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DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

# Departmental Instruction 315 (QM) 13
# Reporting and Reviewing Deaths

## 315-1 BACKGROUND

The Department of Behavioral Health and Developmental Services (DBHDS) is committed to continually monitoring and improving the health and safety of individuals receiving behavioral health and developmental services in the Commonwealth. The purpose of the DBHDS Mortality Review Committee (MRC) and Facility Mortality Review Committee (FMRC) is to focus on system-wide quality improvement through conducting mortality reviews of: (i) individuals with an intellectual or developmental disability (I/DD) who were receiving a service licensed by DBHDS at the time of death; and (ii) individuals receiving service in, a DBHDS state facility at the time of death. Review and analysis of the trends, patterns, and problems related to the deaths of these individuals can identify opportunities for system improvements to reduce risks to all individuals receiving behavioral health or developmental services. On an ongoing basis, DBHDS seeks to prevent occurrences of abuse, neglect, exploitation, and death by identifying and addressing relevant factors during mortality reviews.

## 315-2 PURPOSE

The purpose of this departmental instruction (DI) is to establish policy and procedures that will ensure the thorough and consistent mortality review for all individuals described above by obtaining:

- Reports of all deaths of individuals with I/DD receiving a DBHDS-licensed service that are reported through DBHDS incident reporting systems; and
- Reports of deaths of individuals residing in state facilities that are received and obtained from the individual's facility of residence through documents including internal alerts, 45 day report and root cause analysis of sentinel events.

The purpose of such review is to focus on system-wide quality improvement by ongoing monitoring and data analysis of mortality reviews through the professional engagement of a multidisciplinary team that performs objective, unbiased reviews while promoting ethical integrity and evidenced-based recommendations to promote the health, safety, and well-being of individuals. Reviews serve to:

- Collect and analyze mortality data to identify trends, patterns, and problems at the individual service-delivery and systemic levels;
- Provide oversight to state facilities related to unexpected (unexplained) deaths of individuals through surveillance of existing internal facility mortality review processes; and
- Develop, recommend, and implement quality improvement initiatives in order to

reduce mortality rates to the fullest extent practicable, and to promote patient safety and health care outcomes.

## 315-3 DEFINITIONS

**EXPECTED DEATH**

A death that was consistent with and as a result of an individual's previously diagnosed terminal condition. A death can be expected if the person had a known terminal condition (e.g., end stage renal disease) or if the person was elderly and had a period of deterioration and increasing medical frailty. In both cases, the person, family, and caregivers were aware that the condition was terminal, end of the life decisions were in place, and primary health care and palliative care teams, if applicable, were involved. The individual, legally authorized representative (if the individual lacked capacity to make advance directive decisions), family, or all were aware that the illness or condition would result in death and had an opportunity to discuss, if not decide, end of life matters and clinical measures to be taken or not taken.

For some individuals, the decline from the aging process also may produce an expected death.

Having a do not resuscitate order (DNR, DDNR) in place does not automatically classify the death as expected.

**MORTALITY REVIEW COMMITTEES**

The Central Office (CO) Mortality Review Committee (MRC) and Facility Mortality Review Committee (FMRC) committees charged with reviewing the deaths of all individuals with I/DD who are receiving services:

- In a state facility (FMRC);
- From a provider licensed by DBHDS (MRC); or
- Through one of Virginia's Medicaid Developmental Disability (DD) Waiver services (MRC).

**OVERSIGHT**

DBHDS Mortality Review Office in the Division of the Chief Clinical Officer (CCO) will monitor facility mortality review processes through a review of records and data related to discrepancies, omitted relevant information, or additional documentation (if needed) for the purposes of:

- Standardizing a consistent mortality review process among all state facilities;
- Providing oversight of activities (risk mitigation, health, safety, and freedom from harm);
- Validating and supporting facilities' operational, systems and policy actions;
- Functioning as a resource for state facilities to promote integration of resources and communication in collaboration with other state facilities;
- Tracking availability and receipt of required documents, maintaining secure online storage and entering all required information into electronic formats for committee review; and

- Preparing case reviews, meeting agendas, minutes and data analysis reports for both the MRC and FMRC.

**POTENTIALLY PREVENTABLE**

Deaths that are considered to be premature and may have been avoided, based on a combination of known medical, genetic, social, environmental, or other factors (such as pre-morbid conditions).

**TIER CLASSIFICATIONS**

A system for categorizing deaths for mortality review to be used as the basis for analyses.

A Tier 1 case requires a detailed, comprehensive review of multiple factors and areas of focus by the mortality review committee. Tier 1 Criteria:

- Cause of death cannot clearly be determined or established, or is unknown;
- Any unexpected death (such as suicide, homicide or accident);
- Abuse or neglect is specifically documented;
- Documentation of investigation by or involvement of law enforcement (including forensic) or similar agency; and
- Specific or well defined risks to safety and well-being are documented.

A Tier 2 case does not require a detailed, comprehensive review as the preliminary review was sufficient. Tier 2 Criteria:

- Cause of death can clearly be determined or established;
- An expected death, if no abuse or neglect, involvement of law enforcement or well defined safety and well-being risks are documented;
- An unexpected (unexplained) death that occurred as a result of an acute medical event, a new medical condition, or sudden and unexpected (unexplained) consequences of a known medical condition, if no abuse or neglect, involvement of law enforcement or well defined safety and well-being risks are documented;
- No documentation of abuse or neglect;
- No documentation of investigation by or involvement of law enforcement (including forensic) or similar agency; and
- No documentation of specific or well defined risks to safety and well-being noted.

**UNEXPECTED (UNEXPLAINED) DEATH**

A death that occurred as a result of an acute medical event that was not expected in advance nor based on a person's known medical conditions. Examples might include suicide, homicide, accident, acute medical event, a new medical condition, or sudden and unexpected (unexplained) consequences of a known medical condition. An unexplained death is also considered an unexpected death.

## RESPONSIBLE AUTHORITY

**FACILITY DIRECTORS**

Facility directors are responsible for:

- Reporting the deaths of individuals receiving services in the facility;
- Reporting the deaths of individuals who died within 21 days post discharge, when known;
- Developing policies and procedures for the review of deaths to include the requirements set forth in this DI;
- Ensuring that a mortality review is conducted for every death, including determination of expected, potentially preventable and Tier classification; and
- Ensuring results of the review are reported to both the DBHDS Mortality Review Office under the CCO, and the DBHDS Office of Human Rights as required by this DI.

**DBHDS OFFICE OF LICENSING**

DBHDS Office of Licensing Special Investigations Unit (SIU) is responsible for:

- Conducting an initial review of all deaths of individuals with I/DD reported to DBHDS through the incident reporting system within 24 hours after the death is reported;
- Providing all available records and information obtained by the SIU, including the Office of Licensing Investigation Report, to the MRC within 45 business days of the date the death was reported; and
- Presenting a summary at each MRC meeting of any relevant findings, corrective action plans (CAP), and additional provider information.

**DBHDS CHIEF CLINICAL OFFICER**

The CCO (who shall be a physician), or designee, is responsible for:

- Requesting and obtaining information and records regarding any individual whose death is being reviewed by DBHDS mortality review committees, including the information listed in Code of Virginia § 37.2-314.1. Specifically, this provides that: (i) any report of the circumstances of the death maintained by any state or local law-enforcement agency or the Office of the Chief Medical Examiner and (ii) information or records about the person maintained by any facility, hospital, nursing home, or health care provider that provided services to the individual, any social services agency that provided services to the individual, or any court shall be provided to the Chief Clinical Officer or his designee for inspection upon request of the Chief Clinical Officer. Any presentence report prepared pursuant to § 19.2-299 for any person convicted of a crime that may have led to the death of the person whose death is the subject of review by the Committee shall be made available to the Chief Clinical Officer or his designee for inspection. In addition, the Chief Clinical Officer or his designee may inspect and copy from any health care provider in the Commonwealth, on behalf of the Committee, any health or mental health record of the individual, without authorization;
- Ensuring that the MRC and FMRCs review deaths in accordance with this DI and any applicable state or federal law or regulation;

- Ensuring that the oversight role of facility deaths is maintained by the Mortality Review Office within the CCO's Division in Central Office; and
- Presenting the report of deliberations, findings, and recommendations of the MRC to the commissioner and the DBHDS Quality Improvement Committee (QIC) within 90 days of a death.

## 315- 5 SPECIFIC GUIDANCE

**SPIRIT OF THE REVIEW**

Research has indicated that individuals with a serious mental illness or an intellectual or developmental disability are at greater risk than the general population for premature death.

In addition to the medical, psychiatric, and cognitive complexity they may experience, in many cases individuals with these conditions may be limited in their capacity to: attend to their own health issues; recognize the significance of their medical conditions; or, at times, communicate clearly about their medical symptoms or conditions.

Thorough and consistent mortality reviews ensure that one legacy of each individual after his death is that the system is improved as a result of the review. The intent of the mortality review, therefore, is to:

- Perform comprehensive clinical mortality reviews utilizing a multidisciplinary approach that addresses relevant factors (medical, genetic, social, environmental, risk, susceptibility, and others as specific to the individual) and quality of service;
- Evaluate the quality of the decedent's licensed services related to disease, disability, health status, service use, and access to care, to ensure provision of a reliable, person-centered approach;
- Identify risk factors and gaps in service and recommend quality improvement strategies to promote safety, freedom from harm, and physical, mental, and behavioral health and wellbeing;
- Review DBHDS Office of Licensing CAPs related to required recommendations, to ensure no further action is required and for inclusion in meeting minutes;
- Review internal mortality review documents from state facilities;
- Refer any required recommendations not included in the initial CAP or facility documents back to the Office of Licensing and state facility where the decedent received services at the time of death, for further investigation or discussion; and
- Take action to identify processes that, if improved, may mitigate the risks at the individual, provider, and systemic level.

Each provider licensed by DBHDS and state facility must adhere to established mandates that require provision of an environment that promotes safety and freedom from harm, and should seek to prevent instances of abuse, neglect, exploitation, and unexplained deaths.

**SCOPE OF THE REVIEW**

The mortality review shall include evaluation of the circumstances of each individual and the sequence and nature of events as they unfolded, going back at least 90 days from the date of death, to identify areas where there are opportunities to improve evidence-based standards of practice and safety.

**EXPECTED VERSUS UNEXPECTED (UNEXPLAINED) DEATHS**

The mortality review shall take into consideration multiple variables when making a determination as to whether an individual's death is expected or unexpected (unexplained).

The variables include: the individual's age, chronic or acute medical conditions, medications the individual was taking, and events immediately prior to the individual's death. Information for each mortality review shall be utilized from medical and service records and other documents for the three months preceding the individual's death which include: most recent individual support plan (ISP); progress notes; medication administration record (MAR); consult notes (medical and ancillary, e.g., nutrition and clergy); lab or procedural notes; plan of care/electronic patient care summary (POC/PCS), licensed healthcare provider orders; current assessments; incident reports; and discharge summary, if available.

The relationship between medical conditions and the likely cause of death, along with other relevant factors, should be considered in addition to those listed. At times, the identification of a death as "expected" or "unexpected" (unexplained) is neither clear nor straightforward in the context of the individual's medical conditions or the complexities that posed a chronic risk to the individual.
When the mortality review determines a death is potentially preventable, the committees (DBHDS CO and Facility specific) shall categorize factors that might have prevented the death. For a death to be determined potentially preventable, the actions and events immediately surrounding the individual's death must be related to deficits in the timeliness of, or absence of, at least one of the following four factors:

1. Coordination of care;
2. Access to care, including delay in seeking treatment;
3. Execution of established protocols; and
4. Assessment of the individual's needs or changes in status.

**CONFIDENTIAL AND PRIVILEGED INFORMATION**

Members of, and clinical consultants to, any mortality review committee shall be afforded the opportunity to make critical assessments in an environment that encourages intellectual honesty and clinical integrity. The members of the committee and consultants acting under an agreement with the committee shall maintain as privileged all communications and work product including discussion within or among committee members, consultants, interviewees, or other personnel, or persons invited by the committee to participate in a review. Those portions of meetings in which individual death cases of individuals with developmental

disabilities are discussed by the DBHDS Mortality Review Committee established pursuant to § 37.2-314.1 shall be closed pursuant to subdivision A 21 of § 2.2-3711. Meetings of facility mortality review committees that include discussion or consideration of medical or mental health records shall be closed in accordance with subdivision A 16 of § 2.2-3711.

All information obtained or generated by the MRC or on behalf of the Mortality Review Committee regarding a review shall be confidential and excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq., FOIA) pursuant to subdivision 7 of § 2.2-3705.5. Such information shall not be subject to subpoena or discovery or be admissible in any civil or criminal proceeding. Health records reviewed by facility mortality review committees are excluded from the mandatory disclosure provisions of FOIA pursuant to subdivision 1 of § 2.2-3705.5. In addition, the Developmental Disabilities Mortality Review Committee and facility mortality review committees shall maintain the confidentiality of health records in accordance with § 32.1-127.1:03.

**RECUSAL**

Members must recuse themselves from mortality review (MR) committee proceedings if a conflict of interest arises, in order to maintain neutrality *(prevent bias)* and credibility of the committee mortality review process. Conflict of interest exists when a mortality review committee member has a financial, professional or personal interest that could directly influence committee determinations, findings or recommendations, such as:

- The MR member, or an individual from the member's family, was actively involved in the care of the decedent (direct care r/t employment or financial as listed below).
- The MR member may have participated in a facility or institutional mortality review of the decedent.
- The MR member, or an individual from the member's family, has a financial interest or investment that could be directly affected by the mortality review *(including determinations and recommendations)* of the decedent, to include employment, property interests, research, funding or support, industry partnerships and consulting relationships.

Should a conflict of interest arise during the review process, the MR member will:

- Immediately disclose the potential conflict of interest and cease participation in the case review related to the existing or potential conflict of interest.
- Disclose the conflict of interest privately to the Chair/Co-Chair, or publicly to the members in attendance.

The MR committee will then halt discussion of the conflict of interest case, move on to the next case, and place the conflict of interest case at the end. This allows the MR committee member with a conflict of interest to remain for the review of other

cases, and then leave the proceedings prior to the discussion of the conflict of interest case.

## 315-6 PROCEDURES – STATE FACILITY MORTALITY REVIEW

**STATE REPORTING AND REVIEWING OF DEATHS**

Each facility should establish a culture that supports a rigorous inquiry into the deaths of individuals receiving services for the purpose of identifying ways to improve care and treatment and facilitate growth in the capacity of staff to critically review events and processes. The mortality review is a system tool to support facilities by monitoring adherence to established mandates that require provision of an environment that promotes safety and freedom from harm, and that seeks to prevent instances of abuse, neglect, exploitation and unexplained deaths. To that end;

- Deaths shall be reported within 24 hours of the death or, if the death occurred post discharge, within 21 days of notification of the death.
- Deaths shall be reported by the facility as an Internal Report to the DBHDS Deputy Commissioner of Facility Services, Assistant Commissioner of Facility Services, Facility Operations Specialist, Chief Clinical Officer, and Mortality Review Clinical Manager.

Each facility shall conduct a mortality review of all deaths for:

- Every individual who was receiving services in the facility at the time of death; and
- Every individual who died within 21 days after discharge from the facility, if known.

**STATE FACILITY MORTALITY REVIEW COMMITTEE MEMBERSHIP**

The facility mortality review committee membership shall include, at a minimum, the following participants or their designated alternates, unless otherwise specified in the facility's medical staff bylaws:

- Facility medical director;
- Attending physician;
- Nursing director;
- Quality and risk manager; and
- Others as designated by the facility medical director.

**STATE FACILITY MORTALITY REVIEW COMMITTEE REQUIREMENTS**

Within 45 days of any reported death, the facility shall conduct a mortality review and make a determination as to:

- Whether the death was expected, potentially preventable, and tier classification (utilizing the Tier classification in this DI under 'Specific Guidance');
- Establish the likely cause of death; and
- Identify issues in care that require remediation to reduce risk.
- Recommendations for system improvements to decrease the risk of future occurrence while promoting the health, safety and welfare of individuals residing in the facility.

Within 60 days of any death, an electronic copy of the facility's written report of the mortality review shall be submitted to the deputy commissioner and assistant commissioner with responsibility for the facility, DBHDS facility operations, CCO, the DBHDS Mortality Review Clinical Manager, and to the email designated for this purpose (mortalityreview@dbhds.virginia.gov).

The facility mortality review shall:

- Be conducted within 45 days of the death or, if the individual died post discharge, within 45 days of notification of the death;
- Take place at a formal review meeting with all required members or their designated alternates present;
- Include the review and evaluation of all elements on the facility's internal mortality review form, including the DBHDS state facility mortality review requirements as listed in this DI above, covering a timeframe of at least three months prior to the death; and
- Submit the completed, signed and dated mortality review report (45 day report), with attached supporting documents as appropriate, to CO via email (mortalityreview@dbhds.virginia.gov).

**CO Facility Mortality Review Requirements**

The CO shall convene a Facility Mortality Review Committee (FMRC), which shall conduct a mortality review of the death of every individual who was a resident in a state facility at the time of death.

The CO FMRC shall:

- Have the CCO, or designee, serve as committee chair and be responsible for ensuring the committee performs its functions and quality improvement activities, in addition to core committee functions;
- Review the factual summary and recommendations submitted by the facility;
- Review all facility deaths biannually; and
- Take place at a formal review meeting with all required members or the designated alternates present.

**CO Facility Mortality Review Committee Membership**

The CO FMRC shall include the:

- CCO;
- DBHDS Mortality Review Clinical Manager;
- DBHDS Mortality Review Program Coordinator;
- A member representing the CO Division of Facility Operations;
- A member representing the DBHDS Division of Developmental Services (DDS);
- A member representing the DBHDS Division of Compliance, Regulatory, and Legislative Affairs (CRLA);
- A member representing the DBHDS Quality Improvement Office;
- A member representing the DBHDS Office of Human Rights;
- DBHDS Pharmacy Services Manager;

- A medical director representing the state facilities; and
- A member representing a state facility Quality Improvement and Risk Management Office.

**CO FACILITY MORTALITY REVIEW COMMITTEE MEETINGS**

The CO FMRC shall meet biannually to ensure that all facility deaths are reviewed as required by this DI. After the review, the CO FMRC shall submit a report of findings and any follow-up on facility deaths to the DBHDS Commissioner.

After the receipt of a facility's 45 day report and IMRF, the CCO or the CO mortality review clinical manager shall review the documentation from the facility and:

- Assess for risk mitigation, health, safety, and freedom from harm concerns noted by the facility mortality review;
- Recommend tier reclassification, if circumstances warrant;
- Request additional information from the decedent's facility as needed, including root cause analysis, if appropriate;
- Interview, any persons having information regarding the individual's care; and
- Validate the process of the facility's mortality review.

## 315-7 PROCEDURES – CENTRAL OFFICE MORTALITY REVIEW COMMITTEE

**CO MORTALITY REVIEW REQUIREMENTS**

The DBHDS Central Office shall convene a mortality review committee (MRC), which shall conduct a mortality review of the death of every individual who:

- Had a diagnosis of I/DD and was, at the time of death, either:
- Receiving a service from a DBHDS-licensed provider at the time of death; or
- Being served at a state facility.

The MRC shall:

- Have the CCO, or designee, serve as committee chair and be responsible for ensuring the committee performs its functions; consideration and, as appropriate, approval of quality improvement activities; and MRC core processes.
- Review deaths within 90 days of the date of death; and
- Take place at a formal review meeting with all required members or designated alternates present.

**CONFIDENTIALITY**

In addition to the requirements of § 2.2-3712, all members of the Mortality Review Committee and other persons attending closed meetings of the Mortality Review Committee, including any persons presenting information or records on specific deaths, shall sign an agreement to maintain the confidentiality of the information, records, discussions, and opinions disclosed during meetings at which the MRC reviews a specific death. No member of the Mortality Review Committee or other person who participates in a review shall be required to make any statement regarding the review or any information collected during the review. Violations of this subsection are punishable as a Class 3 misdemeanor.

**CO MRC MEMBERSHIP**

The MRC shall include the following members, all of whom shall have quality improvement (QI) and programmatic and operational expertise:

- DBHDS Chief Clinical Officer (MD);
- DBHDS Deputy Commissioner of Developmental Services, or designee (staff member);
- DBHDS Senior Director of Quality Improvement (staff member);
- DBHDS Director, Community Quality Improvement, or designee (RN and staff member);
- DBHDS Director, Office of Human Rights, or designee (staff member);
- Clinical Manager, Mortality Review (Co-Chair) (NP and staff member);
- Office of Licensing Manager, Incident Team (staff member);
- Manager, Investigation Team (Office of Licensing staff member);
- Manager, Pharmacy Services (PharmD and staff member);
- Mortality Review Team Clinical Reviewer (RN and staff member);
- Mortality Review Team Program Coordinator (staff member);
- Registered Nurse from Office of Integrated Health (staff member); and.
- A member with clinical experience to conduct mortality reviews who is otherwise independent of the State (MD and external member)

Advisory *(non-voting)* members nominated by the commissioner or CCO (as chair) may include:

- One representative from each of these Commonwealth of Virginia agencies:
  - Department of Medical Assistance Services;
  - Department of Health;
  - Department of Social Services;
  - Office of the Chief Medical Examiner;
- One representative from a community services board; and
- Other subject matter experts, such as representatives from DD providers or advocacy organizations.

**CO MRC MEETINGS**

The MRC shall meet as often as necessary but at least monthly to ensure that the deaths of all individuals with I/DD are reviewed as required by this DI and any other applicable state or federal law or regulation.

The DBHDS Mortality Review Team (MRT) shall conduct a preliminary review of each death reported to the DBHDS CO in accordance with this DI. The MRT shall consist of:

- Clinical Manager;
- Clinical Reviewer(s); and
- Program Coordinator.

Within 90 days of a death (and for any unreported deaths), the MRT completes its review of the death. A complete review by the MRT includes development of a succinct, complete case summary by reviewing, and documenting the availability or unavailability, of:

- Medical records including physician case notes and nursing notes for three months preceding death;
- Incident reports for three months preceding death;
- Most recent individualized program plan;
- Medical and physical examination records;
- Death certificate and autopsy report, if applicable;
- Any evidence of maltreatment of the individual related to the death; and
- The MRT shall also interview, as warranted, any persons having information regarding the individual's care.

The MRT clinical reviewer(s) shall document all relevant information onto the electronic Mortality Review Form, and the CCO or clinical manager shall complete a preliminary review of all case summaries prior to an MRC meeting. During the preliminary review, a case shall be identified as Tier 1 or Tier 2. (See explanation of Tier classifications under 'Specific Guidance.').

A clinical reviewer designated by the CCO who is a member of the MRC shall present a summary of the circumstances surrounding each Tier 1 death for its consideration. At that time, a facilitated narration with discussion shall occur.

During the facilitated narration discussion, the MRC seeks to identify:
- The cause of death;
- Whether the death was expected;
- Whether the death was potentially preventable;
- Any relevant factors impacting the individual's death;
- Any other findings that could affect the health, safety, and welfare of these individuals; and
- Whether there are other actions which may reduce these risks, to include provider training and communication regarding risks, alerts, and opportunities for education.

If any actions are identified based on the case review, the MRC will then make and document relevant recommendations and interventions.

Documentation of all the above shall be made in the meeting minutes, the Action Tracking Log, and on the electronic Mortality Review Form.

Within 90 days of a death, the MRC shall prepare and deliver a report specific to the committee's deliberations, findings, and recommendations to the DBHDS Commissioner. If the MRC elected not to make any recommendations, documentation shall affirmatively state that no recommendations were warranted.

**CO MRC Analysis of Mortality Data**

The DBHDS MRC shall analyze mortality data collected through its reviews to identify trends, patterns, and problems at the individual, service delivery, and systemic levels and make recommendations for quality improvement. The MRC documents recommendations for systemic quality improvement initiatives coming

from patterns of individual reviews on an ongoing basis, and patterns that emerge from any aggregate examination of mortality data.

- From this analysis, the MRC shall make one recommendation per quarter *(four recommendations/year)* for systemic quality improvement initiatives, and report these recommendations to the QIC (quarterly) and the DBHDS Commissioner (annually).
- On a quarterly basis, the MRC shall also prepare and deliver to the QIC a report specific to the committee's findings.
- The MRC shall prepare an annual report of aggregate mortality trends and patterns for all individuals reviewed by the MRC within six months of the end of the calendar year. A summary of the findings shall be released publicly. Data from this report shall be included in the DBHDS Annual Quality Management Report.

The QIC and commissioner shall review the aggregate data and recommendations based on deaths reviewed by the MRC and approve recommendations and quality improvement initiatives in order to reduce mortality rates to the fullest extent practicable.

## 315-8 REFERENCES

- Code of Virginia § 37.2-314.1.
- Code of Virginia § 2.2-4002(B)(17) of the Administrative Process Act.
- Code of Virginia § 8.01-581.17. Privileged communications of certain committees and entities.
- Code of Virginia § 32.1-127.1:03. Health records privacy.
- Code of Virginia §§ 2.2-3705.5(1), 2.2-3705.5(7), 2.2-3711, and 2.2-3712 of the Virginia Freedom of Information Act.
- Standards for Privacy of Individually Identifiable Health Information (the HIPAA Privacy Rule), 45 C.F.R. Part 160 and Subparts A and E of Part 164.
- United States of America v. Commonwealth of Virginia, 3:12cv59-JAG

Alison G. Land, FACHE, Commissioner

**EFFECTIVE DATE:** August 28, 2020

**ATTACHMENT:** ☐ YES ☒ NO