**REGULATORY ANALYSIS FOR EMERGENCY REVISIONS TO**
6 CCR 1011-1, Standards for Hospitals and Health Facilities
Chapter 2 – General Licensure Standards
**Emergency rules adopted by the Board of Health on August 30, 2021. Effective August 30, 2021.**

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 |
|---|---|---|
| All licensed healthcare facilities and agencies (as listed below) | 3800 total | C |
| Acute Treatment Units | | |
| Ambulatory Surgical Centers | | |
| Assisted Living Residences | | |
| Behavioral Health Entity | | |
| Birth Centers | | |
| Community Mental Health Center | | |
| Community Clinic | | |
| Community Integrated Health Care Services Agency | | |
| Dialysis Treatment Clinics | | |
| Home Care Agencies | | |
| Home Care Placement Agencies | | |
| Hospice | | |
| Hospitals | | |
| Facilities for Individuals with Intellectual and Developmental Disabilities | | |
| Nursing Homes | | |
| Patients/clients receiving care and services from a licensed healthcare facility or agency | Over 63,000 (based on the number of licensed beds across all facility/agency types) | B |
| Employees and Direct contractors of licensed healthcare facilities and agencies. | Unknown | 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.

C: The potential impact upon the healthcare facilities and agencies that will implement this requirement include: decreased number of positive COVID-19 cases, outbreaks, and deaths experienced in licensed healthcare facilities, decreased costs incurred as a result of staff and client illness, increased positive outcomes for patients and clients, decreased number of staffing shortages related to COVID-19 illness or exposure, and a decrease in the overall healthcare workforce if healthcare providers and support staff choose to leave the profession as a result of this requirement.

B: The impact upon clients, patients, and residents served in and by licensed healthcare facilities and agencies will be lessened exposure to COVID-19, decreasing their chances of experiencing illness or death as a result. The impact upon employees of licensed healthcare facilities and agencies will be that these individuals are also at a decreased risk of exposure in the workforce. However, some of these individuals may choose to leave employment in this field due to these requirements.

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 amendments are cost neutral.

      Anticipated CDPHE Revenues:

      The proposed amendments are revenue neutral.

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

      N/A

      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:

   ___ Comply with a statutory mandate to promulgate rules.

___ Comply with federal or state statutory mandates, federal or state regulations, and department funding obligations.
_X__ 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):

| |
|---|
| 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.<br><br>___ Contributes to the blueprint for pollution reduction<br>___ Reduces carbon dioxide from transportation<br>___ Reduces methane emissions from oil and gas industry<br>___ Reduces carbon dioxide emissions from electricity sector |
| Reduce ozone from 83 parts per billion (ppb) to 80 ppb by June 30, 2020 and 75 ppb by June 30, 2023.<br><br>___ Reduces volatile organic compounds (VOC) and oxides of nitrogen (NOx) from the oil and gas industry.<br>___ Supports local agencies and COGCC in oil and gas regulations.<br>___ Reduces VOC and NOx emissions from non-oil and gas contributors |
| Decrease the number of Colorado adults who have obesity by 2,838 by June 30, 2020 and by 12,207 by June 30, 2023.<br><br>___ Increases the consumption of healthy food and beverages through education, policy, practice and environmental changes.<br>___ Increases physical activity by promoting local and state policies to improve active transportation and access to recreation.<br>___ 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. |
| 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.<br><br>___ Ensures access to breastfeeding-friendly environments. |
| 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.<br><br>___ 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).

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.

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.

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.

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 was chosen. Costs and benefits of inaction not previously discussed include:

Inaction has neither monetary cost nor benefit; however, inaction will result in the further spread of COVID-19 across the state of Colorado. This will result in increased burden on an already overtaxed healthcare system, including the healthcare workforce, economic burdens as individuals are unable to work due to illness or quarantine requirements, disruptions in learning for students K-12, and increased deaths across all sectors of our population.

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

   The less costly or less intrusive methods available in this scenario are for employees, direct contractors, and support staff to voluntarily receive the COVID-19 vaccination and/or for employers to enact vaccination requirements on an individual basis. While that approach has led to a majority of the healthcare workforce receiving the COVID-19 vaccine, approximately 30% of the healthcare workforce remains unvaccinated, and large sectors of the healthcare industry that have not enacted individual vaccination mandates. As such, this regulation is the next step to ensure vulnerable Coloradans are protected from the spread of COVID-19.

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

   There were no alternatives to rulemaking considered except inaction. For the reasons set forth in the above, inaction will result in the further spread of COVID-19 across the state of Colorado, including in our licensed healthcare facilities.

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 Department utilized data collected from various sources by different programs across the Department. This includes information from the Outbreak team on deaths, flu data from the immunization branch, and reported vaccination rates from EMResource. Much of this data is publicly available on the Department website. Flu vaccination information is found at: https://cdphe.colorado.gov/immunization-rates-reports-and-data. COVID-19 data is found at: https://covid19.colorado.gov/data.

   The Department also reviewed recent literature and studies around vaccine efficacy, including: Griffin JB, Haddix M, Danza P, et al. SARS-CoV-2 Infections and Hospitalizations Among Persons Aged ≥16 Years, by Vaccination Status — Los Angeles County, California, May 1–July 25, 2021. MMWR Morb Mortal Wkly Rep. ePub: 24 August 2021. DOI: http://dx.doi.org/10.15585/mmwr.mm7034e5external icon.