUCCESSFULLY COMPLETED DURING ORIENTATION AND ON A PERIODIC BASIS CONSISTENT WITH HOSPITAL POLICIES.

(5) (a) ON OR BEFORE SEPTEMBER 1, 2022, EACH HOSPITAL SHALL REPORT, IN A FORM AND MANNER DETERMINED BY RULES PROMULGATED BY THE STATE BOARD OF HEALTH, THE BASELINE NUMBER OF BEDS THE HOSPITAL IS ABLE TO STAFF IN ORDER TO PROVIDE PATIENT CARE AND THE HOSPITAL'S CURRENT BED CAPACITY. THE REPORTING MAY INCLUDE:

(I) SEASONAL OR OTHER ANTICIPATED VARIANCES IN STAFFED-BED CAPACITY; AND

(II) ANTICIPATED FACTORS IMPACTING STAFFED-BED CAPACITY.

(b) IN PROMULGATING RULES PURSUANT TO SUBSECTION (5)(a) OF THIS SECTION, THE STATE BOARD OF HEALTH SHALL:

(I) USE THE DATA PROVIDED TO THE DEPARTMENT BY EACH HOSPITAL THROUGHOUT THE COVID-19 PANDEMIC THROUGH AN INTERNET-BASED RESOURCE MANAGEMENT AND COMMUNICATION TOOL DEVELOPED FOR AND COMMONLY USED BY HOSPITALS;

(II) DETERMINE THE NUMBER OF SEASONAL VARIATIONS ALLOWABLE WITH REGARD TO SUBSECTION (5)(a)(I) OF THIS SECTION WITH A MINIMUM OF TWO AND A MAXIMUM OF FOUR ALLOWABLE VARIANCES; AND

(III) DEFINE "STAFFED-BED CAPACITY" FOR THE PURPOSES OF THIS SECTION.

(c) ON OR BEFORE SEPTEMBER 1, 2022, AS DETERMINED BY RULES PROMULGATED BY THE STATE BOARD OF HEALTH, IF A HOSPITAL'S ABILITY TO MEET STAFFED-BED CAPACITY FALLS BELOW EIGHTY PERCENT OF THE HOSPITAL'S REPORTED BASELINE FOR NOT LESS THAN SEVEN AND NOT MORE THAN FOURTEEN CONSECUTIVE DAYS, THE HOSPITAL SHALL NOTIFY THE DEPARTMENT AND SUBMIT:

(I) A PLAN TO ENSURE STAFF IS AVAILABLE, WITHIN THIRTY DAYS, TO RETURN TO A STAFFED-BED CAPACITY LEVEL THAT IS EIGHTY PERCENT OF THE REPORTED BASELINE; OR

(II) A REQUEST FOR A WAIVER DUE TO A HARDSHIP, WHICH REQUEST ARTICULATES WHY THE HOSPITAL IS UNABLE TO MEET THE REQUIRED STAFFED-BED CAPACITY IF:

(A) THE HOSPITAL'S CURRENT STAFFED-BED CAPACITY FALLS BELOW EIGHTY PERCENT OF THE HOSPITAL'S REPORTED BASELINE FOR NOT LESS THAN SEVEN AND NOT MORE THAN FOURTEEN CONSECUTIVE DAYS; OR

(B) THE HOSPITAL'S CURRENT STAFFED-BED CAPACITY THREATENS PUBLIC HEALTH.

(d) THE DEPARTMENT MAY IMPOSE FINES, NOT TO EXCEED ONE THOUSAND DOLLARS PER DAY, FOR A HOSPITAL'S FAILURE TO:

(I) MEET THE REPORTED STAFFED-BED CAPACITY OF EIGHTY PERCENT OR MORE OF THE HOSPITAL'S REPORTED BASELINE; OR

(II) ACCURATELY REPORT A HOSPITAL'S BASELINE STAFFED-BED CAPACITY.

(6) EACH HOSPITAL WITH MORE THAN TWENTY-FIVE BEDS SHALL ARTICULATE IN ITS EMERGENCY PLAN A DEMONSTRATED ABILITY TO EXPAND THE HOSPITAL'S STAFFED-BED CAPACITY UP TO ONE HUNDRED TWENTY-FIVE PERCENT OF THE HOSPITAL'S BASELINE STAFFED-BED CAPACITY AND INTENSIVE CARE UNIT CAPACITY WITHIN FOURTEEN DAYS AFTER:

(a) A STATEWIDE PUBLIC HEALTH EMERGENCY IS DECLARED OR THE HOSPITAL IS NOTIFIED BY THE DEPARTMENT THAT SURGE CAPACITY IS NEEDED; AND

(b) THE STATE HAS USED ALL AVAILABLE AUTHORITY TO EXPEDITE WORKFORCE AVAILABILITY AND MAXIMIZE HOSPITAL THROUGHPUT AND CAPACITY, SUCH AS:

(I) LICENSING OR CERTIFICATION FLEXIBILITY FOR HEALTH FACILITIES;

(II) REDUCING REQUIREMENTS FOR LICENSING, CREDENTIALING, AND THE RECEIPT OF STAFF PRIVILEGES;

(III) WAIVING SCOPE OF PRACTICE LIMITATIONS; AND

(IV) WAIVING STATE-REGULATED PAYER PROVISIONS THAT CREATE BARRIERS TO TIMELY PATIENT DISCHARGE.

(7) EACH HOSPITAL SHALL UPDATE ITS EMERGENCY PLAN AT LEAST ANNUALLY AND AS OFTEN AS NECESSARY, AS CIRCUMSTANCES WARRANT. THE EMERGENCY PLAN MUST INCLUDE THE ACTIONS THE HOSPITAL WILL TAKE TO MAXIMIZE STAFFED-BED CAPACITY AND APPROPRIATE UTILIZATION OF HOSPITAL BEDS TO THE EXTENT NECESSARY FOR A PUBLIC HEALTH EMERGENCY AND THROUGH THE FOLLOWING ACTIVITIES:

(a) CROSS-TRAINING, JUST-IN-TIME TRAINING, AND REDEPLOYMENT OF STAFF;

(b) SUPPORTING ALL HOSPITAL FACILITIES, INCLUDING HOSPITAL-OWNED FACILITIES, TO PROVIDE ANY NECESSARY, AVAILABLE,

AND APPROPRIATE PREVENTIVE CARE, VACCINE ADMINISTRATION, DIAGNOSTIC TESTING, AND THERAPEUTICS;

(c) MAXIMIZING HOSPITAL THROUGHPUT BY DISCHARGING PATIENTS TO SKILLED NURSING, POST-ACUTE, AND OTHER STEP-DOWN FACILITIES; AND

(d) REDUCING THE NUMBER OF SCHEDULED PROCEDURES IN THE HOSPITAL.

(8) BEGINNING SEPTEMBER 1, 2022, THE DEPARTMENT MAY FINE A HOSPITAL AN AMOUNT NOT TO EXCEED TEN THOUSAND DOLLARS PER DAY FOR THE FAILURE TO:

(a) ACHIEVE THE REQUIRED STAFFED-BED CAPACITY DESCRIBED IN SUBSECTION (6) OF THIS SECTION WITHIN FOURTEEN DAYS AFTER A DECLARED STATEWIDE PUBLIC HEALTH EMERGENCY OR OTHER NOTIFICATION BY THE DEPARTMENT THAT SURGE CAPACITY IS NEEDED;

(b) INCLUDE THE AMOUNT OF NECESSARY VACCINES FOR ADMINISTRATION IN ITS ANNUAL EMERGENCY PLAN AND HAVE THE VACCINES AVAILABLE, TO THE EXTENT THAT THE VACCINES ARE AVAILABLE, AT EACH OF ITS HOSPITAL FACILITIES AND HOSPITAL-OWNED PRIMARY CARE SITES DURING AND OUTSIDE OF THE PUBLIC HEALTH EMERGENCY, AS DETERMINED BY RULES PROMULGATED BY THE DEPARTMENT; AND

(c) INCLUDE THE NECESSARY TESTING CAPABILITIES AVAILABLE IN ITS ANNUAL EMERGENCY PLAN AND AT EACH OF ITS HOSPITAL FACILITIES AND HOSPITAL-OWNED PRIMARY CARE SITES DURING AND OUTSIDE OF A PUBLIC HEALTH EMERGENCY, TO THE EXTENT THAT THE TESTING IS AVAILABLE, AS DETERMINED BY RULES PROMULGATED BY THE DEPARTMENT.

(9) FOR THE PURPOSES OF THIS SECTION, THE DEPARTMENT SHALL ENTER, SURVEY, AND INVESTIGATE EACH HOSPITAL:

(a) AS DEEMED NECESSARY BY THE DEPARTMENT;

(b) FOR PURPOSES OF INFECTION CONTROL AND EMERGENCY PREPAREDNESS; AND

(c) TO ENSURE COMPLIANCE WITH THIS SECTION.

(10) THE DEPARTMENT SHALL ANNUALLY REPORT ON THE INFORMATION CONTAINED IN THE QUARTERLY REPORT DESCRIBED IN SUBSECTION (3)(d) OF THIS SECTION AS A PART OF ITS PRESENTATION TO ITS COMMITTEE OF REFERENCE AT A HEARING HELD PURSUANT TO SECTION 2-7-203 (2)(a) OF THE "STATE MEASUREMENT FOR ACCOUNTABLE, RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT".

(11) THE DEPARTMENT MAY PROMULGATE RULES TO REQUIRE HEALTH FACILITIES LICENSED PURSUANT TO SECTION 25-1.5-103 TO DEVELOP AND IMPLEMENT INFECTION PREVENTION PLANS THAT ALIGN WITH NATIONAL BEST PRACTICES AND STANDARDS AND THAT ARE RESPONSIVE TO COVID-19 AND OTHER COMMUNICABLE DISEASES. THE REQUIREMENTS MAY INCLUDE TESTING, VACCINATION, AND TREATMENT IN ACCORDANCE WITH APPLICABLE STATE LAWS, RULES, AND EXECUTIVE ORDERS.

(12) THE STATE BOARD OF HEALTH SHALL PROMULGATE RULES AS NECESSARY TO IMPLEMENT THIS SECTION.

25-3-129. Office of saving people money on health care - study - report. (1) THE OFFICE OF SAVING PEOPLE MONEY ON HEALTH CARE IN THE LIEUTENANT GOVERNOR'S OFFICE SHALL STUDY:

(a) THE LEVEL OF PREPAREDNESS OF HEALTH FACILITIES LICENSED PURSUANT TO SECTION 25-1.5-103 TO RESPOND TO POST-VIRAL ILLNESS RESULTING FROM THE COVID-19 VIRUS;

(b) THE EFFECTS OF POST-VIRAL ILLNESS RESULTING FROM THE COVID-19 VIRUS ON THE MENTAL, BEHAVIORAL, AND PHYSICAL HEALTH AND THE FINANCIAL SECURITY OF THE PEOPLE OF COLORADO; AND

(c) THE EFFECTS OF THE COVID-19 PANDEMIC ON THE COST OF HEALTH CARE IN COLORADO AND ON THE ABILITY OF COLORADO'S PUBLIC HEALTH SYSTEM TO RESPOND TO EMERGENCIES.

(2) ON OR BEFORE JANUARY 1, 2023, AND ON OR BEFORE JANUARY 1 EACH YEAR THEREAFTER, THE OFFICE OF SAVING PEOPLE MONEY ON HEALTH CARE SHALL REPORT ITS FINDINGS TO THE GOVERNOR.

(3) THE OFFICE OF SAVING PEOPLE MONEY ON HEALTH CARE SHALL COORDINATE, MONITOR, AND SUPPORT THE EFFORTS TO IMPROVE THE

AFFORDABILITY OF HEALTH CARE, HEALTH OUTCOMES, AND PUBLIC HEALTH READINESS IN STATE PROGRAMS AND DEPARTMENTS.

SECTION 2. In Colorado Revised Statutes, 25-1.5-103, **amend** (1)(a)(I)(C) as follows:

25-1.5-103. Health facilities - powers and duties of department - limitations on rules promulgated by department - definitions. (1) The department has, in addition to all other powers and duties imposed upon it by law, the powers and duties provided in this section as follows:

(a) (I) (C) The department shall extend the survey cycle or conduct a tiered inspection or survey of a health facility licensed for at least three years and against which no enforcement activity has been taken, no patterns of deficient practices exist, as documented in the inspection and survey reports issued by the department, and no substantiated complaint resulting in the discovery of significant deficiencies that may negatively affect the life, health, or safety of consumers of the health facility has been received within the three years prior to the date of the inspection. The department may expand the scope of the inspection or survey to an extended or full survey if the department finds deficient practice during the tiered inspection or survey. The department, by rule, shall establish a schedule for an extended survey cycle or a tiered inspection or survey system designed, at a minimum, to: Reduce the time needed for and costs of licensure inspections for both the department and the licensed health facility; reduce the number, frequency, and duration of on-site inspections; reduce the scope of data and information that health facilities are required to submit or provide to the department in connection with the licensure inspection; reduce the amount and scope of duplicative data, reports, and information required to complete the licensure inspection; and be based on a sample of the facility size. Nothing in this ~~sub-subparagraph (C)~~ SUBSECTION (1)(a)(I)(C) limits the ability of the department to conduct a periodic inspection or survey that is required to meet its obligations as a state survey agency on behalf of the FEDERAL centers for medicare and medicaid services or the department of health care policy and financing to assure that the health facility meets the requirements for participation in the medicare and medicaid programs OR LIMITS THE ABILITY OF THE DEPARTMENT TO ENTER, SURVEY, AND INVESTIGATE HOSPITALS PURSUANT TO SECTION 25-3-128.

SECTION 3. In Colorado Revised Statutes, 25-3-102.1, **amend** (1)(b)(II) as follows:

25-3-102.1. Deemed status for certain facilities. (1) (b) (II) If the standards for national accreditation are less stringent than the state's licensure standards for a particular health facility, the department of public health and environment may conduct a survey that focuses on the more stringent state standards. Beginning one year after the department first grants deemed status to a health facility pursuant to this ~~paragraph (b)~~ SUBSECTION (1)(b), the department may conduct validation surveys, based on a valid sample methodology, of up to ten percent of the total number of accredited health facilities in the industry. ~~excluding hospitals.~~ If the department conducts a validation survey of a health facility, the validation survey is in lieu of a licensing renewal survey that the health facility would have undergone if the health facility did not have deemed status pursuant to this ~~paragraph (b)~~ SUBSECTION (1)(b). NOTWITHSTANDING ANY OTHER LAW TO THE CONTRARY, THE DEPARTMENT MAY ENTER, SURVEY, AND INVESTIGATE HOSPITALS PURSUANT TO SECTION 25-3-128.

SECTION 4. In Colorado Revised Statutes, 25-3-105, **amend** (1)(a)(I)(B) and (1)(a)(I)(C) as follows:

25-3-105. License - fee - rules - penalty - repeal. (1) (a) (I) (B) On or after June 4, 2012, the state board of health may increase the amount of any fee on the schedule of fees established pursuant to subsection (1)(a)(I)(A) of this section that is in effect on June 4, 2012, by an amount not to exceed the annual percentage change in the United States department of labor, bureau of labor statistics, consumer price index for Denver-Aurora-Lakewood for all urban consumers and all goods, or its applicable predecessor or successor index. Nothing in this subsection (1)(a)(I)(B) limits the ability of the state board of health to reduce the amount of any fee on the schedule of fees in effect on such date or to modify fees as necessary to comply with section 24-75-402. NOTWITHSTANDING THE REQUIREMENTS OF THIS SUBSECTION (1)(a)(I)(B), THE STATE BOARD OF HEALTH MAY ASSESS FEES NECESSARY TO COVER THE COSTS ASSOCIATED WITH THE SURVEYS CONDUCTED PURSUANT TO SECTION 25-3-128.

(C) The department of public health and environment shall institute, by rule, a performance incentive system for licensed health facilities under

which a licensed health facility would be eligible for a reduction in its license renewal fee if: The department's on-site relicensure inspection demonstrates that the health facility has no significant deficiencies that have negatively affected the life, safety, or health of its consumers; the licensed health facility has fully and timely cooperated with the department during the on-site inspection; the department has found no documented actual or potential harm to consumers; and, in the case where any significant deficiencies are found that do not negatively affect the life, safety, or health of consumers, the licensed health facility has submitted, and the department has accepted, a plan of correction and the health facility has corrected the deficient practice, as verified by the department, within the period required by the department. NOTWITHSTANDING THE REQUIREMENTS OF THIS SUBSECTION (1)(a)(I)(C), ANY FEES ASSOCIATED WITH THE SURVEYS AND INVESTIGATIONS OF HOSPITALS AUTHORIZED BY SECTION 25-3-128 ARE NOT SUBJECT TO A REDUCTION BASED ON THE PERFORMANCE INCENTIVE SYSTEM.

SECTION 5. In Colorado Revised Statutes, **repeal** 25-3-702.

SECTION 6. In Colorado Revised Statutes, 25-3-703, **amend** (1) as follows:

25-3-703. Hospital report card - rules - exemption. (1) (a) The executive director shall approve a Colorado hospital report card consisting of public disclosure of data assembled pursuant to this part 7. At a minimum, the data shall be made available on an internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific hospitals. The website ~~shall~~ MUST include:

(I) CLINICAL OUTCOMES MEASURES FROM GENERAL AND PUBLIC HOSPITALS LICENSED PURSUANT TO SECTION 25-1.5-103; AND

(II) Such additional information as is determined necessary to ensure that the website enhances informed decision making among consumers and health-care purchasers, which ~~shall~~ MUST include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from hospital to hospital. ~~The data specified in this subsection (1) shall be released on or before November 30, 2007.~~

(b) WHEN MAKING A DETERMINATION AS TO WHAT DATA TO REPORT

AS REQUIRED BY SUBSECTION (1)(a) OF THIS SECTION, EACH EXECUTIVE DIRECTOR SHALL CONSIDER:

(I) INCLUSION OF DATA ON ALL PATIENTS REGARDLESS OF THE PAYER SOURCE FOR COLORADO HOSPITALS AND OTHER INFORMATION THAT MAY BE REQUIRED FOR EITHER INDIVIDUAL OR GROUP PURCHASERS TO ASSESS THE VALUE OF THE PRODUCT;

(II) USE OF STANDARDIZED CLINICAL OUTCOMES MEASURES RECOGNIZED BY NATIONAL ORGANIZATIONS THAT ESTABLISH STANDARDS TO MEASURE THE PERFORMANCE OF HEALTH-CARE PROVIDERS;

(III) DATA THAT IS SEVERITY AND ACUITY ADJUSTED USING STATISTICAL METHODS THAT SHOW VARIATION IN REPORTED OUTCOMES, WHERE APPLICABLE, AND DATA THAT HAS PASSED STANDARD EDITS;

(IV) REPORTING THE RESULTS WITH SEPARATE DOCUMENTS CONTAINING THE TECHNICAL SPECIFICATION AND MEASURES;

(V) STANDARDIZATION IN REPORTING; AND

(VI) DISCLOSURE OF THE METHODOLOGY OF REPORTING.

SECTION 7. In Colorado Revised Statutes, 25-3-703, **add** (3) and (4) as follows:

25-3-703. Hospital report card - rules - exemption. (3) THE STATE BOARD OF HEALTH SHALL PROMULGATE RULES THAT ESTABLISH NURSING-SENSITIVE QUALITY MEASURES BASED UPON A NATIONALLY RECOGNIZED STANDARD AND REVISE THE RULES AS NECESSARY EVERY THREE YEARS TO BE INCLUDED IN THE HOSPITAL REPORT CARD. THE NURSING-SENSITIVE QUALITY MEASURES MUST INCLUDE AT A MINIMUM:

(a) SKILL MIX;

(b) THE NURSING HOURS PER PATIENT PER DAY;

(c) VOLUNTARY TURNOVER;

(d) PATIENT FALLS PREVALENCE RATE;

(e) PATIENT FALLS WITH INJURY; AND

(f) RECORDED INCIDENCES OF VIOLENCE AGAINST STAFF AND CONTRACTED STAFF.

(4) HOSPITALS WITH FEWER THAN ONE HUNDRED BEDS ARE EXEMPT FROM THE REQUIREMENTS OF THIS SECTION.

SECTION 8. In Colorado Revised Statutes, 25-3-705, **amend** (1) as follows:

25-3-705. Health-care charge transparency - hospital charge report. (1) The commissioner of insurance shall work with the duly constituted association of hospitals selected by the executive director ~~pursuant to section 25-3-702~~ for assistance in carrying out the purposes of this section.

SECTION 9. Appropriation. (1) For the 2022-23 state fiscal year, $645,340 is appropriated to the department of public health and environment for use by the health facilities and emergency management services division. This appropriation is from the general fund and is based on an assumption that the division will require an additional 6.2 FTE. To implement this act, the division may use this appropriation for the nursing and acute care facility survey.

(2) For the 2022-23 state fiscal year, $139,939 is appropriated to the office of the governor. This appropriation is from the general fund and is based on an assumption that the office will require an additional 0.9 FTE. To implement this act, the office may use this appropriation for the administration of governor's office and residence.

SECTION 10. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.

Alec Garnett
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Steve Fenberg
PRESIDENT OF
THE SENATE

Robin Jones
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

APPROVED May 18th at 12:42 pm
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES CHAPTER 2 – GENERAL LICENSURE STANDARDS

6 CCR 1011-1 Chapter 2

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

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11.2 General Provisions

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11.2.3 Facilities and agencies shall ensure that ninety percent (90%) of employees and direct contractors have received the influenza vaccine during a given influenza season. In order to demonstrate that the ninety percent (90%) rate has been meet, facilities and agencies shall:

(A) By May 15th of every year, report to the Department, in the form and manner specified by the Department, the vaccination rate for employees and direct contracts for the most recent influenza season.

(B) Have defined procedures to prevent the spread of influenza from unvaccinated healthcare workers.

(C) Maintain for three (3) years the following documentation that may be examined by the Department in a random audit process:

(1) ~~[Emergency rule expired 12/28/2021]~~ PROOF OF IMMUNIZATION, AS DEFINED AT PART 1.51 OF THIS CHAPTER.

(2) A medical exemption signed by a physician, physician assistant, advanced practice nurse, or certified nurse midwife licensed in the State of Colorado stating that the influenza vaccination for the employee or direct contractor is medically contraindicated as described in the product labeling approved by the FDA.

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Part 12. ~~COVID-19 IMMUNIZATION OF EMPLOYEES, DIRECT CONTRACTORS, AND SUPPORT STAFF [Emergency rule expired 07/14/2022]~~ INFECTIOUS DISEASE MITIGATION AND CONTROL

12.1 STATUTORY AUTHORITY

12.1.1 THE REQUIREMENTS OF THIS PART 12 SHALL BE OVERSEEN AND ENFORCED BY THE DEPARTMENT IN A MANNER CONSISTENT WITH PARTS 2.10 AND 2.11 OF THIS CHAPTER.

12.2 GENERAL REQUIREMENTS

12.2.1 INFECTIOUS DISEASE MITIGATION, VACCINE, AND TREATMENT PLANS

(A) ALL FACILITIES LICENSED UNDER THIS CHAPTER SHALL ESTABLISH AND MAINTAIN AN INFECTIOUS DISEASE MITIGATION, VACCINE AND TREATMENT PLAN. THIS PLAN SHALL ADDRESS, AT A MINIMUM, THE FOLLOWING:

(1) IDENTIFICATION OF DESIGNATED STAFF WHO SHALL COORDINATE VACCINE INFORMATION, ADMINISTRATION, AND TRACKING AND REPORTING OF THE VACCINATION STATUS OF STAFF AND, IF APPLICABLE, RESIDENTS ON AN ONGOING BASIS;

(2) THE NAME AND LOCATION OF THE INFECTIOUS DISEASE VACCINE AND TREATMENT PROVIDER(S) THAT WILL BE USED BY THE FACILITY TO FACILITATE ADMINISTRATION OF VACCINES AND TREATMENT;

(3) HOW THE FACILITY WILL ASSESS AND ADDRESS THE VACCINATION OF NEW STAFF AND, IF APPLICABLE, RESIDENTS.

12.2.2 INFECTION CONTROL OFFICER

(A) APPLICABILITY

(1) THE REQUIREMENTS OF THIS PART 12.2.2 SHALL APPLY TO THE FOLLOWING LICENSED FACILITY TYPES ONLY, EXCEPT WHERE OTHERWISE INDICATED:

(A) ASSISTED LIVING RESIDENCES;

(B) NURSING CARE FACILITIES; AND

(C) FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES, INCLUDING BOTH GROUP HOMES AND INTERMEDIATE CARE FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES.

(B) EACH FACILITY SHALL ASSIGN AT LEAST ONE (1) STAFF MEMBER RESPONSIBLE FOR THE SITE MANAGEMENT OF THE FACILITY'S INFECTION PREVENTION AND CONTROL PROGRAM AND TRAINING. THIS INDIVIDUAL SHALL BE RESPONSIBLE FOR THE FOLLOWING:

(1) COMPLETING AN INFECTION PREVENTION AND CONTROL TRAINING FROM A NATIONALLY-RECOGNIZED PROVIDER WITHIN TWO (2) WEEKS OF APPOINTMENT/DESIGNATION THAT MEETS THE FOLLOWING REQUIREMENTS BASED ON FACILITY TYPE;

(A) INFECTION CONTROL OFFICERS AT NURSING CARE FACILITIES AND INTERMEDIATE CARE FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SHALL COMPLETE AT LEAST NINETEEN (19) HOURS OF INITIAL TRAINING.

(B) INFECTION CONTROL OFFICERS AT ASSISTED LIVING RESIDENCES AND ALL GROUP HOMES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SHALL COMPLETE AT LEAST 1.5 HOURS OF INITIAL TRAINING.

(2) COMPLETING A MINIMUM OF 1.5 HOURS OF CONTINUING EDUCATION IN INFECTION PREVENTION AND CONTROL ON AN ANNUAL BASIS FROM A NATIONALLY-RECOGNIZED PROVIDER SUFFICIENT TO STAY CURRENT ON CHANGING GUIDANCE AND REQUIREMENTS IN THE FIELD;

(3) PROVIDING ON-SITE MANAGEMENT OF INFECTIOUS DISEASE PREVENTION AND RESPONSE ACTIVITIES AND GENERAL INFECTION PREVENTION DUTIES;

(4) ENSURING THE FACILITY COMPLIES WITH DEPARTMENT REPORTING REQUIREMENTS RELATED TO INFECTIOUS DISEASES;

(5) PROVIDING FACILITY ACCESS TO, AND ENSURING PROPER SUPPLY, USE, HANDLING, AND IMPLEMENTATION OF PERSONAL PROTECTIVE EQUIPMENT (PPE) AND DISINFECTANTS, USED PER MANUFACTURER'S GUIDELINES;

(6) MAINTAINING A FACILITY RESPIRATORY PROTECTION PROGRAM COMPLIANT WITH OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) RESPIRATORY PROTECTION STANDARD (29 CFR 1910.134);

(7) ADVISING AND EDUCATING RESIDENTS, STAFF, AND VISITORS ON CURRENT PRECAUTIONS BEING TAKEN IN THE FACILITY FOR INFECTIOUS DISEASES AND THE PREVENTION OF THEIR SPREAD; AND

(8) NOTIFYING RESIDENTS, DESIGNATED REPRESENTATIVES, AND STAFF OF UPDATED CENTERS FOR DISEASE CONTROL (CDC) VACCINATION RECOMMENDATIONS, AND ENSURING VACCINES FOR INFECTIOUS DISEASES ARE AVAILABLE TO STAFF AND RESIDENTS INSIDE THEIR FACILITY WITHIN SIXTY (60) DAYS OF ANY UPDATE TO THE CDC'S VACCINE RECOMMENDATIONS.

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