COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Jo Tansey, Acute Care & Nursing Facilities Branch Chief, Health Facilities and Emergency Medical Services Division

Through: Elaine McManis, Division Director

Date: April 19, 2023

Subject: Permanent Rulemaking Hearing concerning 6 CCR 1011-1, Chapter 4, Standards for Hospitals and Health Facilities – General Hospitals

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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 sought to ensure hospitals are prepared for a public health emergency or staffing shortage through the implementation of a robust nurse staffing committee and plan, comprehensive emergency management, and reporting on staffed-bed capacity data to the Department. Parts of the bill required the Board of Health to promulgate rules by September 1, 2022, as related to the creation of a nurse staffing plan and staffed-bed capacity reporting. Emergency rules were first adopted and became effective on August 17, 2022, a second emergency rulemaking was held on November 16, 2022, and a third emergency rulemaking was held on February 2023, to maintain consistency while final permanent rules were formulated. During this time, the Health Facilities and Emergency Medical Services Division ("Division") worked through its extensive stakeholder engagement process. The Division is now bringing these rules forward for permanent rulemaking.

Pieces of HB 22-1401 required rulemaking that was not required to be in place by September 1, 2022. This rulemaking is seeking adoption of all proposed rule changes to 6 CCR 1011-1 Chapter 4 – General Hospitals developed in response to this HB 22-1401. These revisions include rules developed prior to the September 1, 2022 statutory deadline, as well as rules related to the implementation of HB 22-1401 that were outside of that statutory deadline. The rule language for this proposed permanent rulemaking includes the following:

- inclusion of new statutory definitions and definitions that serve to clarify the rule language;
- addition of fines language in Part 3, Department Oversight that comes from the statute as well as supporting language for the Department to consider for enforcement of HB 22-1401 provisions;
- reorganization of the HB 22-1401 provisions within Part 9, Personnel;
- non-substantive changes in Part 14, Nursing Services in order to remove any redundancy that occurred by integrating the existing and statutory nurse staffing requirements and provide clarity on the rule language based on stakeholder input; and
- maintenance of the existing requirements for hospitals to:
    - establish a nurse staffing committee that is required to create, implement, and evaluate a nurse staffing plan and to receive, track, and resolve complaints and receive feedback from direct-care nurses and other staff;
    - submit its nurse staffing plan to the Department on an annual basis;

- evaluate its nurse staffing plan on a quarterly basis and, based on complaints and recommendations of patients and staff, revise the nurse staffing plan accordingly;
- prepare a quarterly report containing the details of the evaluation;
- update its emergency management plans annually and as often as necessary, as circumstances warrant, and include specific provisions to maximize staffed-bed capacity and appropriate utilization of hospital beds to the extent necessary for a public health emergency; and
- assign direct-care providers only to a nursing unit or clinical area of a hospital that the provider is properly trained in.

The Division has been worked extensively with stakeholders since September 2022 to modify and finalize the rules, not only on the emergency basis but also on these proposed changes. To date, the Division has held four (6) meetings, with an average of 86 people attending each meeting. The Division has been working alongside the Colorado Hospital Association (CHA) and individual hospitals to field questions and address hospital concerns, and the Division continues to work with all stakeholders to review the entirety of changes made to Chapter 4 pursuant to HB 22-1401.

In the attached proposed rule language, new proposed language in this permanent rulemaking is in red or stricken. Proposed rule language which is new since the February Board of Health meeting is both red and highlighted.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
6 CCR 1011-1, Chapter 4, Standards for Hospitals and Health Facilities – General Hospitals

Basis and Purpose.
The Department is requesting adoption of permanent rules to meet the requirements created by the passage of House Bill 22-1401, which was signed into law on May 18, 2022. The new law sought to ensure hospitals are prepared for a public health emergency or staffing shortage through the implementation of a robust nurse staffing committee and plan, comprehensive emergency management, and reporting on staffed-bed capacity data to the Department.

The Health Facilities and Emergency Medical Services Division ("Division") has worked extensively with stakeholders and the Department's Disease Control & Public Health Response Division (DCPHR) since the summer of 2022 to incorporate the regulations required under HB 22-1401. The portions of the law relating to the staffed-bed capacity definition and reporting requirements are part of DCPHR rule 6 CCR 1009-5 Preparations for a Bioterrorist Event, Pandemic Influenza, or an Outbreak by a Novel and Highly Fatal Infectious Agent or Biological Toxin. The Division will continue to partner with DCPHR in enforcing these reporting requirements.

The rule language for this proposed permanent rulemaking includes the following:

- inclusion of new statutory definitions and definitions that serve to clarify the rule language;
- addition of fines language in Part 3, Department Oversight that comes from the statute as well as supporting language for the Department to consider for enforcement of HB 22-1401 provisions;
- reorganization of the HB 22-1401 provisions within Part 9, Personnel;
- non-substantive changes in Part 14, Nursing Services in order to remove any redundancy that occurred by integrating the existing and statutory nurse staffing requirements and provide clarity on the rule language based on stakeholder input; and
- maintenance of the existing requirements for hospitals to:
    - establish a nurse staffing committee that is required to create, implement, and evaluate a nurse staffing plan and to receive, track, and resolve complaints and receive feedback from direct-care nurses and other staff;
    - submit its nurse staffing plan to the Department on an annual basis;
    - evaluate its nurse staffing plan on a quarterly basis and, based on complaints and recommendations of patients and staff, revise the nurse staffing plan accordingly;
    - prepare a quarterly report containing the details of the evaluation;
    - update its emergency management plans annually and as often as necessary, as circumstances warrant, and include specific provisions to maximize staffed-bed capacity and appropriate utilization of hospital beds to the extent necessary for a public health emergency; and
    - assign direct-care providers only to a nursing unit or clinical area of a hospital that the provider is properly trained in.

The Division has been working since the summer of 2022 alongside the Colorado Hospital Association (CHA) and individual hospitals to field questions and address hospital concerns. In addition, the Division has held six stakeholder meetings, with an average of 86 people attending each meeting. Through these meetings, the Division has held an open dialogue with stakeholders to develop and refine rule language to implement the new law and support the statutory requirements.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:
Section 25-3-128, C.R.S.
Section 25-3-105, C.R.S.

Other relevant statutes:
Section 25-1-120, C.R.S.
Section 25-3-125, 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 ____ authorized
__X__ 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?

__X__ Yes
____ 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 4, Standards for Hospitals and Health Facilities – General Hospitals

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 hospitals and hospital units:	(109 total)	C
Licensed Children's Hospitals	3	C
Licensed Critical Access Hospitals	32	C
Licensed Hospital Units	1	C
Licensed General Hospitals	50	C
Licensed Long Term Care Hospitals	6	C
Licensed Psychiatric Hospitals	9	C
Licensed Rehabilitation Hospitals	8	C
Patients receiving care at licensed hospitals	Unknown	B
Colorado Hospital Association	101 Member Hospitals	S

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 hospital will be different, but there will be administrative and programmatic costs associated with implementing the proposed rules. Additionally, should a hospital fall below the 80% standard for staffed-bed capacity for longer than seven (7) days and fail to notify the Department and create a plan of action or submit a waiver, the Department may impose a fine. The Department has authority to assess fees necessary to cover the costs associated with the surveys conducted pursuant to HB 22-1401's requirements, as well as fines associated with the implementation of House Bill 22-1401, specifically fines of up to $1,000 per day for a hospital's failure to meet the staffed-bed capacity reporting requirements and up to $10,000 per day for a hospital's failure to achieve the required surge capacity, vaccines, and testing capabilities during a declared statewide public health emergency.

The Department has worked throughout the stakeholder engagement process to determine how to minimize the economic impacts on hospitals while fulfilling the intent of the legislation. Language is included in the proposed permanent rules to support the Department's decision making as fines are considered.

Non-economic: HB 22-1401 requires hospitals to create more robust nurse staffing and emergency management requirements as well as report staffed-bed capacity data to the Department, in a form and manner determined by the Department. While many hospitals already comply with this higher standard, many other hospitals may not have as robust nurse staffing and emergency management programs in place. There may be non-economic administrative, programmatic, and quality improvement costs associated with implementing these proposed rules.

Impact on Beneficiaries (B):

Economic: There will not be an economic impact associated with these proposed rules for patients.

Non-economic: The intention of the bill is to ensure hospitals are prepared for a public health emergency or staffing shortage through the implementation of a robust nurse staffing committee and plan, comprehensive emergency management, and reporting on staffed-bed capacity data to the Department. The non-economic impacts will be greater patient safety, security, and improved care while in the hospital which will lead to improved health outcomes for hospital patients.

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 will ultimately be cost neutral once a fee system is in place to support additional Department costs, which will not occur until the Health Facilities and Emergency Medical Services Division ("Division") is able to vet fees with the stakeholders during a future rulemaking. Additional costs will initially be paid from the General Fund; beginning in FY 2024-25, Department expenditures will be partially paid from the General Licensure Cash Fund. Expenditures are detailed below.

Department Expenditure Impact

Cost Components	FY 2022-23	FY 2023-24	FY 2024-25
Personal Services	$551,066	$529,100	$493,067
Operating Expenses	$9,045	$7,965	$7,425
Capital Outlay Costs	$43,400	-	-
Travel Costs	$41,829	$55,760	$55,760
Centrally Appropriated Costs	$128,879	$121,979	$204,040
FTE – Personal Services	6.2 FTE	5.9 FTE	5.5 FTE
TOTAL	**$774,219**	**$714,804**	**$760,292**

Anticipated CDPHE Revenues: N/A

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.
_X_ 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
___ 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.

Inaction is not an option. HB 22-1401 mandates that hospitals establish a nurse staffing committee and begin reporting to the Department on staffed-bed capacity by September 1, 2022. This permanent rulemaking proposes to incorporate the rules developed through eight months of stakeholder engagement.

HB 22-1401 requires the collection of fees and fines in the instance that a hospital has not met its obligations related to reporting and/or maintaining adequate staffed beds. To date, the Department has not collected any fines as it has worked with hospitals through the baseline setting and the rules contained within the emergency rules. Failure to adopt rules will result in hospitals only having the guidance and clarity found currently in statute.

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 permanent rulemaking were developed in alignment with the requirements of HB 22-1401.

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

The Division has worked closely with stakeholders to streamline and clarify the statutory requirements pursuant to HB 22-1401, therefore the proposed permanent rules reflect that process. In order to define staffed-bed capacity and develop a clear reporting process, the Division worked closely with DCPHR to develop and maintain the rules for these processes. The process continues to be based on what and how the hospitals have been reporting to the Department throughout the entirety of the COVID-19 pandemic, pursuant to Public Health Order 20-38. What the hospitals have been reporting into EMResource throughout the COVID-19 pandemic has been solidified through an iterative process between DCPHR, the Division, and stakeholders.

Additionally, the Division included the fines language from statute in the proposed permanent rules. Since the fines are authorized in statute, the Division wanted to provide clarity as well as supporting language in Part 3, Department Oversight on the decision making process that the Department will take when determining if and to what extent the Division will levy fines.

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.

The Division used existing EMResource data being reported to DCPHR throughout the COVID-19 pandemic, as well as Division-level hospital data on licensed beds and hospital type.

STAKEHOLDER ENGAGEMENT
for Amendments to
6 CCR 1011-1, Chapter 4, Standards for Hospitals and Health Facilities – General Hospitals

State law requires agencies to establish a representative group of participants when considering to adopt or modify new and existing rules. This is commonly referred to as a stakeholder group.

Early Stakeholder Engagement:
The following individuals and/or entities were invited to provide input and included in the development of these proposed rules:

Organization	**Representative Name and Title (if known)**
Arkansas Valley Regional Medical Center	Heidi Gearhart
Banner Health	Danielle May
	Julia Gentry
	Tracy Hays, Emergency Management
Banner Northern Colorado	Tania Hare
Boulder Community Health	Charlie Mathis
	Chuck Merritt
	Jackie Attlesey-Pries, RN, COO/CNO
	Michele Grulke, ACNO
Centura Health	Andy French
	Bryan Williams
	Kelly Gallant
	Nicole Milo
Children's Hospital Colorado	Donna Pinson
	Ellen Stern, Government Affairs
	Jen Roth
	Kathie Seerup
	Linda Michael
	Lori Claussen
Colorado Department of Human Services, Fort Logan	Ronda K Katzenmeyer
Colorado Department of Public Health and Environment	Alejandra Noa
	Anne Strawbridge
	Ann-Marie Harris
	Ash Jackson
	Christina Kemink
	Craig Lee
	Elaine McManis
	Emily Roozen
	Erica Brudjar
	Grace Alford
	Heather Farnsworth
	Jaime Yoder

Organization	Representative Name and Title (if known)
	Jeff Beckman
	Jen Barr
	Jo Tansey
	Kara Johnson-Hufford
	Monica Billig
	Scott Bookman
	Shannon Rossiter
	Shelley Sanderman
Colorado Hospital Association	Bridget Garcia
	Essey Yirdaw
Colorado Mental Health Hospital in Pueblo	Christine Tafoya, Interim CNO
Colorado Mental Health Institute	Katie Cotner, CQO
Colorado Nurses Association	Colleen Casper
	Judith Burke, Retired CNO, Member
	Mary Satre, Board Member
Community Hospital Grand Junction	Benjamin Williams, ACNO
Craig Hospital	Derrek Hidalgo, CNO
	Diane Reinhard
	Julie Negron
CU Anschutz	Stephanie Vega
Delta Health	Dawn Arnett, Director of Med/Surg
	Melissa Palmer, DON
Denver Health	Anne Knudtson, Hospital Compliance
	Emma Paras, Emergency Manager
	Jackie Zheleznyak
	Kathy Boyle, CNO
	Shira Meyerowitz
	Natalie Nicholson
East Morgan County Hospital	Linda Roan
Estes Park Health	Pat Samples
Family Health West Hospital	Britney Guccini
	Travis Dorr
Grand River Health	Melissa Obuhanick
Grandview Hospital	Gretchen Harris, Interim DON
Gunnison Valley Health	Jen Gearhart
	Nicole Huff
Heart of the Rockies Regional Medical Center	April Asbury
	Christine MacMillan
Intermountain Health	Colleen Flack, St. Mary's Hospital
	Geoffrey Hier
	Jamie Refalosells, Director, First Call Command Center
	Collen Flack, St. Mary's Hospital
	Tara Buzzitta

Organization	Representative Name and Title (if known)
	Reagan Goodnight, ACNO, Lutheran Medical Center
	Jeani Frickey Saito
	Sarah Lorenz
Intermountain Peaks Region, St. Mary's	Michelle Shiao
Inverness Rehabilitation Hospital	Brooke Nelson
Keefe Memorial Hospital	Jasmine Shea
Kindred Hospital Denver	Kerri Lowry, CCO
	Mary Corcoran, DNCS
Kiowa County Hospital District	Rachel Bletzacker CNO, FNP-BC
Memorial Regional Health	Olivia Scheele
Middle Park Health	Dani Kloepper, DON, Emergency and Inpatient Services
Montrose Regional Health	CoralAnn Hackett, CNO
	Mary Rasmusson, RN, Director of Education & Emergency Management
Mt. San Rafael Hospital	Calvin Carey
National Jewish Health	Kristi Melton, CNO/Vice-President of Clinical Operations
Pagosa Springs Medical Center	Dan Davis
PAM Specialty Hospital	Dave Hollander, CNO
Parkview Health System	Mandi Smith
Parkview Medical Center	Amelia Vigil
	Andrea Wade
	Kelea Nardini
	Kim Philson, RN-BSN, CMSRN
	Renee Elwell
Parkview Pueblo West	Ruth Baxter
Pioneers Medical Center	Amy Peck, CNO
Prowers Medical Center	Amber Rider
Rangely District Hospital	Makensie Boulger, DON
Reunion Rehabilitation Hospital	Kiera Shaffer
	Laura Dechant
Rio Grande Hospital	Amanda Chapman-Shaw, RN, Clinical Nurse Manager
San Luis Valley Health	Darrick Garcia, Alamosa EMS
	Margaret White, Quality and Safety Director
	Michelle Gay, CHC
	Roberta Bean
SCL Health	Kim de Bruyn Kops
Sedgwick County Health Center	Machelle Newth
Sky Ridge Medical Center	Adam Klatskin
Southeast Colorado Hospital District	Heather Burdick
	Sheri Reed, DON
Spanish Peaks Regional Health Center	Bobbie Trujillo
St. Vincent Health	Jana Weiss
Sterling Regional Medical Center	Karalee Anderson, CNO

Organization	Representative Name and Title (if known)
UCHealth	Cathy O'Brien
	Kathryn Trujillo
	Lisa Camplese, Senior Director, Regulatory Affairs and IP
	Mary Jo Hallaert
	Noreen Bernard, CNO, Longs Peak and Broomfield Hospitals
	Suzanne Golden
	Wendy Sultzman
	Amanda Cobb, Clinical Nurse Director and Colorado Nurse Association Region 2 Director
	Carolyn Carroll Flynn, Capacity Management (South Region)
Vail Health	Amy Lavigne
	Kim Flynn
	Nico Brown
	Ryan Bush
	Sara Dembeck
	William Adochio
Valley View Hospital	Aimee Johnson, Regulatory
	Dawn Sculco, CNO
Wray Community District Hospital	Elena Scarbrough, Director of Quality/Risk Management
	Jennifer Kramer
	Alec Romero
	Ashley Sena
	Ashley Thomas
	Brenda B Simpson
	Colleen Stout
	Colleen Williams
	Dylan Mitchell
	Elaine Gerson
	Jackie Edney
	Jennifer Weibel
	Jessica Short
	Kari Walton
	Kim Philson
	Kristine Cooper
	Kurt Gensert
	Lonnie Martinez
	Lyndsey Olish
	Meg Schroeder
	Melissa Hart
	Michelle Kenney

The Health Facilities and Emergency Medical Services Division ("Division") has worked through its stakeholder process and has held six (6) monthly meetings held between September 2022 and March 2023. So far, 177 unique participants have attended at least one of the monthly meetings.

All stakeholder meetings are open to the public, and there has been substantial interest and attendance, as documented in the table above. All licensed hospitals and interested stakeholders are provided notice of meetings and of alternate methods of providing feedback. The Division sends meeting information through its portal messaging system to impacted facilities and directly emails 241 unique stakeholders that signed up to receive such email as "interested parties." Meeting information and documents are posted to a public Department Google drive in advance of each meeting, including draft rules for discussion.

Stakeholder Group Notification

The stakeholder group was provided notice of the rulemaking hearing and provided a copy of the proposed rules or the internet location where the rules may be viewed. Notice was provided prior to the date the notice of rulemaking and was published in the Colorado Register (typically, the 10th of the month following the Request for Rulemaking).

_____ Not applicable. This is a Request for Rulemaking Packet. Notification will occur if the Board of Health sets this matter for rulemaking.

__X__ Yes.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

This rulemaking is mandated in statute, as is much of the structure and process impacted hospitals need to carry out. The Division continues to work extensively with the Department's Disease Control and Public Health Response Division (DCPHR) and stakeholders to uphold the HB 22-1401 requirements while also taking into consideration the challenges and impacts that this has on Colorado's hospitals and its workforce. Colorado Nurses Association (CNA) has been vocal about adding additional safety measures into the rules for nursing staff that goes above and beyond statutory requirements, and while there are instances where the Division has not been able to reach consensus, there have been robust conversations, collaboration, and compromise between the Division and stakeholders to bring forward the proposed permanent rules.

Please identify the determinants of health or other health equity and environmental justice considerations, values or outcomes related to this rulemaking:

The proposed rule continues to hold all licensed facilities to the same standards, regardless of location or population served.

Overall, after considering the benefits, risks and costs, the proposed rule:

Select all that apply.

	Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.	X	Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.

	Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.		Reduces occupational hazards; improves an individual's ability to secure or maintain employment; or, increases stability in an employer's workforce.
	Improves access to food and healthy food options.		Reduces exposure to toxins, pollutants, contaminants or hazardous substances; or ensures the safe application of radioactive material or chemicals.
X	Improves access to public and environmental health information; improves the readability of the rule; or, increases the shared understanding of roles and responsibilities, or what occurs under a rule.	X	Supports community partnerships; community planning efforts; community needs for data to inform decisions; community needs to evaluate the effectiveness of its efforts and outcomes.
	Increases a child's ability to participate in early education and educational opportunities through prevention efforts that increase protective factors and decrease risk factors, or stabilizes individual participation in the opportunity.		Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
	Monitors, diagnoses and investigates health problems, and health or environmental hazards in the community.		Ensures a competent public and environmental health workforce or health care workforce.
X	Other: Complies with Department's obligation to ensure all regulations are consistent with state law.		Other:_____ _____

JARED POLIS
GOVERNOR

136 STATE CAPITOL
DENVER, COLORADO 80203

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May 18, 2022

The Honorable Colorado General Assembly
The 73rd General Assembly
Second Regular Session
State Capitol
200 E. Colfax Ave.
Denver, CO 80203

Dear Honorable Members of the Colorado General Assembly:

Today I signed into law HB22-1401, "Hospital Nursing Staff Standards." This bill ensures our hospitals are prepared and our nursing workforce is supported in order to respond to emergencies so that a lack of staffed bed capacity doesn't threaten the state economy. The Polis-Primavera Administration is focused on saving people money on health care and improving access to care across the state. Maintaining access to hospital care throughout the state, and especially in small, rural, and frontier areas is crucial to furthering this goal.

I understand the impacts fees can have on businesses, especially during times of high inflation, including on hospitals. I therefore ask the Colorado Department of Public Health and Environment, in the implementation of this bill, to direct the State Board of Health to ideally not implement fees, or at least minimize fees to a negligible amount and avoid fines in particular on small, rural, and frontier hospitals.

HB22-1401 keeps Coloradans safe and healthy while protecting the financial security of small, rural facilities by ensuring:

1. Surge-capacity readiness standards only apply to hospitals with more than 25 beds;
2. All hospitals can submit a request for a hardship waiver articulating why they are unable to meet the required staffed bed capacity of 80% of their baseline to ensure they are not financially burdened if local circumstances prevent compliance. These waiver processes must account for factors such as hospital size, geography, local labor and population dynamics, local challenges and costs of providing care, among other local factors that make it difficult for hospitals to meet the required staffed bed capacity. If they are granted a waiver, they will not be fined. It is not the intent of this bill to fine hospitals that are struggling to hire staff or have increased costs and small margins. It is a shared goal to ensure Coloradans maintain access to hospital care;
3. No fees will be levied against hospitals in FY22-23. The Board of Health has rulemaking authority to implement fees, but it is the Administration's intent that they be avoided or minimized to the extent required for hospital preparedness and safety, and if they ever occur, should be levied equitably among hospitals. The Board of Health should take into account geography, rurality, facility size, and other factors that generally act as proxies for hospital financial wellbeing when determining the formula for how fees are levied to fund inspections; and
4. Hospitals will never be penalized for not providing testing & vaccines in hospitals and hospital-owned primary care sites if those supplies are not available.

I thank the sponsors and proponents for passing HB 22-1401 which will protect Coloradans, support our workforce, and ensure the State is prepared for future emergencies.

Sincerely,

Jared Polis
Governor
State of Colorado

COLORADO
Department of Public Health & Environment

June 7, 2022

The Honorable Colorado General Assembly
The 73rd General Assembly
Second Regular Session
State Capitol
200 E. Colfax Ave.
Denver, CO 80203

CC:
Colorado Board of Health
Colorado Department of Public Health and Environment
4300 Cherry Creek South Drive
Denver, Colorado 80246

Dear Honorable Members of the Colorado General Assembly:

On May 18 Governor Polis signed into law HB22-1401, "Hospital Nursing Staff Standards." This bill protects the health of Coloradans and the strength of the Colorado economy by ensuring our health care system and workforce are prepared and supported in order to respond to disasters. The law charges the Colorado State Board of Health (BOH) with developing rules to implement several of the bill's provisions. One of the rulemaking provisions contemplated in C.R.S. 25-3-128 (2)(b)(I)(B) specifies that hospital nurse staffing committees are responsible for developing a master nurse staffing plan that "includes minimum staffing requirements as established in rules promulgated by the BOH for each inpatient unit and emergency department that are aligned with nationally recognized standards and guidelines". After approval by the hospital's senior nurse executive and the hospital's governing body, if the final plan changes materially from the nurse staffing committee's recommendations, the committee will be provided with an explanation by the senior nurse executive. If the committee believes the plan still does not meet standards established by the BOH promulgated rules, the committee may vote to request the Department of Public Health and Environment (Department) review the plan for compliance with BOH rules.

In the absence of context provided elsewhere in the bill (e.g., C.R.S. 25-3-128(b)(II)(A)), the legislation could be interpreted to direct the BOH to establish which national standards hospitals must use in their staffing plans. The Department will propose rules to the BOH that outline the form and manner required for a hospital's master nurse staffing plan, including a requirement for each plan to demonstrate how it aligns with nationally recognized standards and guidelines pertaining to minimum staffing requirements that each hospital selects to inform its staffing plan. The Department may then survey for hospital compliance with the standard(s) specified in the staffing plan. When surveying and investigating a hospital for compliance, the Department will ensure that a hospital's master nurse staffing plan does indeed describe the nationally recognized clinical standards and guidelines used to develop the nurse staffing requirements for each inpatient unit and emergency department, and that the conditions in the hospital, upon inspection, align with those standards and guidelines. The Department does not interpret the law as directing the State Board of Health to independently create a uniform set of standards against which to compare hospital nurse staffing plans.

COLORADO
Department of Public Health & Environment

The Department thanks the sponsors for passing HB 22-1401 and the Governor for signing the bill into law to ensure Colorado is prepared for future emergencies.

Sincerely,

Jill Hunsaker Ryan, MPH
Executive Director, Colorado Department of Public Health and Environment

An Act

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 4 - GENERAL HOSPITALS

6 CCR 1011-1 Chapter 4

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

INDEX

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Part 1. STATUTORY AUTHORITY AND APPLICABILITY

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1.2 Applicability

(A) All hospitals shall meet applicable federal, state, and local laws and regulations, including but not limited to:

(1) 6 CCR 1011-1, Chapter 2, except as noted below:

(a) Notwithstanding 6 CCR 1011-1, Chapter 2, Part 2.2.2, hospital services or departments provided for under this Chapter 4 shall not require a separate license if they are on the hospital campus.

(b) Services that are subject to separate licensure including, but not limited to, ambulatory surgical centers, assisted living residences, hospices, LICENSED hospital units, home care agencies, nursing care facilities, and dialysis treatment centers, shall not be considered part of the hospital campus.

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Part 2. DEFINITIONS

2.1 "Auxiliary personnel" means any CERTIFIED OR LICENSED PROFESSIONAL working under the supervision of a REGISTERED NURSE OR OTHER individual authorized by law to do so.

2.2 "Campus" means the physical areas immediately adjacent to the hospital's main building(s), other areas and structures that are not strictly contiguous to the main building(s) but are located within 250 yards of the main building(s), and any other areas determined by the Department, on an individual case basis, to be part of the hospital's campus.

2.3 "Care plan" means a plan of care, treatment, and services designed to meet the needs of the patient.

2.4 "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.

2.5 "Critical care unit" means a designated area of the hospital providing specialized facilities and services to care for patients who require continuing, acute observation and concentrated, highly proficient care.

2.6 "Department" means the Department of Public Health and Environment.

2.7 "Dietary services equipment" means an article used in the operation of dietary services, such as, but not limited to a freezer, grinder, hood, ice maker, oven, mixer, range, slicer, or ware-washing machine. "Dietary services equipment" does not include items used for handling or storing large quantities of packaged foods received from a supplier in a cased or over-wrapped lot, such as forklifts, hand trucks, dollies, pallets, racks and skids.

2.8 "Emergency Medical Services provider" means an individual who holds a valid emergency medical service provider certificate or license issued by the Department and includes Emergency Medical Technician, Advanced Emergency Medical Technician, Emergency Medical Technician Intermediate, and Paramedic. An Emergency Medical Services Provider is referred to in this chapter 4 as an EMS provider.

2.9 "Food-contact surfaces" means those surfaces of equipment and utensils with which food normally comes in contact, and those surfaces from which food may drain, drip, or splash back onto surfaces in contact with food. This excludes ventilation hoods.

2.10 "General hospital" means a health facility that, under an organized medical staff, offers and provides inpatient services, emergency medical and emergency surgical care, continuous nursing services, and necessary ancillary services, to individuals for the diagnosis or treatment of injury, illness, pregnancy, or disability, twenty-four (24) hours per day, seven (7) days per week.

(A) A general hospital may offer and provide, but is not limited to, outpatient, preventive, therapeutic, surgical, diagnostic, rehabilitative, or any other supportive services for periods of less than twenty-four (24) hours per day.

(B) Services provided by a general hospital may be provided directly or by contractual agreement. Direct inpatient services shall be provided on the licensed premises of the general hospital.

(C) A general hospital may provide services on its campus and on off-campus locations.

(D) Non-direct care services (such as billing functions) necessary for the successful operation of the hospital that are not on the hospital campus may be incorporated under the license.

2.11 "Governing body" means the board of trustees, directors, or other body in whom the ultimate authority and responsibility for the conduct of the hospital is vested.

2.12 "LICENSED HOSPITAL UNIT" MEANS A PHYSICAL PORTION OF A LICENSED OR CERTIFIED GENERAL HOSPITAL, PSYCHIATRIC HOSPITAL, OR REHABILITATION HOSPITAL WHICH IS LEASED OR OTHERWISE OCCUPIED PURSUANT TO A CONTRACTUAL AGREEMENT BY A PERSON OTHER THAN THE LICENSEE OF THE HOST FACILITY FOR THE PURPOSE OF PROVIDING OUTPATIENT OR INPATIENT SERVICES.

2.13 "Inpatient care unit" means a designated area of the hospital that provides a bedroom or a grouping of bedrooms with respective supporting facilities and services to meet the care and clinical management needs of inpatients; and that is thereby planned, organized, operated, and maintained to function as a separate and distinct unit.

2.14 "INTENSIVE CARE UNIT" MEANS A DESIGNATED AREA OF THE HOSPITAL THAT PROVIDES SPECIALIZED TREATMENT TO PATIENTS WHO ARE ACUTELY UNWELL AND REQUIRE CRITICAL MEDICAL CARE AND INCREASED SUPERVISION AND/OR MONITORING.

2.15 "Investigational drug" means a new drug or biological drug that is used in a clinical investigation. The term also includes a biological product that is used in vitro for diagnostic purposes. The terms "investigational drug" and "investigational new drug" are deemed to be synonymous.

2.16 "Licensed independent practitioner" means an individual permitted by law and the hospital to independently diagnose, initiate, alter, or terminate health care treatment within the scope of their license.

2.17 "Medical Staff" means the organized body that is responsible for the quality of medical care provided to patients by the hospital. The medical staff must be composed of doctors of medicine or osteopathy. The medical staff may also include other categories of physicians and nonphysician practitioners who are determined to be eligible for appointment by the governing body.

2.18 "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.

2.19 "Off-Campus Location" means a facility that meets all of the following criteria:

(A) Whose operations are directly or indirectly owned or controlled by, in whole or in part, or affiliated with a hospital, regardless of whether the operations are under the same governing body as the hospital;

(B) That is located more than two hundred fifty (250) yards from the hospital's main campus;

(C) That provides services that are organizationally and functionally integrated with the hospital;

(D) That is an outpatient facility providing preventative, diagnostic, treatment, or emergency services; and

(E) That is not otherwise subject to regulation under 6 CCR 1011-1.

2.20 "Pharmacist" means a person licensed by the Colorado State Board of Pharmacy as a pharmacist.

2.21 "Recreational therapy" is the use of treatment, education, and recreation to help psychiatric patients develop and use leisure in ways that enhance their health, functional abilities, independence, and quality of life.

2.22 "Specialty hospital" means a hospital that:

(A) Limits admission according to age, type of disease, or medical condition;

(B) Does not maintain a dedicated emergency department; and

(C) Is not otherwise eligible for licensure under 6 CCR 1011-1.

2.23 STAFFED-BED CAPACITY" MEANS THE TOTAL NUMBER OF ALL STAFFED ACUTE CARE INPATIENT BEDS AS DEFINED BY THE DEPARTMENT AT 6 CCR 1009-5, REGULATION 2 – PREPARATIONS BY GENERAL OR CRITICAL ACCESS HOSPITALS FOR AN EMERGENCY EPIDEMIC

2.24 "Surgical recovery room" means designated room(s) designed, equipped, staffed, and operated to provide close, individual surveillance of patients recovering from acute effects of anesthesia, surgery, and diagnostic procedures.

2.25 "Telehealth" means a mode of delivery of health care services through HIPAA-compliant telecommunications systems, including information, electronic, and communication technologies, remote monitoring technologies, and store-and-forward transfers, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a person's health care.

2.26 "Utensil" means any implement used in the storage, preparation, transportation, or service of food.

Part 3. DEPARTMENT OVERSIGHT

3.1 Application Fees

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3.2 Increase in Licensed Capacity

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3.3 The Department is authorized to and shall enter, survey, and investigate each hospital as necessary to ensure compliance with the emergency management plan, staffed-bed capacity reporting, and nurse staffing standards pursuant to Section 25-3-128, et seq., C.R.S.

3.4 Fines

(A) THE DEPARTMENT MAY IMPOSE FINES, NOT TO EXCEED ONE THOUSAND DOLLARS ($1,000.00) PER DAY, FOR A HOSPITAL'S FAILURE TO:

(1) ACCURATELY REPORT A HOSPITAL'S BASELINE STAFFED-BED CAPACITY, OR
(2) MEET THE REPORTED STAFFED-BED CAPACITY OF EIGHTY (80) PERCENT OR MORE OF THE HOSPITAL'S REPORTED BASELINE PURSUANT TO 6 CCR 1009-5, REGULATION 2 – PREPARATIONS BY GENERAL OR CRITICAL ACCESS HOSPITALS FOR AN EMERGENCY EPIDEMIC.
(A) IF A HOSPITAL IS OUT OF COMPLIANCE FOR GREATER THAN FOURTEEN (14) CONSECUTIVE DAYS, AND HAS NOT NOTIFIED THE DEPARTMENT AND SUBMITTED A PLAN OF ACTION OR WAIVER PURSUANT TO 6 CCR 1009-5, REGULATION 2, THE HOSPITAL SHALL BE SUBJECT TO IMMEDIATE ENFORCEMENT ACTION, INCLUDING BUT NOT LIMITED TO FINES, PURSUANT TO SECTION 25-3-128(5)(D), C.R.S.

(B) THE DEPARTMENT MAY IMPOSE FINES, NOT TO EXCEED TEN THOUSAND DOLLARS ($10,000.00) PER DAY, FOR A HOSPITAL'S FAILURE TO:
(1) ACHIEVE THE REQUIRED STAFFED-BED CAPACITY WITHIN FOURTEEN (14) DAYS AFTER A DECLARED STATEWIDE PUBLIC HEALTH EMERGENCY OR OTHER NOTIFICATION BY THE DEPARTMENT THAT SURGE CAPACITY IS NEEDED PURSUANT TO PART 7.1(B)(3)(E);
(2) INCLUDE THE AMOUNT OF NECESSARY VACCINES FOR ADMINISTRATION IN ITS ANNUAL EMERGENCY MANAGEMENT PLAN AND HAVE THE VACCINES AVAILABLE, TO THE EXTENT THAT VACCINES ARE AVAILABLE, AT EACH OF ITS HOSPITAL FACILITIES DURING AND OUTSIDE OF THE PUBLIC HEALTH EMERGENCY; AND
(3) INCLUDE THE NECESSARY TESTING CAPABILITIES AVAILABLE IN ITS ANNUAL EMERGENCY MANAGEMENT PLAN AND AT EACH OF ITS HOSPITAL FACILITIES, TO THE EXTENT THAT TESTING IS AVAILABLE, DURING AND OUTSIDE OF A PUBLIC HEALTH EMERGENCY.

(C) THE DEPARTMENT MAY TAKE INTO CONSIDERATION MITIGATING OR AGGRAVATING FACTORS SUCH AS, AND INCLUDING:
(1) LOCAL FACTORS THAT MAKE IT DIFFICULT FOR HOSPITALS TO MEET THE REQUIRED STAFFED BED CAPACITY, SUCH AS SIZE OF THE HOSPITAL, LOCATION IN A RURAL OR FRONTIER AREA, AVAILABILITY OF HEALTH CARE STAFF, AND OTHER LOCATION-SPECIFIC CHALLENGES OF PROVIDING CARE;
(2) THE DEGREE, SEVERITY, AND HISTORY OF NON-COMPLIANCE;
(3) THE HOSPITAL'S VOLUNTARY, TIMELY, AND COMPLETE NOTIFICATION TO THE DEPARTMENT OF NON-COMPLIANCE PURSUANT TO 6 CCR 1009-5, REGULATION 2; AND
(4) THE IMPACT ON, OR THREAT TO, THE PUBLIC HEALTH AS A RESULT OF NON-COMPLIANCE.

(D) A HOSPITAL MAY SUBMIT A REQUEST FOR A HARDSHIP WAIVER IN ACCORDANCE WITH 6 CCR 1011-1, CHAPTER 2, PART 5, WAIVER OF REGULATIONS FOR FACILITIES AND AGENCIES, ARTICULATING WHY THEY ARE UNABLE TO MEET THE REQUIRED STAFFED-BED CAPACITY OF 80% OF THEIR BASELINE.

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Part 7. EMERGENCY PREPAREDNESS

7.1 Emergency Management Plan

(A) Each hospital shall develop and implement a comprehensive emergency management plan that meets the requirements of this part, utilizing an all-hazards approach. The plan shall take into consideration preparedness for natural emergencies, man-made emergencies, facility emergencies, bioterrorism event, pandemic influenza, or an outbreak by a novel and highly infectious agent or biological toxin, that may include, but are not limited to:

(1) care-related emergencies;

(2) equipment and power failures;

(3) interruptions in communications, including cyber-attacks;

(4) loss of a portion or all of a facility; and

(5) interruptions in the normal supply of essentials, such as water and food.

(B) The emergency management plan shall address, at a minimum, the following:

(1) The plan shall be:

(a) specific to the hospital;

(b) relevant to the geographic area;

(c) readily put into action, twenty-four (24) hours a day, seven (7) days a week; and

(d) updated at least annually and as often as necessary, as circumstances warrant.

(2) The plan shall identify:

(a) who is responsible for each aspect of the plan; and

(b) essential and key personnel responding to a disaster.

(3) The plan shall include:

(a) a staff education and training component;

(b) a process for testing each aspect of the plan at least every two (2) years or as determined by changes in the availability of hospital resources;

(c) a component for debriefing and evaluation after each disaster, incident, or drill;

(d) 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:

(i) cross training, just-in-time training, and redeployment of staff;

(ii) supporting all hospital facilities, including hospital-owned facilities, to provide any necessary, available, and appropriate preventive care, vaccine administration, diagnostic testing, and therapeutics;

(iii) maximizing hospital throughput by discharging patients to skilled nursing, post-acute, and other step-down facilities; and

(iv) reducing the number of scheduled procedures in the hospital;

(E) A PROCESS FOR RECALCULATING THE HOSPITAL'S ORIGINAL BASELINE STAFFED-BED CAPACITY FOR REPORTING STAFFED-BED CAPACITY PURSUANT TO 6 CCR 1009-5, REGULATION 2, BASED ON THE HOSPITAL'S ADJUSTMENT FOR SEASONAL VARIANCES, ANNUAL RECALCULATION, AND/OR OTHER ANTICIPATED FACTORS AFFECTING STAFFED-BED CAPACITY; AND

(F) FOR HOSPITALS WITH MORE THAN TWENTY-FIVE (25) BEDS, A HOSPITAL'S DEMONSTRATED ABILITY TO EXPAND THE HOSPITAL'S STAFFED-BED CAPACITY UP TO ONE HUNDRED TWENTY-FIVE (125) PERCENT OF THE HOSPITAL'S BASELINE

STAFFED-BED CAPACITY AND INTENSIVE CARE UNIT (ICU) CAPACITY WITHIN FOURTEEN (14) DAYS AFTER THE FOLLOWING:

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

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

A. LICENSING OR CERTIFICATION FLEXIBILITY FOR HEALTH FACILITIES;

B. REDUCING REQUIREMENTS FOR LICENSING, CREDENTIALING, AND THE RECEIPT OF STAFF PRIVILEGES;

C. WAIVING SCOPE OF PRACTICE LIMITATIONS; AND

D. WAIVING STATE-REGULATED PAYER PROVISIONS THAT CREATE BARRIERS TO TIMELY PATIENT DISCHARGE.

7.2 Each hospital shall comply with the requirements of 6 CCR 1009-5, Regulation 2 – Preparations by General or Critical Access Hospitals for an Emergency Epidemic.

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Part 9. PERSONNEL

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9.4 All persons assigned to the direct care of, or service to, patients shall be prepared through formal education, as applicable, and on-the-job training in the principles, policies, procedures, and the techniques involved to safeguard the welfare of patients.

(A) Prior to delivering patient care independently, WHETHER UPON HIRE OR ASSIGNMENT TO A NEW PATIENT CARE UNIT, new personnel shall receive orientation regarding the patient care environment and relevant policies and procedures.

(B) THE HOSPITAL SHALL NOT ASSIGN A CLINICAL STAFF NURSE, NURSE AIDE, EMS PROVIDER, OR ANY OTHER PERSONNEL WHO PROVIDES DIRECT PATIENT CARE TO A HOSPITAL UNIT UNLESS PERSONNEL RECORDS INCLUDE DOCUMENTATION THAT THE TRAINING, DEMONSTRATION, AND ACKNOWLEDGMENT FROM TRAINEE OF COMPETENCY WERE SUCCESSFULLY COMPLETED DURING ORIENTATION AND ON A PERIODIC BASIS CONSISTENT WITH HOSPITAL POLICIES.

9.5 The hospital shall maintain position descriptions that clearly state the qualifications and expected duties of the position for all categories of personnel.

9.6 The hospital shall maintain personnel records on each member of the hospital staff, to include:

(A) Employment application;

(B) Verification of licensure, certification, or registration, including maintaining procedures to ensure that staff for whom state and/or federal licenses, registrations, or certificates are required have a current license, registration, or certificate; and

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Part 12. PATIENT RIGHTS

12.1 The hospital shall comply with 6 CCR 1011-1, Chapter 2, Part 7, Client Rights.

12.2 The hospital shall comply with the visitation rights for all hospital patients in accordance with Section 25-3-125, C.R.S.

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Part 14. NURSING SERVICES

14.1 There shall be a nursing department formally organized to provide complete, effective care to each patient.

14.2 Nursing services shall be directed by a registered nurse qualified by education, training, competencies, and experience to direct effective nursing care. For purposes of this chapter, this individual is referred to as the Senior Nurse Executive.

14.3 The Senior Nurse Executive shall be responsible for ensuring that all nursing staff have the qualifications, competencies, and experience necessary to deliver the care assigned in accordance with professional standards of practice and hospital policy and procedure.

14.4 Nursing Services Policies and Procedures

(A) The service shall develop and implement policies and procedures that establish the standards for performance of safe nursing care.

(B) The policies and procedures shall be based on nationally-recognized practice guidelines and data-driven measures.

(C) The policies and procedures shall be reviewed periodically and revised as necessary, no less than every three (3) years.

14.5 Nursing staff shall conduct initial and ongoing assessments and screenings of the patient's physical, cognitive, behavioral, emotional, and psychosocial status in sufficient scope and detail to meet the needs of the patient, according to hospital policy and professional standards of practice.

14.6 Nurse Staffing Committee

(A) Each hospital shall establish a nurse staffing committee, either by creating a new committee or assigning the nurse staffing functions to an existing hospital staffing committee.

(B) The nurse staffing committee shall:

(1) Develop and implement the process for addressing any concerns or complaints brought forth by NURSING staff;

(2) Annually develop and oversee a master nurse staffing plan for the hospital;

(3) Have at least 60% or greater participation by clinical staff nurses WHO ROUTINELY PROVIDE DIRECT CARE TO PATIENTS, in addition to auxiliary personnel and nurse management;

(A) THE NURSE STAFFING COMMITTEE SHALL SET CRITERIA TO DETERMINE WHICH CLINICAL STAFF NURSES ROUTINELY PROVIDE DIRECT CARE TO PATIENTS;

(4) Include a designated leader of workplace violence prevention and reduction efforts;

(5) Describe in writing the process for receiving, tracking, and resolving complaints and receiving feedback on the master nurse staffing plan from clinical staff nurses and other staff; and

(6) Make the HOSPITAL'S complaint and feedback process available to all providers, including clinical staff nurses, nurse aides, and EMS providers, AND INCLUDE INFORMATION ON THE DEPARTMENT'S COMPLAINT REPORTING PROCESS.

(7) MAKE THE NURSE STAFFING COMMITTEE DOCUMENTATION AVAILABLE TO HOSPITAL NURSING STAFF.

(8) DEVELOP, DOCUMENT, AND IMPLEMENT A CHARTER OR GUIDELINE.

14.7 Nurse Staffing Plans

(A) Master Nurse Staffing Plan

(1) The nurse staffing committee shall annually develop and oversee a master nurse staffing plan for the hospital that:

(a) Provides for continuous registered nurse coverage, for distribution of nursing and auxiliary personnel, and for forecasting future needs;

(B) ADDRESSES PATIENT CENSUS; CHURN (ADMISSIONS/DISCHARGES/TRANSFERS); PATIENT OUTCOMES; AND WORKFORCE METRICS AND STAFF FEEDBACK;

(C) Includes minimum staffing requirements for each inpatient unit and emergency department that are aligned with nationally recognized standards and guidelines;

(D) Includes strategies that promote the health, safety, and welfare of the hospitals' employees and patients;

(E) Includes guidance and a process for reducing nurse-to-patient assignments to align with the demand based on patient acuity;

(F) Is voted on and recommended by at least sixty (60) percent of the nurse staffing committee; and

(G) May include innovative staffing models.

(2) The master nurse staffing plan must be based on the different types of patients cared for on each inpatient care unit and in the emergency department, the skill mix, specialized qualifications, and level of competency necessary for nursing staff to ensure that the hospital is staffed to meet the safety and healthcare needs of patients.

(3) The master nurse staffing plan shall specify how each patient is provided access to care from a registered nurse, when applicable.

(4) Once the master nurse staffing plan has been initiated, ongoing staffing effectiveness shall be reviewed and documented through the nurse staffing committee.

(5) The nurse staffing committee shall submit the recommended master nurse staffing plan to the hospital's senior nurse executive and the hospital's governing body for approval

WITHIN SIXTY (60) DAYS OF ADOPTION BY THE COMMITTEE OR AT THE GOVERNING BODY'S NEXT MEETING, WHICHEVER OCCURS FIRST.

(A) If the final staffing plan approved by the hospital changes materially from the recommendations put forth by the nurse staffing committee, the senior nurse executive shall provide the nurse staffing committee with a written explanation for the changes WITHIN SIXTY (60) DAYS.

(I) If, after receiving the explanation referenced above, the nurse staffing committee believes the final staffing plan does not meet the nurse staffing standards established in this Part 14, the staffing committee, with a vote of sixty (60) percent or more of the members, may request the Department review the final adopted staffing plan to ensure compliance with these rules.

(II) THE NURSE STAFFING COMMITTEE MAY PUBLISH A REPORT THAT IS RESPONSIVE TO THE CHANGES MADE TO THE RECOMMENDED MASTER NURSE STAFFING PLAN.

(6) The hospital shall evaluate the master nurse staffing plan and prepare a report for internal review by the nurse staffing committee on a quarterly basis.

(A) IF THE EVALUATION INDICATES THAT THE CURRENT MASTER NURSE STAFFING PLAN HAS NOT RESULTED IN ADEQUATE STAFFING, AND/OR THE HEALTHCARE NEEDS OF THE PATIENTS ARE NOT MET, THE NURSE STAFFING PLAN SHALL BE MODIFIED.

(7) The hospital shall prepare and submit the following to the Department on an annual basis IN A FORM AND MANNER DETERMINED BY THE DEPARTMENT:

(a) The final approved master nurse staffing plan, and

(b) An annual report containing the details of the quarterly evaluation.

(B) Inpatient Care Unit and Emergency Department Plans

(1) Each open inpatient care unit and emergency department within the hospital shall have a twenty-four (24) hour nurse staffing plan.

(C) The master nurse staffing plan, inpatient care unit plans, and emergency department plans shall be made available to and reviewed with each individual member of the nursing staff annually. The hospital shall maintain documentation of the annual plan reviews.

(1) The hospital shall provide the relevant unit-based staffing plan to:

(a) each applicant for a nursing position on a given unit upon an offer of employment, and

(b) a patient upon request.

(D) When updates are made to the master nurse staffing plan, inpatient care unit plan, or emergency department plan, the updates shall be made available to each member of the nursing staff.

14.8 The authority and responsibility of each nurse and auxiliary personnel shall be clearly defined in written policies. Auxiliary personnel shall only be assigned duties for which they are qualified, and shall be under the supervision of a registered nurse.

14.9 At least one (1) registered nurse and one (1) auxiliary personnel shall be on duty at all times in each open inpatient unit and in the emergency department. Additional staffing needs shall be determined by the hospital's master nurse staffing plan.

14.10 One (1) registered nurse qualified by education, training, competencies, and experience, shall be designated in charge of each open inpatient care unit and the emergency department, and that individual shall be delegated the authority and responsibility for the nursing services on that unit. Additional registered nurses or other auxiliary personnel shall be available.

Part 15. PHARMACY SERVICES

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15.14 Medication Administration

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15.15 The hospital shall ensure up-to-date resources are available to professional staff regarding the appropriate use of drugs and biologicals, including but not limited to: therapeutic use, potential adverse effects, dosage, and routes of administration.

15.16 Investigational Drugs

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15.17 Compounding Medications

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15.18 A refrigerator with thermometer and freezing compartment shall be provided for the proper storage of thermolabile products.

15.19 Facilities shall be provided for the adequate storage, preparation, and dispensing of drugs with security, proper lighting, temperature control, moisture, ventilation, and sanitation facilities

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Part 19. DIETARY SERVICES

19.1 The hospital shall have an organized food dietary service that is planned, equipped, and staffed to serve adequate meals to patients. Food prepared outside the hospital shall be from sources that comply with these regulations and other applicable laws and regulations.

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Part 21. EMERGENCY SERVICES

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21.2 Licensed Rehabilitation Hospitals, Psychiatric Hospitals, LICENSED Hospital Units, Long-Term Care Hospitals, as defined at 42 U.S.C. 1395x(ccc), and Specialty Hospitals, as defined at Part 2.18 above, shall not be required to maintain a dedicated emergency department and shall follow the standards in Part 21.4 below. If the hospital chooses to maintain a dedicated emergency department, it shall follow the standards in Part 21.3 below.

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21.4 Hospitals without a Dedicated Emergency Department

(A) Signage indicating that the hospital does not have an emergency department shall be posted at all public entrances.

(B) The hospital shall have the ability to provide basic life saving measures to patients, staff, and visitors, and shall have written policies for the appraisal of emergencies, initial treatment, and transfer when appropriate.

Part 22. OUTPATIENT SERVICES

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Part 23. PERINATAL SERVICES

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23.6 The hospital shall develop and implement admission and transfer criteria for perinatal services that reflect the hospital's scope of services.

23.7 Labor and Delivery

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Part 25. CRITICAL CARE SERVICES

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25.2 Critical care services shall be directed by under the direction of a physician qualified by education, training, competencies, and experience.

25.3 Nurse Staffing

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Part 27. REHABILITATION SERVICES

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27.9 There shall be appropriate facilities, equipment, and supplies to meet the rehabilitative care needs of patients.

Part 28. PEDIATRIC SERVICES

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28.8 When a dedicated pediatric inpatient care unit is established it shall provide, at a minimum:

(A) Washable tables and chairs of various sizes; and

(B) Appropriate entertainment and educational materials.

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