Alan Van Dyne *Legislative Service Commission*

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123rd General Assembly
(As Passed by the General Assembly)

Reps. **Schuck, Barrett, Bender, Evans, Ford, Metelsky, D. Miller, Sullivan, Sykes, Pringle, Van Vyven, Verich, Winkler, Young, Bateman, Haines, Olman, DePiero, Barnes, Williams, Willamowski, Terwilleger, Vesper, Brading, Ogg, Roberts, Tiberi, Schuler, Perry, Goodman, Jones, Corbin, Callender, Calvert, Mottley, Austria, O'Brien, Thomas, Ferderber, Cates, Flannery, Patton, Clancy, Damschroder, Sutton, Jerse, Salerno, Opfer, Myers**

Sens. **Drake, Hagan, Kearns, Armbruster, Spada, Johnson, Brady, Watts, Wachtmann, Prentiss, Latell, Gardner**

Effective date: November 3, 2000

ACT SUMMARY

- Prohibits, beginning November 3, 2002, a hospital or physician from admitting or transferring a trauma patient to a hospital that is not an appropriate trauma center or failing to transfer a trauma patient to an appropriate trauma center.
- Requires the State Board of Emergency Medical Services to develop state triage protocols for the treatment of trauma victims.
- Provides for the establishment of regional triage protocols.
- Requires emergency medical service organizations to develop written protocols for the treatment of trauma victims.
- Imposes additional costs for failure to use an occupant restraining device and for reinstating a driver's license suspended for OMVI and reallocates the use of the funds with respect to programs involving safety education and emergency medical services.
- Directs a portion of the fines collected from state highway patrol tickets and arrests to a program under which grants are made for uses related to trauma and emergency medical services.

- Alters the composition and operation of the State Board of Emergency Medical Services.
- Establishes a trauma committee in the State Board of Emergency Medical Services.
- Requires the State Board of Emergency Medical Services, Department of Health, and Legislative Service Commission to study and report on trauma care emergency medical services in Ohio.
- Permits emergency medical service organizations to contract to provide services in other jurisdictions.
- Allows private fire companies and emergency medical service organizations to participate in Department of Administrative Services purchasing and salvage programs.
- Establishes a sales tax exemption for the purchase of emergency medical equipment and supplies for trauma care and emergency medical services.

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TRAUMA CARE

Overview

The act provides that an adult or pediatric trauma center must be verified by the American College of Surgeons as a condition of representing itself to the public as a trauma center. For a limited period, the act provides that a pediatric trauma center that is not verified by the American College of Surgeons may operate under a designation issued by the Director of Health. The act prohibits a physician from admitting a trauma patient to a hospital that is not a trauma center and prohibits both physicians and hospitals from making inappropriate transfers of trauma patients. Hospitals are required to adopt protocols for providing trauma care and to enter into agreements with trauma centers governing the transfer of trauma patients from hospitals to appropriate trauma centers. The State Board of Emergency Medical Services is required to develop triage protocols for the treatment of trauma victims. Comparable regional triage protocols may be developed, however, that take precedence over the state triage protocols. The Board must develop guidelines for the care of trauma victims provided by emergency medical service personnel.

Types of trauma care and injuries

(sec. 4765.01(N) and (M))

"Trauma" (or "traumatic injury") is defined by the act as "severe damage to or destruction of tissue" that satisfies both of the following conditions:

(1) It creates a significant risk of loss of life; loss of a limb; significant, permanent disfigurement; or significant, permanent disability.

(2) It is caused by blunt or penetrating injury; exposure to electromagnetic, chemical, or radioactive energy; drowning, suffocation, or strangulation; or a deficit or excess of heat.

"Trauma care" is defined as "the assessment, diagnosis, transportation, treatment, or rehabilitation of a trauma victim by emergency medical service personnel or by a physician, nurse, physician assistant, respiratory therapist, physical therapist, chiropractor, occupational therapist, speech-language pathologist, audiologist, or psychologist licensed to practice in Ohio or another jurisdiction.

Authorized trauma centers

(sec. 4765.01)

"Trauma center" is defined by the act as "any hospital that is verified by the American College of Surgeons as an adult or pediatric trauma center, any hospital in Ohio that is designated by the Director of Health as a pediatric trauma center, and any hospital that is licensed or designated under the laws of another state as capable of providing specialized trauma care appropriate to the medical needs of the trauma patient."

State designation of pediatric trauma centers

(sec. 3727.081)

If a hospital has been denied verification as a pediatric trauma center by the American College of Surgeons solely because the hospital does not meet that organization's anesthesia and surgical staffing standards, the act permits the hospital to submit an application to the Director of Health to receive the Director's designation as a Level II pediatric trauma center. The act requires the Director to cease reviewing applications December 31, 2003, and provides that all applications pending on that date are void. The act provides that the Director's designation of a hospital as a pediatric trauma center expires December 31, 2004, unless earlier suspended or revoked by the Director or surrendered by the hospital.

Not later than November 3, 2002, the Director must adopt rules that establish standards and procedures for designating hospitals as Level II pediatric trauma centers. The rules must include standards to be followed by a hospital operating under the Director's designation and procedures for the Director's enforcement of those standards. The rules must be adopted in accordance with the Administrative Procedure Act (R.C. Chapter 119.). Any action taken to suspend or revoke a hospital's designation must be taken in accordance with the Administrative Procedure Act.

The act permits the Director to conduct an inspection before designating a hospital as a pediatric trauma center. The inspection may be conducted by using a contractor of the Department of Health with appropriate competence and independence.

The Director is required to review in a timely manner all applications received. A hospital must be designated as a Level II pediatric trauma center if the hospital submits a complete application and the Director finds all of the following:

(1) The hospital has established trauma care protocols that ensure a surgeon and anesthesiologist are available from outside the hospital in a timely manner and on short notice;

(2) The hospital's protocols ensure that the surgeon will participate in the early care of a trauma patient;

(3) The hospital has adhered to its protocols and the hospital's performance has met the expected outcomes, as evidenced by data obtained from a review of at least two years of the hospital's trauma activities;

(4) The care of patients will not be compromised by issuing the designation.

The act prohibits the Director and any employee or contractor of the Department from making public any information reported to or collected by the Department under the designation program. The prohibition applies to information that identifies or would tend to identify a specific patient.

Prohibitions regarding transfer and treatment

Hospitals

(sec. 3727.10)

Beginning November 3, 2002, the act prohibits a hospital in Ohio from knowingly doing any of the following:

(1) Representing that it is able to provide trauma care to a severely injured patient that is inconsistent with its level of categorization as a trauma center, provided that a hospital that operates an emergency facility may represent that it provides emergency care;

(2) Providing trauma care to a severely injured patient that is inconsistent with applicable federal laws, state laws, and trauma care protocols and patient transfer agreements adopted by the hospital under the act;

(3) Transferring a severely injured trauma patient to a hospital that is not a trauma center with an appropriate level of categorization or otherwise transferring a severely injured trauma patient in a manner inconsistent with any applicable trauma patient transfer agreements adopted by the hospital.

Physicians

(sec. 4765.50)

Beginning November 3, 2002, the act prohibits a physician from purposefully doing any of the following:

(1) Admitting an adult trauma patient to a hospital that is not an adult trauma center for the purpose of providing adult trauma care;

(2) Admitting a pediatric trauma patient to a hospital that is not a pediatric trauma center for the purpose of providing pediatric trauma care;

(3) Failing to transfer a trauma patient to an adult or pediatric trauma center in accordance with applicable federal law, state law, and adult and pediatric trauma protocols and patient transfer agreements adopted by a hospital under the act.

Hospital trauma care protocols

(sec. 3729.09(A))

Not later than November 3, 2002, the act requires each hospital that is not a trauma center to adopt protocols for the trauma care provided in or by that hospital. Each hospital that is an adult trauma center and not a Level I or Level II pediatric trauma center must adopt protocols for pediatric trauma care provided in or by that hospital. Each hospital that is a pediatric trauma center and not a Level I or Level II adult trauma center must adopt protocols for adult trauma care provided in or by that hospital.

In developing its trauma care protocols, each hospital must consider the guidelines for trauma care established by the American College of Surgeons, the American College of Emergency Physicians, and the American Academy of Pediatrics. Trauma care protocols must be written, comply with applicable federal and state laws, and include policies and procedures with respect to all of the following:

(1) Evaluation of trauma patients, including criteria for prompt identification of trauma patients who require a level of trauma care that exceeds the hospital's capabilities;

(2) Emergency treatment and stabilization of trauma patients prior to transfer to an appropriate trauma center;

(3) Timely transfer of trauma patients to appropriate trauma centers based on the patient's medical needs;

(4) Peer review and quality assurance procedures for adult and pediatric trauma care provided in or by the hospital.

Transfer protocols

A hospital's policies and procedures for timely transfer are referred to in the act as "trauma patient transfer protocols." Under the act, a hospital's trauma patient transfer protocols must specify all of the following:

(1) Confirmation of the ability of the receiving trauma center to provide prompt trauma care appropriate to the patient's medical needs;

(2) Procedures for selecting an appropriate alternative trauma center to receive a patient when it is not feasible or safe to transport the patient to a particular trauma center;

(3) Advance notification and appropriate medical consultation with the trauma center to which a trauma patient is being, or will be, transferred;

(4) Procedures for selecting an appropriate method of transportation and the hospital responsible for arranging or providing the transportation;

(5) Confirmation of the ability of the persons and vehicle that will transport a trauma patient to provide appropriate trauma care;

(6) Assured communication with, and appropriate medical direction of, the persons transporting a trauma patient to a trauma center;

(7) Identification and timely transfer of appropriate medical records of the trauma patient being transferred;

(8) The hospital responsible for care of a patient in transit;

(9) The responsibilities of the physician attending a patient and, if different, the physician who authorizes a transfer of the patient;

(10) Procedures for determining, in consultation with an appropriate trauma center and the persons who will transport a trauma patient, when transportation of the patient to a trauma center may be delayed for either of the following reasons: (a) immediate transfer of the patient is unsafe due to adverse weather or ground conditions or (b) no trauma center is able to provide appropriate trauma care to the patient without undue delay.

Hospital trauma patient transfer agreements

(sec. 3727.09(B))

Not later than November 3, 2002, the act requires each hospital to enter into the following written agreements:

(1) An agreement with one or more adult trauma centers in each level of trauma center categorization higher than that of the hospital that governs transfer of adult trauma patients from the hospital to those trauma centers;

(2) An agreement with one or more pediatric trauma centers in each level of trauma center categorization higher than that of the hospital that governs the transfer of pediatric trauma patients from the hospital to those trauma centers.

The act provides that a hospital's trauma patient transfer agreement must comply with applicable federal and state laws and contain provisions conforming to the act's requirements for trauma care protocols.

Exceptions

The act establishes exceptions to the requirement that a hospital enter into patient transfer agreements. Under these exceptions, all of the following apply:

(1) A Level I or Level II adult trauma center is not required to enter into an adult trauma patient transfer agreement with another hospital.

(2) A Level I or Level II pediatric trauma center is not required to enter into a pediatric trauma patient transfer agreement with another hospital.

(3) A hospital is not required to enter into an adult trauma patient transfer agreement with a Level III or Level IV adult trauma center, or enter into a pediatric trauma patient transfer agreement with a Level III or Level IV pediatric trauma center, if no trauma center of that type is reasonably available to receive trauma patients from the hospital.

Public inspection of protocols and agreements

(sec. 3727.09(C))

A hospital is required by the act to make its trauma care protocols and patient transfer agreements available for public inspection during normal working hours. A hospital must furnish a copy of those documents on request and may charge a reasonable and necessary fee for doing so. However, the hospital must furnish copies of the documents to the Director of Health free of charge.

State triage protocols

(sec. 4765.40(A))

Not later than November 3, 2002, the act requires the State Board of Emergency Medical Services to adopt rules establishing written protocols for the triage of trauma victims. The rules must define adult and pediatric trauma in a manner that is consistent with the act's definitions, minimizes overtriage and undertriage, and emphasizes the special needs of pediatric and geriatric trauma patients. The act provides that a pediatric patient is one who is less than age 16; otherwise the patient is an adult patient. A geriatric patient is described as one who is at least 70 years old or exhibits significant anatomical or physiological characteristics associated with advanced aging.

The state triage protocols are to require that a trauma victim be transported directly to a trauma center that is qualified to provide appropriate adult or pediatric trauma care, unless any of the following exceptions applies:

(1) It is medically necessary to transport the victim to another hospital for initial assessment and stabilization before transfer to an appropriate trauma center;

(2) It is unsafe or medically inappropriate to transport the victim directly to an appropriate trauma center due to adverse weather or ground conditions or excessive transport time;

(3) Transporting the victim to an appropriate trauma center would cause a shortage of local emergency medical service resources;

(4) No appropriate trauma center is able to receive and provide trauma care to the victim without undue delay;

(5) Before transport of a patient begins, the patient requests to be taken to a particular hospital that is not a trauma center or, if the patient is less than 18 years of age or is not able to communicate, such a request is made by an adult member of the patient's family or a legal representative of the patient.

The state triage protocols must require trauma patients to be transported to a trauma center that is able to provide appropriate adult or pediatric trauma care, but the protocols must not require a trauma patient to be transported to a particular trauma center. The protocols are to establish one or more procedures for evaluating whether an injury victim requires or would benefit from trauma care. These procedures are to be applied by emergency medical service personnel based on the patient's medical needs.

In developing the state triage protocols, the Board must consider relevant model triage rules. The Board also must consult with the Commission on Minority Health, the regional directors and physician advisory boards appointed under continuing law for each of the state's prehospital emergency medical services regions, and appropriate medical, hospital, and emergency medical service organizations.

Before the Joint Committee on Agency Rule Review considers the Board's proposed state triage protocols, or any amendments to them, the act requires the Board to send a copy of the proposal to the Ohio chapters of the American College of Emergency Physicians, American College of Surgeons, and American Academy of Pediatrics; OHA: the Association for Hospitals and Health Systems; the Ohio Osteopathic Association; and the Association of Ohio Children's Hospitals. The act requires the Board to hold a public hearing at which it considers the appropriateness of the protocols to minimize overtriage and undertriage of trauma victims.

The act requires the Board to provide copies of the adopted state triage protocols, and amendments to the protocols, to each emergency medical service organization, regional director and regional physician advisory board, certified emergency medical service instructor, and person who regularly provides medical direction to emergency medical service personnel in Ohio. The act also requires that copies be provided to each medical service organization in other jurisdictions that regularly provides emergency medical services in Ohio. Others must be given copies on request.

Regional triage protocols

(sec. 4765.40(B))

The State Board of Emergency Medical Services is required by the act to approve regional protocols for the triage of trauma victims and any amendments to them. The act requires that the regional protocols provide a level of trauma care comparable to the state triage protocols. The act specifies that the Board may not otherwise approve regional protocols. The Board may not approve regional triage protocols for regions that overlap and must resolve any such disputes by apportioning the overlapping territory among appropriate regions in a manner that best serves the medical needs of the residents of that territory. The Board's Trauma Committee is to have reasonable opportunity to review and comment on regional triage protocols and amendments to the protocols before the Board approves or disapproves them.

Regional triage protocols and amendments to them must be submitted in writing to the Board by the regional directors or physician advisory boards

appointed under continuing law for each of the state's prehospital emergency medical services regions. The act specifies that the director of the board responsible for submitting the application is the director or board that serves a majority of the population in the region in which the protocols apply.

Before submitting regional protocols or amendments to the Board, a regional director or physician advisory board must consult with each of the following that regularly serves the region in which the protocols apply:

(1) Other regional directors and physician advisory boards;

(2) Hospitals that operate an emergency facility;

(3) Adult and pediatric trauma centers;

(4) Professional societies of physicians who specialize in emergency medicine or trauma surgery;

(5) Professional societies of nurses who specialize in emergency nursing or trauma surgery;

(6) Professional associations of labor organizations of emergency medical service personnel;

(7) Emergency medical service organizations and medical directors of such organizations;

(8) Certified emergency medical service instructors.

The act provides that regional triage protocols must require patients to be transported to a trauma center that is able to provide an appropriate level of trauma care. The regional triage protocols may include any of the exceptions to the transfer requirement that the act includes with respect to the state triage protocols. The act prohibits the regional protocols from discriminating among trauma centers for reasons not related to a patient's medical needs. The act provides that regional protocols must seek to minimize undertriage and overtriage. The act specifies that the regional protocols supersede the state triage protocols in the region where the regional protocols apply.

On the approval of regional triage protocols or an amendment to them, the act requires the State Board of Emergency Services to provide written notice of the approval and a copy of the protocols or amendment to each entity in the region to which the Board is required to send a copy of the state triage protocols.

Review of triage protocols

(sec. 4765.40(C))

The act requires the State Board of Emergency Medical Services to review the state triage protocols at least every three years to determine if they are causing overtriage or undertriage of trauma patients. The Board must modify the protocols as necessary to minimize overtriage and undertriage. Each regional director or physician advisory board that has regional triage protocols must review the protocols at least every three years to determine if they are causing overtriage or undertriage and must submit an appropriate amendment to the State Board as necessary to minimize overtriage and undertriage. The Board must approve the amendment if it will reduce overtriage or undertriage. Otherwise, the Board is prohibited from approving the amendment.

Enforcement of triage protocols

(sec. 4765.40(D) and (E))

The act prohibits a provider of emergency medical services or a person who provides medical direction to emergency medical service personnel in Ohio from failing to comply with the state triage protocols or applicable regional triage protocols. The act requires the Board to adopt rules that provide for the enforcement of the state and regional triage protocols and for education regarding those protocols.

Protocols for emergency medical service personnel

(sec. 4765.41)

Continuing law requires the medical director or cooperating physician advisory board of each emergency medical service organization to establish written protocols to be followed by emergency medical service personnel in performing services when communications have failed or the required response time prevents communication and the life of the patient is in immediate danger. The act requires the organization's protocols to be consistent with the applicable state or regional protocols for the triage of trauma victims, but provides that the organization's protocols may direct to a trauma center an emergency victim who is not required under the state or regional protocols to be transported to a trauma center.

Guidelines for care by emergency personnel

(sec. 4765.12(A))

Not later than November 3, 2002, the act requires the State Board of Emergency Medical Services to develop and distribute guidelines for the care of trauma victims by emergency medical service personnel and for the conduct of peer review and quality assurance programs by emergency medical service organizations. The guidelines must be consistent with the state triage protocols adopted by the Board and must place emphasis on the special needs of pediatric and geriatric trauma victims. In developing the guidelines, the Board must consult with the entities with interests in trauma and emergency medical services and must consider any relevant guidelines adopted by national organizations, including the American College of Surgeons, American College of Emergency Physicians, and American Academy of Pediatrics. The act requires the Board to distribute the guidelines and amendments to them.

Peer review and quality assurance programs

(sec. 4765.12(B))

Not later than November 3, 2003, the act requires each emergency medical service organization to implement ongoing peer review and quality assurance programs designed to improve the availability and quality of the emergency medical services it provides. The form and content of the programs are to be determined by each emergency medical service organization. In implementing the programs, each organization must consider how to improve its ability to provide effective trauma care, particularly for pediatric and geriatric trauma victims, and must take into account the Board's trauma care guidelines.

The act provides that information generated solely for use in a peer review or quality assurance program is not a public record. The information, and any discussion conducted in the course of the program, is not subject to discovery in a civil action and is not to be introduced into evidence in a civil action against the emergency medical service organization on whose behalf the information was generated or the discussion occurred. The act provides that in the absence of willful or wanton misconduct, an emergency medical organization on whose behalf a peer review or quality assurance program is conducted and the person who conducts the program is not liable in a civil action for betrayal of professional confidence or otherwise.

Trauma registry

(secs. 3729.17, 4765.06, 4765.10, and 4765.11)

Continuing law requires the State Board of Emergency Medical Services to establish a registry to be used for the collection of information regarding the care of trauma victims in Ohio. The registry must provide for the reporting of trauma-related deaths, identification of trauma patients, monitoring of trauma patient care data, determination of the total amount of uncompensated trauma care provided annually by each facility, and collection of other information specified by the Board. The Board must maintain the registry in accordance with rules it has adopted.

The act specifies that the Board's pre-existing registry is a "state" trauma registry. The act provides that rules relating to the 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 act 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 act states that "[i]nformation maintained by another trauma registry and reported to the state trauma registry in lieu of being reported directly to the state trauma registry is a public record and shall be maintained, made available to the public, held in confidence, risk adjusted, and not subject to discovery or introduction into evidence in a civil action as provided in [the laws regarding public records]." The act specifies that any person who provides, maintains, or risk adjusts such information must comply with all applicable laws and has the same immunities as a person who performs the same function for the state trauma registry.

The act eliminates a provision of law that required health care providers to make reports on trauma care to the Ohio Health Care Data Center, which is operated by the Department of Health.

Confidentiality of information received by the Board

(secs. 4765.06(B), (C), and (E), 4765.10(C), and 4765.11(A)(20))

Under prior law, the State Board of Emergency Medical Services was required to adopt rules establishing standards for protecting the confidentiality of all information it collects or receives that would identify a specific patient or recipient of emergency medical services or trauma care, unless the laws regarding public records provided otherwise. Prior law expressly required the Board to

follow its rules for maintaining the confidentiality of information it received, including information reported to the trauma registry.

In lieu of the confidentiality provisions of prior law, the act expressly prohibits the Board and any employee or contractor of the Board or the Department of Public Safety from making public any information the Board receives that identifies or would tend to identify a specific recipient of emergency medical services or trauma care. The act requires the Board to adopt rules that specify procedures for ensuring the confidentiality of information that is not to be made public. The act specifies that it does not prohibit the Board from making public any statistical information that does not identify or tend to identify a specific recipient or provider of emergency medical services or trauma care.

Professional confidences

(sec. 4765.06(F))

Under prior law, a provider was not subject to civil liability for betrayal of a professional confidence when the provider furnished information to the State Board of Emergency Medical Services. A provider who made a report could not be held to answer for betrayal of a professional confidence under the laws that permit the State Medical Board to take disciplinary actions against a physician.

The act continues the provisions of prior law that established civil immunity for providers that make reports to the Board, but limits the immunity to cases in which there is an absence of willful or wanton misconduct. The act eliminates the prior law reference to discipline by the State Medical Board, an action that appears to have the effect of including additional types of providers under the pre-existing protection from being held to answer for betrayal of a professional confidence when a report is made to the Board.

Risk adjustment of information

(sec. 4765.06(D))

Not later than November 3, 2002, the act requires the Board to adopt and implement rules that provide written standards and procedures for risk adjustment of information received by the Board. The act does not describe the process of "risk adjustment," but it appears to refer to the act of examining outcome measurements by taking into account variations that may be the result of individual, group, or community differences. For example, risk adjustment may

involve an examination of data according to age, race or ethnicity, sex, or diagnosis or treatment level.[1]

The act requires the Board to develop the risk adjustment rules in consultation with appropriate medical, hospital, and emergency medical service organizations. The rules may provide for risk adjustment by a contractor of the Board.

Before risk adjustment standards and procedures are implemented, neither the Board nor any employee or contractor of the Board or the Department of Public Safety may make public any information that identifies or would tend to identify a specific provider of emergency medical services or trauma care. After risk adjustment standards and procedures are implemented, the Board may make public such information only on a risk adjusted basis. The Board's rules for ensuring the confidentiality of information must specify the circumstances in which deliberations of the persons performing risk adjustment functions are not open to the public and records of those deliberations are maintained in confidence.

Funding

(secs. 4511.191, 4511.81, 4511.99, 4513.263, 4513.99, and 5503.04)

Under continuing law, the fines for failure to use seat belts or other occupant restraining devices are deposited in five funds established in the state treasury for separate purposes, all of which are related to safety education and emergency medical services. The act changes the percentages of the amounts distributed to some of the funds, increases the fine for failing to use seat belts and other occupant restraining devices, and directs a percentage of the fines collected by the State Highway Patrol to programs related to emergency medical services.

With respect to the fines collected for failure to use seat belts or other occupant restraining devices, the act provides for the funds to be distributed as follows:

(1) 8% (reduced from 10%) for establishment of a seat belt education program;

(2) 8% (reduced from 10%) for establishment of elementary school programs that encourage seat belt use;

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[1] *Ohio Department of Mental Health,* Risk Adjustment in Mental Health, *http://www.mh.state.oh.us/offices/oper/feature3.html, last visited 1/23/01.*

(3) 54% (increased from 50%) for making grants to emergency medical service organizations;

(4) 28% (no change) for operating the State Board of Emergency Medical Services;

(5) 2% (no change) for operating the Ohio Ambulance Licensing Board.

The act renames two pre-existing state treasury funds that deal with emergency medical services by including a reference to trauma care. Under the act, these funds are called the Trauma and Emergency Medical Services Fund and the Trauma and Emergency Medical Services Grants Fund.

Under prior law, the fine for operating an automobile without a seat belt or other occupant restraining device was $25 and the fine for riding as a passenger in an automobile without wearing a seat belt or occupant restraining device was $15. The act increases both fines by $5.

Under continuing law, the Department of Health administers a child highway safety program with money received from fines paid by motor vehicle operators who do not properly use child restraint systems. Prior law directed 65% of the fines to the Child Highway Safety Fund for the Department's use in administering the program. The act directs 100% of these fines to the Child Highway Safety Fund and allows the Department to use the funds to defray the cost of "verifying" pediatric trauma centers.[2]

Under continuing law, the fines from State Highway Patrol tickets and arrests are divided between the state and the county or municipality where a case is prosecuted. Prior law directed 45% to the General Revenue Fund and 55% to the county or municipality. The act increases the state share to 50%, directs the additional 5% to the Trauma and Emergency Medical Services Grants Fund, and reduces the local share accordingly.

Continuing law imposes a fee for having a driver's license reinstated after it has been suspended for operating a vehicle while under the influence of drugs or alcohol or similar violations. The act increases the fee by $20 (to $425) and directs the added amount to the Trauma and Emergency Medical Services Grants Fund.

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[2] *The Revised Code section referenced in this provision of the act does not provide for "verification" of trauma centers by the Department of Health. "Designation" of Level II pediatric trauma centers occurs under the act pursuant to R.C. 3727.081.*

Emergency medical services grants

(sec. 4765.07)

Continuing law requires the State Board of Emergency Medical Services to administer a program under which grants are distributed to emergency medical service organizations. Prior law specified that the grants were to be used for personnel training, purchasing equipment, and generally improving emergency medical services. Grants were to be distributed equitably with priority given to grants used for training personnel.

The act establishes priorities for distribution of grants as follows:

(1) First priority, which is essentially a continuation of the pre-existing priority, must be given to emergency medical service organizations for the training of personnel, for the purchase of equipment and vehicles, and to improve the availability, accessibility, and quality of emergency medical services in Ohio. In this category, the act requires the Board to give priority to grants that fund training and equipping of personnel.

(2) Second priority must be given to entities that research the causes, nature, and effects of traumatic injuries, educate the public about injury prevention, and implement, test, and evaluate injury prevention strategies.

(3) Third priority must be given to entities that research, test, and evaluate procedures that promote the rehabilitation, retraining, and reemployment of trauma victims and social service support mechanisms for trauma victims and their families.

(4) Fourth priority must be given to entities that research, test, and evaluate medical procedures related to trauma care.

Medical direction of emergency personnel

(sec. 4765.11(A)(22))

The act requires the Board to adopt rules establishing minimum qualifications and peer review and quality improvement requirements for persons who provide medical direction to emergency medical service personnel.

Regional consultation when adopting rules

(secs. 4765.05 and 4765.11(C))

Continuing law requires the State Board of Emergency Medical Services to divide the state into "prehospital emergency medical services regions." For each region, the Board must appoint a physician to serve as the regional director or a physician advisory board to serve as the regional advisory board. The act requires the Board, in developing and administering all of its rules, to consult with regional directors and regional advisory boards and to emphasize the special needs of pediatric and geriatric patients.

Board composition

(sec. 4765.02)

The act makes the following changes related to the membership of the State Board of Emergency Medical Services:

(1) In addition to the continuing law requirement for the Governor to attempt to appoint members who represent Ohio's urban and rural areas and various geographic areas, the act requires the Governor to attempt to appoint members who represent various schools of training.

(2) With respect to the continuing member who is a surgeon, the act specifies that the member must be active in the practice of trauma surgery. The act includes the Ohio Osteopathic Association among the groups permitted to make nominations for the position.

(3) With respect to the continuing member who is a physician certified in emergency medicine, the act includes the Ohio Osteopathic Association among the groups permitted to make nominations for the position.

(4) The position to be filled by an administrator of a hospital with an active emergency room is replaced by a position to be filled by the administrator of an adult or pediatric trauma center. Each of the following is permitted to make three nominations: (a) OHA: the Association for Hospitals and Health Systems, (b) the Ohio Osteopathic Association, (c) the Association of Ohio Children's Hospitals, and (d) the Health Forum of Ohio.

(5) The act adds a position to be filled by an administrator of a hospital that is not a trauma center. Three nominations for the position may be made by each of the following: (a) OHA: the Association for Hospitals and Health Systems, (b) the Ohio Osteopathic Association, (c) the Association of Ohio Children's Hospitals, and (d) the Health Forum of Ohio.

(6) The act adds a position to be filled by a physician certified by the American Board of Surgery, American Board of Osteopathic Surgery, American Osteopathic Board of Emergency Medicine, or American Board of Emergency Medicine, who is the chief medical officer of an air medical agency and is currently active in providing emergency medical services. The Governor is to appoint this member from among three persons nominated by the Ohio Association of Air Medical Services.

Board operations

(sec. 4765.02)

With respect to the Board's operation, the act does the following:

(1) Requires the Board to select a vice-chair in addition to the pre-existing requirement to select a chair;

(2) Requires the Board to maintain written or electronic records of its meetings;

(3) Permits the Board to adopt bylaws to regulate its affairs;

(4) Replaces the numerical voting requirements specified in prior law with a requirement;

(5) Reduces to five (from ten) the number of members who must submit a written request in order for the chair to be required to call a meeting;

(6) Requires the employer of a Board member, upon 24 hours' notice from the member, to release the member from the member's employment duties to attend a meeting of the full Board. The act provides that it does not require the employer to compensate the member for the time the member is released from employment duties, but any civil immunity, workers' compensation, disability, or similar coverage that applies to the member continues while the member is released from employment.

Executive director and medical director

(sec. 4765.03)

Continuing law requires the Director of Public Safety to appoint a full-time executive director for the State Board of Emergency Services. In addition to the continuing requirement that the executive director be knowledgeable in emergency medical services, the act requires that the director be knowledgeable in trauma care.

Continuing law requires the Board to appoint a medical director who is responsible for directing the executive director and advising the Board with regard to emergency medical services. The act specifies that the medical director's duties include providing direction and advice on trauma care.

Under continuing law, recommendations for the appointment of the medical director may be made by the Ohio Chapter of the American College of Emergency Physicians, the Ohio Osteopathic Association, and the Ohio State Medical Association. Rather than permitting the consideration of recommendations, the act requires the Board to consider the recommendations. The act expands the list of organizations permitted to make recommendations by including the Ohio chapters of the American College of Surgeons and American Academy of Pediatrics.

Continuing law requires the executive director and medical director to attend each meeting of the Board. Under prior law, the attendance requirement did not apply when a meeting concerned the appointment of an executive director or medical director. Under the act, the attendance requirement does not apply if the Board elects to exclude the person from a meeting. The Board's authority to exclude either the executive or medical director extends to meetings that concern a person's performance, as well as meetings that concern the appointment or performance of the person in the opposing position.

Trauma Committee

(sec. 4765.04(B))

The act creates the Trauma Committee of the State Board of Emergency Medical Services. The Committee is to consist of the following members appointed by the Director of Public Safety:

(1) A physician who is certified by the American Board of Surgery or American Osteopathic Board of Surgery and actively practices general trauma surgery, appointed from among three persons nominated by the Ohio Chapter of the American College of Surgeons, three persons nominated by the Ohio State Medical Association, and three persons nominated by the Ohio Osteopathic Association;

(2) A physician who is certified by the American Board of Surgery or American Osteopathic Board of Surgery and actively practices orthopedic trauma surgery, appointed from among three persons nominated by the Ohio Orthopedic Society and three persons nominated by the Ohio Osteopathic Association;

(3) A physician who is certified by the American Board of Neurological Surgeons or the American Osteopathic Board of Surgery and actively practices

neurosurgery on trauma victims, appointed from among three persons nominated by the Ohio State Neurological Society and three persons nominated by the Ohio Osteopathic Association;

(4) A physician who is certified by the American Board of Surgeons or American Osteopathic Board of Surgeons and actively specializes in treating burn victims, appointed from among three persons nominated by the Ohio Chapter of the American College of Surgeons and three persons nominated by the Ohio Osteopathic Association;

(5) A dentist who is certified by the American Board of Oral and Maxillofacial Surgery and actively practices oral and maxillofacial surgery, appointed from among three persons nominated by the Ohio Dental Association;

(6) A physician who is certified by the American Board of Physical Medicine and Rehabilitation or American Osteopathic Board of Rehabilitation Medicine and actively provides rehabilitative care to trauma victims, appointed from among three persons nominated by the Ohio Society of Physical Medicine and Rehabilitation and three persons nominated by the Ohio Osteopathic Association;

(7) A physician who is certified by the American Board of Surgery or American Osteopathic Board of Surgery with special qualifications in pediatric surgery and actively practices pediatric trauma surgery, appointed from among three persons nominated by the Ohio Chapter of the American Academy of Pediatrics and three persons nominated by the Ohio Osteopathic Association;

(8) A physician who is certified by the American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine, actively practices emergency medicine, and is actively involved in emergency medical services, appointed from among three persons nominated by the Ohio Chapter of the American College of Emergency Physicians and three persons nominated by the Ohio Osteopathic Association;

(9) A physician who is certified by the American Board of Pediatrics, American Osteopathic Board of Pediatrics, or American Board of Emergency Medicine, is sub-boarded in pediatric emergency medicine, actively practices pediatric emergency medicine, and is actively involved in emergency medical services, appointed from among three persons nominated by the Ohio Chapter of the American Academy of Pediatrics, three persons nominated by the Ohio chapter of the American College of Emergency Physicians, and three persons nominated by the Ohio Osteopathic Association;

(10) A physician who is certified by the American Board of Surgery, American Osteopathic Board of Surgery, or American Board of Emergency Medicine and is the chief medical officer of an air medical organization, appointed from among three persons nominated by the Ohio Association of Air Medical Services;

(11) A coroner or medical examiner appointed from among three people nominated by the Ohio State Coroners' Association;

(12) A registered nurse who actively practices trauma nursing at an adult or pediatric trauma center, appointed from among three persons nominated by the Ohio Association of Trauma Nurse Coordinators;

(13) A registered nurse who actively practices emergency nursing and is actively involved in emergency medical services, appointed from among three persons nominated by the Ohio Chapter of the Emergency Nurses' Association;

(14) The chief trauma registrar of a trauma center, appointed from among three persons nominated by the Alliance of Ohio Trauma Registrars;

(15) The administrator of a trauma center, appointed from among three persons nominated by OHA: the Association for Hospitals and Health Systems, three persons nominated by the Ohio Osteopathic Association, three persons nominated by the Association of Ohio Children's Hospitals, and three persons nominated by the Health Forum of Ohio;

(16) The administrator of a hospital that is not a trauma center and actively provides emergency care to trauma patients, appointed from among three persons nominated by OHA: the Association for Hospitals and Health Systems, three persons nominated by the Ohio Osteopathic Association, three persons nominated by the Association of Ohio Children's Hospitals, and three persons nominated by the Health Forum of Ohio;

(17) The operator of an ambulance company that actively provides trauma care to emergency patients, appointed from among three persons nominated by the Ohio Ambulance Association;

(18) The chief of a fire department that actively provides trauma care to emergency patients, appointed from among three persons nominated by the Ohio Fire Chiefs' Association;

(19) An emergency medical technician who actively provides trauma care to emergency patients, appointed from among three persons nominated by the Ohio Association of Professional Firefighters, three persons nominated by the Northern Ohio Fire Fighters, three persons nominated by the Ohio State

Firefighters' Association, and three persons nominated by the Ohio Association of Emergency Medical Services;

(20) A person who actively advocates for trauma victims, appointed from three persons nominated by the Ohio Brain Injury Association and three persons nominated by the Governor's Council on People with Disabilities;

(21) A physician or nurse who has substantial administrative responsibility for trauma care provided in or by a trauma center, appointed from among three persons nominated by OHA: the Association for Hospitals and Health Systems, three persons nominated by the Ohio Osteopathic Association, three persons nominated by the Association of Ohio Children's Hospitals, and three persons nominated by the Health Forum of Ohio;

(22) Three representatives of hospitals that are not trauma centers and actively provide emergency care to trauma patients, appointed from among three persons nominated by OHA: the Association for Hospitals and Health Systems, three persons nominated by the Ohio Osteopathic Association, three persons nominated by the Association of Ohio Children's Hospitals, and three persons nominated by the Health Forum of Ohio. The representatives may be hospital administrators, physicians, nurses, or other clinical professionals.

Qualifications and appointment of members

The act requires the members of the Trauma Committee to have substantial experience in their fields of practice and be residents of Ohio. It provides that they may be members of the State Board of Emergency Medical Services. In appointing members, the Director of Public Safety must attempt to include persons who represent urban and rural areas, various geographical areas of Ohio, and various schools of training. The Director may not appoint more than one member who is employed by or practices at the same hospital, health system, or emergency medical service organization.

The act allows the Director to refuse to appoint any of the persons nominated. In that event, the nominating organization or organizations will continue to nominate the required number of persons until the Director makes the appointment.

Initial appointments must be made not later than 90 days after the act's effective date. Members serve at the pleasure of the Director, except that a member who ceases to be qualified for the position must cease being a member. Vacancies are to be filled in the same manner as original appointments.

Members serve without compensation. They are, however, reimbursed for actual and necessary expenses incurred in carrying out official duties.

Operation

The act requires the Trauma Committee to select a chairperson from among its members. A majority of all members constitute a quorum. No action is to be taken without the concurrence of a majority of all members. The committee is to meet at the call of the chair, on written request of five members, and at the direction of the State Board of Emergency Medical Services. The committee must not meet at times or locations that conflict with meetings of the Board. The executive director and medical director of the Board are authorized to participate in any meeting of the committee and must participate at the committee's request.

Duties and powers

The act requires the Trauma Committee to advise and assist the State Board of Emergency Medical Services in matters related to trauma care and the establishment and operation of the state trauma registry. In matters relating to the registry, the Board and committee must consult with trauma registrars from trauma centers in Ohio. The committee may appoint a subcommittee to advise and assist with the registry. The subcommittee may include persons with expertise relevant to the registry who are not members of the Board or committee.

Firefighter and fire safety inspector training committee

(secs. 4765.04(A) and 4765.55(D))

Prior law created the Firefighter and Fire Safety Inspector Training Subcommittee of the State Board of Emergency Medical Services. The act redesignates the subcommittee as a full committee. The committee continues to consist of the Board members who are chiefs of fire departments, and the Board members who are emergency medical technicians appointed from among persons nominated by the Ohio Association of Professional Fire Fighters or the Northern Ohio Fire Fighters and from among persons nominated by the Ohio State Firefighter's Association. The act eliminates the member who was appointed by the Director of Public Safety. Since this member was the designated chairperson, the act requires the committee members or their designees to select a chairperson.

Committee appointments and expiration

(sec. 4765.04(C) and (E))

In addition to the Board's Trauma Committee and Firefighter and Fire Safety Inspector Committee, the act permits the Board to appoint other committees

and subcommittees as it considers necessary. The act specifies that the Trauma Committee and Firefighter and Fire Safety Inspector Committee are not subject to the continuing law that requires a committee created in statute to have a specific expiration date.

Assistance to the Board and its committees

(sec. 4765.04(D))

The Board, and any of its committees or subcommittees, are authorized by the act to request assistance from any state agency. The Board and its committees and subcommittees may permit persons who are not members of those bodies to participate in their deliberations, but no person who is not a member of the Board may vote on the Board and no person who is not a member of a committee may vote on that committee.

Air medical organizations and ambulance service organizations

(secs. 4765.01 and 4765.09)

Continuing law requires the State Board of Emergency Medical Services to prepare recommendations for the operation of ambulance service organizations and emergency medical service organizations. The act expands the requirement by including air medical organizations. "Air medical organization" is defined by the act as an organization that provides emergency medical services, or transports emergency victims, by means of fixed or rotary wing aircraft.

Under the act, the Board's recommendations regarding air medical organizations must include the following:

(1) The definition and classification of medical aircraft.

(2) The design, equipment, and supplies for medical aircraft, including special equipment, supplies, training, and staffing required to assist pediatric and geriatric emergency victims.

(3) The minimum number and type of personnel for the operation of medical aircraft.

(4) The communications systems necessary for the operation of medical aircraft.

(5) Reports to be made by persons holding certificates as emergency medical service providers to ascertain the quantity and quality of air medical organizations throughout Ohio.

With respect to the Board's continuing duty to make recommendations for use of ambulances, the act specifies that the Board must consider the special equipment, supplies, training, and staffing required to assist pediatric and geriatric emergency victims.

Training of firefighters and emergency medical service personnel

(sec. 4765.10)

Prior law expressly required the State Board of Emergency Medical Services to work with the State Fire Marshal's Office in coordinating the training of firefighters and emergency medical service personnel when possible. In turn, the Fire Marshal's Office was required to cooperate with the Board. The act expands the cooperation requirement by requiring the Board to work at all times with "appropriate state offices" and requiring the other state offices to cooperate with the Board and its committees and subcommittees.

Training of emergency medical service personnel

(secs. 4765.16, 4765.35, 4765.37, 4765. 38, and 4765.39)

Continuing law provides that all courses offered through an emergency medical services training program or continuing education program, other than ambulance driving, must be developed under the direction of a physician who specializes in emergency medicine. The act specifies that each course dealing with trauma care must be developed in consultation with a physician who specializes in trauma surgery. The act requires all levels of emergency medical personnel to be trained in triage protocols for trauma victims. In the statutes specifying the services that emergency medical personnel are authorized to perform, the act includes determining triage of trauma victims.

Certification renewal notice

(secs. 4765.11(A)(5) and 4765.30)

The act requires the State Board of Emergency Medical Services to provide notice of the scheduled expiration of an individual's certificate to practice as a first responder or emergency medical technician-basic, emergency medical technician-intermediate, or paramedic. The Board must notify the individual and furnish a renewal application not later than 60 days before the expiration date. The act specifies that the Board's rules on renewal must include any procedures necessary to ensure that adequate notice is provided.

Out-of-state EMS personnel

(sec. 4765.50)

Continuing law exempts from Ohio's certification requirements for emergency medical service personnel a person who performs the same functions under the authority of the laws of a state that borders Ohio. The act extends this exemption to emergency medical service personnel acting under the laws of any other jurisdiction.

Reports and studies

(Sections 3, 5, 6, 7, and 8)

The act requires the State Board of Emergency Medical Services, with the assistance of its Trauma Committee, to study and evaluate the following:

(1) The status and needs of emergency medical services and trauma care provided between Ohio and other jurisdictions.

(2) Methods to improve specialized care provided by emergency medical service organizations to pediatric and geriatric trauma victims.

(3) The feasibility of recording and reporting information to the state trauma registry by means of portable electronic devices, such as electronic notepads. The study must include an analysis of the cost of acquiring, maintaining, and using such devices, potential sources of funding, and training required to ensure effective use of the devices.

(4) Methods to ensure that autopsies are performed on appropriate trauma victims and autopsy data are reported to the state trauma registry in a timely manner.

(5) Methods to increase advanced trauma life support, basic trauma life support, and prehospital trauma life support training among appropriate health care providers, particularly in Ohio's rural areas.

(6) The roles that hospitals that are not trauma centers play in the state and regional trauma systems and methods to enhance those roles.

(7) The causes and impact of trauma on minority populations in Ohio and methods to improve emergency medical services and trauma care for those populations. This study must be conducted in cooperation with the Commission on Minority Health.

Not later than November 3, 2003, the Board must report its findings and recommendations to the Governor, General Assembly, and other appropriate authorities and organizations. The act requires that the Board conduct its study and develop its findings and recommendations in consultation with the following organizations, as appropriate: appropriate committees and subcommittees of the Board; regional directors and regional physician advisory boards; organizations that represent physicians, nurses, and hospitals that care for emergency and trauma patients; emergency medical service organizations; appropriate governmental entities; and the Ohio State Coroners' Association.

Department of Health: injury prevention

The act requires the Director of Health to organize and coordinate a temporary commission to determine how to better prevent traumatic injuries in Ohio. The commission's study is to include consideration of how to improve public safety education and how to prevent pediatric and geriatric injuries. The Departments of Public Safety, Natural Resources, Agriculture, and Education, Commission on Minority Health, and Bureau of Workers' Compensation are to participate in and assist with the study.

Within 120 days after the act's effective date, the Director of Health must appoint to the commission appropriate public health authorities, entities that conduct safety research and education, and advocates for injured persons. Commission members must have expertise in injury prevention, broadly represent relevant disciplines, and represent all regions of Ohio. Within the same timeframe, the Speaker of the House of Representatives must appoint to the commission one member of the majority party and one member of the minority party in the House of Representatives and the President of the Senate must appoint to the commission one member of the majority party and one member of the minority party in the Senate.

In conducting its study and developing its recommendations, the commission must consult with and cooperate with the Trauma Committee of the State Board of Emergency Medical Services. The commission must conclude its study and disband by November 3, 2003, whereupon the Director must transmit the commission's findings to the Governor, General Assembly, chief executive of each state agency that is involved in the study, and other appropriate persons.

Department of Health: improving trauma care

The act requires the Director of Health to organize and coordinate a temporary commission to determine how to improve the accessibility, affordability, quality, and cost-effectiveness of post-critical trauma care. The commission's study is to include consideration of appropriate transfer of trauma

victims from regional trauma centers to other health care facilities; physical, psychological, and vocational rehabilitation of trauma victims; re-employment of trauma victims; social support mechanisms for families of trauma victims; and mitigation of the effects of pediatric and geriatric trauma. The Rehabilitation Services Commission, Department of Aging, Bureau of Workers' Compensation, and Bureau of Employment Services are to participate in and assist with the commission's study.

Within 120 days after the act's effective date, the Director of Health must appoint to the commission appropriate public health authorities; entities that represent injury victims; certified safety professionals; employers; employment training and placement services; agricultural organizations; highway safety and motorists' organizations; health insurers; providers of social services to injury victims; nursing and rehabilitation institutions; victims of violent crime; hospitals; and professionals active in physical, psychological, and vocational therapy. Commission members must have expertise in rehabilitation and retraining of injury victims, broadly represent relevant disciplines, and represent all regions of Ohio. Within the same timeframe, the Speaker of the House of Representatives must appoint to the commission one member of the majority party and one member of the minority party in the House of Representatives and the President of the Senate must appoint to the commission one member of the majority party and one member of the minority party in the Senate.

In conducting its study and developing its recommendations, the commission must consult with and cooperate with the Trauma Committee of the State Board of Emergency Medical Services. The commission must conclude its study and disband by November 3, 2003, whereupon the Director must transmit the commission's findings to the Governor, General Assembly, chief executive of each state agency that is involved in the study, and other appropriate persons.

Legislative Service Commission: trauma report and Board evaluation

The act requires LSC staff, subject to the Legislative Service Commission's approval, to prepare a report on the trauma care system in Ohio. The report must include an analysis of the act's effects pertaining to the delivery of trauma care and the verification of hospitals as trauma centers. The report must be submitted to the Commission by November 3, 2004.

The act requires LSC staff, subject to the Commission's approval, to evaluate the effectiveness of the State Board of Emergency Medical Services and its staff in fulfilling the Board's duties. A preliminary report of the LSC staff's findings and recommendations must be prepared by November 3, 2001. Not later than one year after the preliminary report is submitted, the LSC staff must prepare

a final report, including an analysis of the Board's success in implementing the recommendations made in the preliminary report.

Legislative intent

(Section 4)

According to the act, the General Assembly finds that pediatric and geriatric trauma patients have special medical needs that require particular emphasis to improve outcomes for these patients. The act specifies that it is the intent of the General Assembly to provide for these special needs in a state trauma system and trauma triage protocols approved by the State Board of Emergency Medical Services.

According to the act, the General Assembly recognizes that hospitals that operate emergency facilities, but are not trauma centers, play an important role in the prompt and appropriate diagnosis, stabilization, and treatment of adult and pediatric trauma patients. The act specifies that it is the intent of the General Assembly to enhance the quality of emergency care such hospitals provide to trauma patients and to integrate such hospitals into the state and regional trauma systems provided for by the act. The act specifies that it is also the intent of the General Assembly that community-based emergency medical and trauma services be preserved and that nothing in the act be construed as encouraging the overtriage of patients or the unnecessary transfer of patients.

Technical changes

(secs. 4765.15, 4765.32, 4765.55, 4767.08, and 5502.01)

The act amends several sections of the Revised Code solely to reflect name changes and to make other technical changes.

FIREFIGHTING AND EMERGENCY MEDICAL SERVICE ORGANIZATIONS

Agreements for fire protection or emergency medical services

(sec. 9.60)

Continuing law permits a firefighting agency or private fire company to contract with a governmental entity to provide fire protection, including ambulance and emergency medical services.[3] Fire protection services can also be

[3] *A firefighting agency is a municipal corporation, township, township fire district, joint ambulance district, joint emergency medical services district, or joint fire district.*

provided without a contract if all parties agree. Under prior law, the arrangements had to be made with a government agency in Ohio or an adjoining state. The act permits the arrangements to be made with government entities in other jurisdictions. The act extends the authority to enter into arrangements with government agencies to any public or private emergency medical service organization.

Continuing law provides that firefighting agencies and fire department members are immune from civil liability when they render service outside the boundaries of the firefighting agency. The act specifies that the civil immunity provisions in current law for fire departments and emergency medical service organizations apply to a political subdivision that is operating a fire department or emergency medical service organization when the members are rendering service outside the boundaries of the political subdivision.

The act provides that a private fire company or private, nonprofit emergency medical service organization providing service to a governmental entity in Ohio or another jurisdiction has the same immunities and defenses in a civil action that a political subdivision has under continuing law. Similarly, the act provides that the employees of a private fire company or private, nonprofit emergency medical service organization have the same immunities and defenses in a civil action that employees of a political subdivision have under continuing law.

Participation in state purchasing and salvage programs

(secs. 9.60, 125.04, 125.13, and 3737.66)

Continuing law allows the Department of Administrative Services to permit a political subdivision to participate in contracts into which the Department has entered for the purchase of supplies and services. Continuing law also authorizes the Director of Administrative Services to dispose of declared surplus or excess supplies the Department of Administrative Services has received from state agencies by sale, lease, or transfer.

The act allows private fire companies and private nonprofit emergency medical service organizations to participate in the cooperative purchasing programs operated by the Department of Administrative Services under the same conditions that govern public agencies' participation. Under these conditions, a private fire company or private nonprofit emergency medical service organization is required to file with the Department a written request for inclusion in the program signed by the chief officer of the company or organization. The request must include an agreement to be bound by the terms and conditions the Department prescribes and to make direct payments to the vendor under each purchase contract. The act also allows private fire companies and emergency

medical service organizations to obtain surplus or excess supplies according to the same order of priority that applies to municipal corporations and other political subdivisions. The act permits the Department to charge a reasonable fee to cover the administrative costs it incurs as a result of an entity participating in a purchase contract.

Sales tax exemption

(sec. 5739.02(B)(20))

Continuing law provides a sales tax exemption for the sale of emergency and fire protection vehicles and equipment to nonprofit organizations for use in providing fire protection and emergency services. The act specifies that the exemption applies to vehicles and equipment used in providing trauma care and emergency medical services.

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	02-02-99	p. 166
Reported, H. Health, Retirement & Aging	06-10-99	pp. 824-825
Passed House (95-1)	06-15-99	pp. 832-833
Reported, S. Health, Human Services & Aging	04-20-00	p. 1620
Passed Senate (32-0)	05-03-00	pp. 1654-1655
House concurred in Senate amendments (95-1)	05-10-00	pp. 1916-1917

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