
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 ODH Director to adopt rules to assure annual completion of two 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.
- Prohibits distribution of state or federal funds to boards of health or health districts on a regional basis.

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.

Regulation of ambulatory surgical facilities

- Enacts provisions in the Revised Code (similar to existing administrative rules) requiring each ambulatory surgical facility (ASF) to maintain an infection control program and generally have a written transfer agreement with a local hospital.
- Requires the Director of Health to specify ASF inspection forms in rules, conduct inspections of ASFs that are not certified by the federal Centers for Medicare and Medicaid Services, and deny license renewals unless certain conditions are met.
- Requires an ASF to notify the Director within certain time frames when it modifies its operating procedures or protocols or becomes aware of an event that adversely affects a consulting physician's ability to practice or admit patients to a local hospital.

Prioritized distribution

- Establishes levels of priority regarding the distribution of public funds used for family planning services, including funds received from the federal government.

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.

Nursing facility technical assistance

- Eliminates a requirement that ODH provide advice and technical assistance and conduct on-site visits to nursing facilities for the purpose of improving resident outcomes.
- Eliminates a requirement that ODH annually report those activities and their effectiveness to the Governor and General Assembly.

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.

Water systems

- Exempts a water system that does not provide water for human consumption from obtaining a permit or license, paying fees, or complying with any rule adopted under the existing statutes governing private water systems, which are systems that provide water for human consumption.

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

- Requires the ODH Director to adopt rules governing the distribution of funds to assist families.
- 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 law⁷⁹ 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.

⁷⁹ R.C. 9.482, not in the bill.

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 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.

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 rules that assure annual completion of two 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.

Public health funds

(R.C. 3701.541)

The bill provides that any state funds or funds from the federal government that are distributed by the Ohio Department of Health to a board of health or a city or



general health district must be distributed directly to the board or district. It prohibits the Department from distributing such funds on a regional basis.

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;
and

(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;⁸⁰

(3) Implement and maintain health information technology that meets the requirements of federal law;⁸¹

(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; and

(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

⁸⁰ 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/).

⁸¹ 42 U.S.C. 300jj.

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; and

(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.

Regulation of ambulatory surgical facilities

(R.C. 3702.30 and 3702.302 through 3702.307)

Overview

The bill enacts provisions in the Revised Code requiring each ambulatory surgical facility (ASF) to (1) maintain an infection control program and (2) in general,



have a written transfer agreement with a local hospital that specifies an effective procedure for the transfer of patients from the facility to the hospital when medical care beyond the care that can be provided at the ASF is necessary. These requirements are similar to those in current rules the Director of Health has adopted establishing quality standards for specified types of health care facilities subject to ODH licensure.⁸² In addition, the bill requires that an ASF notify the Director when certain events occur and specifies certain requirements related to ASF inspections.

Infection control programs

Relative to infection control programs, the bill specifies that each program's purposes are to minimize infections and communicable diseases and facilitate a functional and sanitary environment consistent with standards of professional practice. To achieve these purposes, the bill requires ASF staff managing a program to create and administer a plan designed to prevent, identify, and manage infections and communicable diseases; ensure that the program is directed by a qualified professional trained in infection control; ensure that the program is an integral part of the ASF's quality assessment and performance improvement program; and implement in an expeditious manner corrective and preventive measures that result in improvement.

Under current rules, an ASF must establish and follow written infection control policies and procedures for the surveillance, control and prevention, and reporting of communicable disease organisms by both contact and airborne routes. These must be consistent with current infection control guidelines issued by the U.S. Centers for Disease Control and Prevention. The policies and procedures must address use of protective clothing and equipment; storage, maintenance, and distribution of sterile supplies and equipment; disposal of biological waste (including blood, body tissue, and fluid) in accordance with Ohio law; standard precautions or body substance isolation (or the equivalent); and tuberculosis and other airborne diseases.⁸³

Written transfer agreements

Requirement

The bill generally requires each ASF to have a written transfer agreement with a local hospital that specifies an effective procedure for the safe and immediate transfer of patients from the ASF to the hospital when medical care beyond the care that can be provided at the ASF is necessary. This includes situations when emergencies occur or

⁸² Ohio Administrative Code (O.A.C.) 3701-83-09(D) and 3701-83-19(E). An ASF is one of six types of health care facilities subject to these quality standards and licensing provisions (R.C. 3702.30(A)(4)).

⁸³ O.A.C. 3701-83-09(D).

medical complications arise. A copy of the agreement must be filed with the Director of Health and an ASF must update an agreement each year and file the updated agreement with the Director.

The bill specifies that an ASF is not required to have a written transfer agreement if either of the following is the case:

(1) The ASF is a provider-based entity of a hospital and the ASF's policies and procedures to address such situations are approved by the governing body of the facility's parent hospital and implemented. Under federal law, a "provider-based entity" is a provider of health care services or a rural health clinic that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider and that is under the ownership and administrative and financial control of the main provider. (A provider-based entity comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program and the personnel and equipment needed to deliver the services at that facility.)⁸⁴

(2) The Director has granted the ASF a variance pursuant to the procedure specified in the bill.

The bill's requirement is similar to the written transfer agreement requirement in current rule. The rule requires an ASF to have a written transfer agreement with a hospital for the transfer of patients in the event of "medical complications, emergency situations, and for other needs as they arise." It specifies that a formal agreement is not required, however, in those instances where the ASF is a provider-based entity of a hospital and the ASF policies and procedures to accommodate medical complications, emergency situations, and for other needs as they arise are in place and approved by the governing body of the parent hospital.⁸⁵

Variations

Application. The bill authorizes the Director of Health to grant a variance from the written transfer agreement requirement if the ASF submits to the Director a complete variance application prescribed by the Director and the Director determines (after reviewing the application) that the ASF is capable of achieving the purpose of the written transfer agreement in the absence of one. A variance application is complete if it contains or includes as attachments all of the following:

⁸⁴ 42 C.F.R. 413.65(a)(2).

⁸⁵ O.A.C. 3701-83-19(E).



--A statement explaining why application of the requirement would cause the ASF undue hardship and why the variance will not jeopardize the health and safety of any patient;

--A letter, contract, or memorandum of understanding signed by the ASF and one or more consulting physicians who have admitting privileges at a minimum of one local hospital, memorializing the physician or physicians' agreement to provide back-up coverage when medical care beyond the level the ASF can provide is necessary;

--For each consulting physician described above, all of the following:

- A signed statement in which the physician attests that the physician is familiar with the ASF and its operations and agrees to provide notice to the ASF of any changes in the physician's ability to provide back-up coverage;
- The estimated travel time from the physician's main residence or office to each local hospital where the physician has admitting privileges;
- Written verification that the ASF has record of the name, telephone numbers, and practice specialties of the physician;
- Written verification from the State Medical Board of Ohio that the physician possesses a valid certificate to practice medicine and surgery or osteopathic medicine and surgery;
- Documented verification that each hospital at which the physician has admitting privileges has been informed in writing by the physician that the physician is a consulting physician for the ASF and has agreed to provide back-up coverage for the ASF when medical care beyond the care the ASF can provide is necessary;
- A copy of the ASF's operating procedures or protocols that, at a minimum, do all of the following: (1) address how back-up coverage by consulting physicians is to occur, including how back-up coverage is to occur when consulting physicians are temporarily unavailable, (2) specify that each consulting physician is required to notify the ASF, without delay, when the physician is unable to expeditiously admit patients to a local hospital and provide for continuity of care, and (3) specify that a patient's medical record maintained by the ASF must be transferred contemporaneously with the patient when the patient is transferred from the ASF to a hospital; and

- Any other information the Director considers necessary.

Under current rule, an ASF must submit an application for a variance containing the specific nature of the request and the rationale for the request; the specific building or safety requirement in question, with a reference to the relevant rule; the time period for which the variance is requested; and a statement of how the ASF will meet the intent of the requirement in an alternative manner.⁸⁶

Decision. The bill specifies that the Director's decision to grant or refuse a variance is final and not subject to any administrative proceedings under the Administrative Procedure Act (R.C. Chapter 119.) or any other Revised Code provision. The Director must consider each application for a variance independently without regard to any decision the Director may have made on a prior occasion to grant or deny a variance to that ASF or another ASF.

The bill's requirement is similar to one in current rule. The rule:⁸⁷

--Authorizes the Director to grant a variance if the Director determines that the requirement has been met in an alternative manner;

--Specifies that the Director's refusal to grant a variance is final and does not create any rights to an administrative hearing;

--Prohibits the Director's granting of a variance to be construed as constituting precedence for the granting of any other variance; and

--Specifies that variance requests must be considered on a case-by-case basis.

Conditions; revocation. The bill also authorizes the Director to impose conditions on any variance the Director has granted. The Director may at any time revoke the variance if the Director determines that the ASF is failing to meet one or more of the conditions.

Similar authorizations are incorporated in current rule.⁸⁸

Duration. The bill specifies that a variance is effective for the period of time specified by the Director, except that it cannot be effective beyond the date the ASF's license expires. If a variance is to expire on the date the ASF's license expires, the ASF

⁸⁶ O.A.C. 3701-83-14(B).

⁸⁷ O.A.C. 3701-83-14(C), (F), and (G).

⁸⁸ O.A.C. 3701-83-14(E).

may submit to the Director an application for a new variance with its next license renewal application.

Current rule specifies that the Director may stipulate a time period for which a variance is to be effective. The time period may be different than the time period sought by the ASF in the written variance request.⁸⁹

Inspections

The bill requires that rules the Director must adopt under current law establishing quality standards for health care facilities include provisions specifying the inspection form that must be used during ASF inspections. The bill also requires the Director to conduct an inspection of any ASF that is not certified by the federal Centers for Medicare and Medicaid as an ambulatory surgical center each time the ASF submits a license renewal application. Under current rules, the Director is not required to make any inspections, but is permitted to make them at any time as the Director considers necessary or for the purpose of investigating alleged violations of law governing health care facilities.⁹⁰

The bill prohibits the Director from renewing an ASF license unless all of the following conditions are met:

--The inspector completes each item on the following, as applicable:

- Until the Director adopts rules specifying the inspection form that must be used during ASF inspections, the form approved by the Director on the bill's effective date; or
- The form specified by the Director in rules.

--The inspection demonstrates that the ASF complies with all quality standards established by the Director in rules; and

--The Director determines that the most recent version of the updated written transfer agreement that the ASF files with the Director is satisfactory.

Notifications

The bill requires an ASF to notify the Director of Health within 48 hours when the ASF modifies its operating procedures or protocols that address back-up coverage

⁸⁹ O.A.C. 3701-83-14(D).

⁹⁰ O.A.C. 3701-83-06(A) and (E).



by consulting physicians and medical record maintenance and transfers. Additionally, an ASF must notify the Director within one week when it becomes aware of an event, including disciplinary action by the State Medical Board, that may affect a consulting physician's certificate to practice or the physician's ability to admit patients to a hospital identified in a variance application. Current rules do not contain similar requirements.

Prioritized distribution

(R.C. 3701.027, 3701.033, 5101.101, 5101.46, and 5101.461)

The bill requires that ODH and the Ohio Department of Job and Family Services (ODJFS), when distributing funds for family planning services, award them first to public entities that (1) have applied for funding, (2) are operated by state or local government entities, and (3) provide or are able to provide family planning services. If any funds remain after distributing funds to those public entities, the bill permits ODH and ODJFS to distribute funds to nonpublic entities in the following order of descending priority:

(1) Nonpublic entities that are federally qualified health centers (FQHCs), FQHC look-alikes, or community action agencies;

(2) Nonpublic entities that provide comprehensive primary and preventive care services in addition to family planning services;

(3) Nonpublic entities that provide family planning services, but do *not* provide comprehensive primary and preventive care services.

Federal funds

The funds subject to the priority levels described above include federal funds received under (1) the Maternal and Child Health Block Grant (Title V of the Social Security Act), (2) the Family Planning Program (Title X of the Public Health Service Act), (3) the Social Services Block Grant (Title XX of the Social Security Act), and (4) the Temporary Assistance for Needy Families Block Grant (TANF, Title IV-A of the Social Security Act), to the extent that TANF funds are being used by Ohio to provide Title XX social services.

Exemptions

The bill exempts from the prioritized distribution both of the following: (1) the Medicaid program and (2) funds awarded by ODH as women's health services grants.



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; and

(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.

Nursing facility technical assistance

(R.C. 3721.027; R.C. 3721.026 (repealed))

The bill repeals a requirement that the ODH Director establish a unit within ODH to provide advice and technical assistance and to conduct on-site visits to nursing facilities for the purpose of improving resident outcomes. With the repeal, the Director is no longer required to submit an annual report to the Governor and General Assembly describing the unit's activities for the year and its effectiveness in improving resident outcomes.

Newborn screenings for critical congenital heart defects

(R.C. 3701.5010)

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.⁹¹ 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.⁹² 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

⁹¹ R.C. 3701.501, not in the bill.

⁹² R.C. 3701.503 through 3701.506, 3701.508, and 3701.509, not in the bill.

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 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.



Water systems

(R.C. 3701.344)

The bill exempts a water system that does not provide water for human consumption from obtaining a permit or license issued under, paying fees assessed or levied under, or complying with any rule adopted under the existing statutes governing private water systems. 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.

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.⁹³

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.

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

Financial assistance to purchase hearing aids for children

(Sections 285.10 and 285.20)

The bill requires that the ODH Director adopt rules governing the distribution of the additional \$200,000 it appropriates per fiscal year for fiscal years 2014 and 2015 to assist families in purchasing hearing aids for children under 21 years of age. These must include rules that do both of the following: (1) establish eligibility criteria to include families with incomes at or below 400% of the federal poverty line and (2) develop a

⁹³ 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.



sliding scale of disbursements based on family income. The bill authorizes the Director to adopt any other rules necessary to distribute these funds.

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.

