DEPARTMENT OF HEALTH

General and city health districts

- Authorizes the Department of Health (ODH) to require general or city health districts to enter into shared services agreements.
- Authorizes ODH to reassign substantive authority for mandatory programs from a general or city health district to another general or city health district under certain circumstances.
- Authorizes the ODH Director to require general or city health districts to be accredited as a condition precedent to receiving funding from the ODH.
- Eliminates a requirement that two or more city health districts be contiguous to form a single city health district.
- Eliminates the requirements (1) that two or more general health districts be contiguous to form a combined general health district and (2) that not more than five contiguous general health districts may combine to form a general health district.
- Requires the health commissioner of a general health district to develop a comprehensive community health assessment for the county.
- Requires the district advisory council of a general health district, and the mayor of a city health district, to appoint to the board of health one member who is an executive officer or medical director of a hospital or the district's largest medical facility.
- Requires sanitarians of a city or general health district who perform inspections of food service operations or retail food establishments to obtain and maintain certification from the U.S. Food and Drug Administration.
- Authorizes a multi-county, combined general health district to have each board of county commissioners place on the ballot a property tax levy for the district's expenses, under an existing tax levy law that applies to a general health district.
- Eliminates a requirement that specific rules adopted by the ODH Director cannot take effect unless approved by concurrent resolution of the General Assembly.
- Requires the ODH Director to adopt rules to assure annual completion of eight continuing education units by each member of a board of health.

- Eliminates the Public Health Standards Task Force that assists and advises the Director in the adoption of standards for boards of health.

Patient Centered Medical Home Program

- Establishes in ODH the Patient Centered Medical Home Program (which is separate from the existing Patient Centered Medical Home Education Program).

- Requires ODH to establish a patient centered medical home certificate and specifies the requirements and goals to be achieved through voluntary certification.

- Permits ODH to establish an application and annual renewal fee for certification.

- Requires each certified patient centered medical home to report health care quality and performance information to the ODH.

- Requires ODH to submit a report to the Governor and General Assembly three and five years after ODH adopts rules to certify patient centered medical homes.

Nursing facilities' plans of correction

- Requires a nursing facility's plan of correction regarding a deficiency to include additional information, including a detailed description of an ongoing monitoring and improvement process to be used at the facility.

- Requires ODH to consult with the Ohio Departments of Medicaid and Aging and the Office of the State Long-Term Care Ombudsperson Program in certain circumstances when determining whether a nursing facility's plan of correction or modification of an existing plan meets ODH's requirements for approval.

Newborn screenings

- Requires that hospitals and freestanding birthing centers screen newborns for critical congenital heart defects, unless a parent objects on religious grounds.

- Authorizes the ODH Director to adopt rules establishing standards and procedures for the required critical congenital heart defects screenings.

Distribution of state household sewage treatment system permit fees

- Reallocates the distribution of money collected from state household sewage treatment system permit fees by:

  -- Decreasing the percentage of money allocated to fund installation and evaluation of sewage treatment system new technology pilot projects; and

-- Increasing the percentage of money allocated for use by the ODH Director to administer and enforce the Household and Small Flow On-Site Sewage Treatment Systems Law and rules adopted under it.

Requirements governing private water systems contractors

- Revises the existing rules adopted by the ODH Director with which private water systems contractors must comply as follows:

  -- Adds that the rules must require those contractors to comply with competency testing and continuing education requirements; and

  -- Specifies that the rules must allow those contractors to provide other equivalent forms of proof of financial responsibility rather than only surety bonds as under current law.

Ohio Cancer Incidence Surveillance System

- Authorizes ODH to designate, by contract, a state university as an agent to implement the Ohio Cancer Incidence Surveillance System.

- Repeals provisions expressly governing the confidentiality of cancer information provided to or acquired by an Ohio cancer registry or ODH, but continues general provisions governing the confidentiality of protected health information.

Other provisions

- Eliminates the January 1 deadline for the ODH Director to determine the changes in charges that may be imposed for copies of medical records.

- Eliminates a requirement that trauma centers report to the ODH Director information on preparedness and capacity to respond to disasters, mass casualties, and bioterrorism.

- Abolishes the Council on Stroke Prevention and Education.

- Specifies that the Excluded Parties List System is available at the federal web site known as the System for Award Management.

General or city health districts

Expansion of Department of Health's authority over health districts

(R.C. 3701.13)

The bill authorizes the Department of Health (ODH) to require general or city health districts to enter into shared services agreements under existing law[68] that permits a political subdivision to enter into an agreement with another political subdivision whereby a contracting political subdivision agrees to exercise any power, perform any function, or render any service for another recipient political subdivision that the recipient political subdivision is otherwise legally authorized to exercise, perform, or render.

The bill authorizes ODH to reassign substantive authority for mandatory programs from a general or city health district to another general or city health district when an emergency exists, or when the board of health of the general or city health district has neglected or refused to act with sufficient promptness or efficiency or has not been lawfully established.

Accreditation of general or city health districts

(R.C. 3701.13)

As a condition precedent to receiving funding from ODH, the bill authorizes the ODH Director to require general or city health districts to be accredited by an accreditation body approved by the ODH Director. Accreditation must be obtained not later than July 1, 2018.

Formation of combined general or city health districts

(R.C. 3709.01, 3709.051, and 3709.10)

The bill eliminates the requirement that city health districts be contiguous to form a single city health district. Under existing law, two or more contiguous city health districts may be united to form a single city health district by a majority affirmative vote of the legislative authority of each city affected by the union, or by petition of at least 3% of the qualified electors residing within each of the two or more contiguous city health districts.

The bill also eliminates the requirement that general health districts be contiguous to form a single general health district, and eliminates the limitation that not

[68] R.C. 9.482, not in the bill.

more than five general health districts may combine to form a single general health district. Existing law authorizes two or more contiguous general health districts, not to exceed five, to unite in the formation of a single general health district if approved by an affirmative majority vote of the district advisory councils. The bill's revisions result in authorization for an unlimited number of noncontiguous general health districts to form a single general health district.

Community health assessment for general health districts

(R.C. 3709.43)

The bill requires the health commissioner of a general health district to develop a comprehensive community health assessment for the county. The assessment must be developed not later than January 1, 2014, and then not later than January 1 of each even-numbered year thereafter. The health commissioners of two or more counties may jointly develop a comprehensive community health assessment for the counties.

The assessment must be developed in collaboration with all of the following entities located in the county:

- Every city health district;

- A representative sample of private health care providers, including private doctors and dentists;

- Every hospital, including public, nonprofit, and proprietary hospitals;

- A representative sample of unaffiliated medical facilities or medical service providers;

- A representative sample of mental or behavioral health providers; and

- At least two members of the general public.

The community health assessment must comply with the national community health assessment standards of the National Association of County and City Health Officials, which generally concentrate on the health status of a county's population. The assessment must include all of the following:

(1) A description of the community, as defined in the national community health assessment standards, and a description of the existing community health resources;

(2) A description of the process used to conduct the assessment, with a listing of all of the individuals with whom the health commissioner collaborated to develop the assessment;

(3) The health needs identified through the assessment process, with an evaluation of access to affordable health care and an evaluation of the necessary physical facilities for furnishing adequate services to all of the people of the county; and

(4) A description of how the current assessment compares to the previous assessment, except for the first year the assessment is developed.

The health commissioner must electronically submit a copy of the comprehensive community health assessment to ODH not later than the first day of March of the year in which the assessment is due.

The bill requires every city health district in the county to participate in the development of the comprehensive community health assessment.

Board of health members

(R.C. 3709.03 and 3709.05)

The district advisory council of a general health district appoints four members to the district's board of health. Likewise, the mayor of a city health district, with the confirmation of the legislative authority of the city, appoints four members to the city's board of health.[69] The bill requires that the district advisory council of a general health district and the mayor of a city health district appoint to the board of health as one of those four members an individual who is an executive officer or medical director of a hospital or the district's largest medical facility.

Certification of sanitarians

(R.C. 3709.15(B))

The board of health of a city or general health district may appoint as sanitarians as many persons for sanitary duty as the public health and sanitary conditions of the district require. The bill requires sanitarians who perform inspections of food service operations or retail food establishments to obtain certification from the U.S. Food and Drug Administration not later than July 1, 2017, and thereafter to maintain that certification for as long as the Administration continues to certify sanitarians.

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[69] This law applies only to cities that have not established a different administration of public health under their charters, and to cities that are not part of a combined city health district.

Tax levies for combined general health districts

(R.C. 3709.29)

A board of health of a general health district may certify to the board of county commissioners any insufficiency in the estimated amount of money needed to meet the expenses of a general health district program, and upon receiving the certification, the board of county commissioners must place a tax levy issue on the ballot to provide the board of health with sufficient funds to carry out the health program.[70] The bill authorizes a combined general health district located in more than one county to have each board of county commissioners use this same property tax levy procedure to place on the ballot the question of levying a tax for the combined general health district's expenses. (Under the bill, the combined general health districts are not required to be contiguous, and there may an unlimited number of general health districts that unite to form a combined general health district. Each county that is part of the combined general health district would have to place the question of levying the tax on the ballot.)

Director of Health's rules for boards of health

No General Assembly approval of rules

(R.C. 3701.342)

Currently, certain minimum standards for boards of health that are adopted by rule of the ODH Director,[71] including rules that establish a formula for distribution of state health district subsidy funds to boards of health, cannot take effect unless they are approved by concurrent resolution of the General Assembly. The bill eliminates this General Assembly approval requirement.

Continuing education for board of health members

(R.C. 3701.342)

The bill adds to the minimum standards for boards of health that the ODH Director is required to adopt by rule the adoption or rules that assure annual

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[70] The Attorney General has advised that boards of county commissioners, when receiving a board of health's certification of insufficiency under this law, have mandatory duties to pass a resolution stating that it is necessary to levy a tax in excess of the ten-mill limitation and to file the resolution with the board of elections for placement on the ballot, so long as the certification has been properly adopted by the board of health and is otherwise lawful. O.A.G. No. 2001-013 (2001).

[71] R.C. 3701.342.

completion of eight continuing education units by each member of a board of health. The bill does not specify the subject matter of those continuing education units.

Elimination of Public Health Standards Task Force

(R.C. 3701.342; R.C. 3701.343 (repealed))

The bill eliminates the nine-member Public Health Standards Task Force that assists and advises the ODH Director in formulating and evaluating public health services standards for boards of health. Currently, the ODH Director adopts the standards by rule, after consulting with the Task Force.

Patient Centered Medical Home Program

(R.C. 3701.921, 3701.922, 3701.94, 3701.941, 3701.942, 3701.943, and 3701.944)

The bill establishes the Patient Centered Medical Home (PCMH) Program in ODH. The PCMH Program is established separately from the existing PCMH Education Program, and the ODH Director's authority to establish pilot projects that evaluate and implement the PCMH model of care under that program is eliminated. A PCMH model of care is an advanced model of primary care in which care teams attend to the multifaceted needs of patients, providing whole person comprehensive coordinated patient centered care.

Voluntary PCMH certification program

As part of the PCMH Program, ODH is required to establish a voluntary PCMH certification program.

Goals of PCMH Program

Through certification of PCMHs, ODH is to seek to do all of the following:

(1) Expand, enhance, and encourage the use of primary care providers, including primary care physicians, advanced practice registered nurses, and physician assistants, as personal clinicians;

(2) Develop a focus on delivering high-quality, efficient, and effective health care services;

(3) Encourage patient centered care and the provision of care that is appropriate for a patient's race, ethnicity, and language;

(4) Encourage the education and active participation of patients and patients' families or legal guardians, as appropriate, in decision making and care plan development;

(5) Provide patients with consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care;

(6) Ensure that PCMHs develop and maintain appropriate comprehensive care plans for patients with complex or chronic conditions, including an assessment of health risks and chronic conditions;

(7) Ensure that PCMHs plan for transition of care from youth to adult to senior;

(8) Enable and encourage use of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables those professionals to practice to the fullest extent of their professional licenses.

Certification requirements

A primary care practice that seeks PCMH certification must submit an application and pay any application fee ODH establishes. ODH may also require an annual renewal fee. If ODH establishes a fee, the fee must be in an amount sufficient to cover the cost of any on-site evaluations.

Each primary care practice with PCMH certification must do all of the following:

(1) Meet any standards developed by national independent accrediting and medical home organizations, as determined by ODH;

(2) Develop a systematic follow-up procedure for patients, including the use of health information technology and patient registries;[72]

(3) Implement and maintain health information technology that meets the requirements of federal law;[73]

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[72] According to the National Center for Biotechnology Information, U.S. National Library of Medicine, "patient registry" refers to an organized system that uses observational study methods to collect uniform data to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes (www.ncbi.nlm.nih.gov/books/NBK49448/).

[73] 42 U.S.C. 300jj.

(4) Report to ODH health care quality and performance information, including any data necessary for monitoring compliance with certification standards and for evaluating the impact of PCMHs on health care quality, cost, and outcomes;

(5) Meet any process, outcome, and quality standards ODH specifies;

(6) Meet any other requirements ODH establishes.

Data collection

ODH is authorized to contract with a private entity to evaluate the effectiveness of certified PCMHs. ODH may provide to the entity any health care quality and performance information data that ODH has. ODH may also contract with national independent accrediting and medical home organizations to provide on-site evaluation of primary care practices and verification of data collected by ODH.

Report

The bill requires ODH to submit a report to the Governor and General Assembly evaluating the PCMH Program no later than three and five years after first establishing the standards and procedures for certifying a primary care practice as a PCMH, the types of medical practices that constitute primary care practices eligible for certification, and the health care quality and performance information that a certified PCMH must report to ODH.

Each of the reports must include all of the following:

(1) The number of patients receiving primary care services from certified PCMHs and the number and characteristics of those patients with complex or chronic conditions. To the extent available, information regarding the income, race, ethnicity, and language of the patients is to be included in the report;

(2) The number and geographic distribution of certified PCMHs;

(3) Performance of and quality of care measures implemented by certified PCMHs;

(4) Preventative care measures implemented by certified PCMHs;

(5) Payment arrangements of certified PCMHs;

(6) Costs related to implementation of the PCMH Program and payment of care coordination fees;

(7) The estimated effect of certified PCMHs on health disparities;

(8) The estimated savings from establishing the PCMH Program, as those savings apply to the fee for service, managed care, and state-based purchasing sectors.

Nursing facilities' plans of correction

(R.C. 5165.69)

Nursing facilities are required to undergo surveys to determine whether they continue to meet the requirements for certification to participate in the Medicaid program. Continuing law requires a nursing facility that receives a statement of deficiencies following a survey to submit to ODH a plan of correction for each finding cited in the statement. The bill requires a nursing facility's plan of correction to include additional information.

Under current law, a plan of correction must describe the actions the nursing facility will take to correct each finding and specify the date by which each finding will be corrected. In the case of a finding that existed during the period between two surveys and that the nursing facility substantially corrected before the second survey, a plan of correction must describe the actions that the facility took to correct the finding and the date on which it was corrected.

Under the bill, the part of a plan of correction that describes the actions the nursing facility will take to correct each finding must be detailed and include actions the facility will take to protect residents situated similarly to the residents affected by the causes of the findings. A plan of correction also must include both of the following:

(1) A detailed description of an ongoing monitoring and improvement process to be used at the nursing facility that is focused on preventing any recurrence of the causes of the findings;

(2) If the plan concerns a finding assigned a severity level indicating that a resident was harmed or that immediate jeopardy exists, (a) detailed analyses of the facts and circumstances of the finding, including identification of its root cause, (b) a detailed explanation of how the actions the nursing facility will take to correct the findings relate to the root cause of the finding, and (c) a detailed explanation of the relationship between the ongoing monitoring and improvement process and the root cause of the finding.

Current law requires ODH to approve a nursing facility's plan of correction, and any modification of an existing plan, that conforms to the requirements for approval established in federal regulations, guidelines, and procedures issued by the U.S. Secretary of Health and Human Services under federal Medicare and Medicaid Law.

The bill adds an extra condition for ODH approval: a plan of correction must include all the information that continuing law and the bill require.

The bill requires ODH to consult with the Ohio Departments of Medicaid and Aging and the Office of the State Long-Term Care Ombudsperson Program when determining whether a plan of correction concerning a finding assigned a severity level indicating that a resident was harmed or immediate jeopardy exists, or modification of such a plan, conforms to the requirements for approval.

Newborn screenings for critical congenital heart defects

(R.C. 3701.5010 and 3701.507)

The bill requires that each hospital and freestanding birthing center screen each newborn born in the hospital or center for critical congenital heart defects. Current law requires that all newborns be screened, through a blood sample, for 35 genetic, endocrine, and metabolic disorders. ODH is charged with administering the Newborn Screening Program with the assistance of the Newborn Screening Advisory Council.[74] Ohio law also requires that each hospital and each freestanding birthing center conduct a hearing screening on each newborn born in the hospital or center before discharge, unless the newborn is transferred to another hospital.[75] The Infant Hearing Screening Subcommittee of the Medically Handicapped Children's Medical Advisory Council consults with and makes recommendations to the ODH Director regarding newborn hearing screenings.

Under the bill, each hospital and freestanding birthing center must use a physiologic test to screen each newborn born in the hospital or center for critical congenital heart defects. The hospital or center must conduct the screening after the newborn reaches 24 hours of age but before discharge, unless the newborn is transferred to another hospital. In the case of a transfer, that hospital must perform the screening when determined to be medically appropriate. A hospital or center is prohibited from conducting the screening if the newborn's parent objects on religious grounds.

The bill requires that each hospital or center notify the following of the screening results: the newborn's parent, guardian, or custodian; the attending physician; and ODH. ODH is required to establish a statewide tracking system to ensure that universal critical congenital heart defects screening is implemented. The bill requires the ODH

[74] R.C. 3701.501, not in the bill.

[75] R.C. 3701.503 through 3701.506, 3701.508, and 3701.509, not in the bill.

Director to adopt rules establishing standards and procedures for the mandated screenings. The rules must address the following topics:

(1) Identifying the critical congenital heart defects to be included in the screening;

(2) Specifying screening equipment and methods;

(3) Designating the persons responsible for performing screenings and rescreenings;

(4) Providing notice to the newborn's parent, guardian, or custodian of the required screening and the possibility that rescreenings may be necessary;

(5) Communicating results to the newborn's parent, guardian, or custodian and attending physician;

(6) Causing rescreenings to be performed when initial screenings have abnormal results; and

(7) Referring newborns who receive abnormal results to providers of follow-up services.

Distribution of state household sewage treatment system permit fees

(R.C. 3718.06)

The bill reallocates the distribution of money collected from state household sewage treatment system installation and alteration permit fees as follows:

(1) Decreases the percentage allocated to fund installation and evaluation of sewage treatment new technology pilot projects from not less than 25% as provided in current law to not less than 10%; and

(2) Increases from not more than 75% to not more than 90% the percentage used by the ODH Director to administer and enforce the Household and Small Flow On-site Sewage Treatment Systems Law and rules adopted under it.

Requirements governing private water systems contractors

(R.C. 3701.344)

The bill revises the rules adopted by the ODH Director with which private water systems contractors must comply in order to do business in Ohio as follows:

(1) Adds that the rules must require those contractors to comply with competency testing and continuing education requirements; and

(2) Specifies that the rules must allow those contractors to provide other equivalent forms of proof of financial responsibility rather than only surety bonds as under current law.

Currently, a private water systems contractor, as a condition of doing business in Ohio, must annually register with, and comply with surety bonding requirements of, ODH. No such contractor is permitted to register if the contractor fails to comply with all applicable rules adopted by the ODH Director and the board of health of the city or general health district. The annual registration fee is $65, but it may be increased by the ODH Director by rule.

A private water system is any water system for the provision of water for human consumption if the system has fewer than 15 service connections and does not regularly serve an average of at least 25 individuals daily at least 60 days out of the year. A private water system includes any well, spring, cistern, pond, or hauled water and any equipment for the collection, transportation, filtration, disinfection, treatment, or storage of such water extending from and including the source of the water to the point of discharge from any pressure tank or other storage vessel; to the point of discharge from the water pump where no pressure tank or other storage vessel is present; or, in the case of multiple service connections serving more than one dwelling, to the point of discharge from each service connection. A private water system does not include the water service line extending from the point of discharge to a structure.

Ohio Cancer Incidence Surveillance System

(R.C. 3701.261, 3701.262, 3701.264, and 3701.99; R.C. 3701.263 (repealed))

The bill authorizes ODH to designate, by contract, a state university as an agent to implement the Ohio Cancer Incidence Surveillance System (OCISS). "State university" means the following: University of Akron, Bowling Green State University, Central State University, University of Cincinnati, Cleveland State University, Kent State University, Miami University, Ohio University, Ohio State University, Shawnee State University, University of Toledo, Wright State University, and Youngstown State University.

The OCISS is a population-based cancer registry established by the ODH Director that collects and analyzes cancer incidence data in Ohio. Each physician, dentist, hospital, or person providing diagnostic or treatment services to patients with cancer must report each case of cancer to ODH. ODH is required to record in the registry all reports of cancer it receives.

In implementing the OCISS, current law requires the ODH Director to:

-- Monitor the incidence of various types of malignant diseases in Ohio;

-- Make appropriate epidemiologic studies to determine any causal relations of such diseases with occupational, nutritional, environmental, or infectious conditions;

-- Alleviate or eliminate any of the conditions listed above;

-- Advise, consult, cooperate with, and assist federal, state, and local agencies, universities, private organizations, corporations, and associations; and

-- Accept and administer grants from the federal government or other sources.

Confidentiality of cancer reports

Current law includes confidentiality provisions that apply only to information on cancer provided to or obtained by a cancer registry and ODH. It specifies that this information is confidential and is to be used only for statistical, scientific, and medical research for the purpose of reducing the morbidity or mortality of malignant disease. The bill repeals this provision. However, both federal law and Ohio law unchanged by the bill include general provisions governing the confidentiality of protected health information.[76]

In general, protected health information reported to or obtained by ODH is confidential and cannot be released without the written consent of the individual who is the subject of the information, unless one of the following applies:

(1) The release of the information is necessary to provide treatment to the individual or to ensure the accuracy of the information and the information is released pursuant to a written agreement that requires the recipient of the information to comply with confidentiality requirements.

(2) The information is released pursuant to a search warrant or subpoena issued by or at the request of a grand jury or prosecutor in connection with a criminal investigation or prosecution.

(3) The ODH Director determines the release of the information is necessary to avert or mitigate a clear threat to an individual or to the public health to the extent necessary to control, prevent, or mitigate disease.

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[76] *See* the Health Insurance Portability and Accountability Act of 1996, 104 Pub. L. No. 191, 110 Stat. 2021, 42 U.S.C. 1320d *et seq*; 45 C.F.R. 16.304; and R.C. 3701.17, not in the bill.

Information that does not identify an individual is not protected health information and may be released in summary, statistical, or aggregate form.

Charges for copies of medical records

(R.C. 3701.741 and 3701.742)

The bill eliminates a requirement that adjustment to changes that may be imposed for copies of medical records be made not later than January 1 of each year. Current law specifies the amounts that may be charged for medical records, but provides for an annual adjustment based on the Consumer Price Index (CPI). Under the bill, amounts specified in statute plus any previous adjustments must be increased or decreased by the average percentage of increase or decrease in the CPI for the immediately preceding calendar year over the calendar year immediately preceding that year.

The bill eliminates a requirement that the ODH Director provide a list of the adjusted amounts on request but maintains a requirement that the list be available on ODH's Internet site.

Trauma center preparedness report

(R.C. 149.43; R.C. 3701.072 (repealed))

Under current law, the ODH Director must adopt rules requiring a trauma center to report to the ODH Director information on the center's preparedness and capacity to respond to disasters, mass casualties, and bioterrorism. The ODH Director is required to review the information and, after the review, may evaluate the center's preparedness and capacity. The bill eliminates the requirement that the ODH Director adopt those rules and the accompanying authority to evaluate the center's preparedness and capacity.

Council on Stroke Prevention and Education

(R.C. 3701.90, 3701.901, 3701.902, 3701.903, 3701.904, 3701.905, 3701.906, and 3701.907 (repealed))

The bill abolishes the Council on Stroke Prevention and Education, a council that was established within ODH in 2001 to do the following:

- Develop and implement a comprehensive statewide public education program on stroke prevention, targeted to high-risk populations and to geographic areas where there is a high incidence of stroke;

- Develop or compile for primary care physicians recommendations that address risk factors for stroke, appropriate screening for risk factors, early signs of stroke, and treatment strategies;

- Develop or compile for physicians and emergency health care providers recommendations on the initial treatment of stroke;

- Develop or compile for physicians and other health care providers recommendations on the long-term treatment of stroke;

- Develop or compile for physicians, long-term care providers, and rehabilitation providers recommendations on rehabilitation of stroke patients; and

- Take other actions consistent with the purpose of the council.

The Council was required to meet at least once annually, at the call of the chair, to review and make amendments as necessary to the recommendations developed or compiled by the Council.

System for Award Management web site

(R.C. 3701.881)

Continuing law requires an individual to undergo a database review as part of a criminal records check if the individual is under final consideration for employment with (or is referred by an employment service to) a home health agency in a full-time, part-time, or temporary position that involves providing direct care to an individual. The ODH Director is permitted to adopt rules also requiring individuals already employed by (or referred to) home health agencies in such positions to undergo the database reviews. A home health agency is a person or government entity (other than a nursing home, residential care facility, hospice care program, or pediatric respite care program) that has the primary function of providing certain services, such as skilled nursing care and physical therapy, to a patient at a place of residence used as the patient's home.

Continuing law specifies various databases that are to be checked as part of a database review. The ODH Director is permitted to specify additional databases in rules. The Excluded Parties List System is one of the databases specified in statute. It is maintained by the U.S. General Services Administration. The bill specifies that the Excluded Parties List System is available at the federal web site known as the System for Award Management.