FACT SHEET

virginia interfaith center FOR PUBLIC POLICY
1716 East Franklin Street, Richmond, VA 23223
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HB5 / SB199 Paid Sick Days

Patron: Delegate Kelly Convirs-Fowler & Senator Barbara Favola

Problem: Approximately 41 percent of private sector workers, **1.2 million workers in Virginia, have no paid sick days** or any paid time off (PTO). This creates a crisis for low-wage workers who must choose between taking a sick day for themselves or their children and getting paid. Workers who go to work sick endanger their co-workers, the public and the ability of the business to remain open.

Policy solution: These bills would create a paid sick day standard to require all employers to provide five paid sick days (40 hours) each year for full-time workers that can be used for themselves or to care for sick children. Part-time employees could accrue fewer paid sick hours based on hours worked. PTO policies qualify as paid sick days.

Who benefits: Almost everyone benefits from a paid sick day standard, which is why 83 percent of Virginia registered voters support a policy proposal to provide paid sick days. Strong majorities of Democrats (96 percent, Independents (78 percent) and Republicans (72 percent) all support a paid sick day standard. Paid sick days help:

Workers and their families - When a worker takes 3.5 unpaid sick days, the average family loses a month's worth of groceries. Workers are forced to choose between feeding their families and caring for themselves or their children.

Schools - Parents who don't have paid sick days are more than twice as likely to send their children to school sick, than parents who have paid sick days. Sick children can't learn. Sick children spread germs to children and teachers.

Public health – Workers in low wage sectors are the least likely to have paid sick days. More than 80 percent of food industry workers and 75 percent of childcare workers have no paid sick days. More than half of all Norovirus outbreaks can be traced back to sick food service workers who were forced to choose between working sick and losing pay or their job. An October 2020 report in Health Affairs showed that the paid sick leave provision of the Families First Coronavirus Response Act (FFCRA) reduced the spread of coronavirus. Researchers called paid sick days "a highly effective tool to flatten the curve."

Businesses - Employers lose $160 billion annually in productivity due to "presenteeism" (the practice of coming to work despite illness or injury). Providing paid sick days results in reduced turnover – saving businesses money. The restaurant industry, which has a high turnover rate, found that implementing workplace benefits can reduce turnover by 50 percent.

People of color – In the US, about 38 percent of African Americans and 50 percent of Latinos do not have access to a single paid sick day. More than 25 percent of Latino households and 30 percent of African American households have no savings and cannot afford to take unpaid time off from work.

Can Virginia businesses afford paid sick days? Most Virginia businesses already provide paid sick days or PTO. The pandemic has made clear that businesses need a paid sick day policy. Seventeen states and the District of Columbia have already passed paid sick day standards and most of them rank higher than Virginia in overall health.

Sources: A Better Balance, Family Values @ Work, National Partnership for Women & Families, United Health Foundation, U.S Bureau of Labor & Statistics, YouGov American poll

Contact: Ramón Zepeda Ramos, Economic Justice Organizer,
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January 2026

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Bias Reduction Training Licensing Criterion

Patrons: Senator Locke and Delegate Hayes
SB22/HB1147 Medicine and Nursing, Boards of; continuing education, bias reduction training.

Problem: Black women in Virginia continue to have two to three times higher rates of pregnancy-associated deaths compared with their white counterparts. In 2022, the rate was 138.1 for Black women and 50.6 for white women (per 100,000 live births).[1] **A recent look at Virginia data revealed that the infant death rate for *non-smoking* African-American mothers is three times the infant death rate for White American *smokers*.[2]** Virginia Pregnancy Risk Assessment Monitoring System (PRAMS) reported that 18% of women experienced discrimination or harassment as a result of their insurance or Medicaid status, 25% as a result of their race, ethnicity or culture, and 42% of women experienced discrimination or harassment due to their weight.[3] **Studies show that when you control for education and income, racial disparities do not disappear, suggesting that bias plays a role.** In one study, the wealthiest Black mothers had higher mortality rates than the poorest White mothers.[4]

Policy solution: This bill makes evidence-based bias reduction training a criterion for licensing for health care professionals licensed by the Virginia Board of Medicine and the Board of Nursing. Bias can be both explicit (conscious) or implicit (unconscious). Unconscious bias is a bias (attitude or belief about a person or group that can affect judgement or behavior) that is present but not consciously held or recognized. It has long been identified as a factor contributing to lower health care quality for Black Americans. Numerous studies show implicit bias can impact patient safety and is directly correlated with lower quality of care.[5] High quality care is integral to improving maternal and infant mortality. The American Medical Association, the American Hospital Association, the Association of American Medical Colleges have urged the adoption of bias reduction training strategies such as unconscious bias and cultural competency. In recent longitudinal studies of bias reduction training, over 90% of healthcare providers reported that training: Improved their patient care. Enhanced patient encounters. Elevated the patient experience. Increased their confidence in caring for diverse populations.[6]

Costs: In 2024, the Department of Health Professions indicated that the Board of Medicine will need one new pay band 5 FTE at a cost of $140,750.

Who benefits: With passage of this bill, Virginia sends a strong message that VA Healthcare professionals are committed to equal treatment for all.

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[1] "2024 Virginia Maternal Morality Review Team Annual Report" Submitted February 20, 2025 to the Governor and the General Assembly per Code of Virginia, § 32.1-283.8.
[2] "Exploring Implicit Bias in Care Settings & the Respectful Maternal Care Model" Kenesha Barber, PhD and Lauren Kozlowski, MPH, MSW.
[3] Virginia PRAMS Facts-2021, https://www.vdh.virginia.gov/content/uploads/sites/67/2023/12/Virginia-PRAMS-Facts-2021.pdf
[4] National Bureau of Economic Research, Maternal and Infant Health Inequality: New Evidence from Linked Administrative Data, 2023. https://www.nber.org/system/files/working_papers/w30693/w30693.pdf
[5] Agency for Healthcare Research and Quality, (2024) Healthcare Worker Implicit Bias Training and Education, Rapid Review. https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/mhs-IV-rapid-response-implicit-bias.pdf
[6] "Learner-Reported Impact of the Dignity in Pregnancy & Childbirth Course: A Summary of Three Studies, Diversity Science Institute, 2024" https://www.humanitasinst.com/dipc-feedback

Kathryn Haines, Health Equity Manager, kathryn@virginiainterfaithcenter.org - Jan. 12, 2026

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Support Mom/Baby in Pregnancy with Substance Exposure

Patrons: Senator Locke and Delegate Hayes
SB133/HB652
Problem: Fear of a child protective services referral means Virginia moms do not seek prenatal care. This finding is supported by research; threat-based approaches discourage care.[1] Early entry into prenatal care improves outcomes. **This is a bill to encourage pregnant moms to enter prenatal care.**

Virginia's law currently implies child abuse when an infant is born affected by substance use. The language automatically links prenatal substance exposure with child abuse or neglect, even when the mother is engaged in medicated assisted treatment (MAT), or when the substance involved, such as cannabis, has been decriminalized. This punitive section of code refers solely to the child, ignoring the best practice method of supporting the mother/baby together. Substance use in the Virginia code does not have a uniform definition, *which results in inconsistent implementation of this law and mandatory reporting when there is no risk of harm to the child.* Research reports that maternal race and ethnicity, substance type and socioeconomic status affect whether or not a child protective services report will be made.[2]

Providers and community members report the current code discourages pregnant individuals from seeking prenatal care, increasing risk. Organizations like the American College of Obstetrics and Gynecology (ACOG) and the Centers for Disease Control (CDC) recommend avoiding labeling prenatal exposure as abuse/neglect by default and emphasize treatment access and family preservation. Public health experts and federal guidance (CAPTA) recommend a Plan of Safe Care approach, focusing on treatment and family support rather than punitive action.

Policy solution: This is a section 1 bill that will bring state agencies and stakeholders together to evaluate the Commonwealth's response to and services available to address parental prenatal and postnatal substance use and the effects of such substance use on newborns and children. The group will review current practices and determine whether changes in statute, regulation, or guidance are necessary to meet the needs of families, emphasize preservation of the mother-infant dyad and ensure the safety of children. The group's work will include addressing service and data gaps, Plans of Safe Care, opportunities for training as well as current inconsistencies in implementation.

Costs: The current code encourages inconsistent implementation and does not address the development and use of Plans of Safe Care under the *Federal Child Abuse Prevention and Treatment Act.* This critical evaluation work should be covered by the agency budget. Federal funding exists to support family-based care. Virginia should consider using Opiate Abatement funding to increase support for these services.

Who benefits: This work will move us towards an evidence-based system that delivers better outcomes for moms and babies. When we explicitly work to support healthy moms and babies, we all benefit.

Contact: Kathryn Haines, Health Equity Manager
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February 2026

[1] https://www.pregnancyjusticeus.org/wp-content/uploads/2020/11/Understanding-CAPTA-and-State-Obligations_2020.pdf

[2] https://pubmed.ncbi.nlm.nih.gov/40118246/

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Expand Access to Midwives for Virginia Moms

Patrons: Senator Deeds and Delegate Willett
Budget Amendment 295 #13s, 295 #3h
Problem: Multiple barriers prevent Virginia moms on Medicaid from accessing midwives through their Managed Care Organization (MCO). As a result, moms must leave their healthcare home to see a midwife. Patients lose extra benefits provided by their MCOs such as diapers, cell phones and the care coordination needed to access lactation and mental health services.

Currently, all midwives licensed in the state of Virginia (CNM/CM, CPM) are eligible for Medicaid reimbursement under Fee for Service Medicaid. However, the vast majority of Medicaid recipients are placed into MCOs, which offer more comprehensive wrap-around services. Contracting with individual MCO's is a major barrier for lower volume community practices. Most private midwifery practices do not accept Medicaid. For the few midwifery practices that do accept Medicaid reimbursement under Fee For Service, the process for patients and providers is daunting. Patients must contact their individual MCO, have themselves removed from coverage and go into Fee For Service Medicaid. This process can take months, requires a high level of health systems literacy and is resource heavy for patients, providers and the Virginia Department of Medical Assistance Services (DMAS).

Research shows that integrating midwives into the maternity care system (including comprehensive insurance coverage) improves outcomes.[1] This is especially critical in rural areas experiencing obstetric service closures where a midwife might be the only option. Maternal mortality rates are higher in maternity care deserts.[2]

Policy solution: This budget amendment directs DMAS and the Virginia Department of Health (VDH) to convene a work group to bring stakeholders together to study barriers that prevent Virginia moms on Medicaid from accessing Cardinal Care with all midwives licensed by the state upon entry into care. VDH must be in the workgroup because midwives are a public health solution. **Include the voices of parents that struggle to access this care and midwives who serve impacted families in the work to expand coverage.**

Costs: Pregnant women are already covered by Cardinal Care. Integrating midwives lowers costs by improving outcomes and reducing cesarean section rates. This quality-improvement focused work should be a part of the DMAS and VDH budget. **Virginia's 2026 Budget must support a fully-functioning VDH and DMAS, agencies critical to supporting a healthy Virginia.**

Who benefits: When patients are able to stay in their healthcare home and access a cost-effective model of care that improves outcomes, we build stronger families and communities. When midwives are able to receive reimbursement for services offered in the communities they live and serve, the midwifery workforce will grow.

[1] How Expanding the Role of Midwives in U.S. Health Care Could Help Address the Maternal Health Crisis, May 5, 2023. https://www.commonwealthfund.org/publications/issue-briefs/2023/may/expanding-role-midwives-address-maternal-health-crisis

[2] Atwani, Rula MD; Robbins, Lindsay MD, MPH; Saade, George MD; Kawakita, Tetsuya MD, MS. Association of Maternity Care Deserts With Maternal and Pregnancy-Related Mortality. Obstetrics & Gynecology 146(2):p 181-188, August 2025. | DOI: 10.1097/AOG.0000000000005976 https://journals.lww.com/greenjournal/fulltext/2025/08000/association_of_maternity_care_deserts_with.2.aspx

Kathryn Haines, Health Equity Manager, kathryn@virginiainterfaithcenter.org - Jan. 12, 2025

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Supporting Student Health and Achievement: RNs and APRNs

Patrons: Senator Favola and Delegate McQuinn
SB33/HB195 Programs for at-risk students; permissible uses of funding.

Problem: Despite the fact that every teacher knows that a sick child will struggle to learn, **the current lack of explicit state support for a Registered Nurse (RN) or an Advanced Practice Registered Nurse (APRN) in schools unintentionally encourages the redirection of funding towards instruction and away from health. We must prioritize both.** To quote the former Surgeon General Joycelyn Elders, "You can't educate a child who isn't healthy, and you can't keep a child healthy who isn't educated." This is a bill to clarify that health, (physical and mental), and education go hand in hand and that certain licensed providers (RNs and APRNs) are critical to meet the current need.

The Virginia School Safety Audit Program[1] survey reveals mental health as a top concern for Virginia Schools. There is a youth mental health crisis and school nurses provide preventive help by recognizing early psychological distress.[2]

Today's school staff work with kids that have complex medical needs. An RN's scope of practice includes working independently to assess, plan, implement patient care, and when a referral/care coordination is required. An RN knows when more or less help is needed. An RN can interpret medical records and write a plan of care for a health plan that is a part of a IEP/504. An APRN, is an RN with an advanced degree. In the school setting, the APRN would most likely be a Nurse Practitioner. While few schools currently use APRNs, as more schools in health deserts build partnerships with local health care entities to create school-based health centers, it will be critical to expand access to a broader scope of care.

Policy solution: This bill adds specific language about supporting a student's physical and mental health and adds RNs/APRNs to the list of approved expenditures for the at-risk-add-on. The At Risk Add On is an existing funding formula in the General Assembly budget designed to help the schools with the most need. The current formula does not explicitly address the physical and mental health of the student.

Costs: None. This bill is permissive. Local school boards decide how to use their allotted funding. This gives explicit permission to use this funding to support school health.

Who benefits: Everyone. Access to providers that improve a student's physical and mental health and achievement will increase classroom and ultimately, community health. Our students are our future.

[1] https://www.dcjs.virginia.gov/virginia-center-school-and-campus-safety/virginia-school-safety-audit-program
[2] https://news.virginia.edu/content/theres-youth-mental-health-crisis-school-nurses-can-help

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HB1041 Correctional Education Reform

Patron: Delegate Betsy Carr

Problem: Despite recent #1 rankings for Education and Business (2024), Virginia has failed to adopt a broad strategy for postsecondary education in prison, which is proven to advance state goals in workforce expansion, educational attainment, and public safety. Instead, Virginia leaves $105 million on the table every year in federal, college student aid. Specifically, Pell grants, for which 67% of incarcerated Virginians are academically- and income-qualified to utilize for self-improvement and career-readiness purposes.

Despite aiming for recognition as the "Top State for Talent," Virginia is failing to adequately scale Pell-fundable, postsecondary partnerships in VADOC with Virginia public colleges and universities, leaving thousands of Virginians to exit state prisons annually with less advanced education and fewer credentials to show for it than returning citizens in neighboring states like Maryland, North Carolina, and Tennessee. Virginia's 23 community colleges, facing revenue and enrollment cliffs, stand ready while 15,000 potential enrollees a semester, with Pell dollars in their figurative pockets, go unserved in prisons across the Commonwealth. Currently, only 580 eligible, incarcerated Virginians (4%) in state sponsored care are matriculated in college programs, despite research indicating recidivism is halved by participation in degree programs.

Approximately 12,000 individuals annually enter Virginia's labor force from incarceration in state prisons—a number comparable to the graduating class of George Mason University. By 2030, 62% of jobs will require postsecondary education, yet educational pathways in Virginia's prisons remain limited, even after the restoration of federal Pell Grant eligibility in 2023.

Solution: This bill modernizes Virginia's prison education system by aligning literacy instruction with state standards, institutes a task force on correctional education, with a higher education advisory group, engages VDOC to participate in multi-agency data sharing that allows evaluation of educational impacts, and requires study of teacher salaries. The bill strengthens workforce readiness, improves public safety, and moves Virginia toward fully leveraging restored Pell grants for college behind bars.

Context: In 2024, the **Virginia Consensus for Higher Education in Prison** (**VCHEP**) was established by the Virginia Interfaith Center for Public Policy to facilitate multi-sector, multi-agency collaboration to expand postsecondary education pathways in VADOC. In 2025, key partners—including **VADOC**, **Virginia Works**, **VCCS**, the **State Council of Higher Education for Virginia** (**SCHEV**), and nonprofit **Resilience Education**—joined the Virginia Consensus, reflecting growing alignment across corrections, higher education, and workforce systems. In Fall 2025, these named agencies and nonprofits initiated a voluntary, collaborative strategic planning process for higher education in Virginia as members of the Virginia Consensus.

This bill builds on this foundation by providing a statutory framework to address interagency, public-private collaboration to plan for and implement high-value postsecondary partnerships statewide, align prison education with workforce needs, and ensure continuity from incarceration through reentry.

Policy Details: This bill:

- Requires prison literacy instruction to align with the Virginia Literacy Act
- Establishes a multi-agency Prison Education Task Force with a Higher Education Advisory Group
- Engages VADOC to join in multi-agency data-sharing that makes assessment of long-term education effects on post-incarceration outcomes possible
- Requires study of VDOC teacher salaries to compare with regional standards

For more information, contact:

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Bias Reduction Training Licensing Criterion

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SB22/HB1147 Medicine and Nursing, Boards of; continuing education, bias reduction training.

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Costs: In 2024, the Department of Health Professions indicated that the Board of Medicine will need one new pay band 5 FTE at a cost of $140,750.

Who benefits: With passage of this bill, Virginia sends a strong message that VA Healthcare professionals are committed to equal treatment for all.

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[3] Virginia PRAMS Facts-2021, https://www.vdh.virginia.gov/content/uploads/sites/67/2023/12/Virginia-PRAMS-Facts-2021.pdf
[4] National Bureau of Economic Research, Maternal and Infant Health Inequality: New Evidence from Linked Administrative Data, 2023. https://www.nber.org/system/files/working_papers/w30693/w30693.pdf
[5] Agency for Healthcare Research and Quality, (2024) Healthcare Worker Implicit Bias Training and Education, Rapid Review. https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/mhs-IV-rapid-response-implicit-bias.pdf
[6] "Learner-Reported Impact of the Dignity in Pregnancy & Childbirth Course: A Summary of Three Studies, Diversity Science Institute, 2024" https://www.humanitasinst.com/dipc-feedback

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Expand Access to Midwives for Virginia Moms

Patrons: Senator Deeds and Delegate Willett
Budget Amendment 295 #13s, 295 #3h
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Currently, all midwives licensed in the state of Virginia (CNM/CM, CPM) are eligible for Medicaid reimbursement under Fee for Service Medicaid. However, the vast majority of Medicaid recipients are placed into MCOs, which offer more comprehensive wrap-around services. Contracting with individual MCO's is a major barrier for lower volume community practices. Most private midwifery practices do not accept Medicaid. For the few midwifery practices that do accept Medicaid reimbursement under Fee For Service, the process for patients and providers is daunting. Patients must contact their individual MCO, have themselves removed from coverage and go into Fee For Service Medicaid. This process can take months, requires a high level of health systems literacy and is resource heavy for patients, providers and the Virginia Department of Medical Assistance Services (DMAS).

Research shows that integrating midwives into the maternity care system (including comprehensive insurance coverage) improves outcomes.[1] This is especially critical in rural areas experiencing obstetric service closures where a midwife might be the only option. Maternal mortality rates are higher in maternity care deserts.[2]

Policy solution: This budget amendment directs DMAS and the Virginia Department of Health (VDH) to convene a work group to bring stakeholders together to study barriers that prevent Virginia moms on Medicaid from accessing Cardinal Care with all midwives licensed by the state upon entry into care. VDH must be in the workgroup because midwives are a public health solution. **Include the voices of parents that struggle to access this care and midwives who serve impacted families in the work to expand coverage.**

Costs: Pregnant women are already covered by Cardinal Care. Integrating midwives lowers costs by improving outcomes and reducing cesarean section rates. This quality-improvement focused work should be a part of the DMAS and VDH budget. **Virginia's 2026 Budget must support a fully-functioning VDH and DMAS, agencies critical to supporting a healthy Virginia.**

Who benefits: When patients are able to stay in their healthcare home and access a cost-effective model of care that improves outcomes, we build stronger families and communities. When midwives are able to receive reimbursement for services offered in the communities they live and serve, the midwifery workforce will grow.

[1] How Expanding the Role of Midwives in U.S. Health Care Could Help Address the Maternal Health Crisis, May 5, 2023. https://www.commonwealthfund.org/publications/issue-briefs/2023/may/expanding-role-midwives-address-maternal-health-crisis

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Support Mom/Baby in Pregnancy with Substance Exposure

Patrons: Senator Locke and Delegate Hayes
SB133/HB652 Abused or neglected child; prenatal substance abuse
Problem: Fear of a child protective services referral means Virginia moms do not seek prenatal care. This finding is supported by research; threat-based approaches discourage care.[1] Early entry into prenatal care improves outcomes. **This is a bill to encourage pregnant moms to enter prenatal care.**

Virginia's law currently implies child abuse when an infant is born affected by substance use. The language automatically links prenatal substance exposure with child abuse or neglect, even when the mother is engaged in medicated assisted treatment (MAT), or when the substance involved, such as cannabis, has been decriminalized. This punitive section of code refers solely to the child, ignoring the best practice method of supporting the mother/baby together. Substance use in the Virginia code does not have a uniform definition, which results in inconsistent implementation of this law. Community members report blanket cord-blood testing without informed consent, presumably due to the false belief that cord-blood testing is required to ensure compliance with the law. Despite similar substance use rates across racial groups, Black patients are significantly more likely to undergo drug screening and be reported to CPS.[2] A University of Virginia report on Charlottesville's Child Welfare System found that Black and multiracial children were overrepresented among referrals to CPS relative to the population[3].

The abuse/neglect classification discourages pregnant individuals from seeking prenatal care and increases risk. Organizations like the American College of Obstetrics and Gynecology (ACOG) and the Centers for Disease Control (CDC) recommend avoiding labeling prenatal exposure as abuse/neglect by default and emphasize treatment access and family preservation. Public health experts and federal guidance (CAPTA) recommend a Plan of Safe Care approach, focusing on treatment and family support rather than punitive action.

Policy solution: This bill removes the automatic "abuse/neglect" label for all cases of prenatal substance exposure, require full-informed consent for cord-blood testing, and include the needs of the mother in addition to the child. This bill also clarifies notification pathways, including coordination with community services boards, and includes aggregate data reporting to support oversight and evaluation without increasing surveillance of individual families.

Costs: None. This code change should bring consistency to current implementation and end punitive referrals to CPS. Federal funding exists to support family-based care. Virginia should consider using Opiate Abatement funding to increase support for these services.

Who benefits: Amending this code section moves us closer to a code that reflects the worth and dignity of all persons. When we explicitly work to support healthy moms and babies, we all benefit.

[1] https://www.pregnancyjusticeus.org/wp-content/uploads/2020/11/Understanding-CAPTA-and-State-Obligations_2020.pdf
[2] American Society of Addiction Medicine, 2022 Public Policy Statement on Advancing Racial Justice in Health Care through Addiction Medicine. https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/advocacy/2022-pps-on-advancing-racial-justice-in-health-care-through-adm---final.pdf?sfvrsn=3ba5e94f_3
[3] Charlottesville Child Welfare Study, 2018, Accessed Nov 2025 https://www.charlottesville.gov/DocumentCenter/View/817/Child-Welfare-Study-PDF

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Supporting Student Health and Achievement: RNs and APRNs

Patrons: Senator Favola and Delegate McQuinn
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Problem: Despite the fact that every teacher knows that a sick child will struggle to learn, **the current lack of explicit state support for a Registered Nurse (RN) or an Advanced Practice Registered Nurse (APRN) in schools unintentionally encourages the redirection of funding towards instruction and away from health. We must prioritize both.** To quote the former Surgeon General Joycelyn Elders, "You can't educate a child who isn't healthy, and you can't keep a child healthy who isn't educated." This is a bill to clarify that health, (physical and mental), and education go hand in hand and that certain licensed providers (RNs and APRNs) are critical to meet the current need.

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Policy solution: This bill adds specific language about supporting a student's physical and mental health and adds RNs/APRNs to the list of approved expenditures for the at-risk-add-on. The At Risk Add On is an existing funding formula in the General Assembly budget designed to help the schools with the most need. The current formula does not explicitly address the physical and mental health of the student.

Costs: None. This bill is permissive. Local school boards decide how to use their allotted funding. This gives explicit permission to use this funding to support school health.

Who benefits: Everyone. Access to providers that improve a student's physical and mental health and achievement will increase classroom and ultimately, community health. Our students are our future.

[1] https://www.dcjs.virginia.gov/virginia-center-school-and-campus-safety/virginia-school-safety-audit-program
[2] https://news.virginia.edu/content/theres-youth-mental-health-crisis-school-nurses-can-help

Kathryn Haines, Health Equity Manager, kathryn@virginiainterfaithcenter.org - Jan. 12, 2026

FACT SHEET

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SB 367/388; HB 1279 Yes in God's Backyard (Faith and Housing)

SB 367 & SB 388 / HB 1279
Patrons: Sens. Jennifer Carroll Foy & Jeremy McPike
Del. Josh Cole

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At the same time, many faith communities understand that caring for neighbors is a part of their mission. Congregations own land in localities all over Virginia and are interested in supporting community members, and some are interested in developing affordable housing on their land. However, the process is made unnecessarily difficult because of the uncertainty and high cost of rezoning.

Background: There are already more than a dozen congregations in Virginia that have developed affordable housing on their property. **The process usually takes between 7 and 20 years**, and a significant part of that time is spent applying for Special Use Permits or zoning changes, along with convincing nearby residents that the development is good for the community. These projects range from a rural congregation building 12 small homes for halfway houses, to a large faith community in an urban area building more than 200 apartments. Communities have already seen the benefits of affordable housing built on faith land. Allowing other congregations to live their mission would benefit all Virginians.

Policy Solution: This bill would streamline the permitting process for property tax-exempt nonprofits (most of which are faith communities) to build affordable multi-family housing on their land. In response to an exclusionary attitude of "not in my backyard" (NIMBY), this policy can be thought of as a "Yes in God's backyard" (YIGBY) approach.

Clergy and faith leaders hear about the need for affordable housing from their members and community, and many want to offer housing. Developing affordable housing allows congregations to provide resources to community members who are struggling, while putting faith into action.

Key provisions

- **Affordable Housing Requirements**:
  - Property must be owned by congregation or non-profit 5 years prior to application
  - At least 60% of homes must be affordable to residents making the area median income
  - Must remain affordable for at least 50 years
- **Design & Occupancy Provisions**:
  - Must comply with Virginia Fair Housing Act
  - Subject to local real estate tax
  - Height restricted to 3 stories or the height of the tallest building within 500 feet
  - Ground floor may contain other uses (including child day care and worship space)
- **Delayed Effective Date**: September 1, 2026

COMMONWEALTH HOUSING COALITION

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HB 594 - Expediting Affordable Housing

Patron: Del. Shelly Simonds

Problem: Virginia's affordable housing crisis is worsening every year. The Joint Legislative Audit and Review Commission (JLARC) reported in 2021 that approximately 905,000 households, nearly 29% of all households, were burdened by housing cost. Since then, the situation has grown more severe. The Virginia Housing Commission estimates the current statewide shortage at 187,000 units, and the Department of Housing and Community Development estimates that 300,000 units are needed to alleviate cost burden among renters.

JLARC identified zoning and permitting delays as significant barriers to new housing production. These shortages affect every region of the state, driving up costs for both renters and prospective homeowners and making it harder for families, seniors, and essential workers to find a safe, stable, and affordable place to live.

Background: In Virginia code, affordable housing is based on an area's median income. This means that housing classified as "affordable" families making up to the local average (100% AMI).

There is a history of zoning being used to amplify discrimination in housing. Zoning played an important role in keeping people segregated by race and continues to segregate people by income. Even today, many neighborhoods that are zoned for single-family residential use are places that historically had race-restricted deeds. This bill allows an administrative process to cut through the discriminatory attitude and meet community needs.

Policy Solution: Expediting affordable housing is a bill that would allow localities to adopt ordinances speeding up the approval process for increased density to build affordable housing. Under these ordinances, localities could approve projects through a streamlined administrative process, cutting red tape and decreasing uncertainty.

These ordinances would focus on projects creating affordable housing, since so many families are paying too much for a place to live. In addition, the increased density is concentrated in areas the locality has already identified as being able to support additional units.

Beyond those limitations, this bill allows localities to craft the ordinance that makes sense in their context. Rural southern Virginia is facing different challenges than localities on the DC border, but all these places recognize the need for affordable housing development. The legislation allows cities, towns, and counties to incorporate zoning flexibility into these ordinances, and ensures accountability by reporting on how many units are approved and built under qualifying ordinances.

Localities adopting and successfully implementing these expedited ordinances would receive priority consideration for state infrastructure grants and loans, creating both incentives and capacity for faster, more efficient affordable housing development across the Commonwealth.

Conclusion: By giving localities the tools to speed up approvals for multi-family affordable housing projects, Virginia can help close its housing gap more efficiently. This approach removes unnecessary delays while ensuring developments are well-located, connected to services, and meet high standards for accessibility and inclusion.

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Tenant Protections

Problem: People with lower incomes tend to rent instead of owning homes, and more than one-third of renters in Virginia are cost-burdened by their housing. Many tenants aren't familiar with all their rights, and legal jargon can be confusing. In addition, much of Virginia law is slanted disproportionately in favor of protecting landlords, creating a power imbalance for tenants. Religious traditions recognize the need to stand with the poor. People of faith want to reduce evictions and see those who rent treated fairly.

Solution: Virginia must pass legislation to protect renters and strengthen existing tenants' rights. Here are a few policies that would help:

Housing Stability:

14-Day Pay-Or-Quit (HB 15 Del. Price, SB 48 Sen. Rouse) Extending the pay-or-quit period from 5 days to 14 days would give tenants more time to catch up on rent payment before having to appear in court.

Appeal Bond Waiver (HB 221 Del. Hope) This bill would remove the "pay-to-play" requirement that indigent tenants pay a large bond to appeal and get a fair trial.

Eviction Diversion Program (HB 873 Del. McClure) This bill would remove barriers to make the program more accessible and effective at keeping Virginians housed.

Housing Affordability

Regulate Junk Fees (HB 379 Del. Bennet-Parker, Del. Charlie Schmidt, SB 349 VanValkenburg) This bill would regulate excessive fees during application, lease signing and renewal.

Require Payment Plans (HB 95 Del. Bennett-Parker) This bill would allow tenants to have a payment plan rather than face eviction if they owe a small amount of rent.

Right of First Refusal *(for manufactured housing communities:* HB 375 Del. Krizek*) (for multifamily affordable housing:* HB 4 Del. Bennett-Parker*)* These bills would keep housing communities affordable to the public and preserve affordable housing by giving localities a chance to buy properties containing manufactured housing, or multifamily units with expiring subsidies.

Healthy Housing:

Warranty of Habitability (HB 281 Del. Callsen, SB 373 Sen. Boysko) This bill would give renters living in unsuitable/unhealthy conditions a defense against being evicted for not paying rent.

Tenant Assertion (HB 848 Del. Cousins) Tenants would be able to sue landlords for having bad living conditions in their units.

Housing Rights:

Anti Retaliation: (HB 329 Del. McClure) This bill would protect tenant's right to organize for better living conditions without retaliation from landlords.

Homelessness Bill of Rights (HB 1394 Del. J. G. Cole) Prohibits the criminalization of homelessness, and gives legal protection for people face charges.

Effective Expungement (HB 1078 Del. Hernandez) Prohibits housing discrimination based on history of dismissed or non-suited evictions.

Protect Manufactured Homeowners (HB 374 Del. Krizek) provide basic rights for MHC residents, such as the right to renew year-long leases w/ fee disclosures.

ALLIES FOR HOUSING ACTION

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HB5 / SB199 Paid Sick Days

Patron: Delegate Kelly Convirs-Fowler & Senator Barbara Favola

Problem: Approximately 41 percent of private sector workers, **1.2 million workers in Virginia, have no paid sick days** or any paid time off (PTO). This creates a crisis for low-wage workers who must choose between taking a sick day for themselves or their children and getting paid. Workers who go to work sick endanger their co-workers, the public and the ability of the business to remain open.

Policy solution: These bills would create a paid sick day standard to require all employers to provide five paid sick days (40 hours) each year for full-time workers that can be used for themselves or to care for sick children. Part-time employees could accrue fewer paid sick hours based on hours worked. PTO policies qualify as paid sick days.

Who benefits: Almost everyone benefits from a paid sick day standard, which is why 83 percent of Virginia registered voters support a policy proposal to provide paid sick days. Strong majorities of Democrats (96 percent, Independents (78 percent) and Republicans (72 percent) all support a paid sick day standard. Paid sick days help:

Workers and their families - When a worker takes 3.5 unpaid sick days, the average family loses a month's worth of groceries. Workers are forced to choose between feeding their families and caring for themselves or their children.

Schools - Parents who don't have paid sick days are more than twice as likely to send their children to school sick, than parents who have paid sick days. Sick children can't learn. Sick children spread germs to children and teachers.

Public health – Workers in low wage sectors are the least likely to have paid sick days. More than 80 percent of food industry workers and 75 percent of childcare workers have no paid sick days. More than half of all Norovirus outbreaks can be traced back to sick food service workers who were forced to choose between working sick and losing pay or their job. An October 2020 report in Health Affairs showed that the paid sick leave provision of the Families First Coronavirus Response Act (FFCRA) reduced the spread of coronavirus. Researchers called paid sick days "a highly effective tool to flatten the curve."

Businesses - Employers lose $160 billion annually in productivity due to "presenteeism" (the practice of coming to work despite illness or injury). Providing paid sick days results in reduced turnover – saving businesses money. The restaurant industry, which has a high turnover rate, found that implementing workplace benefits can reduce turnover by 50 percent.

People of color – In the US, about 38 percent of African Americans and 50 percent of Latinos do not have access to a single paid sick day. More than 25 percent of Latino households and 30 percent of African American households have no savings and cannot afford to take unpaid time off from work.

Can Virginia businesses afford paid sick days? Most Virginia businesses already provide paid sick days or PTO. The pandemic has made clear that businesses need a paid sick day policy. Seventeen states and the District of Columbia have already passed paid sick day standards and most of them rank higher than Virginia in overall health.

Sources: A Better Balance, Family Values @ Work, National Partnership for Women & Families, United Health Foundation, U.S Bureau of Labor & Statistics, YouGov American poll

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January 2026

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2026 Budget Priorities

Virginia's budget reflects the Commonwealth's priorities. Lawmakers must protect those in need through their funding choices. These amendments are proposed changes to proposed changes to the biennial budget, bill numbers SB 30 and HB 30, which cover spending from July 2026 to June 2028.

Supporting Working Families

Protecting food stamps (SNAP) access. Budget amendments 328 #6h, 329 #1s and 329 #1s would provide money for Virginia's Department of Social Services to create and administer a food assistance program like SNAP to provide state funded food assistance to individuals who meet all other eligibility requirements for SNAP, but are no longer eligible due federal changes from HR 1.

Affordable Housing

Housing Trust Fund. Budget amendments 102 #23h and 102 #2s would provide $200.0 million each year for the Virginia Housing Trust Fund, which is an increase from the budget.

Expanding access to Virginia's Eviction Reduction Program. Budget amendments 102 #3s, 102 #4s, and 102 #9h would provide additional money for Virginia's Eviction Reduction Program (VERP). These funds can pay rent or cover expenses that will prevent households from being evicted.

Support people experiencing homelessness. Budget amendments 102 #18s and 102 #13h would ensure that Continuum of Care services receive support after federal cuts

Health Equity

Creating additional funding for free and charitable clinics. Amendment 282 #3s would increase funds for Virginia Federally Qualified Health Clinics to continue providing comprehensive health services for the most vulnerable and uninsured Virginians. Amendment 282 #9s would provide money to support the clinics' delivery of medical, dental, vision, speech, hearing, and behavioral health care, along with medications.

Protecting FAMIS investments to maintain access to prenatal care and health insurance. Budget amendments 290 #1s and 290 #1h would restore the FAMIS Prenatal Coverage Program so that pregnant women with low incomes have access to prenatal care.

Protecting Medicaid. Items 291 #1s and 291 #9h would restore inflation adjustments for various Medicaid providers, such as hospitals and nursing homes, that were proposed in the introduced budget to be withheld for the 2026-2028 Biennium.

Increasing access to Children's Health coverage; increase FAMIS eligibility to 305% of the federal poverty level. Item 290 #4s would provide additional resources to increase the upper income eligibility for coverage for Virginia's Children's Health Insurance Program (CHIP) beyond households with income below 205 percent of the Federal Poverty Level (FPL), of the lowest rates in the country.

Creating a midwifery taskforce. Budget amendment 295 #13s pays for a new position for the Department of Medical Assistance Services and the Virginia Department of Health to convene a workgroup to identify the barriers that prevent certain midwives licensed by the State of Virginia from contracting with managed care organizations (MCOs) through Cardinal Care.

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Protecting Immigrant Neighbors

Problem: Immigrants and people of color are scared to continue everyday civic life, whether they have a documented presence in the United States. Federally and locally, there are examples of law enforcement officers abusing their positions to unjustly detain members of local communities. According to Immigration and Customs Enforcement (ICE) data, nearly 70% of those booked into Central Virginia ICE facilities since 2025 have no criminal record. The Commonwealth of Virginia must take measures to restrict immigration enforcement from over policing our communities.

Solution: People of faith want to see Virginia's legislature stand with the immigrant community. The Virginia Interfaith Center for Public Policy supports limiting indiscriminate immigration enforcement around Virginia.

Protecting Sensitive Locations
HB 650 – Callsen, Glass, Lopez, Shin
SB 351 – Salim

The House version of this bill would limit civil arrests, including immigration arrests, in certain facilities owned by state and local government. That means that people could go to school, public hospitals, polling places, and courthouses without fear of detention based on immigration status. The Senate version of the bill specifically focuses on preventing civil arrests in courthouses.

These bills make sure people who are trying to comply with the law are treated fairly. In addition, these bills protect people against discrimination when exercising human rights to access school, health care, or legal support. Neither bill would prevent criminal arrests or impede detaining someone with a judicial warrant.

Limit collaboration with immigration enforcement
HB 1441 – Lopez, Guzman
SB 783 – Salim

These bills would prevent local police from being deputized by ICE. Local law enforcement should be focused on keeping communities safe. Some local police have entered 287(g) agreements or Intergovernmental Service Agreements, which force officers to perform federal duties. In addition, there are informal agreements around detaining immigrants and asking status. These actions decrease trust in police, negatively impacting public safety and misusing local resources.

Conclusion: Both policies are focused on community safety and public trust. The bills would not prevent law enforcement from pursuing legitimate criminal cases. Instead, they support innocent community members in maintaining stability and trust.

Virginia lawmakers must ensure that local and state law enforcement aren't detaining people based on perceived immigration status, and that our communities continue to be welcoming places for all residents. These changes in state policy, take steps to protect immigrant communities from unlawful or dangerous treatment and maintain peace in our neighborhoods.

Background: Across many faith traditions, treating neighbors with fairness and respect is a priority. There is a special call to welcome immigrants and strangers within the community. With immigration making national headlines, it is crucial that Virginia support residents who were born in other countries.

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