Ohio Legislative Service Commission

Bill Analysis

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Sub. H.B. 261

131st General Assembly
(As Reported by H. Health and Aging)

Reps. Grossman and Huffman, K. Smith, Blessing

BILL SUMMARY

- Establishes the State Trauma Board as the regulatory authority for trauma centers.
- Beginning one year after the bill takes effect, prohibits the operation of a facility that admits trauma patients unless the facility is designated by the Board as a trauma center.
- Requires that trauma patient transfer protocols include procedures for selecting an appropriate trauma center to receive a trauma patient.
- Subjects a physician to discipline by the State Medical Board for admitting a trauma patient to a facility that is not a trauma center or failing to transfer a trauma patient to an appropriate trauma center.
- Requires the Board of Emergency Medical, Fire, and Transportation Services (EMFTS Board) to consult with the State Trauma Board when establishing state protocols or approving regional protocols for the triage of trauma victims.
- Requires the State Trauma Board to develop a statewide system for improvement in the quality of trauma care and rehabilitation.
- Transfers responsibility for maintaining the state trauma registry from the EMFTS Board to the State Trauma Board.
- Provides that fines for failure to comply with motor vehicle child safety restraint laws are to be used by the State Trauma Board, rather than the Department of Health, to defray the cost of designating pediatric trauma centers and to establish and administer a child highway safety program.

- Requires the State Trauma Board to research best practices for implementing a time critical diagnosis system of care.

- Modifies the EMFTS Board's duties regarding trauma care.

- Permits the EMFTS Board and the State Trauma Board to establish a joint committee to review matters that are within the jurisdiction of both boards.

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Trauma care

Trauma center designation

The bill establishes the State Trauma Board within the Department of Health and requires facilities that admit trauma patients to be designated by the Board as trauma centers.[1] The designation requirement applies to both private and governmental entities and begins one year after the bill takes effect.[2]

Current law does not provide for designation of trauma centers as such. It prohibits a hospital from representing that it can provide trauma care that is inconsistent with its level of categorization as a trauma center,[3] but does not specify how this requirement is to be enforced.

The bill provides for six levels of trauma center designation: level I, II, III, and IV adult trauma centers and level I and II pediatric trauma centers. A facility that does not admit trauma patients is not required to seek trauma center designation.[4]

The Board is to determine whether a facility is operating as a trauma center and is thus subject to the designation requirement. A facility may appeal the Board's

[1] R.C. 3728.02 and 3728.20.

[2] Section 3.

[3] R.C. 3727.10 in current law.

[4] R.C. 3728.09(C) and 3728.20.

determination to the Director of Health, who is to hear the appeal in an adjudication conducted under Ohio's Administrative Procedure Act (R.C. Chapter 119.).[5]

Trauma care protocols

Under current law, a hospital must adopt protocols for the provision of any trauma care by the hospital that is inconsistent with that hospital's level as a trauma center. Therefore, each hospital that is not a trauma center must adopt protocols for the provision of any type of trauma care, each adult trauma center must adopt protocols for the provision of pediatric trauma care, and each pediatric trauma center must adopt protocols for the provision of adult trauma care. The bill continues this requirement but modifies the definition of "hospital" to include an emergency department that is operated as an independent facility, thus applying the trauma care protocol requirement to all emergency departments. Urgent care centers are expressly excluded from the definition of "hospital."

A hospital's trauma care protocols must provide for the timely transfer of trauma patients from that hospital to an appropriately designated trauma center. The bill requires the trauma patient transfer protocols to specify procedures for selecting an appropriate trauma center to receive a patient. Those procedures must provide that a patient younger than 16 years of age is to be transported to a pediatric trauma center, but may provide that a 16 or 17 year old patient is to be transported to either a pediatric or an adult trauma center.

Continuing law requires each hospital, in developing its trauma care protocols, to consider the guidelines for trauma care established by ACS, the American College of Emergency Physicians, and the American Academy of Pediatrics. The bill requires hospitals to also consider the guidelines established by the regional trauma organization that serves the hospital's trauma region.

Current law requires each hospital to furnish a copy of its trauma care protocols and trauma patient transfer agreements to the Director of Health on request free of charge. The bill requires hospitals to furnish a copy to the State Trauma Board as well.[6]

[5] R.C. 3728.01(B).

[6] R.C. 3728.15.

Admission of patients by physicians

The bill modifies a provision of current law prohibiting a physician from admitting a trauma patient to a facility that is not a trauma center or failing to transfer a trauma patient to a trauma center.[7]

The bill specifies that a physician is prohibited from doing either of the following:

(1) Admitting a patient for trauma care to a facility that is not a level I, II, or III adult trauma center or a level I or II pediatric trauma center;

(2) Failing to transfer a trauma patient to a level I, II or III adult trauma center or level I or II pediatric trauma center in accordance with trauma protocols and patient transfer agreements.[8]

There is no sanction for violating the current prohibition, whereas a physician who violates the bill's prohibition may be subject to discipline by the State Medical Board.[9] The bill creates an exception for situations in which compliance with the state prohibition would preclude a physician from complying with the federal "Emergency Medical Treatment and Labor Act," 42 U.S.C. 1395dd, which requires a hospital to stabilize a patient who seeks treatment in an emergency room. There are also exceptions for circumstances in which the patient, or a person authorized to make informed health care decisions on the patient's behalf, refuses to give or withdraws informed consent to be admitted or transferred to a trauma center. [10]

The bill provides for the designation of level IV trauma centers. However, the bill does not permit a physician to admit or transfer a patient for trauma care to a level IV adult trauma center. Therefore, physicians are prohibited from doing so and level IV adult trauma centers are not authorized to admit patients for trauma care.

"Trauma" definition

"Trauma" is defined in existing law as severe damage to or destruction of tissue that creates a significant risk of loss of life or limb or significant and permanent disfigurement or disability and is caused by blunt or penetrating injury; exposure to electromagnetic, chemical, or radioactive energy; drowning, suffocation, or

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[7] R.C. 4765.50 in current law.

[8] R.C. 4731.28.

[9] *See* R.C. 4731.22, not in the bill.

[10] R.C. 4731.28.

strangulation; or a deficit or excess of heat. The bill adds exposure to thermal energy as a cause of trauma.[11]

Trauma center designation

Designation requirements

Under the bill, each facility seeking a trauma center designation must submit an application to the Board in accordance with procedures established by the Board.[12]

The Board must designate a facility as a level I, II, III, or IV adult trauma center or a level I or II pediatric trauma center if the facility has been verified as a trauma center by ACS, participates in a regional trauma organization that serves the trauma region in which the facility is located, and meets additional requirements established by the Board.[13] The bill limits the additional requirements the Board may establish to the following:[14]

(1) Participation in statewide or regional injury prevention, quality improvement, and interfacility communication activities;

(2) Submission of information requested by the Board for the maintenance of the State Trauma Registry.

The bill permits the Board to designate a facility as a level III adult trauma center, regardless of whether the facility has been verified as a trauma center by ACS, if the following conditions are satisfied:[15]

(1) The facility applied for ACS verification and received a determination regarding the application;

(2) The facility submitted to the Board a written plan to correct any deficiencies identified in ACS's report of the results;

(3) The Board determines that the written plan will adequately correct the deficiencies identified in the report;

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[11] R.C. 3728.01(A)(7) and 4765.01(N).

[12] R.C. 3728.22.

[13] R.C. 3728.22.

[14] R.C. 3728.09.

[15] R.C. 3728.23.

(4) The facility satisfies all other Board-established designation requirements.

Designation renewal

A trauma center designation, other than a provisional designation, is valid for one year, unless earlier revoked or suspended by the Board. A facility may renew its designation in accordance with procedures established in rules adopted by the Board. To have its designation renewed, a trauma center must meet the requirements for an initial designation that are in effect on the date the renewal application is submitted. The bill prohibits the Board from renewing more than twice the designation of a facility that is not verified as a trauma center by ACS.[16]

Provisional designation

The bill permits the State Trauma Board to provisionally designate a facility as a level I, II, III, or IV adult trauma center or a level I or II pediatric trauma center. If a facility is provisionally designated, the certificate of designation must indicate the provisional status. Provisional designation does not affect the level of trauma care a trauma center is authorized to provide.[17]

To be eligible for provisional designation, a facility must satisfy the following requirements:[18]

(1) The facility must submit to the Board a written report of the results of a consultation visit or reverification visit by ACS;

(2) The facility must complete the application process for ACS verification or reverification not later than one year after receiving the report;

(3) The facility's chief medical officer and chief executive officer must certify in writing to the facility's governing board, and the governing board must adopt a resolution stating, that the facility is committed and able to provide trauma care consistent with the level of verification or reverification being sought from ACS;

(4) The facility's governing board must approve a written plan and timetable for obtaining the level of verification or reverification being sought, including provisions for correcting at the earliest practicable time any deficiencies identified in the ACS report;

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[16] R.C. 3728.21 and 3728.24.

[17] R.C. 3728.23.

[18] R.C. 3728.221.

(5) The facility must satisfy all other Board-established requirements.

The bill requires a provisionally designated facility to make all of the following available for public inspection on request during normal working hours: its application for ACS verification, the chief medical officer and chief executive officer's written certification, and the governing board's resolution. The facility may charge a reasonable fee to cover necessary expenses incurred in furnishing copies other than copies provided to the Director of Health or the Board.

The bill requires a facility to furnish to the Director or the Board on request a copy of the report of the ACS consultation or reverification visit and a copy of the written plan and timetable for obtaining verification or reverification. The documents may omit patient identifying information, and furnishing the documents does not waive a patient's privilege or right of confidentiality. The documents and the information in them are not public records and may not be disclosed to any person other than an employee of the Department of Health or the Board who is expressly authorized by the Director or the Board to examine them. The documents and the information in them are not subject to discovery in any civil action, except an action brought by the Director or the Board against the facility or a person that authorized, approved, or created the original documents and the information in them.[19]

Provisional designation is valid until one of the following occurs:[20]

(1) The facility's application for ACS verification or reverification is denied, suspended, terminated, or withdrawn;

(2) If the facility is seeking initial verification, verification at a different level, or reverification after having ceased to be verified for one year or longer, the facility does not obtain verification or reverification within 18 months of receiving provisional designation;

(3) If the facility is seeking reverification after having ceased to be verified for less than one year, the facility does not obtain reverification within one year of receiving provisional designation;

(4) The Board suspends or revokes the provisional designation;

(5) The facility's provisional designation is replaced by the Board with a trauma center designation that is not provisional.

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[19] R.C. 3728.242.

[20] R.C. 3728.241(A).

When a facility's provisional designation ceases to be valid for a reason other than having received nonprovisional designation, the bill requires the facility to transfer the facility's trauma patients to one or more appropriate trauma centers at the earliest practicable date and promptly comply with laws governing the provision of trauma care according to its current trauma center status. Not later than 180 days after the provisional designation ceases to be valid, the facility must prepare trauma patient transfer protocols.[21]

The bill prohibits a facility whose provisional status ceases to be valid from re-applying for provisional designation for two years after ceasing to operate under its provisional designation.[22]

Existing facilities

The bill permits a facility to admit trauma patients before being designated as a trauma center if the facility receives ACS verification either before the trauma center designation requirement takes effect or before the Board begins accepting applications for trauma center designation. As long as such a facility maintains ACS verification, it may continue admitting trauma patients until the Board makes a determination regarding its application for trauma center designation. Under the bill, such a facility is considered to be designated as a trauma center at the level at which the facility is verified by ACS. However, such a facility is not exempt from the requirement that all facilities that admit trauma patients apply for trauma center designation.[23]

Appeals

If the Board refuses to designate a facility as a trauma center, to designate it at the level requested, to grant provisional designation, or to renew a designation, the facility may appeal the decision to the Director of Health. The appeal must be heard in an adjudication conducted under the Administrative Procedure Act (APA, R.C. Chapter 119.). If the Director determines that the facility meets the requirements for designation or renewal, the Director must order the Board to designate the facility as a trauma center at the level specified by the Director or to renew the facility's designation.[24]

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[21] R.C. 3728.241(B).

[22] R.C. 3728.241(C).

[23] R.C. 3728.20(B) and 3728.201.

[24] R.C. 3728.23 and 3728.24.

Changes in level of designation and verification

The bill modifies a provision requiring a facility to provide prompt written notice if there is a change in its trauma center verification by ACS. Under current law, a facility must provide the notice to the Director of Health, the Emergency Medical Services Division of the Department of Public Safety, and the physicians and physician advisory boards serving as regional directors and regional advisory boards for the applicable emergency medical service region. The bill replaces the Director of Health with the State Trauma Board as an entity that must receive this notification. The bill also requires a facility to provide notice to those entities when either of the following occurs:

(1) The facility commences operation as a trauma center under a provisional designation.

(2) The facility ceases to operate under its provisional designation.

The bill adds a requirement that a facility provide prompt written notice to the Emergency Medical Services Division of the Department of Public Safety and the physicians and physician advisory boards if either of the following occurs:

(1) The facility changes the level of designation it is seeking under its provisional designation.

(2) The facility receives a designation that is not provisional in place of its provisional designation.[25]

Suspension and revocation

Acting in accordance with the APA, the Board may suspend or revoke a facility's trauma center designation if the Board determines that the facility has done any of the following:

(1) Made material misrepresentations in the application for designation;

(2) Violated a statute or administrative rule;

(3) Failed to maintain standards required for ACS verification;

(4) Failed to continue to meet the criteria for designation as a trauma center.

A facility may appeal a suspension or revocation to the Director of Health. The Director must hear the appeal in an adjudication conducted under the APA. The

[25] R.C. 3728.25.

Director may order the Board not to take the action or to reverse or modify the action, or the Director may uphold the Board's decision.

The Board may suspend a trauma center designation without adjudication if it believes there is clear and convincing evidence that continued operation of a trauma center presents a danger of immediate and serious harm to the public. The suspension order must be written and delivered by certified mail or in person. If the facility appeals the order, a court may not suspend the order while the appeal is pending. If the facility requests adjudication, the Director of Health must conduct the adjudication under the APA within seven to fifteen days after the request is made, unless the facility and the Director agree on another time. The suspension order remains in effect until the Director issues a final adjudication order. The final adjudication order must be issued not later than 90 days after the adjudication is complete. If a final order is not issued within that time period, the suspension order becomes void, but a subsequent final order is not affected.

If a facility continues to operate as a trauma center after having its designation suspended or revoked, the Attorney General, at the request of the Board or the Director, must apply to the court of common pleas of the facility's county for an order enjoining its operation. The court must grant the order on a showing that the facility continues to operate as a trauma center.[26]

Triage of trauma victims

State triage protocols

Current law requires the State Board of Emergency Medical, Fire, and Transportation Services in the Division of Emergency Medical Services of the Department of Public Safety (EMFTS Board) to adopt rules establishing written protocols for the triage of trauma victims that apply throughout the state. The EMFTS Board must review the state triage protocols once every three years to determine their efficacy. The bill requires the EMFTS Board to consult with the State Trauma Board in adopting the rules and to provide a copy of the triage protocols to the State Trauma Board. Under the bill, the State Trauma Board, in addition to the EMFTS Board, must review the protocols once every three years.

Current law establishes requirements the state triage protocols must satisfy. The bill adds a requirement that the state triage protocols require that pediatric trauma

[26] R.C. 3728.28.

patients be transported to pediatric trauma centers and trauma patients who are 16 or 17 years old be transported to either adult or pediatric trauma centers.[27]

Regional triage protocols

Current law permits a regional physician advisory board or regional director to submit regional protocols for the triage of trauma victims to the EMFTS Board for approval. If approved, regional protocols supersede the state triage protocols in the region where the regional protocols apply. Before submitting regional protocols for approval, the regional physician advisory board or regional director must consult with specified entities that regularly serve the applicable region. The bill removes professional associations and labor organizations of emergency medical service personnel from the entities that must be consulted and requires the EMFTS Board to consult with the State Trauma Board before approving regional triage protocols.[28]

State Trauma Board

Membership

The State Trauma Board is to consist of 19 members appointed by the Governor, the Director of Health, or the EMFTS Board. The Governor's appointments must be made with the advice and consent of the Senate. The members include the following:[29]

(1) A physician certified by the American Board of Surgery or the American Board of Osteopathic Surgery who actively practices general trauma surgery at a level I or II trauma center. The member is to be appointed by the Governor from among three physicians nominated by the Ohio Chapter of the ACS, three physicians nominated by the Ohio State Medical Association, and three physicians nominated by the Ohio Osteopathic Association.

(2) A physician certified by the American Board of Surgery , the American Board of Osteopathic Surgery, the American Board of Orthopaedic Surgery, the American Osteopathic Board of Orthopedic Surgery, or the American Board of Neurological Surgery who actively practices orthopedic trauma surgery or neurosurgery on trauma patients. The member is to be appointed by the Governor from among three physicians nominated by the Ohio Orthopaedic Society, three physicians nominated by the Ohio Osteopathic Association, and three physicians nominated by the Ohio State Neurosurgical Society.

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[27] R.C. 4765.40.

[28] R.C. 4765.40(B).

[29] R.C. 3728.02(A).

(3) A physician certified by the American Board of Surgery or the American Board of Osteopathic Surgery who has special qualifications in pediatric surgery and actively practices pediatric trauma surgery. The member is to be appointed by the Governor from among three physicians nominated by the Ohio Chapter of the American Academy of Pediatrics, three physicians nominated by the Ohio Osteopathic Association, and three physicians nominated by the Ohio State Medical Association.

(4) A registered nurse who actively practices trauma nursing at a level I or II trauma center. The member is to be appointed by the Governor from among three registered nurses nominated by the Ohio Society of Trauma Nurse Leaders and three registered nurses nominated by the Ohio Emergency Nurses Association.

(5) A registered nurse who actively practices trauma nursing at a level III trauma center. The member is to be appointed by the Governor from among three registered nurses nominated by the Ohio Society of Trauma Nurse Leaders, three nominated by the Ohio Emergency Nurses Association, and three nominated by the Ohio Hospital Association.

(6) A registered nurse who actively practices trauma nursing at a pediatric trauma center. The member is to be appointed by the Governor from among three registered nurses nominated by the Ohio Society of Trauma Nurse Leaders and three nominated by the Ohio Emergency Nurses Association.

(7) An administrator of a level III trauma center. The member is to be appointed by the Governor from among three administrators nominated by the Ohio Hospital Association and three nominated by the Ohio Osteopathic Association.

(8) An administrator of a level I or II trauma center. The member is to be appointed by the Governor from among three administrators nominated by the Ohio Hospital Association and three nominated by the Ohio Osteopathic Association.

(9) An administrator of a hospital that provides emergency care but does not include a trauma center. The member is to be appointed by the Governor from among three administrators nominated by the Ohio Hospital Association and three nominated by the Ohio Osteopathic Association.

(10) A physician certified by the American Board of Physical Medicine and Rehabilitation or the American Osteopathic Board of Rehabilitation Medicine who actively provides rehabilitative care to trauma victims. The member is to be appointed by the Governor from among three physicians nominated by the Ohio Society of Physical Medicine and Rehabilitation and three nominated by the Ohio Osteopathic Association.

(11) A physician certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine who actively practices emergency medicine at a level I or II adult trauma center and is actively involved in emergency medical services. The member is to be appointed by the Governor from among three physicians nominated by the Ohio Osteopathic Association, three nominated by the Ohio State Medical Association, and three nominated by the Ohio Chapter of the American College of Emergency Physicians.

(12) A physician certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine who actively practices at a facility that is not a level I, II, or III trauma center. The member is to be appointed by the Governor from among three physicians nominated by the Ohio Osteopathic Association and three nominated by the Ohio Chapter of the American College of Emergency Physicians.

(13) An individual who practices burn surgery or nursing at a burn center verified by the American Burn Association. The member is to be appointed by the Governor from among three Physicians nominated by the Ohio Chapter of ACS and three nurses nominated by the Ohio Society of Trauma Nurse Leaders.

(14) An injury prevention expert appointed by the Director of Health.

(15) An emergency medical technician who is a member of and appointed by the EMFTS Board.

(16) An emergency medical technician (EMT) employed by an emergency medical service organization that primarily uses paid individuals. The member is to be appointed by the Governor from among three EMTs nominated by the Ohio Fire Chiefs' Association, three nominated by the Ohio Association of Professional Fire Fighters, three nominated by the Northern Ohio Fire Fighters, and three nominated by the Ohio State Firefighters' Association.

(17) An EMT employed by an emergency medical service organization that primarily uses volunteers. The member is to be appointed by the Governor from among three EMTs nominated by the Ohio Fire Chiefs' Association, three nominated by the Ohio State Firefighters' Association, and three nominated by the Ohio Association of Emergency Medical Services.

(18) A physician certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine who is actively involved in air medical support. The member is to be appointed by the Governor from among three

physicians nominated by the Ohio chapter of the American College of Emergency Physicians and three nominated by the Ohio Association of Critical Care Transport.

(19) An administrator of a pediatric trauma center. The member is to be appointed by the Governor from among three administrators nominated by the Ohio Osteopathic Association and three nominated by the Ohio Children's Hospital Association.

Appointment of members

In appointing members, the appointing authorities must attempt to include members who represent urban and rural areas, various geographical areas of the state, and various schools of training. The appointments must be coordinated so that no two members are employed by or practice at the same facility or emergency medical service organization.

The bill permits an appointing authority to accept nominations from an organization that is not listed if one of the listed nominating organizations fails to make nominations within a reasonable time after nominations are requested. An appointing authority may refuse to appoint any of the persons nominated. In that event, the nominating organizations are to continue nominating individuals until the appointing authority makes an appointment. If a nominating organization ceases to exist, the bill specifies that the successor organization is to assume the nominating authority.[30]

Terms of office

Initial appointments must be made not later than 90 days after the bill's effective date. The initial terms begin on the first day of the first month following the appointment of the last member and are as follows:

(1) The initial members described in (1), (2), (3), (4), (7), and (18) above (see, "**Membership**") are appointed for five-year terms.

(2) The initial members described in (5), (8), (9), (10), and (16) above are appointed for four-year terms.

(3) All other initial members are appointed for three-year terms.

After the initial terms, all terms are three years, and there is no limit on the number of terms a member may serve. Generally, a member holds office until the end of the member's term. If a member is appointed to fill a vacancy occurring before the

[30] R.C. 3728.02(B).

expiration of the predecessor's term, the replacement member is to serve until the expiration of that term. On the expiration of a member's term, the member is to serve until a successor takes office or until a period of 60 days has elapsed, whichever occurs first. Members are to be reimbursed by the Board for necessary expenses incurred in the performance of official duties.[31]

Each member serves at the pleasure of that member's appointing authority, except that a member who ceases to be qualified for the position must cease being a member.[32]

Organization of the Board

The bill requires the Board to select a chairperson and a co-chairperson from among its members. Each officer serves in that capacity for one-year and may administer oaths.

The Board may form committees as it considers appropriate. The committee members are to be chosen by the Board and may include Board members and others chosen for their expertise.[33]

The bill requires the Board to adopt internal management rules setting forth criteria for assessing the board's accomplishments, activities, and performance. The assessment must be included in an annual report on the condition of trauma care in Ohio that is submitted to the General Assembly and the Governor and made available to the public. The bill permits the Board to enter into and enforce contracts in the Board's name.[34]

Board and committee meetings

The Board must meet at least six times a year and at other times specified by the chairperson. The meetings must be open and accessible to the public unless the Board is meeting in executive session.

A majority of the members of the Board or a committee constitutes a quorum. No action can be taken without a concurrence of a majority of the Board or committee. The bill permits a member to attend a meeting by interactive video conference or teleconference and still be part of a quorum and vote if all of the following apply:

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[31] R.C. 3728.03.

[32] R.C. 3728.02(C).

[33] R.C. 3728.06(A).

[34] R.C. 3728.07(C) and (D).

(1) The meeting is held in a location that is open and accessible to the public.

(2) There is a clear audio connection that enables all members participating at the meeting location to hear all members' participation.

(3) A roll call vote is recorded for each vote taken.

(4) The minutes from the meeting identify which members participated by video conference or teleconference.

The Board or a committee may limit the number of members who may participate in a particular meeting by video conference or teleconference and the number of times that a member may participate in meetings in that way.[35]

Board employees

Executive director

The bill requires the Director of Health to appoint a full-time executive director to serve as the chief executive officer of the Board. The executive director must attend all Board meetings, except for those meetings concerning the employment or performance of the executive director or the Board's medical director. The executive director must meet with the Director of Health at the Director's request and submit a report to the Director once every three months regarding the status of trauma services in Ohio. The executive director is to receive a salary and be reimbursed for actual and necessary expenses incurred in carrying out official duties.

The executive director must be knowledgeable in trauma systems and trauma care and serves at the pleasure of the Director of Health. The Director must appoint the executive director from among three persons nominated by the Board. The Director may refuse, for cause, to appoint any of the nominees. In that case, the Board must continue nominating groups of three people until the Director appoints one.[36]

Medical director

The bill requires the Board to appoint a medical director to direct the executive director and advise the Board with regard to trauma services and trauma system issues. The medical director must also attend all Board meetings, except for those meetings concerning the appointment or performance of the medical director or executive

[35] R.C. 3728.06(B) and (C).

[36] R.C. 3728.07(A).

director. The medical director is to be employed and paid by the Board and be reimbursed for actual and necessary expenses incurred in carrying out official duties.

The medical director must be a physician certified by the American Board of Surgery or the American Osteopathic Board of Surgery, be active in the practice of general trauma surgery, and have been actively involved with trauma services organizations for at least five years prior to being appointed. The Board must consider recommendations for the appointment from the Ohio Osteopathic Association, the Ohio State Medical Association, and the Ohio chapters of ACS and the American Academy of Pediatrics. The medical director serves at the pleasure of the Board.[37]

Other employees

The bill permits the Board to appoint other employees as it determines necessary. The duties and titles of those employees are to be prescribed by the Board.[38]

Exemption from sunset review

The bill exempts the State Trauma Board from the laws governing sunset review and the expiration of agencies.[39]

State Trauma Board duties

Statewide system for improvement in trauma care and rehabilitation quality

The bill requires the Board to develop a statewide system for improvement in the quality of trauma care and rehabilitation. The bill creates a quality committee to advise and assist in the system's development.

The quality committee is to consist of members appointed by the Board. Members must be Ohio residents and may also be members of the Board. Committee members serve without compensation. They are, however, reimbursed for expenses incurred in carrying out official duties. The committee must select two members to serve as chairperson and vice-chairperson. The committee must meet at the call of the chair and at the direction of the Board, but the meetings may not conflict with Board meetings.

The bill establishes that information, data, reports, and records received by the quality committee in the execution of its duties are confidential and not subject to

[37] R.C. 3728.07(B).

[38] R.C. 3728.07(E).

[39] R.C. 101.82.

discovery in a civil action. The committee members may use the information, data, reports, and records only in advising and assisting the Board in matters related to the development of the quality improvement system. The bill establishes that all information, data, reports, and records that are confidential when in the committee's possession remain confidential and are not subject to discovery when in the possession of the Board or a Board member or employee. The Board is required to adopt rules specifying procedures to ensure the confidentiality of the material.[40]

State trauma registry

The bill transfers responsibility for maintaining the state trauma registry from the EMFTS Board to the State Trauma Board. The Registry is to be used to collect data regarding trauma care in Ohio, including information related to trauma-related deaths, identification of trauma patients, monitoring of trauma patient care data, determination of the total amount of uncompensated trauma care provided by each facility that provides care to trauma victims, and other information specified by the Board. The Board must develop a single patient identifier system to be used by the Registry and other registries that report information to it. In carrying out its duties, the Board must consult with trauma data specialists. To assist in its duties, the Board may appoint a committee consisting of persons with relevant expertise.

The bill requires persons designated by the Board to submit information to the Registry when requested to do so by the Board. In addition, the Board may request any state agency to provide relevant trauma care information in that agency's possession. The bill establishes that, in the absence of willful or wanton misconduct, a person who provides information to the Board with respect to that person's patient will not be held liable in damages or be held to answer for betrayal of a professional confidence. The information provided to the Board is not subject to introduction in any civil action against the information provider. A person who provides information to the Board is not to be held liable for the misuse or improper release of the information by the Board or by any person.[41]

Emergency medical technicians and organizations

The bill limits the Board's authority to request information from emergency medical organizations, first responders, and emergency medical technicians (EMTs). The Board may request information from these persons only if the Board cannot obtain the information from the EMFTS Board or through the Emergency Medical Services Incidence Reporting System. Before requesting information from an emergency medical

[40] R.C. 3728.09 and 3728.11.

[41] R.C. 3728.12.

organization, first responder, or EMT, the Board must request and receive permission to do so from the EMFTS Board.[42]

Other trauma registries

The bill provides that rules relating to the state trauma registry may not prohibit the operation of other trauma registries. It specifies that the rules may provide for the reporting of information to the state trauma registry by or through other trauma registries in a manner consistent with information otherwise reported to the state trauma registry. The bill allows other trauma registries to report aggregate information to the state trauma registry, provided that the information can be matched to the person who reported it. The Board may not require a person to report information to the state trauma registry through another trauma registry.

The bill establishes that all laws concerning the information maintained by the state trauma registry also apply to the information maintained by trauma registries that report information to the state trauma registry. A person who provides, maintains, or adjusts information for risk for trauma registries that report to the state trauma registry enjoys the same immunities as a person who performs those functions for the state trauma registry.[43]

Confidentiality of patient information

With certain exceptions (see "**Disclosure of information**," below) the bill prohibits the Board, Board employees and contractors, other trauma registries, and the Department of Health from making public information they receive that identifies or would tend to identity a specific trauma care patient. The Board is required to adopt rules establishing procedures to ensure the confidentiality of that information. The bill permits the Board to make public statistical information that does not identify or tend to identify a specific trauma care patient or provider.[44]

Risk adjustment of information

The bill requires the Board to adopt rules establishing written standards and procedures for risk adjustment of information received by the Board. The rules must specify the circumstances in which deliberations regarding the risk adjustment are not open to the public and the records of the deliberations are confidential. The Board may have the risk adjustment performed by a contractor. A person who performs risk

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[42] R.C. 3728.12(B).

[43] R.C. 3728.12(A).

[44] R.C. 3728.12(A).

adjustment functions is not to be held civilly liable for betrayal of professional confidence or otherwise in the absence of willful or wanton misconduct.

With certain exceptions (see "**Disclosure of information**," below) the bill prohibits a Board member, employee, or contractor and the Department of Health from making public information received by the Board that identifies or would tend to identify a specific facility or provider of trauma care before the Board implements the risk adjustment procedures. Once the procedures are implemented, the information may be made public only on a risk adjusted basis.

Disclosure of information

The bill permits the Board to transmit data that identifies or tends to identify a specific trauma care patient and information that identifies or tends to identify a specific provider of trauma care on a nonrisk adjusted basis directly to the National Trauma Data Bank, which is maintained by ACS, or to another state's trauma registry. The Board may transmit data to another state's trauma registry only if the information concerns a patient who either suffered a traumatic injury in this state and received care in the other state or suffered an injury in the other state and received care in this state. The information must be transmitted in accordance with a written contract between the Board and the operators of the other registry under which the operators agree, to the extent permitted by law, to use the data solely for inclusion in the National Trauma Data Bank or the other state's registry. The operators of the other registry must also agree not to disclose information to the public in a manner that identifies or tends to identify a specific patient or provider of trauma care.[45]

Investigations

The bill requires the State Trauma Board to monitor compliance with the laws governing trauma care and to investigate possible violations. The bill permits any person to report information to the Board in a signed writing that appears to show a violation. In the absence of bad faith, a person who reports information to the Board or testifies before the Board is not to be held civilly liable as a result of the report or testimony.

As part of its investigatory authority, the Board may question witnesses; conduct interviews; administer oaths; order the taking of depositions; inspect and copy any books, accounts, papers, records, or documents; issue subpoenas; and compel the attendance of witnesses and production of books, accounts, papers, records, documents, and testimony. A subpoena for patient record information may not be issued without

[45] R.C. 3728.12(C) and (D).

consultation with the Attorney General's office and approval of the chairperson of the Board.

The bill permits a Board-issued subpoena to be issued by a sheriff, the sheriff's deputy, or a Board employee. The subpoena may be served by certified mail with return receipt requested, by delivering the subpoena to the named person, by reading it to the person, or by leaving it at the person's usual residence, place of business, or address on file with the Board. The subpoena is deemed served on the date it is delivered or the date it is refused. If a subpoena is refused, it may be served to an attorney who notifies the Board that the attorney is representing the person. A sheriff's deputy who serves a subpoena is to receive the same fees as a sheriff.

Each witness who appears before the Board in obedience to a subpoena is to receive the fees and mileage provided for by the APA. If a person fails to comply with a subpoena after reasonable notice, the Board may move for an order compelling the production of persons or records pursuant to the Ohio Rules of Civil Procedure.

Reports that are required to be submitted to the Board, complaints, and information received by the Board in the course of an investigation are confidential and not subject to discovery in a civil action. The Board is required to conduct all investigations and proceedings in a manner that protects the confidentiality of patients and people who make complaints with the Board. The Board is prohibited from making public the names or any other identifying information about patients or complainants unless consent is given, the patient's privilege is waived, or the Board possesses reliable and substantial evidence that no bona fide physician-patient relationship exists.

The bill permits, to the extent permitted by federal and state law, the Board to share any information it receives during the course of an investigation, including patient records, with law enforcement agencies, licensing boards, and other government agencies that are prosecuting, adjudicating, or investigating alleged violations of statutes or administrative rules. An agency that receives the information from the Board is subject to the same confidentiality standards that apply to the Board, even if that agency is subject to conflicting laws governing the confidentiality of information in that agency's possession. When the information is admitted into evidence during a judicial proceeding, the court must require that appropriate measures are taken to ensure patient or complainant-identifying information remains confidential. Those measures may include sealing the records or deleting specific information from its records.[46]

[46] R.C. 3728.26.

Child highway safety

The bill modifies the law governing the Child Highway Safety Fund. The fund consists of fines collected for violations of statutes regarding child restraint systems in vehicles. Under current law, the money in the fund is to be used by the Department of Health to defray the cost of designating pediatric trauma centers and to establish and administer the Child Highway Safety Program, which educates the public about child restraint systems and booster seats. Under the bill, the State Trauma Board, instead of the Department, receives the money and must use it for the same purposes.[47] (See **COMMENT**.)

Time critical diagnosis system of care

Research into best practices

The bill requires the State Trauma Board to research best practices and other issues related to the development and implementation of a statewide time critical diagnosis system of care for medical conditions including trauma, stroke, and myocardial infarction (heart attack).[48] The bill permits the Board to periodically submit a report of its findings to the Governor, the General Assembly, or any other person.[49]

The bill creates the Time Critical Diagnosis Committee to advise and assist the Board in conducting this research. Members of the Committee are to be appointed by the Board and must be residents of this state. Members of the Board may also serve as members of the Committee. Committee members are to serve without compensation but will be reimbursed for actual and necessary expenses incurred in carrying out their duties.

The Committee must select a chairperson and vice-chairperson from among its members. The Committee must meet at the call of the chairperson and the direction of the Board. The times and locations of meetings must not conflict with meetings of the Board. The initial meeting must be held not later than 90 days after the Board's initial meeting.[50]

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[47] R.C. 4511.81.

[48] R.C. 3728.09(A)(13).

[49] R.C. 3728.13.

[50] R.C. 3728.13.

Implementation of future legislation

The bill prohibits legislation establishing a time critical diagnosis system of care from being implemented until the Board has developed an inclusive trauma system that recognizes and collaborates with all entities that play a role in trauma care or prevention. However, this provision applies only to legislation enacted later than one year after the bill's effective date.

The bill defines "time critical diagnosis" as a diagnosis of trauma, stroke, myocardial infarction, or illness or injury of similar severity that requires immediate diagnosis and care.[51]

Regional trauma organizations

The bill requires the State Trauma Board to establish standards and procedures for Board recognition of regional trauma organizations and to collaborate with those organizations recognized by the Board. The bill permits Board-recognized regional trauma organizations to impose a participation fee if the fee has been approved by the Board. The Board is required to establish procedures for approving fees and establish limits on the fees.[52]

Additional State Trauma Board duties

In addition to the duties discussed above, the bill requires the State Trauma Board to do all of the following: [53]

(1) Develop an inclusive trauma system that recognizes and collaborates with all groups and institutions that have a role in trauma care or prevention;

(2) Seek and distribute grants;

(3) Develop and provide trauma-related education;

(4) Develop a statewide system for injury prevention in consultation with the Department of Health;

(5) Make recommendations to the EMFTS Board regarding the establishment of standards for providers of trauma care in prehospital settings;

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[51] R.C. 3728.091.

[52] R.C. 3728.09(A)(10) and 3728.14.

[53] R.C. 3728.09(A).

(6) Make recommendations to licensing agencies regarding continuing education requirements for providers of trauma care, other than physicians and dentists;

(7) With regard to regional trauma organizations, do all of the following:

(a) Establish procedures for Board recognition of regional trauma organizations;

(b) Develop minimum standards for Board recognition;

(c) Collaborate with Board-recognized regional trauma organizations.

(8) Divide the state geographically into trauma regions.

EMFTS Board

Duties related to trauma care

The bill modifies the EMFTS Board's role regarding trauma care in Ohio. The bill requires the EMFTS Board to adopt rules establishing standards for providers of trauma care in prehospital settings. In establishing the standards, the EMFTS Board must consider recommendations from the State Trauma Board.[54] The bill also repeals provisions of law establishing the trauma committee of the EMFTS Board and requiring the medical director of the EMFTS Board to direct and advise the Board with regard to adult and pediatric trauma issues.[55]

Continuing education

The bill permits courses offered through an emergency medical services training program or an emergency medical services continuing education program that deals with trauma care to be developed in consultation with a physician who specializes in either emergency medicine or trauma surgery. Current law requires that the consulting physician specialize in trauma surgery.[56]

Patient identifying information in the Emergency Medical Services Incident Reporting System

Continuing law permits the EMFTS Board to transmit certain information that would otherwise be confidential from the Emergency Medical Services Incident Reporting System directly to the National Emergency Medical Services Information

[54] R.C. 4765.11.

[55] R.C. 4765.04.

[56] R.C. 4765.16(A).

System pursuant to a written contract between the EMFTS Board and the national system administrators. The bill includes information that identifies or tends to identify a specific recipient of emergency medical services as information that may be transmitted pursuant to such a contract.[57]

Grant program

Continuing law requires the EMFTS Board to establish and administer a grant program under which grants are distributed to entities engaged in activities related to emergency medical services, such as personnel training and relevant research. The grants are to be distributed in accordance with statutorily established priorities. The bill repeals provisions establishing priorities for entities that research and test medical procedures and systems related to trauma care, research traumatic injuries and injury prevention strategies, research and test procedures promoting the rehabilitation of trauma victims, or operate paramedic training and are seeking national accreditation. The bill establishes that entities that conduct research on emergency medical services in general are to be given third priority for grant distributions.[58]

Distance meetings

The bill permits a member of the EMFTS Board or a committee of the Board to attend a meeting by interactive video conference or teleconference and still be part of a quorum and vote if all of the following apply:

(1) The meeting is held in a location that is open and accessible to the public.

(2) There is a clear audio connection that enables all members participating at the meeting location to hear all members' participation.

(3) A roll call vote is recorded for each vote taken.

(4) The minutes from the meeting identify which members participated by video conference or teleconference.

The EMFTS Board or a committee may limit the number of members who may participate in a particular meeting by video conference or teleconference and the number of times that a member may participate in meetings in that way.[59]

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[57] R.C. 4765.06(F).

[58] R.C. 4765.07.

[59] R.C. 4765.02 and 4765.04.

Membership

The bill eliminates a member of the EMFTS Board and replaces that member with another. The bill eliminates the member who is a trauma program manager or director and has been nominated by the Ohio Nurses Association, the Ohio Society of Trauma Nurse Leaders, and the Ohio State Council of the Emergency Nurses Association. The bill replaces this member with a member who is an EMT, AEMT, or a paramedic and has been nominated by the Association of Professional Fire Fighters.[60]

Joint committee

The bill permits the EMFTS Board and the State Trauma Board to establish a joint committee to review matters that are within the jurisdiction of both boards. The committee is to consist of five members of each board appointed by the chair of that board. The committee is to review all matters submitted by the boards and recommend a course of action. To make a recommendation, an affirmative vote of seven committee members is required. The committee must provide written notice of its recommendations to each board.

Each committee member serves at the pleasure of the chair that appointed that member. Vacancies are to be filled in the same manner as the original appointment. Members serve without compensation, but are to be reimbursed for reasonable and necessary expenses incurred in the performance of their duties.[61]

Technical and corresponding changes

The bill modifies or removes provisions of law to reflect its requirement that trauma centers be designated by the State Trauma Board, which replaces the current requirement that trauma centers be verified by ACS.[62] The bill also removes a reference to level III and level IV pediatric trauma centers, because those designation levels do not exist under the bill.[63] It removes "adult or pediatric" and "adult and pediatric" when either of those phrases is used to describe trauma care in the EMFTS Board chapter (R.C. Chapter 4765.).[64]

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[60] R.C. 4765.02(A)(2).

[61] R.C. 4765.44.

[62] R.C. 3727.081 (repealed), 3727.101 (repealed), 3728.15, 3728.16, 3728.25, and 4765.01.

[63] R.C. 3728.15.

[64] R.C. 4765.01, 4765.02, 4765.03, 4765.05, 4765.06, 4765.07, 4765.11, 4765.16, 4765.35, 4765.37, 4765.38, 4765.39, 4765.40, and 4765.41.

Effective date

The bill's provisions requiring designation of trauma centers take effect one year after the bill's effective date. The delayed effective date does not apply to provisions that create the State Trauma Board and establish its organization.[65]

COMMENT

Child Highway Safety Program

The bill provides that fines for failure to comply with motor vehicle child safety restraint laws are to be used by the State Trauma Board, rather than the Department of Health, to defray the cost of designating pediatric trauma centers and to establish and administer a child highway safety program. However, the bill retains provisions that reference the Department as the agency that administers the program. An amendment may be necessary to clarify the roles of the Board and the Department regarding the program.[66]

HISTORY

ACTION	DATE
Introduced	06-17-15
Reported, H. Health & Aging	05-25-16

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[65] Section 3.

[66] R.C. 4511.81.