State Board of Emergency Medical Services

Preliminary Report
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This publication is a report of the research staff of the Legislative Service Commission. The report consists solely of information relating to the subject matter as prepared by the research staff. It does not purport to represent the findings and opinions of the Legislative Service Commission.

The Legislative Service Commission authorized its staff to prepare and publish the report pursuant to the mandate of Am. Sub. H.B. 138 of the 123rd General Assembly, but the Commission has taken no position in regard to the material contained in the report.

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INTRODUCTION

The Emergency Medical Services Board (EMS Board), which is within the Division of Emergency Medical Services in the Department of Public Safety, has a variety of duties under the Ohio Revised Code. Am. Sub. House Bill 138 of the 123rd General Assembly requires Legislative Service Commission staff, subject to the Commission's approval, to evaluate the effectiveness of the Board and its staff in fulfilling the Board's duties and to prepare two reports. This, the first of the two, is a preliminary report that describes the Board's duties as specified in the Revised Code and the actions the Board is taking to fulfill those duties.

Although H.B. 138 makes reference to LSC staff findings and recommendations, this report is more limited. As explained at the Commission's meeting on October 10, 2001, making recommendations would place the staff in the role of policymaker with regard to the delivery of emergency medical services in Ohio. The Commission is considering appointing a joint legislative committee to consider the Board's activities and make recommendations. Those recommendations will be included in the second report.

This report starts with a brief history of the licensing of emergency medical services performed in Ohio. It then considers the duties of the EMS Board, including licensing procedures, oversight of quality of services, statewide planning, administration of grant programs, information gathering, government and public liaison activities, and trauma system duties. The report concludes with a description of issues addressed by the Board as identified in Board meeting minutes. There is also an appendix containing information pertaining to the Board's duties and activities and a glossary of terms used in the report.

EMS Board membership

The Board is composed of 20 members, 19 of whom are appointed by the Governor. The other member is a Department of Public Safety staff person appointed by the Director of Public Safety.[1] The Board members appointed by the Governor must include:

(1) One physician certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine who is active in the practice of emergency medicine and is actively involved with an emergency medical association;

(2) One physician certified by the American Board of Surgery or the American Osteopathic Board of Surgery who is active in the practice of trauma surgery and is actively involved with emergency medical services;

[1] Revised Code section 4765.02.

(3) One physician certified by the American Academy of Pediatrics or American Osteopathic Board of Pediatrics who is active in the practice of pediatric emergency medicine and actively involved with an EMS organization;

(4) One administrator of an adult or pediatric trauma center;

(5) One administrator of a hospital that is not a trauma center;

(6) One registered nurse who is in the active practice of emergency nursing;

(7) One chief of a fire department that is also an EMS organization in which more than 50% of the persons who provide emergency medical services are full-time paid employees;

(8) One chief of a fire department that is also an EMS organization in which more than 50% of the persons who provide emergency medical services are volunteers;

(9) One person who is certified by the Board to teach an EMS training program or an EMS continuing education program;

(10) One person who is an emergency medical technician-basic (EMT-basic) nominated by the Ohio Association of Professional Fire Fighters or the Northern Ohio Fire Fighters;

(11) One person who is an EMT-Intermediate (EMT-I) nominated by the Ohio Association of Professional Fire Fighters or the Northern Ohio Fire Fighters;

(12) One person who is an EMT-Paramedic (paramedic) nominated by the Ohio Association of Professional Fire Fighters or the Northern Ohio Fire Fighters;

(13) One person who is an EMT-basic nominated by the Ohio State Firefighter's Association;

(14) One person who is an EMT-I nominated by the Ohio State Firefighter's Association;

(15) One person who is a paramedic nominated by the Ohio State Firefighter's Association;

(16) One person who is an EMT-basic, EMT-I, or paramedic nominated by the Ohio Association of Emergency Medical Services;

(17) One person who is an EMT-basic, EMT-I, or paramedic affiliated with an EMS organization;

(18) One person who is a member of the Ohio Ambulance Association;

(19) One 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.

Each Board member serves a term of three years. Board members serve without compensation but are reimbursed for expenses incurred in fulfilling their duties as Board members. The chair and vice-chair of the Board are selected annually from among its members. The Board meets at least four times annually and at the call of the chair. The following is the roster of current Board members and the organization or occupation each member represents.

EMS Board Membership 2001	
James Augustine, M.D. American College of Emergency Physicians, Ohio Chapter Dayton, OH	**Amy Lynn** Northern Ohio Fire Fighter's Association Mentor, OH
Mark R. Burgess Ohio Fire Chief's Association Ashland, OH	**Martin Mace** Northern Ohio Fire Fighter's Association Rocky River, OH
Ed Close Ohio Association of Emergency Medical Services Beverly, OH	**Charlene Mancuso** Administrator of Hospital with Adult or Pediatric Trauma Center Cleveland, OH
William H. Cotton, M.D. American Academy of Pediatricians, Ohio Chapter Gahanna, OH	**Mark R. Mankin** Ohio State Firefighter's Association Reynoldsburg, OH
David B. Fiffick Ohio Ambulance Association/Member of the OAA Clemente-McKay Ambulance Struther, OH	**Mark Marchetta** EMT-Paramedic, Affiliated with an EMS organization Akron, OH
Richard Fratianne, M.D. American College of Surgeons, Ohio Chapter Metro Health Center Cleveland, OH	**Mark N. Resanovich** Ohio State Firefighter's Association Uniontown, OH
Kathryn Haley Ohio State Council of Emergency Nurses Worthington, OH	**Merle Stewart** Ohio State Firefighter's Association East Palestine, OH
Andrew Hawk Ohio Association of Critical Care Transport Dayton, OH	**Joseph Toth** Ohio Emergency Medical Technician Instructors Association Medina, OH
Carl Jordan Ohio Association of Professional Fire Fighters Massillon, OH	**Raymond Walendzak** Ohio Fire Chief's Association Oregon Fire Department Oregon, OH
Lt. Gary Lewis Ohio State Highway Patrol Ohio Department of Public Safety Columbus, OH	**Larry Willard** Ohio Association for Hospitals and Health Systems Hocking Valley Community Hospital Logan, OH

The Director of Public Safety is required to appoint a full-time executive director for the Board who is knowledgeable in emergency medical services and trauma care. The executive director serves as the chief executive officer of the Board and as the executive director of the Division of Emergency Medical Services. Laura L. Tiberi is the executive director.

The Board is required to appoint a medical director who is a physician certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine who is active in the practice of emergency medicine and has been actively involved with an EMS organization for at least five years prior to being appointed. The medical director is required to direct the executive director and advise the Board with regard to adult and pediatric trauma and EMS issues. Dr. John Drstvensek is the Board's medical director.

A BRIEF HISTORY OF EMERGENCY MEDICAL SERVICES LAW IN OHIO

The General Assembly has enacted much legislation in the last quarter century regulating the provision of emergency medical services. In general, entities providing training in emergency medical services and individuals providing those services have been required to obtain certificates. The entity or entities responsible for regulating the training and services has changed over the years as have the duties regulated and the titles of the service providers.

Am. Sub. H.B. 832 of the 111th General Assembly

(Effective 08-31-76)

H.B. 832 authorized the Board of Regents to issue certificates of accreditation to training programs for emergency medical technicians-paramedic (paramedics). The State Board of Education was authorized to issue a certificate of accreditation to training programs for emergency medical technicians-ambulance (EMT-As). The act required the Board of Regents to adopt rules for administration of the accreditation process for paramedic training programs and the State Board of Education to adopt rules for administration of the accreditation process for EMT-A training programs.[2]

Accredited EMT-A training programs were authorized to issue certificates of competency to EMT-As, and the State Board of Education was given the duty of renewing the certificates. Accredited paramedic training programs were authorized to issue certificates of competency to paramedics, and the Board of Regents authorized to renew the certificates.[3]

H.B. 832 created the Emergency Medical Services Advisory Council. The council consisted of two public members and seven members representing the following: (1) physicians, (2) hospital associations, (3) volunteer fire and ambulance emergency medical services, (4) volunteer rescue emergency medical services not operated in conjunction with a volunteer fire service, (5) public professional emergency medical services, (6) private emergency medical services, and (7) funeral businesses or associations engaged in ambulance services. The council was required to prepare a plan for the statewide regulation of emergency medical services during periods of disaster and prepare and recommend standards for the operation of ambulance and emergency medical services.[4]

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[2] R.C. 4731.83.

[3] R.C. 4731.86.

[4] R.C. 4731.93.

Am. Sub. H.B. 1092 of the 112th General Assembly

(Effective 07-21-78)

Under H.B. 1092, the Board of Regents was authorized to issue certificates of accreditation to training programs for advanced emergency medical technicians-ambulance (ADV EMT-As).[5] Accredited ADV EMT-A training programs were authorized to issue certificates of competency to ADV EMT-As, and the Board of Regents was authorized to renew the certificates.[6]

Am. Sub. H.B. 222 of the 116th General Assembly

(Relevant provisions effective 05-15-86)

H.B. 222 was the first major revision of the law regulating emergency medical services. The act created the Ohio Emergency Medical Services Agency in the Department of Education.[7] The authority of the State Board of Education and the Board of Regents to issue certificates of accreditation to EMT-A, ADV EMT-A, and paramedic training programs was transferred to the agency. The Board of Regents' rule-making authority regarding administration of the accreditation process for ADV EMT-A and paramedic training programs was transferred to the State Board of Education.[8]

The act transferred the authority of accredited training programs' to issue EMT-A, ADV EMT-A, and paramedic certificates to the Ohio Emergency Medical Services Agency, but the agency was required to issue a certificate on recommendation of an accredited training program. The authority of the State Board of Education and Board of Regents to renew EMT-A, ADV EMT-A, and paramedic certificates was also transferred to the agency. The State Board of Education was required, however, to adopt rules establishing requirements for renewal of the certificates and permitted to adopt rules establishing grounds for revocation of the certificates and for other disciplinary actions against EMT-As, ADV EMT-As, and paramedics.[9]

The Ohio Emergency Medical Services Board was created, consisting of 26 voting members and 11 nonvoting members. The voting members were the Director of Health, Chairperson of the Emergency Medical Services Advisory Council, Chancellor of the

[5] R.C. 4731.83.

[6] R.C. 4731.86.

[7] R.C. 3303.09.

[8] R.C. 3303.11.

[9] R.C. 3303.15 and 3303.201.

Board of Regents, five physicians, two hospital administrators, a nurse, three fire chiefs, a physician advisor to a fire department's emergency medical system, three volunteer firefighters, three paid firefighters, a private provider of emergency medical services, a public provider of emergency medical services, a representative of the Ohio Funeral Directors Association, an instructor in a vocational school instruction program for EMT-As, and an instructor in a post-secondary or hospital training program for ADV EMT-As or paramedics. The nonvoting members were the Director of Highway Safety, President of the State Board of Pharmacy, Adjutant General, a representative of the Ohio Nurses Association, a representative of the public, three representatives of the interests of health care consumers, a fire department EMS training officer, a private EMS training officer, and a training officer of a public EMS agency. The Board was required to: (1) approve or disapprove a proposed statewide EMS plan, and any revisions to the plan, prepared by the Ohio Emergency Medical Services Agency, (2) advise applicants for state or federal EMS funds and review and comment on applications for those funds, (3) serve as a statewide clearinghouse for discussion, inquiry, and complaints concerning emergency medical services, (4) advise and make recommendations to the Ohio Emergency Medical Services Agency on all aspects of its responsibilities, (5) advise and make recommendations to the State Board of Education on rules and standards for emergency medical services, and (6) make recommendations to the General Assembly on legislation to improve the delivery of emergency medical services.[10]

H.B. 222 required the State Board of Education to submit its proposed rules regarding emergency medical services to the Ohio Emergency Medical Services Board and authorized that board to disapprove the rules by a two-thirds vote.[11]

Am. Sub. S.B. 98 of the 119th General Assembly

(Effective 11-12-92)

S.B. 98 was the next major revision of the law governing emergency medical services. The act created the major features of the currently existing law.

The Ohio Emergency Medical Services Board was replaced with the State Board of Emergency Medical Services (EMS Board), which exists today. The EMS Board was created in the Division of Emergency Medical Services of the Department of Public Safety. It originally consisted of the following 18 members: (1) three physicians, (2) a hospital administrator, (3) a registered nurse, (4) two chiefs of fire departments that were also EMS organizations, (5) a person certified to teach emergency medical services, (6) two EMT-As, (7) two ADV EMT-As, (8) two paramedics, (9) two individuals who

[10] R.C. 33093.10.

[11] R.C. 3309.101.

are an EMT-A, ADV EMT-A, or paramedic, (10) a member of the Ohio Ambulance Association, and (11) an employee of the Department of Public Safety.[12]

The EMS Board was required to perform, in a modified manner, the Ohio Emergency Medical Services Board's duties to: (1) advise applicants for state or federal EMS funds and review and comment on applications for those funds, (2) serve as a statewide clearinghouse for discussion, inquiry, and complaints concerning emergency medical services, and (3) make recommendations to the General Assembly on legislation to improve the delivery of emergency medical services.[13]

S.B. 98 abolished the Ohio Emergency Medical Services Agency and required the EMS Board to perform, in a modified manner, the agency's duties to: (1) issue certificates of accreditation to EMS training programs, (2) issue EMT-A, ADV EMT-A, and paramedic certificates, and (3) prepare a statewide EMS plan.[14]

The EMS Board was authorized to issue: (1) certificates of approval to EMS continuing education programs and (2) certificates to teach in an EMS training program or an EMS continuing education program.[15]

The State Board of Education's EMS rule-making responsibilities were terminated. The EMS Board was required to adopt rules, subject to the Director of Public Safety's approval, regulating emergency medical services.[16]

S.B. 98 also abolished the Emergency Medical Services Advisory Council and provided for the EMS Board to perform, in a modified manner, the council's duties of preparing a plan for the regulation of emergency medical services during periods of disaster and recommendations for the operation of ambulance and EMS organizations.[17] The EMS Board was required to establish: (1) a curriculum and textbook advisory group,

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[12] R.C. 4765.02.

[13] R.C. 4765.10.

[14] R.C. 4765.03, 4765.08, and 4765.15. Unlike the Ohio Emergency Medical Services Agency, the EMS Board was not required to issue an EMT-A, ADV EMT-A, or paramedic certificate on the recommendation of an accredited EMS training program. However, S.B. 98 provided for accredited training programs and approved continuing education programs to issue certificates of completion. The EMS Board was required to provide for the examination of applicants for EMT-A, ADV EMT-A, and paramedic certificates. (R.C. 4765.24 and 4765.29.)

[15] R.C. 4765.17 and 4765.23.

[16] R.C. 4765.11, 4765.15, and 4765.24.

[17] R.C. 4765.08 and 4765.09.

(2) a continuing education advisory group, (3) a trauma care advisory group, and (4) an access, delivery, and quality care advisory group.[18] The act created the Subcommittee of the EMS Board for Firefighter and Fire Safety Inspector Training to provide the EMS Board's executive director advice and counsel regarding the regulation of fire service training programs established by the state or a local government for firefighters and fire safety inspectors.[19]

The act gave the EMS Board the following additional duties: (1) divide the state into pre-hospital EMS regions and appoint either a physician to serve as the regional director or a physician advisory board to serve as the regional advisory board, (2) establish an EMS incidence reporting system and a trauma system registry, (3) establish a grant program, (4) maintain a toll-free long distance telephone number for responding to questions about emergency medical services, (5) work with the State Fire Marshal in coordinating the training of firefighters and EMS personnel when possible, (6) provide a liaison to the State Emergency Operation Center during Governor-declared disasters, and (7) make a semiannual report on its activities to the Joint Legislative Committee on Emergency Medical Services Oversight.[20]

Am. Sub. S.B. 150 of 121st General Assembly

(Effective 11-24-95)

S.B. 150, which mainly concerned the certificate of need program, retitled EMT-As as emergency medical technicians-basic (EMTs-Basic) and ADV EMT-As as emergency medical technicians-intermediate (EMTs-I).[21]

Sub. H.B. 405 of the 121st General Assembly

(Effective 10-01-96)

Under H.B. 405, the EMS Board was authorized to issue certificates to practice to first responders.[22]

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[18] R.C. 4765.04.

[19] R.C. 4765.55.

[20] R.C. 4765.05, 4765.06, and 4765.10. The semiannual report requirement was eliminated by Sub. H.B. 670 of the 121st General Assembly, which abolished the oversight committee.

[21] R.C. 4765.01.

[22] R.C. 4765.30.

Am. Sub. H.B. 138 of the 123rd General Assembly

(Effective 11-03-00)

H.B. 138 made a number of changes to the EMS law. It increased the membership of the EMS Board by adding an adult or pediatric trauma center administrator and another physician.[23] The EMS Board was required to establish a state trauma registry rather than a trauma system registry.[24]

In addition to renaming the EMS Board's subcommittee concerning firefighter and fire safety inspector training,[25] the act created a trauma committee within the Board to advise and assist the Board in matters related to adult and pediatric trauma care and the establishment and operation of the state trauma registry. The EMS Board was authorized to appoint other committees and subcommittees as it considered necessary.[26]

The act also changed or established a number of EMS Board duties. The act requires the Board to work with appropriate state offices, rather than the State Fire Marshal, in coordinating the training of firefighters and EMS personnel.[27] It is to consult with regional directors and regional physician advisory boards when developing and administering rules regulating emergency medical services.[28] The Board is required to develop and distribute guidelines for the care of trauma victims by EMS personnel and for the conduct of peer review and quality assurance programs by EMS organizations.[29] It is to establish written protocols for the triage of adult and pediatric trauma victims and is authorized to approve regional protocols for the triage of adult and pediatric trauma victims submitted by regional physician advisory boards or regional directors.[30]

[23] R.C. 4765.02.

[24] R.C. 4765.06.

[25] The subcommittee was renamed the Firefighter and Fire Safety Inspector Training Committee.

[26] R.C. 4765.04 and 4765.55.

[27] R.C. 4765.10.

[28] R.C. 4765.11.

[29] R.C. 4765.12.

[30] R.C. 4765.40.

DUTIES OF THE BOARD: TRAINING AND ISSUANCE OF CERTIFICATES

The EMS Board is required to establish standards for training of EMS personnel and qualifications of instructors, accreditation of training programs, and the conduct of examinations. The Board has adopted rules regarding all these matters.

Accreditation of training programs

The EMS Board is required to administer the accreditation and approval processes for Ohio's EMS training programs.[31] The Board has adopted by rule criteria that each training program (including fire services training programs) must meet to receive accreditation.[32] Each program must, for example, employ a program coordinator and a medical program coordinator, and select an advisory committee to oversee the program.[33]

To operate as an EMS training program a program must be approved and receive a certificate from the EMS Board. The Board does not charge applicants a fee for the application process or for the accreditation certificate. An applicant must submit information about the proposed program, such as the program's location and intended instructors, to the Board by completing a series of application forms. The Board may also, in the process of approving an application for accreditation, conduct inspections of sites to be utilized by an applicant's training program. A certificate of accreditation is valid for three years. In 2000, there were 122 Board-accredited EMS and firefighter schools in Ohio.[34]

The Board may provisionally certify a training program that does not meet all the requirements. A provisional accreditation certificate is good for one year and may not be renewed. If, within a year, the applicant can demonstrate the program's compliance with the requirements, the Board will issue the program a regular certificate, good for three years.

A program may not change the content of the curriculum or the number of hours included in the curriculum without first providing notice of the proposed changes to, and receiving written approval from, the Board. If, at any time, the program's physical

[31] R.C. 4765.17.

[32] R.C. 4765.15, 4765.16.

[33] Ohio Administrative Code Chapter 4765-8.

[34] Laura Tiberi, EMS Board Executive Director, July 2001 (See **APPENDIX D**).

facilities, faculty, or affiliation agreements change unexpectedly, the program must inform the Board of the changes within ten days of the change.[35]

The EMS Board also oversees the renewal process for training program accreditation certificates. By no later than 90 days prior to a certificate's expiration date, the EMS Board must mail a renewal application to each training program that holds a certificate.

EMS personnel certificates

An applicant for a certificate to practice emergency medical services who has completed approved training must register for and pass a written and practical examination.[36] Examination registration forms may be obtained from EMS instructors and program coordinators or from a training facility. The Board recently expanded its web site to include online examination, registration, and testing schedules. Out-of-state applicants may also register by phone.[37]

The National Registry of EMTs grades the EMT-Basic examinations, which takes from four to five weeks. Test grades take approximately 30 days to process. Once test scores are entered into the EMS Board's examination database, certificates to practice are issued for candidates who have passed.[38]

An applicant unable to pass the written examination in three attempts must wait a time specified by the Board before attempting the examination again. The Board may require the applicant to complete additional training before retaking the examination.[39]

Certificate to teach

The Board administers the application and certification process for EMS instructors, specifying by rule the education requirements.[40] The Board may waive the requirements for a certificate to teach for a physician who serves as an active medical director of an EMS organization or who is recommended by the regional physician advisory board. The Board may also accept training completed in another state or

[35] O.A.C. 4765-7-06.

[36] R.C. 4765.29.

[37] http://www.state.oh.us/odps/division/ems/ems_local/newonlin.pdf.

[38] http://www.state.oh.us/odps/division/ems/ems_local/Training/ExamGuidlines.htm.

[39] R.C. 4765.29(B).

[40] R.C. 4765.22.

another field of study on verification that the training was substantially similar to the Ohio curriculum. All other requirements to teach must be met, including passing a written certification examination approved by the Board.[41]

Continuing education requirements

The Board requires certificate holders to complete continuing education requirements. It has established the requirements by rule.[42] Continuing education credit may be offered and earned through classroom instruction, individual study, skills practicum, or other format approved by the Board. The Board also accepts as valid continuing education courses approved by any of the following: an EMS licensing agency in another state, the National Registry of Emergency Medical Technicians, the United States military, a medical or nursing licensing board of this or another state, or a course related to EMS operations or patient care offered through a journal or publication of a state or national medical, nursing, or EMS organization.[43]

Certificate holders do not necessarily have to take a course to fulfill continuing education requirements. Instead, they may elect to re-take their certification examination.[44] The Board does not assess an examination fee for individuals who elect to take the test.

The Board may exempt an applicant for renewal of a certificate from all or part of the continuing education requirements due to active military service, unusual circumstances or special hardship, emergency, or any other cause the Board considers reasonable. The procedures are established by rule.[45]

Bridge courses

In 1992, legislation was passed that altered the scope of practice for EMT-Intermediates.[46] Training in manual defibrillation and the administration of epinephrine by subcutaneous injection, which had previously been optional components of the EMT-I program, became mandatory. In 1996, the EMS Board adopted new rules

[41] O.A.C. 4765-8-12(A)(4).

[42] R.C. 4765.16; O.A.C. Chapter 4765-8.

[43] O.A.C. 4765-8-05.

[44] O.A.C. 4765-8-09.

[45] R.C. 4765.31; O.A.C. 4765-8-11.

[46] Sub. S.B. 98, effective 11-12-92.

that incorporated the new skills into the curriculum. Any EMT-I not certified for the additional training must complete a bridge course prior to January 1, 2002.

In 1995, Ohio also adopted new curriculum that expanded the scope of practice for EMT-Basics. By January 1, 2002, any EMT-Basic not trained in the new procedures must complete a 26 hour bridge course.

The Board requires that following successful completion of the bridge coursework, including written and practical examinations, the training program present each EMT provider with a certificate of completion stating that the EMT has successfully completed the bridge course and notify the appropriate EMS division. [47]

Disciplinary actions

Standards and ethics related to emergency medical services, as well as the procedures for handling complaints and disciplinary actions, are established by rule of the EMS Board.[48] Each EMS organization must have an internal procedure in place to handle complaints relating to the provision of services by the organization, its employees, and other persons affiliated with the organization.[49] If the Emergency Medical Services Division administrator, on reviewing a complaint, decides that further investigation is needed, the Division must record and assign a number or similar identifier to the complaint. The investigation must be conducted in such a manner as to protect patient confidentiality. The Division may also notify the person who is the subject of the complaint, the director or medical director of any EMS organization by which the subject of the complaint is employed or with which the subject is affiliated, and the appropriate regional medical director or regional physician advisory board. The Division must then review all complaints received against the individual implicated by the complaint and examine any evidence that appears to show that the individual violated any provisions of the statutes and rules governing the provision of emergency medical services. Based on the findings of an investigation, the Board may initiate disciplinary proceedings.[50]

With a vote of at least ten members, the Board may revoke, refuse to grant, or refuse to renew a certificate to practice emergency medical services. The Board may also issue a written reprimand, or may impose a fine not to exceed $1,000 if it determines that the person committed fraud in passing the certification examination; committed fraud, misrepresentation, or deception in applying for or securing a certificate from the Board;

[47] http://www.state.oh.us/odps/division/ems/ems_local/Bridge/letter.pdf.

[48] O.A.C. 4765-9, 4765-10.

[49] O.A.C. 4765-10-01.

[50] R.C. Chapter 119; O.A.C. 4765-10-02.

or violated any provision of the statutes and administrative rules governing the provision of emergency medical services.[51]

A certificate to practice that has been suspended, limited, or revoked may be reinstated by the vote of at least ten members of the Board. In voting to reinstate a certificate, the Board may impose any limitation or conditions on the reinstatement that it deems necessary or appropriate.[52]

Certification of firefighters and fire safety inspectors

The EMS Board is required to oversee the training and issuance of certificates to firefighters and fire safety instructors.[53] The process for issuing certificates is established by rule.[54] No person may provide firefighter or fire safety inspector services without possessing a certificate issued by the EMS Board. Those engaged in fire service who do not directly participate in fire fighting activities, such as dispatchers, alarm operators, and emergency medical technicians, are not required to obtain a firefighter certificate.[55] Applicants for a certificate to practice as a firefighter or fire safety inspector must present documented proof of completion of a Board-approved training course. There is no examination. [56]

If the Board determines that an applicant submitted misleading, false, or fraudulent information in applying for a certificate, it may revoke the applicant's firefighter or fire safety inspector certificate. In the event that a certificate is revoked, the notice of the revocation must be published in *Siren,* the firefighters' newsletter published by the Division of Emergency Medical Services.[57]

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[51] O.A.C. 4765-10-03.

[52] O.A.C. 4765-10-03(C).

[53] R.C. 4765.55.

[54] O.A.C. 4765-11.

[55] O.A.C. 4765-11-09(E).

[56] A certificate in lieu of completion of a chartered training program may be issued to an applicant who submits evidence of service as a firefighter in the state of Ohio as (1) a volunteer firefighter with a fire department of any township, fire district, city, or village prior to July 2, 1979, or (2) a permanent full-time paid firefighter with a fire department of any city or village prior to July 2, 1970.

[57] O.A.C. 4765-11-09.

DUTIES OF THE BOARD: OVERSEEING QUALITY OF SERVICE

The EMS Board has a number of statutory duties related to overseeing the quality of service provided by those licensed by the Board. This section describes the Board's duties concerning standards of performance for EMTs and instructors and for ambulance staffing.

The Board is statutorily required to adopt rules addressing the performance of all levels of EMTs.[58] The Board is also responsible for developing detailed triage protocols,[59] making recommendations concerning the staffing of ambulances,[60] and initiating action against EMTs who practice beyond their scope of practice.

The Board has not adopted rules regarding EMT performance. According to EMS Board Executive Director Laura Tiberi, this is because the scope of practice and EMT performance standards are specified in statute.[61]

The Board is required to adopt rules establishing standards for the minimum qualifications, peer review, and quality improvement requirements for persons who provide medical direction to EMTs.[62] Although the Board has not yet adopted these rules, according to Ms. Tiberi, the Board has reviewed a proposal from the Board's medical director and the regional physician advisory boards regarding the requirements for persons who provide the medical direction. Ms. Tiberi stated that the Board approved a proposal at its September meeting and anticipates that the rules process will proceed accordingly.

The Board is required to adopt rules establishing qualifications for a certificate to teach and has adopted several rules specifying the requirements for a certificate to practice as an EMS or first-responder instructor.[63] As required by statute, the rules designate the different levels of instructor training required to instruct each level of EMS

[58] R.C. 4765.11. There are four levels of EMTs: first responders, emergency medical technicians-basic, emergency medical technicians-intermediate, and emergency medical technicians-paramedic. R.C. 4765.11(A)(2), 4765.35-4765.39.

[59] R.C. 4765.40.

[60] R.C. 4765.09.

[61] R.C. 4765.35, 4765.37 - 39.

[62] R.C. 4765.11.

[63] O.A.C. 4765-8-12, 4765-8-14, 4765-12-09.

personnel. An additional certificate is provided for in rule for instruction in special topics of emergency medicine.

The Board has a statutory duty to adopt rules "establishing written protocols for the triage of adult and pediatric trauma victims."[64] The Board was given two years from the effective date of H.B. 138 of the 123rd General Assembly to develop these rules. Since H.B. 138 became effective on November 3, 2000, the rules are to be adopted by November 3, 2002. The Board has begun to develop the rules. The Trauma Committee established to work on the drafting process has draft documents of the trauma protocols on the Internet and is currently engaged in further drafting and obtaining public comment through trauma town meetings.[65]

Another of the Board's duties concerns ambulance staffing. The Revised Code specifies the training each person in an ambulance is to have. It also specifies the minimum level of training each person on an ambulance must have during an emergency run. This standard is different when the ambulance is staffed by volunteers.[66] These statutes are not further addressed in Board rules.

The Board has authority regarding emergency medical technicians who have entered the emergency department of a hospital. In a hospital emergency department or while moving a patient between the emergency department and another part of the hospital, all levels of emergency medical technicians may perform emergency medical services, but only pursuant to the direction and supervision of a physician or registered nurse.[67] The Board has authority to pursue disciplinary action against an emergency medical technician who exceeds the scope of practice within a hospital. According to Ms. Tiberi, however, it is not the Board's practice to monitor the activities of emergency medical technicians within a hospital. The Board does not have the authority to monitor or discipline a physician or nurse who delegates tasks to an emergency medical technician that are outside of the emergency medical technician's scope of practice.

The Board uses its authority to investigate complaints from the public as a means of monitoring the quality of emergency medical services.[68] Ms. Tiberi explained that the Board concerns itself with the quality of emergency medical services by maintaining curricula, standards of accreditation, and continuing education. The complaint and

[64] R.C. 4765.40.

[65] http://www.state.oh.us/odps/division/ems/ems_local/trauma/DraftDoc.htm. (See **APPENDIX E**.)

[66] R.C. 4765.43.

[67] R.C. 4765.36.

[68] R.C. 4765.10(B)(1).

investigation processes serve as additional means of monitoring the quality of performance. It is the Board's policy to investigate every complaint by conducting "[f]air, impartial and consistent investigations of all complaints, problem applications or alleged rule violations brought to the attention of the Division of Emergency Medical Services, [build] public confidence and [promote] high professional standards for all associated emergency medical service organizations."[69] The public can make complaints to the Board by accessing its web site or using a toll-free telephone number. The Board publishes an explanation of its investigation process and a copy of its complaint form on its web site for public access.

If its investigation determines legal action is warranted, the Board may file a complaint with the Attorney General or a prosecuting attorney or city director of law. On receiving the complaint, the official must prosecute or seek an injunction against any person violating the law governing EMS personnel.[70]

[69] Emergency Medical Services Investigation Policy. Available at http://www.state.oh.us/odps/division/ems/ems_local/Enforcement/Policy.pdf.

[70] R.C. 4765.48.

DUTIES OF THE BOARD: STATEWIDE PLANNING

Under Ohio law, the EMS Board has duties regarding statewide EMS planning. The Board must provide day-to-day planning and also planning for disaster situations.

Day-to-day EMS planning

Prehospital emergency medical services

For purposes of overseeing the delivery of adult and pediatric prehospital emergency medical services, the EMS Board is required to establish prehospital EMS regions. The term "prehospital emergency medical services" is defined in law as "an emergency medical services system that provides medical services to patients who require immediate assistance, because of illness or injury, prior to their arrival at an emergency medical facility."[71] According to Ms. Tiberi, these services are emergency medical services.

For each prehospital EMS region, the EMS Board is required to appoint either a physician to serve as the regional director or a physician advisory board to serve as the regional advisory board. The Board must specify the duties of each regional director and regional advisory board. The Board has established ten regions that cover the entire state.[72] A regional physician advisory board has been established for each region, so no regional directors have been appointed. Advisory board members serve without compensation, but must be reimbursed for actual and necessary expenses incurred in

[71] R.C. 4765.05.

[72] The regions and their constituent counties are as follows: **Region 1** (Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren); **Region 2** (Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby); **Region 3** (Allen, Auglaize, Hancock, Hardin, Mercer, Paulding, Putnam, and VanWert); **Region 4** (Defiance, Erie, Fulton, Henry, Huron, Lucas, Ottawa, Sandusky, Seneca, Williams, and Wood); **Region 5** (Delaware, Fairfield, Fayette, Franklin, Knox, Licking, Madison, Marion, Morrow, Pickaway, Pike, Ross, Scioto, Union, and Wyandot); **Region 6** (Athens, Belmont, Coshocton, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Vinton, and Washington); **Region 7** (Ashland, Carroll, Crawford, Holmes, Richland, Stark, Tuscarawas, and Wayne); **Region 8** (Portage and Summit); **Region 9** (Cuyahoga, Lake, Lorain, Geauga, and Medina); and **Region 10** (Ashtabula, Columbiana, Mahoning, and Trumball).

Because Regions 5 and 6 are so big, the EMS Board has proposed that they be split to create an 11th region that would consist of Athens, Gallia, Hocking, Jackson, Lawrence, Meigs, Pike, Scioto, and Vinton counties. This proposal has not yet been adopted.

carrying out their duties as members. The EMS Board has adopted several administrative rules governing the organization, operations, and responsibilities of the advisory boards.

With respect to operations, the rules require each advisory board to do the following: (1) annually appoint a chairman and vice chairman from among its members and notify the EMS Board's medical director no later than February 15, (2) meet as often as needed to carry out its duties, but at least four times annually, (3) meet at least four times annually with the medical director and advise the medical director of all advisory board meetings, (4) hold at least two public forums annually on the subject of delivery of prehospital emergency medical care in the region, and (5) submit to the medical director and all EMS organizations in its region, prior to the last day of February each year, a report that documents activities, improvements, accomplishments, and problem areas in the previous calendar year.[73] According to Carol MacDowell, the EMS Board's Advisory Board Coordinator, the advisory boards are generally meeting the operations requirements. She acknowledges, however, that the advisory boards have not been complying with the public forum requirement. She said that the problem is being remedied. The EMS Board is requiring each advisory board to have held at least one public forum by the end of 2001 and to meet the minimum two forum requirement starting in 2002.

With respect to responsibilities, the rules require each advisory board to (1) develop and recommend written medical protocols for EMS providers, organizations, and personnel operating in the region, (2) provide services to assist in developing and maintaining appropriate emergency medical services in its region, and (3) assist all EMS organizations in its region in procuring the services of a medical director or physician advisory board (as required by law) and serve as the physician advisory board for the EMS organization until a medical director or physician advisory board can be obtained.[74]

The services each advisory board is required to provide to assist in developing and maintaining appropriate emergency medical services are to (1) assist in developing EMS continuing education programs within its region, (2) assist in the organization, evaluation, and procurement of equipment for EMS organizations in its region, (3) maintain information regarding all EMS providers and organizations in the region including the name of the medical director or physician advisory board members for each, (4) maintain a listing of all EMS equipment owned by or available to each EMS provider in the region, (5) maintain a listing of all EMS training and continuing education programs in the region, (6) identify problems with the provision of emergency medical services in the region and develop strategies to address the problems, (7) facilitate agreements for

[73] O.A.C. 4765-3-03.

[74] O.A.C. 4765-3-04.

mutual aid and assistance between EMS organizations in the region, and (8) review any experimental procedures proposed to be included in EMS protocols within its region.[75]

Ms. MacDowell said that the advisory boards are complying, or in the process of coming into compliance, with the requirements concerning their duties. However, she indicated that she is not sure what the advisory boards are doing regarding the organization, evaluation, and procurement of equipment for EMS organizations in their regions and the maintenance of listings of all EMS equipment owned by or available to each EMS provider in the regions. She also indicated that she is not aware of many reviews being conducted by advisory boards of experimental procedures proposed to be included in EMS protocols. She said the issue "doesn't come up."

Statewide planning

The EMS Board is required to prepare a statewide EMS plan and to revise it as necessary.[76] But, according to Ms. Tiberi, a plan has not yet been prepared. The reason she gave for the plan not yet being prepared is that the Board has not determined all the necessary components for such a plan. Ms. Tiberi attributes this to lack of experience and understanding engendered by the Board's relatively recent creation.[77]

Ms Tiberi explained that the first eight years of the EMS Board's existence have been focused primarily on rulemaking in order for the Board to operate as required by state law. However, Ms. Tiberi stated that the Board has recently undertaken a commitment to strategic planning by reviewing an EMS assessment that was completed in 1991 and inviting EMS professionals from around the country to conduct a reassessment of Ohio's emergency medical services under a grant from the National Highway Traffic Safety Administration. Scheduled for November 2001, this reassessment will be used to craft a five-year strategic plan at the Board's annual planning retreat in January 2002.

Recommendations for air medical, ambulance, and EMS organizations

Ohio law requires the EMS Board to prepare recommendations for the operation of air medical, ambulance, and EMS organizations. The recommendations must include (1) the definition and classification of ambulances and medical aircraft, (2) the design, equipment, and supplies for ambulances and medical aircraft (including special equipment, supplies, training, and staffing required to assist pediatric and geriatric

[75] O.A.C. 4765-3-04(B).

[76] R.C. 4765.08.

[77] The initial appointments to the EMS Board were to be made within 90 days of November 12, 1992. S.B. 98, effective on that date, established the Board.

emergency victims), (3) the minimum number and type of personnel for the operation of ambulances and medical aircraft, (4) the communication systems necessary for the operation of ambulances and medical aircraft, and (5) reports to be made to ascertain compliance with the Revised Code chapter governing emergency medical services and rules and recommendations adopted thereunder and to ascertain the quantity and quality of air medical, ambulance, and EMS organizations in the state.[78]

The EMS Board has yet to adopt any recommendations, but has proposed recommendations for the operation of air medical organizations.[79] With respect to ambulance and EMS organizations, the EMS Board has not acted. According to Ms. Tiberi, the Board does not plan to act in those two areas because Board members feel that the Board does not have adequate legislative authority to regulate the organizations. Regarding ambulance service organizations specifically, Ms. Tiberi said that the EMS Board defers to the licensing requirements for those organizations that have been adopted by the Ohio Ambulance Licensing Board.

Disaster situations

"Disaster" is defined in Ohio law as "any imminent threat or actual occurrence of widespread or severe damage to or loss of property, personal hardship or injury, or loss of life that results from any natural phenomenon or act of a human."[80] To deal with disasters, the EMS Board must provide a state EMS disaster plan and work closely with the Ohio Emergency Management Agency (OEMA).

State plan for disasters

Under Ohio law, the EMS Board must prepare a plan for the statewide regulation of emergency medical services during periods of disaster. This emergency operations plan must be consistent with the statewide EMS plan and with the statewide emergency operations plan adopted by OEMA. The EMS Board must submit the plan to OEMA.[81]

The EMS Board has adopted a state plan for emergency medical services during periods of disaster and has submitted it to OEMA. The plan has been incorporated into

[78] R.C. 4765.09.

[79] Draft Guidelines for the Operation of Air Medical Services, June 13, 2001. See http://www.state.oh.us/odps/division/ems/ems_local/trauma/DraftDoc.htm. (See **APPENDIX G**.)

[80] R.C. 5502.21(E).

[81] R.C. 4765.08. The current emergency operations plan was adopted March 20, 2001. According to Candice Sherry of OEMA, the emergency operations plan is completely revised every four years, with 25% being revised annually.

the emergency operations plan. According to Candice Sherry of OEMA, the emergency operations plan is adequate to meet disaster situations.

Relationship with OEMA

The EMS Board is required by statute and administrative rules to do the following: (1) cooperate with OEMA in any manner it considers necessary to develop and implement the emergency operations plan,[82] (2) participate on the incident command system steering committee,[83] and (3) provide a liaison to the state emergency operation center during those periods when a disaster has occurred in Ohio and the Governor has declared an emergency.[84] Ms. Tiberi said that the EMS Board is meeting all of these requirements.

[82] *Id.*

[83] O.A.C. 4501:3-2-05. The deputy director of OEMA is authorized to adopt an incident command system and establish a steering committee. The duties of the committee are to (1) coordinate implementation of an incident command among state agencies, (2) develop and approve training for state emergency response officials and personnel on an incident command system, (3) monitor and evaluate implementation and use of an incident command system and training by state agencies, (4) recommend local implementation of an incident command system and assist local emergency response officials and personnel in development, training, and evaluation of the incident command system, on request of local officials, and (5) develop and make available an all-risk overhead management team.

[84] R.C. 4765.10(A)(8). "Emergency" means any period during which the Congress of the United States or chief executive has declared or proclaimed that an emergency exists. R.C. 5502.21(F).

DUTIES OF THE BOARD: EMERGENCY MEDICAL SERVICES FUNDING

EMS Grants

The EMS Board has distributed funding to assist organizations in providing training, equipment, and improving availability, accessibility, and quality of their programs through a grant program that has been in place since 1995. The grants are provided from a portion of seat belt fine revenues. Previously, 50% of seat belt fine revenue was distributed to the appropriation in line item 765-637 EMS Grants. Effective November 1, 2001, however, 54% of fines are to be distributed to this fund.

There are approximately 1,500 EMS providers and agencies eligible to apply for grants in Ohio. Am. Sub. H.B. 138 of the 123rd General Assembly has expanded the pool of eligible applicants to include those who focus on research and injury prevention, especially in the area of trauma. Until the revised program required by H.B. 138 is implemented, however, eligible applicants include only:

(1) EMS organizations established or operated by a township, village, city, or county within Ohio;

(2) Non-profit EMS organizations having principal responsibility for emergency medical response within a political subdivision that provide emergency medical services under contract with that political subdivision;

(3) Private, for-profit ambulance services, or divisions of those services, that provide emergency medical services under contract with a political subdivision;

(4) EMS organizations that are established by a joint fire district, joint ambulance district, or joint township fire district.[85]

Of the eligible applicants, the following table illustrates the number of applications received versus the number of applications approved by the Board. The approval rate ranges from 93% to 99% for applications received. EMS Board staff reported that the Board's intent and action has been to award every eligible applicant agency some amount of the funding requested. For example, if the total amount of funding requested is $10 million but the actual appropriation is only $5 million, the Board may choose to award each approved applicant 50% of the requested amount rather than deny an applicant any funds.

[85] O.A.C. 4765-5-02.

Selection criteria currently used in the grant application process includes determining whether the requested item: (1) is necessary for emergency medical care; (2) will improve patient care or the ability of the EMS organization to provide care; (3) is logical in light of current or future funding needs; (4) will improve the overall EMS system in the affected area; and (5) is a reasonable solution or approach to a problem or situation. In addition, financial hardship to the EMS organization is considered.

Comparison of Applications Received vs. Applications Approved			
Year	Applications Received	Applications Approved	Percent Approved
1995	345	321	93%
1996	650	600	92%
1997	575	543	94%
1998	526	493	94%
1999	623	512	98%
2000	600	592	99%
2001	608	603	99%
2002	813	785	97%

Additional information was provided by the EMS Board staff related to total dollars requested versus total reimbursements requested by those awarded grants. Although over 90% of eligible applicants have been awarded some level of funding, it appears that grantees have only sought reimbursement for 65% or less of the awarded funds since the grant program was created.

Grants Requested versus Grants Requested for Reimbursement (in millions of dollars)					
Year	Appropriated Dollars* for Line Item 765-637	Total Grant Dollars Requested by Applicants	Total EMS Grant Awards	Total Reimbursements Requested by Grantees	Percent Requested for Reimbursement by Grantees
1995	$1.8	Unknown	Unknown	$1.0	Unknown
1996	$2.5	Unknown	Unknown	$.22	Unknown
1997	$3.5	$7.0	$3.3	$2.2	65%
1998	$3.0	$6.2	$3.0	$1.7	56%
1999	$3.0	$7.4	$3.0	$1.3	42%
2000	$5.0	$8.0	$4.8	$1.5	31%
2001	$5.0	$9.4	$4.9	$.50	9%**
2002	$5.7	$28.3	$5.6	Unknown	Unknown

* Including Controlling Board Transfers
** Note: Grantees have requested an extension and have until 12/30/01 to seek reimbursement.

EMS Board staff suggested possible reasons for the low reimbursement request rate might include the following:

(1) Cash flow issues: Because the grants require grantees to first spend the money, and then be reimbursed, many departments may not have the initial funding available for the originally intended purchase. It was noted that some equipment can cost as much as $25,000.

(2) Training: An initial grant request may assume a certain number of staff will attend training. When grants are actually awarded, however, the number of staff who remain interested in the training may have been reduced.

(3) Staffing levels: Grant requests may include an assumption that an increase in staff may occur when, by the time the grant moneys are available, the increase has not occurred.

(4) Volunteer organizations: Paperwork may be misplaced or overlooked.

Assistance to funding applicants

The EMS Board is required to assist applicants for state or federal EMS funds. The Board must review and comment on applications for these funds and approve the use of all state and federal funds designated solely for EMS programs unless federal law requires another state agency to approve the use of all such federal funds.[86]

According to Ms. Tiberi, an EMS agency seeking state funds receives assistance with the grant application if necessary. The Board maintains a toll free telephone line that may be used by local EMS agencies to receive assistance with the applications. Questions are often received about applications for funds for purchasing new equipment. The Board also monitors federal and state grants as they become available and notifies the local agencies of other sources of funding.

[86] R.C. 4765.10(A)(3).

DUTIES OF THE BOARD: INFORMATION GATHERING SYSTEMS

The EMS Board oversees and maintains two systems of data collection on the delivery of emergency medical services in Ohio: the EMS Incident Reporting System and the Trauma System Registry. Through the Incident Reporting System, the EMS Board collects data on all EMS runs in the state, both trauma and medical, with a primary focus on pre-hospital treatment of patients. The Ohio Trauma Registry (OTR) collects data from trauma cases only. While eventually the Board plans to collect more expansive information on each trauma case, currently, the Registry collects only in-patient hospital data. In the future, the EMS Board plans to link the information in the OTR and EMS Incident reporting systems to allow for a broader examination into emergency medical services in Ohio.[87]

EMS Incident Reporting System

The Revised Code requires the EMS Board to establish and maintain an EMS Incident Reporting System for the collection of information regarding the delivery of emergency trauma and medical services and the frequency at which the services are provided.[88] Rules establishing the system were promulgated on June 29, 2001.[89] The information collected by the Incident Reporting System will be distributed in aggregate form by region and county levels, and will include an annual report on each.

A nine-member Incidence Run committee, appointed by the EMS Board, oversees and advises the Board on matters concerning the Incident Reporting System. Membership of the committee must represent professionals who interact with the EMS system frequently and is to include firefighters, physicians, nurses, and EMS professionals.[90]

Ohio EMS organizations must report all incidents. "Incident" is defined as "any ground or air response to a call for emergency medical services by a public or private emergency medical services organization."[91] Each EMS organization must submit, at a minimum, the following information on each incident:

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[87] *The Register,* newsletter of The Ohio Trauma Registry, Issue 3, June 2001.

[88] R.C. 4765.06(A).

[89] http://www.state.oh.us/odps/division/ems/ems_local/rules/New/menu.html.

[90] O.A.C. 4765-13-09.

[91] O.A.C. 4765-13-01.

(1) Name and address of the EMS organization;

(2) Time and date of the incident;

(3) Location of the incident;

(4) EMS personnel involved;

(5) Patient identification (name, date of birth, etc.);

(6) Information regarding provider assessment;

(7) Description of the treatment provided to the patient;

(8) Transport information.[92]

In the event of a natural disaster or other situation resulting in mass casualties, the Board can grant exemptions from reporting the incidents.

EMS organizations that respond to less than 10,000 incidents annually must submit quarterly reports to the Board. Those that respond to more than 10,000 incidents annually must submit data to the Board in monthly reports. Reports may be filed in written form, or in an electronic submission via the EMS Board's web site.[93]

All EMS organizations must submit any additional information the Board considers necessary for maintaining the reporting system. EMS organizations that fail to submit an incident report in a timely manner will first be notified in writing, advising the organization of the requirements and consequences of failing to report. The Board will also send a copy of the notification letter to the chief executive officer of the political subdivision or private organization and to the chairperson of the appropriate regional physician advisory board. Continued failure of the EMS organization to report to the Board can result in the organization's ineligibility for the EMS Grants Program.[94]

Ohio Trauma System Registry

The Revised Code requires the EMS Board to establish the Trauma Registry Committee to oversee and maintain a state trauma system registry to collect information regarding the care of adult and pediatric trauma victims.[95] Procedures for the registry's

[92] O.A.C. 4765-13-03.

[93] O.A.C. 4765-13-05.

[94] O.A.C. 4765-13-06, -07, -08.

[95] R.C. 4765.06(B).

operation have been established by rule.[96] The Committee must annually appoint a chairperson from among its members and, if necessary, may establish subcommittees to aid in certain endeavors.[97]

Who must report to the registry

The registry began collecting data in 1999.[98] All health care facilities, including hospitals, nursing facilities, county homes, county nursing homes, inpatient rehabilitation facilities, and ambulatory surgical facilities must submit the required information regarding trauma patients to the registry. The Board must take into consideration the financial and other burdens the registry's requirements impose on the affected health care providers and health care facilities. In addition, at the Board's request, any person or state agency possessing information regarding adult or pediatric trauma care must also provide the required information to the Board.

All trauma-related deaths must be reported to the registry by the coroner of the county in which the death occurs within 180 days after occurrence. The coroner must include in the report copies of the investigative summary, autopsy report, if applicable, and death certificate.[99]

Information collected by the registry

A trauma injury is defined in statute as "any tissue damage that creates a significant risk for loss of life or limb, or significant permanent disfigurement or disability; is caused by blunt or penetrating mechanisms; is caused by exposure to electromagnetic, chemical or radioactive energy; or is caused by drowning, suffocation, strangulation, or a deficit or excess of heat."[100]

Not all injuries are entered into the Trauma Registry. For an injury to be entered, the patient must be admitted or observed in the hospital for at least 48 hours or transfer into or out of the hospital. The patient must have at least one serious injury, such as burns, hypothermia, smoke inhalation, or the effects of hanging or drowning. Some

[96] O.A.C. 4765-4.

[97] O.A.C. 4765-4-02.

[98] *The Register,* newsletter of the Ohio Trauma Registry, Issue 2, March 2001.

[99] O.A.C. 4765-4-03.

[100] R.C. 4765.01.

injuries are not to be included in the Registry, including contusions, abrasions, insect bites, foreign bodies, and isolated hip fractures. [101]

The Trauma Committee has developed a format for reports to the registry. The information to be provided includes the name of the treating hospital, identification of the patient, the date of treatment, and how the patient incurred the injury.[102] Aggregate reports of each facility's trauma incidents must be made on a quarterly basis. The reports must be provided and maintained in a way that protects the individual identity of the patient. Specific physicians and health care facilities must be identified by a code or similar designation rather than by name.[103]

The Board uses the information compiled in the registry to analyze and evaluate the delivery of trauma care within the state. The Board considers the geographic patterns of trauma incidence around the state, the types and severity of the trauma injuries incurred, and the criteria for, and appropriateness of, the triage decisions made in treating the reported trauma injuries. The Board must also determine what areas of the state need improvements to the system of trauma care delivery and public education in trauma prevention. Furthermore, the Board must be able to assess, through the registry, a patient's access to trauma care, the availability and responsiveness of the prehospital emergency care system, and the cost of each patient's trauma care.[104]

Confidentiality

H.B. 138 requires that by November 3, 2002, the Board adopt and implement rules that provide written standards and procedures for risk adjustment of information received by the Board. The rules must be developed in consultation with appropriate medical, hospital, and EMS organizations and may provide for risk adjustment by a contractor of the Board. Before these risk adjustment standards and procedures are implemented, no member of the Board and no employee or contractor of the Board or Department of Public Safety may make public any information received by the Board under the EMS law that identifies or tends to identify any specific provider of emergency medical services or adult or pediatric trauma care. After the standards and procedures are implemented, the Board may make public such information only on a risk-adjusted basis.

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[101] *The Register*, newsletter of the Ohio Trauma Registry, Issue 3, June 2001.

[102] http://www.state.oh.us/odps/division/ems/ems_local/trauma/Green_book%20DRAFT%20REV%20September%2027%202001.pdf.

[103] O.A.C. 4765-5-04.

[104] O.A.C. 4765-5-01; *The Register*, newsletter of The Ohio Trauma Registry, Issue 2, March 2001.

H.B. 138 also requires the Board to adopt rules that specify procedures for ensuring the confidentiality of information that is not to be made public and 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. These rules have not yet been adopted, however a draft version of the rules is available on the Board's web site.[105]

[105] http://www.state.oh.us/odps/division/ems/ems_local/trauma/DraftDoc.htm. (See **APPENDIX F**.)

DUTIES OF THE BOARD: GOVERNMENT AND PUBLIC LIAISON ACTIVITIES

Several of its statutory duties cause the EMS Board to act as a liaison between the EMS community and both state government and the public.[106] The Board is required by statute to work with other state agencies in coordinating training of firefighters and EMS personnel and to make recommendations to the General Assembly on legislation to improve the delivery of emergency medical services. The Board is also required to serve as a statewide clearinghouse for discussion, inquiry, and complaints concerning emergency medical services and is permitted to establish a statewide public information system.

Liaison with state government

To fulfill its duty to work with appropriate state offices in coordinating the training of firefighters and EMS personnel, the Board establishes the curriculum for all initial and mandatory training of EMS personnel and firefighters. The Board has adopted rules establishing uniform minimum standards for the training, classification, and certification of firefighters and fire safety instructors.[107] To receive a charter as a fire service training program, a program must meet or exceed requirements established in the rules.

Regarding its duty to make recommendations concerning EMS legislation, Ms. Tiberi explained that the Board acts through the Department of Public Safety, rather than independently. The Board's recommendations are made to the legal council and legislative liaison of the Division of Emergency Medical Services. Ms. Tiberi said that the Board monitors relevant legislation throughout its progress in the General Assembly.

Liaison with the public

The Board acts as a liaison with the public through its toll-free telephone line, web site, and public information programs.[108] The web site includes a detailed list of e-mail and phone contacts.[109] Both the phone line and the web site can be accessed by the public and EMS workers and organizations to contact the Board with questions, comments, and complaints.

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[106] R.C. 4765.10. Information for this section of the report was obtained from Laura Tiberi and the EMS web site.

[107] O.A.C. Chapter 4765-11.

[108] The toll free telephone number is 1-800-233-0785.

[109] The web site address is http://www.state.oh.us/odps/division/ems/ems_local.default.

The Board provides free safety information and conducts public outreach and education programs. According to Ms. Tiberi and information on the EMS web site, these programs include radio and television public service announcements and participation in National EMS Week each May and in the EMS Data Collection Project. Programs for children include school visits, conducting coloring contests for children and publishing a calendar for the contest winners' designs, and maintaining the EMS for Children and Ohio Safe Kids programs. An Ohio Department of Public Safety (ODPS) press release reported that "in 2000, more than 3.1 million pieces of safety literature were sent to almost 7,000 organizations, including 1,787 schools.[110] ODPS Director, Lieutenant Governor Maureen O'Connor, has stated that "providing free safety materials is one way we're fulfilling our mission to provide education, service, and protection to residents of Ohio."[111]

The Board publishes two newsletters, "The Register" and "The Siren," to provide current information on emergency medical services to local agencies.

[110] Press release, July 11, 2001. Available on ODPS web site.

[111] *Ibid.*

DUTIES OF THE BOARD:
TRAUMA DUTIES UNDER AM. SUB. HOUSE BILL 138

Appointment of a trauma committee

The trauma committee within the EMS Board was created by H.B. 138 to advise and assist the Board in developing the state trauma registry and rules and protocols to match severely injured adults and children with the hospitals best equipped to provide the specialized medical care that critical trauma victims require.[112] Lt. Governor O'Connor appointed the Committee's twenty-two members on November 3, 2000.[113]

The Board may also appoint other committees and subcommittees as it considers necessary.

Guidelines for the triage of trauma patients

H.B. 138 also requires that by November 3, 2002, the Board adopt rules establishing written protocols for the triage of adult and pediatric trauma victims that minimize overtriage and undertriage, and emphasize the special needs of pediatric and geriatric trauma patients. The Board has published a draft version of these new rules on its web site. [114]

Once the rules are approved, the Board must review them at least every three years to determine whether they are causing overtriage or undertriage, and modify them as necessary. In addition, the Board must adopt rules that provide for enforcement of the state and regional triage protocols and for education regarding those protocols for EMS organizations and personnel, regional directors and regional physician advisory boards, EMS instructors, and persons who regularly provide medical direction to EMS personnel in Ohio.[115]

Guidelines for the care of trauma victims

H.B. 138 requires the Board to develop and distribute guidelines for the care of trauma victims by EMS personnel and for the conduct of peer review and quality

[112] R.C. 4765.04; Laura Tiberi, EMS Executive Director, July 2001.

[113] Laura Tiberi, EMS Executive Director, July 2001.

[114] http://www.state.oh.us/odps/division/ems/ems_local/trauma/prehospital%20trauma%20document.pdf. (See **APPENDIX E**.)

[115] R.C. 4765.40.

assurance programs by EMS organizations.[116] The guidelines must be consistent with the state trauma triage protocols and place emphasis on the special needs of pediatric and geriatric trauma victims. In developing the guidelines, the Board may consult with entities interested in trauma and emergency medical services and consider any relevant guidelines adopted by national organizations, including those adopted by the American College of Surgeons, American College of Emergency Physicians, and the American Academy of Pediatrics.

The Board must distribute the guidelines by November 3, 2002, to each EMS organization, regional director, regional physician advisory board, certified EMS instructor, and person who regularly provides medical direction to EMS personnel in Ohio.

Report on study of trauma care

Section 3 of H.B. 138 requires the EMS Board and its trauma committee to study and evaluate the following matters:

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

(2) Methods to improve specialized care provided by EMS 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 is to include an analysis of the cost of acquiring, maintaining, and using these 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 rural areas of the state;

(6) The roles hospitals that are not trauma centers play in the state trauma system and regional trauma systems in Ohio, 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.

[116] R.C. 4765.12.

The Board must conduct this aspect of the study in cooperation with the Commission on Minority Health.

The Board must, in conducting its study and developing its recommendations, consult as needed the appropriate committees and subcommittees of the Board; regional directors; regional physician advisory boards; organizations that represent physicians, nurses, and hospitals that care for emergency and trauma patients; EMS organizations; government entities; and the Ohio State Coroners' Association, as needed.

By no later than November 3, 2003, the Board must submit a report of its findings and recommendations to the Governor, the General Assembly, and other appropriate authorities and organizations.

EMS BOARD MEETINGS

The EMS Board meets every two months. Some issues of concern to the Board are discussed in the following excerpts from Board meeting minutes:

- November 2000: A Board member expressed concern over the disparity that continues in grants honored and funds actually expended. Specifically, he wanted the Board to discuss avenues for a better expenditure record and to continue investigating the need and use of grant funds. Another Board member added that there is a need to follow up with agencies that do not spend the awarded funds and examine the true need for these funds as a function for bettering pre-hospital care. Director Tiberi stated that the grant application allows flexibility for needed items and that the typical pattern for awardees is to wait until the end of the fiscal year to file for reimbursement.

- November 2000: A Board member reported that $500,000 was available in left over money carried over from fiscal year 1998. Grant applicants will receive a letter stating that the money must be used towards purchasing a computer and once the state has implemented the data collection system in Ohio they will have to comply and submit their data in a timely fashion. There are 533 applications, and each applicant will receive approximately $938.08 per computer.

- January 2001: Director Tiberi reported that the Governor's Management Improvement Commission (MIC) 2000 had released its report to the Governor in November 2000. One of the recommendations included in the report was to "merge all EMS and firefighter training in a single agency of Emergency Services within an existing cabinet agency. There was insufficient time to reach a conclusion as to which cabinet agency should house this function. A small team of subject matter experts and customers of these services should work out the details of where the merged function is to be housed." Director Tiberi reported that the Department of Public Safety has responded with a plan, as requested, suggesting how this challenge might be addressed. She said that the Ohio Department of Public Safety [ODPS] emphatically supports the executive director of the board as a lead person to any small group that is put together.

  Director Tiberi concluded that:

  > [ODPS] has also supported that representatives, customers, and consumers of services of different agencies, organizations, and professional associations that are represented on the EMS

> Board be represented if such a group is developed. Certainly, if consolidation continues to be considered in any significant way, we feel very strongly along with the Fire Alliance that the logical place would be [ODPS]. The focus would be on saving lives and preserving safety in the state of Ohio. With the passage of the Trauma Bill [H.B. 138 of the 123rd General Assembly], which adds the new medical focus to the Division of EMS and EMS Board, it seems clear that [ODPS] is the mission-centered choice. With the budget on the legislative plate, no quick follow up is foreseen at this time on this section of the MIC 2000 report.

The Board unanimously approved a motion authorizing Director Tiberi to support the Board's regulatory authority and the Board's official position in opposition to moving the EMS Division to any other state agency if further discussions on the MIC 2000 report take place, since the Board feels that a mission and customer focused consolidation, if it would occur, should be at ODPS, maintaining the designated EMS fund and the Board's rule-making authority.

- January 2001: Director Tiberi stated that:

> The Board is charged by law with making a State Disaster Plan, but on the other hand we have no accompanying authority or ability to truly submit an active response plan. The EMA is responsible and has authority for the State Disaster Plan and management. My concerns are the accountability to the Emergency Management Agency's current document, which says we will do certain things that we technically have no ability to do. We can assist; we can aide; we can call on other agencies; we can give a list of agencies; we can work with the Ohio Fire Chief's Association which has a fine disaster response plan; there are many things that we can do. Ohio is quite unique in the fact that we have oversight over the certificate holders, but there is no oversight over the agency, except for the private ambulance companies that have standards for private licensing.

Director Tiberi's comments were meant to alert the Board to the need to consider this issue as an active topic for 2001.

- January 2001: The Board provided the following directions to the Trauma Committee concerning actions relative to H.B. 138:

  (1) The establishment of minimum qualifications and peer review and quality improvement requirements for persons who provide medical direction to EMS personnel was delegated to the regional physicians advisory board level;

  (2) The establishment of the curriculum, number of hours of instruction and training and instructional materials to be used for pediatric EMS training and continuing education programs was delegated to the Education Committee;

  (3) The grant program rules that create additional priorities for funding to include injury prevention, rehabilitation, retraining, and reemployment, and medical procedures related to trauma care was delegated to the Grant Committee;

  (4) The development and distribution of guidelines for the care of trauma victims by EMS personnel was delegated to the Trauma Committee;

  (5) The conduct of peer review and quality assurance programs by EMS organizations was referred to the Systems Management Committee.

- March 2001: A Board member initiated a discussion of the continuing education rule violations that were on the increase. He stated that:

  > In the past couple of months we have discovered at least two departments where there is a continuing education problem. The instructor was not operating under the direction of any approved school which then invalidates all the continuing education for those EMTs. We have also found out through the audit process (10% of all renewals annually) that there are EMTs without appropriate continuing education to be currently certified…. The case review team has discussed this at length. Our research included other boards in state government and how they deal with continuing education…. From the investigative standpoint, it was asked that the Board give some direction on this matter. These [cases] can be processed through the [Ohio Revised Code Chapter] 119 process or through consent agreements for first offenders.

  A draft consent agreement policy was presented to the EMS Board to review (see **APPENDIX A**) and voted on at the May 2001 EMS Board meeting. (On May 16, 2001, the Board approved the draft consent agreement policy.)

- March 2001: Mike Glenn, Trauma Coordinator, reported that, in addition to the Trauma Registry Advisory Committee, the Pre-hospital, Hospital, and Air Medical Subcommittees have been developed and are meeting to work on specific aspects of [implementing] H.B. 138. Mr. Glenn stated that since the "Committee and the subcommittee members are aware that the Joint Commission on Agency Rule Review (JCARR) process is lengthy and will require them to have final documents ready for JCARR **no later** than January 31, 2002, this requires that all final drafts be ready for EMS Board review by mid fall and ready for final public hearing later fall/early winter."

- March 2001: A Board member reported that the EMS For Children (EMS-C) Committee's *Emergency Guidelines for Schools* have been revised and are in the process of being reprinted. They will be distributed on request to schools, EMS agencies, and other groups caring for children.[117]

- May 16, 2001: The following is from a Continuing Education Audit Report presented to the Board:

Overall Statistics [as of May 16, 2001]

Total Number Audited (since 12/00)	217
Total Number Approved (as of 05/16/01)	141
Total Number Waiting on Additional Documentation	70
Total Number Referred to the Investigative Division (Non-compliance/No response)	6

Breakout

Total EMT-Basic Audits	118
Total EMT-Intermediate Audits	23
Total EMT-Paramedic Audits	76

? May 16, 2001: Mike Glenn, Trauma Coordinator, reported that the Trauma Committee meets monthly. A series of trauma town meetings will be held in eight locations around Ohio to introduce the first draft of the destination protocol and transfer agreement template. The Board also approved a motion for the Trauma Committee to continue discussion with the Ohio Ambulance Licensing Board for the purpose of allowing air medical transport services to be licensed by that body. Director Tiberi stated that H.B. 138 requires that the

[117] The *Guidelines* are also available on the EMS Board's web site at the following Internet address: http://www.state.oh.us/odps/division/ems/ems_local/emsc/EMSCGuide.pdf.

Board adopt standards for [air medical transportation] organizations even though the Board does not have the authority to certify them.

- July 2001: Director Tiberi reported that there was approximately $1.5 million in funds that were unspent in the last fiscal years. She had been asked to approach the Controlling Board with a request to allow those funds to be utilized by the EMS Division to do a special additional grant opportunity for computers for the EMS Incidence Reporting System and perhaps look at offering Incidence Reporting cost offset. The Board approved this request to go to the Controlling Board.

- July 2001: Mike Glenn, Trauma Coordinator, reported that 359 people have participated in seven out of the eight trauma town meetings. [The numbers from the eighth meeting were unavailable.] Of these, 246 participants were from hospitals and 113 from EMS/fire agencies. Health care professionals from 58 counties have participated, and at least one Trauma Committee member has been present at all seven meetings.

- July 2001: It was reported that the Ohio EMS-C program has been selected to participate in a pediatric assessment project funded by the National EMS-C program. The project is modeled after the National Highway Traffic Safety Administration's Technical Assessment Team process for emergency medical services. The process offers states an approach to assessing their EMS system as it relates to children and adolescents. The process will provide a comprehensive assessment to help Ohio continue to improve emergency medical service for children and provide information to the Federal EMS-C program documenting strengths and weaknesses of its program. The review team will be in Columbus for the three-day assessment on December 4, 2001. The team will hear presentations and conduct interviews on Ohio's EMS-C activities.

GLOSSARY

Emergency Medical Services Incidence Reporting System - A system established by the State Board of Emergency Medical Services for the collection of information regarding the delivery of emergency medical services in Ohio and the frequency at which services are provided. (R.C. 4765.06.)

Emergency Medical Services Personnel - First Responders, EMT-basic, EMT-intermediate, EMT-paramedic, and persons who provide medical direction to such persons. (R.C. 4765.01(L).)

Emergency Medical Technician-Basic (EMT-Basic) - A person who holds a valid certificate to practice as an EMT-Basic. An EMT-basic may operate an ambulance and give emergency medical services to patients. Services may include determining the nature and extent of illnesses or injuries and establishing priority for required emergency services, opening and maintaining an airway, chest compressions, controlling hemorrhages, stabilizing fractures, assisting in childbirth, cardiac resuscitation, and any other services approved by adoption of a rule by the State Board of Emergency Medical Services. (R.C. 4765.01 and 4765.37.)

Emergency Medical Technician-Intermediate (EMT-I) - A person who holds a valid certificate to practice as an EMT-I. An EMT-I may perform the emergency services including the following: cardiac monitoring, electrical interventions to support or correct cardiac function, administering epinephrine, determining triage, and any other service approved by rule of the State Board of Emergency Medical Services. (R.C. 4765.01 and 4765.38.)

Emergency Medical Technician-Paramedic (Paramedic) - A person who holds a current certificate to practice as an EMT-Paramedic. Paramedics may perform emergency medical services including cardiac monitoring, electrical interventions to support or correct cardiac function, airway procedures, relief of pneumothorax, administering appropriate drugs and intravenous fluids, triage of trauma victims, and any other services, including life support or intensive care techniques, approved by rule of the State Board of Emergency Medical Services. (R.C. 4765.01 and 4765.39.)

First Responder - A volunteer for a non-profit emergency medical services organization or a non-profit fire department who holds a certificate to practice as a first responder. A first responder may provide limited emergency services until an EMT arrives on the scene of the emergency. Limited emergency services include opening and maintaining an airway, giving mouth to barrier ventilation, chest compressions, electrical interventions with automated defibrillators, assisting in childbirth, and triage of trauma victims. (R.C. 4765.30 and 4765.35.)

Life Support Care (life support) - Care provided to patients requiring extraordinary therapeutic measures to sustain and prolong life. (Online Medical Dictionary, (December 1998) <www.graylab.ac.uk/omd/index.html>.)

State Trauma Registry - A register containing information on adult and pediatric trauma-related deaths, the identification of trauma patients, the monitoring of trauma patient care data, amounts of uncompensated adult and pediatric trauma care provided annually by each

facility, and any other information specified by the State Board of Emergency Medical Services. (R.C. 4765.06.)

Trauma (or traumatic injury) - Severe damage to or destruction of tissue that creates a significant risk of loss of life; loss of limb; significant, permanent disfigurement; or significant, permanent disability and is caused by one of the following: blunt or penetrating injury; exposure to electromagnetic, chemical, or radioactive energy; drowning; suffocation; strangulation; or a deficit or excess of heat. (R.C. 4765.01(N).)

Triage - The sorting out and classification of patients or casualties to determine priority of need and proper place of treatment. (Online Medical Dictionary, (December 1998) <www.graylab.ac.uk/omd/index.html>.)

APPENDIX

APPENDIX A: EMS Board's Draft Consent Agreement Policy

process and how the testing has impacted the state of Ohio. There are ten other states doing the 99 Intermediate Curriculum and the committee would like to receive input from them to see how it is affecting the work they're doing.

INVESTIGATIVE TEAM REPORT - Richard Rucker & Melissa Vermillion

The investigative team passed out a "Summary of Past Adjudication Orders to Date of the State Board of EMS."

DRAFT CONSENT AGREEMENT POLICY

Draft Consent Agreement Policy was provided March 21, 2001 to Board for review. The policy was brought before the Board today for approval.

\- CONSENT AGREEMENTS

I. POLICY

The State Board of Emergency Medical Services through the Division of Emergency Medical Services will consider entering into consent agreements for rule violations under ORC/OAC 4765. with certificate holders and accredited schools when deemed appropriate. *Consent agreements* provide the State EMS Board and the certificate holders or accredited institutions an alternate method in lieu of the Chapter 119 process to comply with established rules, and where appropriate, be administered discipline as the circumstances warrant.

Consent agreements will be presented to the State EMS Board for consideration after the following conditions are satisfied:

1. The Office of Investigative Services has completed a thorough investigation.
2. The Assistant Attorney General representing the State EMS Board believes a consent agreement is appropriate for the particular circumstances.
3. The EMS Executive Director approves the consent agreement.
4. The certificate holder or accredited institution agrees to the conditions set forth in the consent agreement.

When applicable, the Case Review Team as outlined in the Investigative Process Policy may be convened by the Executive Director to provide input into consent agreement consideration.

II. SPECIAL PROVISIONS

The Assistant Attorney General representing the State EMS Board shall prepare and present consent agreements to the State EMS Board for consideration after review by the Executive Director and Office of Investigative Services. A

majority vote by State EMS Board Members is necessary to approve a consent agreement.

Eligibility for certificate holders and accredited institutions to participate in consent agreements should fall within the following guidelines:

1. First offenders.
2. The rule violation can be readily remedied through a consent agreement.
3. High probability that the certificate holder or accredited institution will fulfill the conditions of the consent agreement.

Consent agreements approved by the State EMS Board in previous cases have Included but not limited to criminal convictions, scope of practice and patient care issues. These consent agreements when applicable, contained provisions requiring the certificate holders to complete education or training to reinforce appropriate emergency medical technicians behavior. Ethics courses, anger management and critical decision making are primary examples. When educational or training courses are part of a consent agreement; the following conditions shall be satisfied to successfully meet the terms of the agreement.

l.The certificate holder shall submit the proposed relevant education or training course for approval to the Division of Emergency Medical Services prior to attending the course.

a. Universities, colleges, and educational institutions are appropriate sources for obtaining such education or training.
b. Consideration will be given to local education or training by the department's medical director, department's training officer or other
c. instructional source approved by the Division of Emergency Medical Services.

1. The education or training with rare exceptions should be multiple sessions.
2. The length and hours of education or training will be approved (disapproved) on a case by case basis. The prime consideration is reinforcing appropriate emergency medical technician behavior.
3. The certificate holder attending the education or training must demonstrate attendance and satisfactory completion of the course within the agreed upon time frame. Submissions of grade transcripts, certificates of completion or signed letterheads by the program director are examples of documents giving evidence of attendance and satisfactory completion.

When all conditions of the consent agreement have been completed, then the case shall be presented to the State EMS Board for consideration of closure.

Certificate Holders who fail to complete the conditions outlined in the consent

agreement shall be processed in accordance with all applicable provisions of Ohio Revised Code Chapters 4675, 119 and terms listed in the agreement.

ACTION: Motion to approve Draft Consent Agreement policy. Burgess first. Fratianne second. None opposed. Motion approved.

Mr. Resanovich stated he felt as being part of the case review team this is a way to do business for these offenses and do business quickly.

Mr. Mace asked on several different occasions we have dealt with patient care standards and entered into consent agreements. He didn't see the medical director being consulted on these matters. Would that be a part of the investigative process?

Ms. Vermillion answered the medical director on most cases have been consulted. The medical directors are implementing remedial training.

Ms. Petrella stated actually that is part of the investigation.

ACTION: Motion to go into Executive Session at 12:55 p.m. to deliberate on report and recommendations of case #OOI-10 (Rumbaugh) and several consent agreements. Burgess first. Close second. None opposed. Motion approved.

ROLL CALL

Mark G. Burgess	Yes
Edward L. Close	Yes
William H. Cotton, MD	Yes
David B. Fiffick	Yes
Richard Fratianne, MD	Yes
Amy P. Gaddis-Lynn	Yes
Kathryn Haley	Yes
Andrew Hawk, MD	Yes
Carl A. Jordan	Yes
Martin Mace	Yes
Charlene Mancuso	Yes
Mark R. Mankins	Yes
Mark Marchetta	Yes
Mark N. Resanovich	Yes
Merle Stewart	Yes
Raymond Walendzak	Yes
Larry Willard	Yes

ACTION: Motion to go out of Executive Session at 1:04 p.m.

APPENDIX B

Ohio Task Force on Fire and Emergency Response Training
Summary Report and Recommendations
December 15,1999

I. Executive Summary

Under the authority of Governor Bob Taft, Lt. Governor Maureen O'Connor and Commerce Director Gary Suhadolnik convened the Ohio Task Force on Fire and Emergency Response Training on September 15, 1999.

The purpose of the Ohio Task Force on Fire and Emergency Response Training was to accomplish the following:

1) To survey and compile information on all of the fire and emergency response programs provided by or coordinated through state government, including a list of all training programs, the oversight agency (agencies) and sources of funding. 2) To make formal, written recommendations to the Directors of the Departments of Commerce and Public Safety regarding the following: a) How can the state coordinate fire and emergency services training so as to increase efficiencies, lower overall costs and provide customers simpler points of contact for arranging training opportunities. b) How can the state agencies which provide fire and emergency services training better coordinate their offerings with those provided by or coordinated through local government and/or by the federal government. c) What additional training opportunities should the state offer and which agency should provide the training? d) How can test scheduling and registration be improved to provide for the prompt test registration needs of the fire and EMS services. e) Which agency or agencies should administer each type of training offered?

Using historical, evaluative, and action research methodology, the Task Force held public hearings throughout the state, surveyed similar agencies throughout the United States, and reviewed models for the efficient delivery of fire and emergency medical training and certification for the State of Ohio. Public hearings, research and interaction by the Task Force members revealed the following problems:

- Frustration with the service delivered by the Division of Emergency Medical Services and the Office of the State Fire Marshal.
- Dissatisfaction with the Division of EMS regarding telephone and information systems, and the certification and testing process.

- Poor communications between state agencies and local governments, local training institutions, local fire and EMS service providers, and instructors.
- The need to coordinate services through consolidation.
- The length of time it takes for BCI to conduct background and fingerprint checks of fire and EMS candidates.
- Live fire training centers not readily available.
- Concern with the usefulness of the National Registry as the testing source for EMTs.
- Perceived inequities in the fire and EMS funding mechanisms.

Using the Quality Service through Partnership problem solving processes and quality improvement techniques, the Task Force developed both immediate and long-term recommendations for improvements.

The immediate goals include:

- Re-establishing regional training coordinators.
- Establishing, publicizing and utilizing a Communications Plan.
- Utilizing technology, especially the Internet, to design an information clearinghouse. Developing an interactive inquiry system for information regarding status of certification, test, or renewal.
    - Establishing an automated telephone system for response to Frequently Asked Questions.
    - Coordinating and updating all curricula, materials, and corresponding tests.
    - Establishing and monitoring a clearinghouse for grants.
    - Increasing communications to and solidifying the relationship with schools and instructors.
    - Working with training delivery partners, such as local training institutions, to decentralize the testing and grading process for fire and EMS certification tests and to review alternative testing mechanisms for fire and EMS.
    - Evaluating the disparities between re-certification of EMTs and no renewal requirements for Firefighters and seeking the necessary legislative changes to make for a more equivalent system of requirements.
    - Implementing a more prompt and efficient certification and card issuance process, such as using the state's deputy registrar locations to issue certification identification cards with proof of requirements met.

The Task Force believes that many of these goals can be accomplished with in-house operational changes and administrative direction. Possible long-term solutions may require budgetary, legislative or administrative rules changes in order to occur.

Long-term goals include the following recommendations:

- A single agency approach to fire and EMS training and certification.

- Additional funding for current training and grants, as well as the construction of regional live fire training facilities.

- Efficient use of the Internet and technology to bring effective training into the individual fire stations and chartered agencies, and for more efficient testing and certification.

The Task Force also requests that the Management Improvement Commission, scheduled to meet early next year, review these findings and determine how the State of Ohio can otherwise improve the quality delivery of fire and EMS training to all emergency responders.

Respectfully submitted this 15th day of December, 1999

II. Ohio Task Force on Fire and Emergency Response Training

On July 27, 1999, by written notice, Ohio's Governor Bob Taft appointed thirteen individuals to work with Director Gary Suhadolnik (Department of Commerce) and Lt. Governor/ Director Maureen O'Connor (Department of Public Safety) as members of Ohio's Task Force on Fire and Emergency Response Training. On September 15, 1999, Directors Suhadolnk and O'Connor convened the first meeting of the task force to review the purpose and goals and establish timelines for the task force. State Fire Marshal Robert Rielage and Public Safety Assistant Director Gary Joseph were appointed as co-chairpersons of the task force and charged with coordinating future meetings and activity.

Task Force members appointed by the Governor represent the fire and emergency medical services professional community including fire chiefs, training institutions, practitioners, state agencies, and local government. They are: Jim Beckner, Rural Fire Council; Charles Geloff, Miami Valley CTC and Joint Vocational Schools; Ed Humphrey, Ohio Township Association; Gary Joseph, Department of Public Safety; Mike Kelly, Ohio Municipal League; Daniel Leffler, Northern Ohio FireFighters; Laura Ludwig, Department of Public Safety and EMS Board; Cheryl Lyman, Department of Commerce; John Preuer, Ohio Fire Chief's Association; David Price, Fire Chief and County Emergency Management; Robert Rielage, State Fire Marshal; Rodger Sansom, Ohio State Firefighters' Association; Kevin Watts, Ohio Association of Professional Firefighters. (Appendix A)

The written recommendations of the Task Force were to be shared with the Directors of Commerce and Public Safety no later than 90 days after the first meeting, or by December 15, 1999. The Directors of Commerce and Public Safety will review the recommendations and forward the report, with their comments, to the Governor no later than thirty days after the receipt of the recommendations. Unless otherwise directed by the Governor, the Task Force on Fire and Emergency Response Training has completed its charge and ceases to exist with the issuance of these recommendations.

III. Task Force Mission and Purpose

The purpose of the Ohio Task Force on Fire and Emergency Response Training was to accomplish the following:

3) To survey and compile information on all of the fire and emergency response programs provided by or coordinated through state government, including a list if all training programs, the oversight agency (agencies) and sources of funding. 4) To make formal, written recommendations to the Directors of the Departments of Commerce and Public Safety regarding the following: f) How can the state coordinate fire and emergency services training so as to increase efficiencies, lower overall costs and provide customers simpler points of

contact for arranging training opportunities.

g) How can the state agencies which provide fire and emergency services training better coordinate their offerings with those provided by or coordinated through local government and/or by the federal government.

h) What additio nal training opportunities should the state offer and which agency should provide the training?

i) How can test scheduling and registration be improved to provide for the prompt test registration needs of the fire and EMS services.

j) Which agency or agencies should administer each type of training offered?

IV. Step One: **Information Collected on Current Fire and EMS Training Programs in State Government**

The first meeting of the Task Force focused on surveying and compiling information about fire and EMS training offered through state agencies. Staff of the Office of the State Fire Marshal and Public Safety's Division of EMS made presentations to explain the role they play and the training offered. Information gathered from multiple sources was shared with all task force members.

A. **Current Training and Certification** Training required for certification as an Ohio Firefighter or EMT is essentially administered.by one state agency, the Department of Public Safety, through the Division of Emergency Medical Services. Service and training delivery involves multiple agencies and organizations including the State Fire Academy, Joint Vocational Schools, Fire Departments, Hospitals and other charters and accredited agencies.

The Division of Emergency Medical Services (ODPS), along with the State Board of Emergency Medical Services, regulates EMS Training and Certification for the state of Ohio. (Appendix B) The State Board of EMS has the authority to make rules regarding Emergency Medical Services. EMS training includes the initial training for certification levels of First Responder, Basic and Intermediate EMT, and EMT-Paramedic and all continuing education training. The Division, with the approval of the Board, also accredits the training institutions which are permitted to conduct certified training programs and continuing education courses for EMT training at all levels. There are currently 90 such accredited training institutions and 280 sites with certificates of approval to teach continuing education. (Appendix C) The Division and the Board also approve EMS Instructor qualifications, training and recertification.

The Division of EMS, with the advice of a Firefighter and Fire Safety Instructor Training Sub-Committee of nine (9) members selected by the Fire Service Members of the EMS Board, also oversees the requirements for firefighter training, instructor qualification, firefighter certification requirements and chartering fire training institutions. (Appendix D) A Fire Chartered Agency is permitted to conduct certified firefighter training programs, including Firefighter l A, 1B, 1 C, Firefighter 1 and 2, Fire Safety Inspector and

Fire Instructor. There are currently 64 such chartered agencies which are approved to conduct .firefighter training. (Appendix C)

All of the Division of EMS rules regarding mandatory certification training for EMS and Fire and accredited institutions are governed by rule as published in the Ohio Administrative Code. (Appendix E) There are about 1260 fire departments in Ohio, approximately 45,000 firefighters, 1600 EMS services, and 35,000 EMTs of all levels. EMTs must recertify every three years. 70-75% of Ohio's firefighters are volunteer or part-time and about 70% of EMS response is provided by fire departments. The Division of EMS certification standards are based upon nationally recognized standards for Firefighters and Emergency Medical Services professionals. Finally, while EMS renewals require meeting continuing education requirements, no additional training is required by the state for Fire personnel.

The Office of the State Fire Marshal, (SFM) a division of the Department of Commerce (DOC) sets the certification standards for Underground Storage Tank Inspectors (UST), a mandatory training program. The SFM, through the Ohio Fire Academy, offers optional advanced and specialized classes in such areas as fire service supervision and management, fire safety education, fire investigation and fire inspection. While none of these are requirements for state certification as a firefighter, the wide variety of programs offered through the Fire Academy resident program and the Outreach program offer advanced learning opportunities for fire personnel. The Fire Academy conducts 150 resident programs annually at the Academy facility in Reynoldsburg for 3,000 participants and an estimated 800 Outreach programs statewide for 13,000 participants. The SFM also operates a Film Library and Resource Center to support local training efforts. The Ohio Fire Academy is not chartered or accredited institution for mandatory fire and EMS certification training, but does hold a charter to teach the courses required to obtain certification as a Certified Fire Safety Inspector and Instructor. Additionally, the Academy does offer certification levels of training in its course catalog by virtue of a contract with another chartered and accredited training institution, a local joint vocational/adult education institution. The Fire Academy has also recently been approved to offer continuing education for EMS. (Appendix F)

In fact, the vast majority of certification level training for Fire and EMS is conducted at local Joint Vocational Schools (JVS) and community and technical colleges. Other training delivery institutions include hospitals, county and regional Fire/EMS programs, private entities, and fire departments. Fire departments may apply for and qualify as a chartered or accredited institution to conduct fire and/or EMS training and/or to provide continuing education training programs.

B. Current Funding Sources

The cost of and funding for training is diverse. Individuals, the employer or sponsoring agency, government stipends, or grants may cover the cost of training. Mandatory

training required for certification as an EMT or Firefighter appears to be most often paid for by the individual or the sponsoring agency. The Division of EMS, entirely supported by Ohio's safety belt fines, uses 50% of the safety belt fine fund for grants to local EMS providers. The percentage is designated by statute. Approximately $3.5 million a year in this grant fund supports EMS initial training, continuing education, training equipment and patient care equipment to eligible local EMS agencies.

The Office of the State Fire Marshal offers some grants for fire equipment and training, mostly to smaller fire departments. An estimated $750,000 is available in equipment grants to small, rural departments. There is an additional modest set-aside for equipment for departments in forest fire districts. Finally, there is an estimated $1 million for reimbursement for basic training for firefighters from areas with less than 25,000 population.

The cost of the training itself also varies. For specialized firefighter training beyond the certification requirements, the Fire Academy, on-premise and through statewide outreach, charges a fee for courses offered. The fee generally covers the cost of the instructor and class materials. Technical schools and JVS's, offering the mandated state training for certification as a firefighter or an EMT, depend on course fees, local support (such as administrative budget and local levies) and a modest reimbursement through the State Department of Education per hour taught ($440,262 total statewide in FY 1999). Because schools are a competitive business and do not have equal resources, the class costs do remain the prerogative of the school. Several JVS's report a deficit in the area of Public Safety training, yet continue to offer what is considered this vital service and attempt to offset the costs through other program areas or through dedicated local support, such as through a hospital. Fire departments that hold a charter to teach firefighter training or EMS do not receive the Department of Education reimbursement. These class expenses are entirely absorbed by the local department, the individual student, or may be offset by EMS grants available through the Division of EMS.

The most visible funding-mechanisms are the state budget and the dedicated funding sources that support the operations of the Office of the State Fire Marshal, including the Fire Academy, and the Division of Emergency Medical Services.

The Fire Marshal's Office and Fire Academy's operating budget's primary source (64%) of funding is taxes levied in the amount of .75% of gross fire insurance premium receipts collected by insurance companies operating in Ohio. This fund, Fund 546 (O.R.C. 3737.7) also earns interest. The current FY 2000 budget, accounting for revenues from all sources, for the State Fire Marshal's Office is slightly over $13 million. An historical comparison is available in Appendix G. Included also is a chart reflecting FY 1999 expenditures which illustrates in summary fashion where the funding goes: 13% to Capital improvement; 13% to BUSTR; 11 % Fire Academy; 6% Fire prevention; 3% Forensic Lab; 14% Code Enforcement; 11 % Fire Investigations; 1 % Firefighters Dependents Fund; 12% Grants to Fire Departments; 16% Administration Costs. The figures also reflect that the Office of the State Fire Marshal has statutory responsibilities

beyond the training issues this task force has researched.

The safety belt fines collected in the state of Ohio provide the dedicated funding source for the operations of the Division of Emergency Medical Services and the expenses incurred with the support of the State EMS Board. By statute (O.R.C. 4513.263), the safety belt fines are distributed as follows:

- 10% School age safety belt program
- 10% Statewide safety belt public information and education
- 28% EMS Administration (Division and Board)
  50% EMS Grants to local agencies
  2% Ambulance Licensing Board

The current fiscal year budgets $1.5 million for the EMS Administration and $4.8 for EMS grants. Comparison and historical figures can be found in Appendix G.

Finally, the broad scope of emergency response training includes a host of other specialized training programs offered by/through the Ohio Emergency Management Agency (OEMA), a division of the Department of Public Safety, and the Ohio Department of Natural Resources (ODNR). The ODNR provides specialized training through the Division of Forestry on Wildfire Behavior, limited to their designated fire protection areas. The Division of Forestry is the State's liaison with the U.S. Forest Service and supports the training and equipping of national fire crews. The OEMA provides specialized training in Emergency Planning and Exercise, Emergency Management, Radiological Incidents, terrorism and CAMEO (Computer Aided Management of Emergency Operations). All of the special offerings are federally funded through sources such as the Federal Emergency Management Agency (FEMA) and the Environmental Protection Agency. The OEMA is the State's liaison with the Federal Emergency Management Agency's Emergency Management Institute. (Appendix H)

V. Regional Meetings

The collection of information about all the training opportunities for fire and EMS personnel, and the accompanying concerns, issues and complaints about training and testing procedures led the Task Force early on to establish a priority stage in their work; the need to gain input from boundaries beyond Columbus, Ohio. The Task Force considered necessary the involvement and contributions from the fire and EMS service customers statewide. Inviting user groups into regional forums illustrated quite clearly the significance of this effort and the importance of customer input. Task Force members shared the responsibility for hosting five regional meetings on October 6, 1999 in Columbus, Findlay, Akron, Nelsonville, and Middletown. (Appendix I)

An estimated 225 representatives from local governments, EMS services, fire

departments, Joint Vocational Schools, and other interested parties attended the five regional information gathering sessions. Each regional forum was equally well attended, and the participants who gave of their own time to attend were well prepared, thoughtful, and earnest in their remarks. The comments heard by the task force members were mirrored across the state. Most of these "customers" of Ohio's Fire and EMS training and certification delivery system expressed frustration with the service delivered by the Division of EMS and, to some extent, some concerns with the Office of the State Fire Marshal. The comments overwhelmingly, however, signaled dissatisfaction with the Division of EMS in relation to telephone and information systems, the certification and testing process, and confusion surrounding educational requirements, in general. Suggestions were made to add continuing education requirements for firefighters and to equalize or standardize somewhat the fire and EMS certification and education requirements. Poor communications between state agencies and local governments, local training institutions, local fire and EMS service providers and instructors also surfaced as a concern. Funding issues for vocational schools, the dedicated budgets, the distribution of EMS grants and the desire for additional fielding and grants for local fire departments were also a significant topic. Finally, a substantial number of attendees at the regional meetings noted the difficulty of working between two state agencies and expressed a wish for consolidated services from the state level. All of the testimony heard at the regional forums was recorded on videotape for accuracy of reporting and for the archive.

The Task Force members reported back to the third meeting of the full membership all details of comments and concerns from the field; messages consistent from all areas of the state and all representative customer organizations. Joined with similar concerns that Task Force members themselves had taken the opportunity to express, a substantial list of issues was compiled. The Task Force then divided the list into three primary categories: Training; Testing and Certification; and Service Delivery. Subcommittees were established to review, summarize and prioritize the issues in each of these areas and did do with a narrative and summary chart report. Full subcommittee reports are included in Appendix J.

VI. **Survey From Other States**

Because the input of Ohio's Fire and EMS community was valuable in crafting the recommendations of the Task Force, the members also decided to look beyond Ohio's borders. How did other states administer emergency training? How did other states pay for public safety services? With the goal of benchmarking in mind, and seeking best practices, the task force queried other states through the State Training Director's, the State Fire Marshal's Association, and the Association of State EMS Director's. (Survey -Appendix K)

The one lesson clearly learned was the diversity in organization and funding of public safety services across the nation. The 37 surveys returned are rich in information with

little consistency among the states and the agencies responding. The Task Force agreed that while it was of benefit to have made the collection effort, the information assembled was difficult to make use of at this time. The members concurred that the collected information would be saved as a source of data for both the Office of the State Fire Marshal and the Division of EMS to continue to review for best practice concepts.

VII. Recommendations of the Ohio Task Force on Fire and EMS Training

Information collected, digested, and discussed at length, the task force turned to the responsibility of the assigned report and recommendations. These recommendations follow the format as set by the formal charge to the Task Force. Most of the issues and suggestions as reported by the Subcommittees on Training, Testing and Certification, and Service Delivery will have a logical position in these overall recommendations. The Task Force requests that the subcommittee issues which perhaps stretched beyond the bounds of the charge of the task force, yet are identified concerns, be addressed by the departments and divisions/offices involved.

A) How can the state coordinate fire and emergency services training so as to increase efficiencies, lower overall costs and provide customers simpler point of contact for **arranging training opportunities?**

Based upon comments from the field and the Task Force membership, most feel that significant consideration should be given to consolidation of fire and EMS training, certification and service delivery in one agency. Members of the state's fire services organizations seem particularly adamant about the need to coordinate services by consolidation, and, in fact, presented a model for consideration. (Appendix L) The customer base feels that a single agency point of contact would be simpler, more efficient, and more cost effective. A "one-stop-shop" approach consolidating the rules and regulations, testing, training and certification, resource and information delivery, and funding and grants clearly has merit. To accomplish this would require no less than the Governor's support and legislative and statutory changes regarding placement of offices in state agencies and finding mechanisms, as well as a substantive redirection of the involved agencies' budgets.

- The Task Force recommends that the issue of single agency consolidation of fire and EMS training and services be given serious consideration by the Directors of Commerce and Public Safety and the Governor's Management Improvement Commission.

In the meantime, as noted in the subcommittee reports, a great deal can be accomplished by focusing on administrative and operational changes which will improve training

delivery. It is recommended that the state coordinate training and delivery by:

- Re-establishing regional training coordinators. (EMS) Establishing, publicizing
- and utilizing a Communications Plan. (EMS and SFM)

- Utilizing technology, especially the Internet, in addition to current forms of communication, to design an information clearinghouse. Developing an interactive inquiry system for information regarding status of certification, test, or renewal. (EMS and SFM)
- Establishing an automated telephone system for response to Frequently Asked Questions. (EMS)
- Updating and keeping communication current regarding all curricula, materials, and corresponding tests. (EMS)
- Establishing and monitoring a clearinghouse of grants for local agencies. (EMS)
- Increasing communications to and solidifying the relationship with schools and instructors.(EMS)
- Working with training delivery partners, such as local training institutions, to decentralize the testing and grading process for fire and EMS certification tests and to review alternative testing mechanisms for fire and EMS. (EMS)
- Evaluating the disparities between recertification of EMTs and no renewal requirements for Firefighters and seeking the necessary legislative changes to make for a more equitable system of requirements. (EMS and SFM)
- Implementing a more prompt and efficient certification and card issuance process, such as using the state's deputy registrar locations to issue certification identification cards with proof of requirements met.(EMS)

B) **How can the state agencies which provide fire and emergency** services **training better coordinate their offerings with those provided by or coordinated through** local and/or federal government?

The Task Force believes a single agency system would provide more coordinated training, certification and testing, rules and information delivery. A single agency training model was prepared as an example by Fire Academy staff of the Office of the State Fire Marshal. (Appendix M)

In the short-term, the Division of EMS and the Office of the State Fire Marshal should make an Internet and print version clearinghouse of information regarding training, certification and testing readily available, as noted above. A concentrated effort to create and continue this information base as a shared responsibility of the two primary agencies, the State Fire Marshal and the Division of EMS, would go a long way to improving communications statewide.

Another coordination issue of concern is the length of time it takes for BCI to conduct a background and fingerprint check of Fire and EMT candidates for the local employers, Fire Departments and EMS services. The Task Force requests that BCI be made aware of the Task Force concerns and asked to expedite the process and the turn around time for Firefighter and EMS personnel. In fact, the Task Force believes that EMTs and Firefighters should qualify as public safety candidates, much like law enforcement, and be granted prompt processing.

C) **What additional training opportunities should the state offer and which agency should provide the training?**

The significant issue here was the ability to equalize training opportunities statewide. For example, the Task Force recommends that funds be sought and obtained for regional live fire facilities throughout the state, perhaps under the supervision of the recommended regional coordinators. These facilities should be located regionally so that there is a training facility within an hour's drive of every fire department in the state. Under the current required training standards, and the hours set by law, many beginning volunteer firefighters do not participate in a live fire as a training exercise, but experience their first live fire in a real emergency scenario. Live fire training centers are not readily available. In fact, 80 of Ohio's 88 counties do not have such a training facility. Large paid-professional fire services may operate a training facility, but the vast majority of Ohio's firefighters outside these services have less opportunity in the way of live fire training, a significant safety concern, as well as a training issue. Live fire training facilities are the physical setting necessary for achieving additional training recommendations as listed below which place an emphasis on firefighter safety through required live fire training. The Task Force recommends that these training centers and training recommendations be adopted within two years time.

Other additional training recommendations include:

- Better vigilance at maintaining a standard fire curriculum and testing system.(EMS)
- Develop and seek approval for a continuing education program for firefighters.(EMS and
- SFM) Waive the teaching methodology requirement for instructor certification candidates with a teaching degree or demonstrated ability, and require continuing
- education for instructor certificate renewal. Revise the 36-hour Basic Firefighter course with supplemental modules for specialty training such as wildland, interior structural firefighting, and hazardous materials awareness.(EMS)
- Revisions to the volunteer and part-time firefighter training requirements:
  Volunteer Firefighter

1 St year	Complete 36-hour Basic training course with a focus on orientation, firefighter safety, and basic skills. Satisfactory completion of a haz mat awareness and operations

program. Prior to engaging in interior structural firefighting, satisfactory completion of alive fire training module. By End of 3rd year Satisfactory completion of a 74 hour (1-B) training program and

meet NFPA Firefighter I standards.

Part-Time Firefighter

1 St year	Meet all requirements above, including the 1-B program, and the NFPA Firefighter I standards.

Career Firefighter

1 st year	Complete the 240 hour fire recruit training course, and meet NFPA Firefighter II standards.

D) How can test scheduling and registration be improved to provide for the prompt test registration needs of the fire and EMS services?

The Task Force recommends no less than an entire overhaul of the testing process conducted by the Division of EMS. No program gathered as much criticism and concern from all customers as the current testing registration and grading process. Lost registrations, inefficient service, testing locations, lag time between test and grade, incapability in accessing information and actual employment concerns because of inability to be promptly tested and certified all surfaced as viable concerns. An additional consideration was the usefulness of the National Registry as the testing source and mechanism for EMTs. Timeliness, pertinence to practical training, pass rates, and simply the fact that the Registry does not represent an Ohio test, all numbered as Task Force discussion points. With this significant concern, the Task Force felt that the recommendations must include a strong endorsement to evaluate testing methods, timeliness and alternatives to the National Registry.

The fire service representatives of the Task Force remain adamant about testing on demand. Funding, time demands, staff levels and a comparison with a multitude of other professional examinations for certification or licensure suggest that this is not a viable option. However a great deal can be done to improve this process in service and efficiency.

- Establish "permanent" testing sites statewide with established and published hours of operation so that tests may be given at any time to individual applicants during hours of operation. Such sites might include deputy registrar/driver exam stations, vocational schools, colleges or universities. The final approved listing will be based on geographic representation, customer demand and reasonable cost.
- Offer the option for application for a specific test date request at the class location with a proctor for large class groups.
- Establish decentralized prompt grading so that with proper paperwork, upon

successful passage of the appropriate test, an individual can report to a designated site and be issued a certification card.

- The certification card would be an identification card, such as a driver's license, with the appropriate Fire and EMT endorsement, renewable at recertification time, as designated by rule or code. A small appropriate cost for issuing the certification card would be considered based on reasonable costs and funding availability.
- Utilizing such technology would allow for the compilation of a database of certified firefighters, instructors, inspectors and EMTs at all levels which could form the basis of an interactive inquiry system for status of an individual's certification.

E) **Which agency or agencies should administer each type of training offered?**

The Task Force feels a service improvement could be gained by moving towards a single agency system for training. With the addition of regional training coordinators, improved training, outreach, and communications would be more easily achieved. However, given the legislative and budgetary modifications this would entail, this project needs substantive review and planning and ultimately, approval.

In the meantime, achievements in service delivery, through recommendations noted throughout this report, will go a long way to bettering the administration of training. Currently, the Division of EMS, with the approval of the EMS Board, administers all EMS training. The Division also administers fire training. While the basic administration of training is in one agency, the service delivery is more fragmented. In fact, while the Fire Academy is renowned for fire service training, the Academy itself is not a chartered training institution for fire or EMS certification training. While the EMS Board represents the fire and EMS community, by statute, there is no designated representation from the SFM or the Fire Academy. At a minimum, staff level coordination and participation should broaden to include EMS and SFM staff at EMS Board meetings and Firefighter Training Sub-Committee meetings and Public Safety EMS staff at Fire Commission meetings so that a more thorough and connected approach in planning, information exchange and training can be achieved.

In addition, basic service delivery, or customer service, improvements need to be made by the administering agency, the Division of EMS, as noted throughout this report.

F) **Funding**

Although not one of the original questions to.be addressed, the issue of funding crosses all boundaries in the points reviewed. The Task Force felt that a specific, separate, and priority recommendation regarding funding be indicated.

- The Task Force strongly encourages that policy and budget decisions made regarding the dedicated funding sources that exist for the Office of the State Fire Marshal and the Division of EMS utilize and account for all of the dedicated funds, and that these fiends go entirely to the benefit of the service as designated by law.

There are also perceived inequities in the fire and EMS funding mechanisms. EMS services currently have $3.5-4 million in grants available to them in a state fiscal year to be used for initial training or continuing education, training equipment and patient care equipment. The Fire Marshal's budget includes $1.5 million for firefighter grants in specific categories. With 70-75% of Ohio's firefighters in the volunteer or part-time category, and nearly 70% of EMS provided by Ohio's fire departments, volunteer and paid, the fire services hope that impetus can be given to seeking more training and equipment assistance funding for fire service needs.

The survey conducted of other state's fire and EMS training and budgets revealed multiple fiinding mechanisms across the nation for public safety services, including some states that support local public safety services training entirely from state budgets. The Task Force advocates continued review of finding sources to better support Ohio's' not-for-profit fire and emergency medical services. At a minimum, it is hoped that alternative and additional sources for training and equipment grants for fire services can be identified. Mindful of the concern mandates pose for state and local governments, yet recognizing that public safety services represent a partnership between state and local governments and a valuable and necessary service for the protection of all of Ohio's citizens, consideration should be given to state funding to offset the costs of mandatory training for EMS and fire personnel.

The Task Force also wishes to call special attention to the following funding concerns:

- Joint Vocational Schools rely heavily on the minimum reimbursement received per hours taught in public safety services, yet this funding is entirely reliant upon the Ohio Department of Education Budget. With no dedicated source, the funding levels are not assured.

- The Task Force is concerned with the flat level of income directed to the Office of the State Fire Marshal over the years as generated by the .75% of gross fire insurance premium receipts. While there has been a 27% increase in the gross state product, the insurance premium receipts show no increase that could be attributed to economic growth over time. Instead, the fund has remained static. The Task Force questions whether the total amount is being collected, if some adjustment factor occurs, or if there is some other rationale for this fund not

reflecting economic growth patterns. In fact, the question is whether the funding amount available is consistent with the intent of the original legislation.

VIII. Conclusions

The members of Ohio's Task Force on Fire and Emergency Response Training thank Governor Taft, Lt. Governor O'Connor and Director Suhadolnik for their leadership and interest in Ohio's firefighters and emergency medical services personnel, partners in the protection of and service to Ohio's citizens. The ninety -day deadline was a challenge to meet. Members of the Task Force engaged in a candid and forthright exchange of information over the three-month period.

With an earnest dedication from all members, and the dialogue and synergy that evolved, the Task Force is confident that this report summarizes the issues and challenges that face Ohio's public safety services in the matter of training, testing and certification, and service delivery. The Task Force also deems these recommendations and solutions achievable. Many of the solutions proposed should entail no more than sound administrative changes and good management.

On behalf of the broad representation of Ohio's fire and emergency services community that the Task Force represents, we respectfully recommend these changes for better assistance to emergency services in Ohio and protection for Ohio's citizens.

-Submitted by the Ohio Task Force on Fire and Emergency Response Training-
December 15,1999

APPENDIX C

Bob Taft, Governor

Lt. Governor Maureen O'Connor, Director

Laura L. Tiberi
Executive Director
Emergency Medical Services
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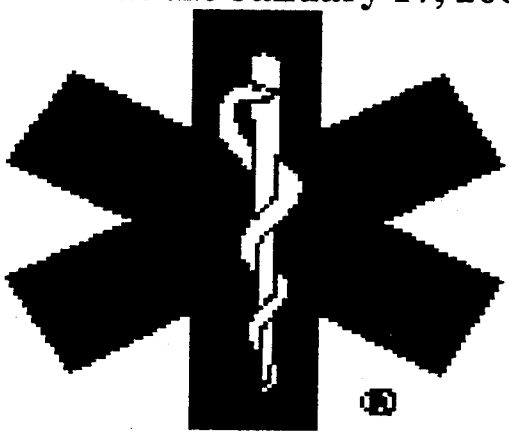
Columbus, OH 43218-2073
(614) 466-9447 ● (800) 233-0785

OHIO DEPARTMENT OF PUBLIC SAFETY
- Administration
- Ohio State Highway Patrol
- Bureau of Motor Vehicles
- Emergency Medical Services Division
- Emergency Management Agency

Division of Emergency Medical Services
Staff and Committee reports to the State EMS Board for 2000
Presented to the Board at the January 17, 2001 Board Meeting



Mission of the Division of EMS: To save lives and minimize disability to Ohio's citizens and visitors by developing and continually enhancing a statewide, comprehensive, systematic response to injury, illness and fire, primarily through education and training, certification, and strategic planning.

The EMS Division of the Ohio Department of Public Safety serves as the administrative arm of Ohio's State EMS Board, a regulatory board. This statutorily created Board includes representatives from Ohio's medical community, EMT organizations and practitioners, and representatives from Ohio's fire services.

State Board of Emergency Medical Services
O.R.C. 4765.02

James Augustine	Dayton	November 12, 2001	1.
Mark Burgess	Ashland	November 12, 2001	6.
Larry Ables	Dayton	November 12, 2001	9.
Merle Stewart	East Palastine	November 12, 2001	12.
David B. Fiffick	Youngstown	November 12, 2001	16.
Kathryn Haley	Columbus	November 12, 2001	5.
William Cotton	Columbus	November 12, 2002	3.
Charlene Mancuso	Cleveland	November 12, 2002	4.

Mission Statement
"to save lives, reduce injuries and economic loss, to administer Ohio's motor vehicle laws and to preserve the safety and well being of all citizens with the most cost-effective and service-oriented methods available."

Martin Mace	Fairview Park	November 12, 2002	10.
Mark Mankin	Reynoldsburg	November 12, 2002	13.
Ed Close	Beverly	November 12, 2002	15.
Raymond Walendzak	Oregon	November 12, 2003	7.
Joseph Toth	Parma	November 12, 2003	8.
Carl A. Jordan	Massillon	November 12, 2003	11.
Mark N. Resanovich	Uniontown	November 12, 2003	14.
Mark Marchetta	Akron	November 12, 2003	17.
Richard Fratianne	Cleveland	November 12, 2003	2.
Andrew Hawk	Dayton	November 12, 2003	18.
Larry Willard	Logan	November 12, 2003	19.
Sgt. Gary Lewis	Columbus	Appointed by the Director of Public Safety	

Membership
20 members, 19 appointed by the Governor; 1 ODPS staff person appointed by the Director of Public Safety

Term
Three years

Qualifications
Members must have a background or experience in emergency medical services or trauma care. The Governor makes the appointments based on recommendations submitted by the following groups, each of which submits three names to the Governor.

1. American College of Emergency Physicians, Ohio Chapter / EMS Certified Physician
2. American College of Surgeons, Ohio Chapter / EMS Certified Surgeon
3. American Academy of Pediatricians, Ohio Chapter / EMS Certified Pediatrician
4. OHA; Osteopathic Association; Children's Hospitals Association; Health Forum / Administrator of a Hospital with adult or pediatric trauma center
5. Ohio State Council of Emergency Nurses and Ohio Nurses Association / RN
6. Ohio Fire Chiefs Association / Fire Chief with primarily full-time EMS squad
7. Ohio Fire Chiefs Association / Fire Chief with primarily voluntee EMS squad
8. Ohio Emergency Medical technicians Instructors Association/ EMT Instructor
9. Ohio Association of Professional Firefighters and Northern Ohio Firefighters/ EMT-Basic
10. Ohio Association of Professional Firefighters and Northern Ohio Firefighters / EMT-I
11. Ohio Association of Professional Firefighters and Northern Ohio Firefighters / EMT-Paramedic
12. Ohio State Firefighters Association / EMT-Basic
13. Ohio State Firefighters Association / EMT-I
14. Ohio State Firefighters Association / EMT-Paramedic
15. Ohio Association of Emergency Medical Services / EMT-Basic, Intermediate OR Paramedic
16. Ohio Ambulance Association / Member
17. EMT-Basic, EMT-Intermediate or EMT-Paramedic / at-large member affiliated with an EMS Organization
18. Ohio Association of Air Medical Services (Ohio Assoc of Critical Care Transport) / Chief Medical Officer
19. OHA; Osteopathic Association; Children's Hospitals Association; and Health Forum / Administrator of Hospital Not a Trauma Center

Compensation
Expenses only.

EMS Board and Division Responsibilities include:

- Certification of Emergency Medical Technicians at the First Responder, Basic, Intermediate and Paramedic levels
- Accreditation and approval of EMS training sites for initial certification and continuing education programs
- Certification of approved state EMS instructors
- Curriculum design and oversight for EMS
- Administration of a multi-million dollar grants program; in 2000, $4.9 million was awarded to EMS agencies for training, training equipment, and patient care equipment
- Creation and implementation of a statewide trauma registry
- Implementation of H.B. 138, the "Trauma Bill," with the assistance of a Trauma Committee appointed by the Director
- Coordination of statewide regional physicians advisory boards which oversee EMS systems at the regional level and provide input and guidance into statewide protocols
- Coordination of the federally funded initiative designed to improve emergency care for children, EMS-C and the statewide leadership for Ohio's SafeKids
- Creation and maintenance of statewide EMS incidence reporting and data collection

EMS FACTS:

Total Active Certifications

First Responder	1426
EMT-Basic	20,382
EMT-Intermediate	3,059
EMT-Paramedic	11,187
Total	36,054
EMS Instructors	1468
Special Topics Instructors	968

Certifications Issued in 2000 (through December)

First Responder	832
EMT-Basic	7,595
EMT-Intermediate	1310
EMT-Paramedic	4000
Totals for 2000	13737

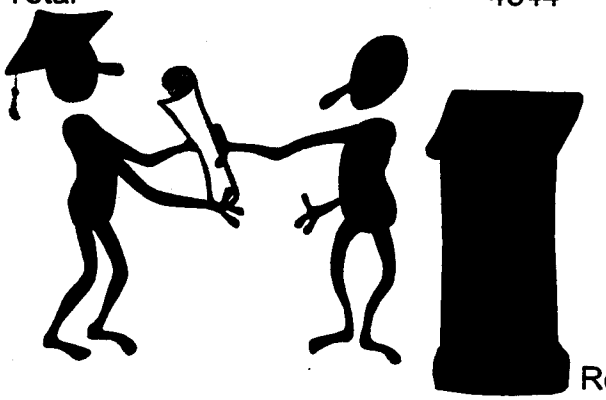
Current Continuing Education Sites 330
Accredited Schools (EMS) and Fire Charters 122

Total EMS certifications eligible for renewal/recertification

EMT-Basic	8455
EMT-Intermediate	1910
EMT-Paramedic	3532

Total renewals processed in 2000

EMT-Basic	1941
EMT-Intermediate	471
EMT-Paramedic	2132
Total	4544



Renewals Randomly Audited 480

Approximate First Time Pass Rates:

First Responder	79%
EMT-Basic	72%
EMT-Intermediate	65%
EMT-Paramedic	78%

Extensions given in 2000 989
Reciprocity granted in 2000 142

Fire Certifications:

Total Active Certifications By Level

Firefighter 1A (Volunteer)	42,957
Firefighter 1/1B	3,376
Firefighter 1&2/1C	19,749
Fire Safety Inspector	15,709
Total Fire Certifications	81,521
Fire Instructors	1743
Asst. Fire Instructors	427

Fire Certifications Issued in 2000 (through December):

Firefighter 1A	1960	
Firefighter 1B	551	
Firefighter 1C		350
Firefighter Level 1		119
Firefighter Level 2		1060
Fire Safety Inspector		579
Totals for 2000		4619

Office Operations:

The telephone auto-attendant system was put into place in April 2000. Up to that point, there was no mechanism for calculating telephone calls.

April through December 2000

44,497 telephone calls received and answered on the office main line only
Only 961 received the greeting that says "due to heavy volume we are not able to take your call at this time. Please call back later."
23 callers were not able to get through at all because all phone ques were full

Case Investigations/ EMS Investigative Services

Case Classification	Year-to-Date Total (year 2000)
101-Misdemeanor Convictions	13
102-Felony Convictions	15
201-Falsification	1
203-Forgery	1
206-Falsified EMS Application	1
303-Instructor Certification	1
306-Unauthorized Possession of Exams	1
307-Improper Instruction	1
401-Patient Care	4
402-Protocol Procedures	3
403-Scope of Practice	7
404-Staffing Procedures	1
405-Transporting Errors	2
505-Non Paymnt/Child Support	1
Total	52
Notices of Opportunity Approved by Board	23
Chapter 119 Hearings Conducted	8
Number of Completed Cases	9
Cases Open/Active	43

Investigative Services on behalf of the State Board made significant strides in efficiency and effectiveness. A lead investigator, an additional compliance officer, and a secretary were added to Division staff. Improvements and Achievements include:

- Presentation to and adoption by EMS Board of a formal investigative policy to promote uniformity in the conduct of investigations and to ensure investigations are Fair, Impartial and Reasonable.
- Persons party to an investigation are fully informed at the outset of the investigation
- Standardized complaint forms and policy initiated; available for download on web-site
- Case investigation classification and tracking system fully implemented to promote management of the system from initial complaint to final adjudication and comprehensive monthly statistical reports to Executive Director and Board
- EMS case tracking identifies common areas of investigation and discipline which will lead to the categorizing of trends and training needs
- The EMS certification database reflects internally pending cases or disciplinary actions

Regional Physicians Advisory Boards

A coordinator was hired in 2000 to recreate the Board's and Divisions efforts in the area of coordination of the RPAB's. In Ohio's ten (10) regions, most have 7-9 members. An Annual RPAB meeting was conducted in November to kick-off the new organizational details, encourage participation, and highlight information needed by the physicians who assist in medical direction for Ohio's EMS services. The newly rejuvenated RPABs will provide a strategic resource for the success of the statewide trauma system. All regions have resumed regular meetings. A quarterly Chair's meeting calendar has been established. And a protocal advisory group is currently forming to assist in the development and evaluation of state minimum guidelines. State EMS Medical Director, Dr. Drstvensek, and the RPAB Coordinator continue to work closely on these medical issues.

Legislative Activity

The year 2000's legislative highlight was the passage of HB 138, the Trauma Bill, signed by the Governor in a ceremony at Children's Hospital in July and effective November 3, 2000.
The new trauma bill establishes a statewide trauma system. Over the next two years, rules and protocols will be developed to match severely injured adults and children with the hospitals best equipped to provide the specialized medical care that critical trauma victims require.

The bill, sponsored by Rep. William Schuck (R-Columbus), provides for the establishment of a state wide trauma system, linking EMS, hospitals, and trauma centers. The EMS Board's Trauma Committee and the Regional Physician Advisory Boards will play a significant role in helping the EMS Board develop these protocols The Ohio Department of Public Safety's EMS Division and State EMS Board will oversee the development of a state protocol for the triage of severely injured adult and pediatric trauma victims.

Hospitals caring for severely injured patients will be required to meet national standards for trauma centers set by the American College of Surgeons. All hospitals in Ohio will be required to have trauma care protocols and transfer agreements with trauma centers. The goal is to provide the most seriously injured with the best care possible.

The EMS Board's Trauma Committee is comprised of 24 healthcare and EMS experts from across the state. Appointed by the Director of the Ohio Department of Public Safety, Lt. Governor Maureen O'Connor were the following:

1. Jay A, Johannigman, MD	General Trauma Surgery/Cincinnati
2. Martin A. Torch, MD	Orthopedic Surgery/ Columbus
3. Michael B. Shannon, MD	Neurosurgery/Zanesville
4. Sidney F. Miller, MD	Surgery with Burn Victim Specialty/ Dayton
5. Mark L. Billy, DDS	Oral and Maxillofacial Surgery/ Austintown

6. Greg Nemunaitis, MD	Physical Medicine and Rehabilitation / Toledo
7. Victor Garcia, MD	Pediatric Surgery / Cincinnati
8. Michael D. Mackan, MD	Emergency Medicine Physician / Akron
9. Joseph W. Luria, MD	Pediatric Emergency Medicine / Cincinnati
10. Howard Werman, MD	Air Medical Physician / Columbus
11. William Emery, MD	Coroner /Ashland County
12. Kathryn Jo Haley, RN	Registered Nursing-Trauma Center / Columbus
13. Nancie M. Bechtel, RN	Emergency Nursing /Columbus
14. Timothy Erskine	Trauma Registrar / Cincinnati
15. Jean Kirchner	Trauma Center Administration / Toledo
16. Lynn V. Horner	Hospital Administration / Orrville
17. Michael H. Perkins	Ambulance Company Operations / West Lafayette
18. Kenneth A. Rybka	Fire Chief / Bedford
19. Jason Kinley	Firefighter and EMT-P / Xenia
20. Enrique Grisoni, MD	Physician with Trauma Administrative Responsibility / Cleveland
21. Sue Fickle, RN	Hospital Representative / Lima
22. Karen Weaver	Hospital Representative / Defiance
23. Patrick Dunster, MD	Hospital Representative / Millersburg

One additional appointment, a trauma victim advocate, remains to be named.

The Trauma Committee, working closely with the Regional Physician Advisory Boards, will assist the EMS Board over the next two years in developing the rules and protocols necessary to ensure that the most seriously injured trauma victims in Ohio are matched with an appropriate level of medical care.

The **Board's Legislative Committee** also prepared a Board approved legislative agenda which was presented to Lt. Governor Maureen O'Connor, Director of Public Safety, for endorsement. The following legislative goals have been recognized by ODPS and will be carried by the department's legislative liaison into the legislative process in 2001 with the 124th General Assembly. The items to be pursued in this legislative package include:

- A realignment/redrawing of the prehospital emergency medical services regions as currently outlined under O.R.C. 3702.58 to allow for the defining of these districts by the Division of EMS authorized under O.R.C. 4765.
- The establishment of subpoena power for the Board as an investigating agency.
- Authority to issue summary suspension of a certificate to practice for individuals where overwhelming evidence shows a violation of the O.R.C./O.A.C. that is serious in nature and may effect the safety or well-being of the public.

OHIO EMSC – 2000

As a section of the Division, Ohio's EMS-C coordinators have combined EMS leadership in Injury Prevention, state leadership for Ohio's SafeKids, and the

federally-funded EMS-C effort into a comprehensive injury prevention program focusing on children. Utilizing the strength of Board members in pediatric medicine, the result is an EMS Board committee for EMS-C which provides oversight and direction to these projects.

EMS and Injury Prevention: Advocates for Children

The primary goal of our new EMSC Partnership Grant is to increase the involvement of EMS providers in community-based injury prevention initiatives. This goal will be accomplished by 1) offering regional injury prevention training to EMS providers; 2) offering funding to EMS agencies through sub-contracts; and 3) creating an injury prevention resource manual for EMS. Following is a summary of progress for each of these objectives:

1. Contracted with an injury prevention specialist to facilitate 10 regional training sessions. The injury prevention training sessions have been successful, with over 150 participants in attendance.

1. Injury prevention subcontract proposal forms have been developed based on models provided by the Delaware, Virginia and New Mexico EMSC programs. Thirty-two applications were received this year. Eighteen subcontracts were awarded in November for an approximate total of $89,000.

1. Adapted the New Mexico EMSC Program's *EMTs and Injury Prevention:Advocates for Children* for use in Ohio. Three hundred training manuals have been printed for use in 10 regional trainings.

Child Day Care Project

The Ohio EMSC program has updated and revised Ohio's approved first-aid curriculum for child day care personnel in an effort to standardize training and establish a statewide network of trainers. In 2000, twelve train-the-trainer sessions were completed, resulting in the training of over 300 eligible instructors. Those who have completed the training have been added to regional referral lists to be accessed by day care providers. Training manuals are currently available to anyone eligible to teach the curriculum. To date, we have distributed 525 of the revised first aid curricula to eligible instructors in Ohio.

Ohio has also collaborated with the State of Oklahoma to put our curriculum on a CD ROM with their current day care project. They are currently available through the EMSC Resource Center.

Guidelines Evaluation

Ohio EMSC has recently completed an evaluation of our *Emergency Guidelines for Schools* which were created under a previous enhancement grant. Over 20,000 copies of the guidelines have been distributed throughout the state and thousands more nationwide. The guidelines are in the process of being revised and reprinted.

PEPP Training

The Ohio EMSC program has sponsored training for six individuals to become PEPP course coordinators. These coordinators will train EMS personnel throughout the state and establish a network of PEPP trained instructors. Our goal is to sponsor train-the-trainer PEPP meetings in Ohio specifically in areas where there are no pediatric hospitals or trauma centers. We are sponsoring a PEPP train-the-trainer course in Southeast Ohio in March, 2001. The Ohio EMS Board has approved the PEPP course for continuing education in Ohio and has approved grant funds to be utilized for PEPP training.

Ohio SAFEKIDS

The Ohio EMSC Program has responsibility for lead agency activities for the Ohio SAFE KIDS Coalition. The Coalition serves seventeen local coalitions. The Ohio program has recently secured state grant funding for Ohio SAFE KIDS activities and workshops.

Ohio SAFE KIDS Coalition

Children's Safety Calendar

We are coordinating our annual EMS Children's Safety Poster Contest. An awards ceremony took place in October to award prizes and honor the winners of this annual EMS event. Fourteen winners were selected from over 4,000 entries. The winners received a bicycle with a helmet. Over 220 helmets were given as honorable mention prizes. The calendars are being distributed throughout Ohio to all EMS agencies, schools, child care centers, health departments, pediatricians, SAFE KIDS Coalitions and others upon request.

EMSC Staff

Ohio has two full-time EMSC coordinator positions funded by state funds. Alan Boster, and Christy Beeghly, MPH, EMT-B, EMSC Coordinators

EMSC Website

The Ohio EMSC website was expanded and enhanced during 2000. All current Ohio EMSC products and resources are available on the website. It also contains descriptions of current projects and links to other related sites.

TRAUMA COMMITTEE

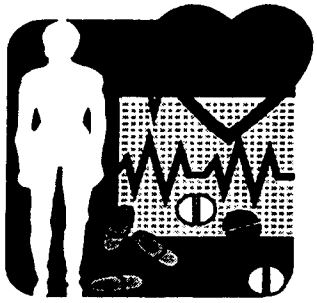
Trauma Report to EMS Board
Activities for 2000
Reporting in January 2001

Trauma Committee

1. The trauma committee has met 3 times, and has scheduled monthly meetings though the end of 2001.
2. Elected a chair (Dr. Luria) and vice chair (Dr. Johanningman)
3. Adopted a basic set of committee standard operating procedures.
4. Two standing and one AdHoc committee have been created to address details of certain assigned activities
5. Requests that the EMS allow the Trauma Registry Advisory Committee to report to the Board through the Trauma Committee, thus eliminating the need to have a second data committee under the trauma committee.
6. The position of victim advocate is being pursued, the two nominating organizations have been contacted, expect nominations list from the Governors Council on People with Disabilities soon, awaiting the Ohio Brain Injury

Association's list. The OBIA Ex. Dir. attended the December meeting as a guest

7. Triage protocols are a priority activity



Trauma Registry Advisory Committee

1. Held six meetings between April and October 2000. Meetings in November and December were not held in deference to the Trauma Committees activities.
2. The TRAC meet several times between May 1999 and October 1999, without ever achieving a quorum. Thus, a chair as required was never elected, nor any official business conducted. The committee did review several reports, looking at the baseline validity of the data collected to date.
3. The database of hospital registry contacts has been updated and a scheduled contact information data maintenance is in place.
4. The first issue of a regular newsletter, ***The Register***, was published on June 1
5. Regular monthly meetings are scheduled for 2001.
6. The nominating organizations for seats on the TRAC have been contacted with a renewed request to nominate if the seat is empty, re-consider their nominee if they have not attended, or confirm that their existing member is interested in continuing.
7. The TRAC is planning to publish an annual report of 1999 trauma registry data, early in 2001.
8. The Register will be published on regular basis (4 issues/2001, 6 issues/2001)
9. The state data set will be evaluated and possible deletions/additions/changes to data points will be recommended
10. The framework for collecting data from the County Coroners and Rehabilitation facilities will be developed. The goal is to begin collection of data 1/1/02. Beta testing of data downloads as early as the 3rd quarter 2001 (electronic data transfer from the death certificate database at the DOH)
11. Develop a web based data system, for Rehab facilities to report through.

Trauma Coordinator Activity

- Several speaking engagements were undertaken addressing the trauma legislation, especially on trauma registry issues, pertinent to regional organizations in Lima, Dayton, Cleveland, and Toledo.
- Established contacts with state trauma coordinators and/or state EMS offices

and Health Departments which have jurisdiction over their trauma systems in Texas, Washington, New York, Oregon, California

- Created a power point presentation for use by EMS office in speaking to public and professional organizations about the trauma legislation.
- Have met with several Ohio state organizations to create a liaison/contact with them for enhanced communication (College of Surgeons, Trauma Coordinators, Trauma registrars, Ambulance Association). During early 2001 plan to meet with College of Emergency Physicians, Hospital Association, Coroners Association, Air Medical Association and Emergency Nurses)
- Attended the Annual Regional physicians advisory board meeting and spoke on the status of the trauma legislation activity
- Created an extensive mail and e-mail database of trauma committee members, trauma committee nominees, interested individuals, EMS Board members and nominating organizations to facilitate communications.
- Developed a base of information to be used for trauma legislation and registry information on the EMS website.

GRANTS COMMITTEE

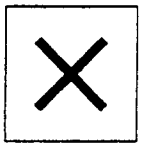
The Division of EMS Grants Coordinator provided staff assistance to the Grants Committee in 2000. The safety belt funded state EMS Grants Fund provided for 603 grants to state EMS agencies in FY2000 for a total of $4,922,091 in reimbursement grants awarded. These grants, per statute and rules developed by the EMS Board, are dedicated to training, training equipment, patient care equipment and research regarding the quality and accessibility of care. Money's above the projected $3,000,000 available were added to the FY 2000 grant base by gaining Controlling Board approval for a carryover of unspent grant funds from previous years.

In a separate grant award, a joint venture of the Board's Grants and Systems Management Committee, a portion of unspent grant funds from previous years was carried forward for a special computer assistance grant. This special offering provides funds for eligible EMS agencies, to purchase the hardware necessary for compliance with Ohio's upcoming EMS data collection effort. 538 agencies applied for and received computer grants totaling $505,585.

The grants process was also administratively streamlined to allow for local determination and justification of training and equipment needed, rather than intensive selection by the committee at the state level. The grants committee continues to seek appropriate methods and rules changes to allow for even more efficiency and maximum use of the available grant funds.

See grants insert for funds history

EDUCATION



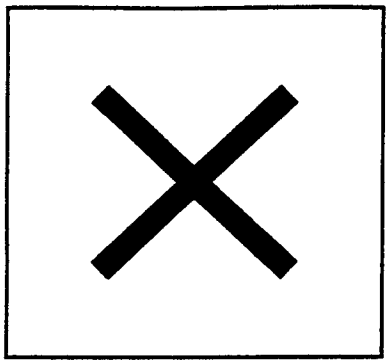
In 2000, the Education Committee finalized the rules language for the paramedic curriculum which were subsequently approved by the Board; assisted the Board with an animated Public Hearing; and followed through with the final filing of the rules January 2, 2001. (effective date March 1, 2001) The committee led the roll-out sessions for paramedic training institutions relative to the new paramedic curriculum, the USDOT curriculum adopted by the Board in 2000. Thirty-eight of the forty-one paramedic programs were represented at the roll-outs.

The Committee also maintained a subcommittee to review the new USDOT Intermediate curriculum and recommendations. By motion of the committee, the EMS Board approved adoption of the national Intermediate curriculum in Ohio. The committee remains charged with a recommendation of hours. The national recommendation is 600 hours; the committee reported to the Board that they were evaluating a range of hours probably between 230-400 and asked for Board members final comments by August 16, 2000. However, the final report to the Board on recommendations has not been issued.

In additional activities in 2000, the Education Committee:

- Recommended with successful Board adoption a 12 hour strategy for an equivalent cardiac class as an option to the ACLS
- Evaluated available testing options and the National Registry and, while timeliness remains an issue, the time factor can be adequately addressed with administrative actions. Developing, maintaining, validating, and administering a separate test/ test service would be cost prohibitive to the Division/Board.

Systems Management



The systems management committee continues to provide leadership to the daunting task of finalizing Ohio's statutorily required EMS data collection effort. The committee presented this year to the EMS Board for approval the draft final rules, a complete draft procedure manual, and the data elements for collection based on the National model data set. Rules language is pending final legal office review and should be filed with a rules change package in February. The committee also worked with the grants committee to set the parameters of the special computer assistance grant, establish the system requirements of the computers, and worked operationally with staff from the ODPS Technology Section to craft a final plan for software and file transfer development. A powerpoint presentation of the data collection effort is posted on the EMS web-site for use as a self study to the elements of this project and will also be used in 5 regional information sessions in 2001.

Firefighter and FSI Training Subcommittee

Additional Accomplishments/Highlights of 2000

- Executive Director served as member of the MIC 2000 addressing issues relative to possible consolidations of fire and EMS training. The final report (November 2000) leaves this question for the departments and customers to determine.
- Successful Controlling Board requests added a rollover of unspent grant funds to the FY 2000 base grants for a total of nearly $5 million directly benefiting EMS agencies in Ohio. Another successful request carried over operational funds from a previous year to begin office improvements and automation as driven largely by the ***Report and Recommendations of the Governor's Task Force on Fire and Emergency Response Training*** in December 1999.
- AG's office issued a Draft Opinion on EMS run reports and the confidentiality issue
- The Division participated in a successful State Fire School in May 2000
- Executive Director keynote at May 2000 Star of Life Awards, sponsored by partner ACEP
- Celebration of National EMS Week including Board photo, presentation of EMS-C

t-shirt with Ohio's Meredith Murphy (student calendar contest) at Parma Christian Academy

- EMS-C program won the innovation and Product Development Award for an Outstanding Publication, the Emergency Guidelines for Schools
- EMS Staff and Board members worked the display at the Ohio State Fair in August
- EMS Board approved the expansion of scope of practice for EMT-B's to allow for the administration of aspirin under local medical control and direction
- The Trauma Committee transition required per HB 138 coordinated by former Chair James Augustine, with transition materials and the work of the prehospital subcommittee forming the basis of the new committee start-up
- Approved the PEPP course as eligible for Ohio's reimbursement grant program and with EMS-C sponsored initial EMS-C trainings in Ohio
- New Board appointments nominated and made in timely fashion for continued work of Board in November 2000
- Adopted the USDOT curriculum for Paramedics and Intermediates.
- Fire Prevention Week celebrated with Firefighter Subcommittee in an event handing out smoke detectors to area residents and Hilltop employees
- ***The Siren***, the newsletter of the EMS Board, established a regular publication date and is available on the website. Publication set for the 30th of every Board meeting month.
- Executive Director attended "Feel the Heat," a day-long training in firefighting for public safety officials
- EMS staff spoke and organized display at quarterly and annual conferences of the Ohio Association of EMS
- Conducted 16 instructor orientation sessions for new EMS and Fire instructors
- Executive Director attended "boot camp" for new State EMS Directors coordinated by the National Association of State EMS Directors (NASEMSD); also attended the NASEMSD Annual Conference and Meeting
- Division web page expanded for better ease of use and more information available to customers
- Teleconference held with all exam proctors
- Executive Director participated in several television and radio interviews on special topics such as National EMS Week, National Fire Prevention Week, Toy Safety issues during the holidays, and multiple other injury-prevention topics
- Executive Director attending regular meetings of Ohio's Regulatory Boards, a joint information and educational group
- Contractual agreements developed to update all accredited and chartered training institutions
- Database for all training programs established to improve communications with and monitoring of all programs

GOALS 2000

At the January 2000 meeting, the State EMS Board set a number of Goals for the Year 2000

Goal	Status
The Board should become more Public Focused/Friendly	Achieved and ongoing
Update the Newsletter and Web page	Achieved and ongoing
Improve Telephone System/Service	Achieved
Implement the Trauma Registry	Achieved and ongoing
Trauma Committee develop data oversight group or procedure	In process
Continue EMS-C program/grants	Achieved
Prepare Board Notebooks/copies of rules	Achieved
Examine Task Force Recommendations	Achieved and ongoing
Establish committee membership/Orientation for Chairs	Achieved
Review Office Operations to Improve delivery of Service	Achieved
Make an Office Automation Plan	Achieved
Implement new Paramedic and Intermediate Curricula	In process/Planned
Continue Regional Conferences for Information Sharing	did not do in 2000 However information sharing did occur in many other ways
Seek RPAB Legislative Change	In process
Meet with Border States to discuss EMS issues	Not done
Update the State Disaster Plan	In process w/EMA

APPENDIX D:
EMS Board Executive Director's 2001 Update of EMS Board Accomplishments

EMS ACCOMPLISHMENTS

EMS FACTS:

Total Active Certifications

First Responder	1426
EMT-Basic	20,382
EMT-Intermediate	3,059
EMT-Paramedic	11,187
Total	36,054
EMS Instructors	1468
Special Topics Instructors	968

Certifications Issued in 2000 (through December)

First Responder	832
EMT-Basic	7,595
EMT-Intermediate	1310
EMT-Paramedic	4000
Totals for 2000	13737

Current Continuing Education Sites	330
Accredited Schools (EMS) and Fire Charters	122

Fire Certifications:

Total Active Certifications By Level

Firefighter 1A (Volunteer)	42,957
Firefighter 1/1B	3,376
Firefighter 1&2/1C	19,749
Fire Safety Inspector	15,709
Total Fire Certifications	81,521
Fire Instructors	1743
Asst. Fire Instructors	427

Fire Certifications Issued in 2000 (through December):

Firefighter 1A	1960
Firefighter 1B	551
Firefighter 1C	350
Firefighter Level 1	119
Firefighter Level 2	1060
Fire Safety Inspector	579

Office Operations:
The telephone auto-attendant system was put into place in April 2000. Up to that point, there was no mechanism for calculating telephone calls.
April through December 2000

44,497 telephone calls received and answered on the office main line only
Only 961 received the greeting that says "due to heavy volume we are not able to take your call at this time. Please call back later."
23 callers were not able to get through at all because all phone ques were full

July 2001
Rolled out the results of a one year project to redesign the EMS database for efficiency and web-based capabilities. Customers can register on-line for a test, search for a school, and verify their certification and expiration dates. Planned for the next phase of technology enhancements are grant applications on-line

Investigative Services on behalf of the State Board made significant strides in efficiency and effectiveness. A lead investigator, an additional compliance officer, and a secretary were added to Division staff. Improvements and Achievements include:

- Presentation to and adoption by EMS Board of a formal investigative policy to promote uniformity in the conduct of investigations and to ensure investigations are Fair, Impartial and Reasonable.
- Persons party to an investigation are fully informed at the outset of the investigation
- Standardized complaint forms and policy initiated; available for download on web-site
- Case investigation classification and tracking system fully implemented to promote management of the system from initial complaint to final adjudication and comprehensive monthly statistical reports to Executive Director and Board
- EMS case tracking identifies common areas of investigation and discipline which will lead to the categorizing of trends and training needs

Legislation

The year 2000's legislative highlight was the passage of HB 138, the Trauma Bill, signed by the Governor in a ceremony at Children's Hospital in July and effective November 3, 2000.
The new trauma bill establishes a statewide trauma system. Over the next two years, rules and protocols will be developed to match severely injured adults and children with the hospitals best equipped to provide the specialized medical care that critical trauma victims require.

The bill, sponsored by Rep. William Schuck (R-Columbus), provides for the establishment of a state wide trauma system, linking EMS, hospitals, and trauma centers. The EMS Board's Trauma Committee and the Regional Physician Advisory Boards will play a significant role in helping the EMS Board develop these protocols The Ohio Department of Public Safety's EMS Division and State EMS Board will oversee the development of a state protocol for the triage of severely injured adult and pediatric trauma victims.

Trauma

- Trauma committee appointed by Lt. Governor O'Connor November 3, 2000
- Trauma Committee presents 8 regional trauma town meetings June-July 2001
- Trauma Registry Committee redesigns registry and publishes the *Register* to highlight Ohio's trauma data and knowledge

OHIO Emergency Medical Services for Children

- EMS has combined EMS leadership in Injury Prevention, state leadership for Ohio's SafeKids, and the federally-funded EMS-C effort into a comprehensive injury prevention program focusing on children. Utilizing the strength of Board members in pediatric medicine, the result is an EMS Board committee for EMS-C which provides oversight and direction to these projects.
- **Child Day Care Project**
  The Ohio EMSC program has updated and revised Ohio's approved first-aid curriculum for child day care personnel in an effort to standardize training and establish a statewide network of trainers. In 2000, twelve train-the-trainer sessions were completed, resulting in the training of over 300 eligible instructors. Those who have completed the training have been added to regional referral lists to be accessed by day care providers. Training manuals are currently available to anyone eligible to teach the curriculum. To date, we have distributed 525 of the revised first aid curricula to eligible instructors in Ohio.
- **Guidelines Evaluation**
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- **PEPP Training (Pediatric Education for Prehospital Professionals)**
  The Ohio EMSC program has sponsored training for six individuals to become PEPP course coordinators. These coordinators will train EMS personnel throughout the state and establish a network of PEPP trained instructors. Our goal is to sponsor train-the-trainer PEPP meetings in Ohio specifically in areas where there are no pediatric hospitals or trauma centers. We are sponsoring a PEPP train-the-trainer course in Southeast Ohio in March, 2001. The Ohio EMS Board has approved the PEPP course for continuing education in Ohio and has approved grant funds to be utilized for PEPP training.

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In a separate grant award, a joint venture of the Board's Grants and Systems Management Committee, a portion of unspent grant funds from previous years was carried forward for a special computer assistance grant. This special offering provides funds for eligible EMS agencies, to purchase the hardware necessary for compliance with Ohio's upcoming EMS data collection effort. 538 agencies applied for and received computer grants totaling $505,585.

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- ***The Siren***, the newsletter of the EMS Board, established a regular publication date and is available on the website. Publication set for the 30th of every Board meeting.
- Division web page expanded for better ease of use and more information available to customers

APPENDIX E: Draft Trauma Triage Protocol

DRAFT – June 13, 2001

Persons 16 Years of Age and Older

These criteria are used to define the Adult trauma patient and include, but are not limited to the following:

Physiologic Criteria

1. GCS <12, Loss of consciousness greater than 5 minutes, alteration in level of consciousness with evidence of head injury at time of exam or thereafter, or fails to localize pain.
2. Respirations less than 10 or greater than 29 or intubation or relief of a tension pneumothorax.
3. Pulse greater than 120 in combination with any other physiologic criteria.
4. Systolic blood pressure less than 90 or absent radial pulse with carotid pulse present.

Anatomy of Injury

1. Penetrating trauma to head, neck, torso, or extremities proximal to knee or elbow.
2. Abdominal injury with tenderness, distention, or seatbelt sign
3. Flail chest and/or tension pneumothorax.
4. Two or more proximal long bone fractures.
5. Evidence of pelvic fracture (exception: isolated hip fracture).
6. Signs or symptoms of a spinal cord injury.
7. Amputation proximal to wrist and/or ankle.
8. Crush injury to head, neck, torso, or extremities proximal to knee or elbow.
9. Burns greater than 10% Total BSA or other significant burns involving the face, feet, hands, genitalia, or airway.

Patients with any of the mechanisms of injury and/or special considerations that appear in standardized pre-hospital trauma education curriculum, or who in the judgment of the on-scene EMS provider, may be considered trauma patients for the purpose of this document.

Persons Under 16 Years of Age

These criteria are used to define the Pediatric trauma patient and include, but are not limited to the following:

Physiologic Criteria

1. GCS <12, Loss of consciousness greater than 5 minutes, alteration in level of consciousness with evidence of head injury at time of exam or thereafter, or fails to localize pain.
2. Evidence of poor perfusion (i.e.; weak distal pulse, pallor, cyanosis, delayed capillary refill, or tachycardia)
3. Evidence of respiratory distress or failure (i.e.; stridor, grunting, retractions, cyanosis, nasal flaring, hoarseness or difficulty speaking)

Anatomy of Injury

1. Penetrating trauma to head, neck, torso, or extremities proximal to knee or elbow.
2. Abdominal injury with tenderness, distention, or seatbelt sign
3. Flail chest and/or tension pneumothorax
4. Two or more proximal long bone fractures.
5. Evidence of pelvic fracture including hip
6. Signs or symptoms of a spinal cord injury.
7. Amputation proximal to wrist and/or ankle.
8. Crush injury to head, neck, torso, or extremities proximal to knee or elbow.
9. Burns greater than 5% Total BSA or other significant burns involving the face, feet, hands, genitalia, or airway.

Patients with any of the mechanisms of injury and/or special considerations that appear in standardized pre-hospital trauma education curriculum, or who in the judgment of the on-scene EMS provider, may be considered trauma patients for the purpose of this document.

DRAFT – June 13, 2001

Destination Guidelines
Pre-hospital Sub-Committee

EMS personnel should limit on scene time to **Ten Minutes** or less after the trauma patients extrication except in extenuating circumstances. The receiving facility should be notified prior to arrival

Trauma patients as defined in this document and as required by law should be transported to the nearest appropriate Trauma Center.

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 directly to another hospital for initial assessment and stabilization before transfer to an appropriate trauma center:

Including but not limited to:
a.) Blunt Cardiac Arrest
b.) Unstable Airway not controlled by conventional means
c.) Uncontrolled hemorrhage

(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:

For purposes of defining excessive consider 15-30 minutes

(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 transportation 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.

DRAFT – May 21, 2001

Note: This page was NOT reviewed/revised at the June 13th pre-hospital sub-committee meeting

Air Medical Document

Air Medical Transportation

1. General principles

   a. Prolonged delays at the scene waiting for air medical transport should be avoided. If air medical transportation is unavailable (e.g., weather conditions), patient should be transported by ground guidelines as listed above.

   b. Air transport, if dispatched to the scene, should be diverted to the hospital if the patient appeared appropriate for air transport but the decision was made to transport to the nearest facility (non-trauma center) in the interim.

   c. Air Medical Programs share the responsibility to educate EMS units and facilities on appropriate triage. They should also institute an active utilization and quality review program that provides feedback to EMS units.

   d. Patients with uncontrolled ABC's should be taken to the closest appropriate facility (24-hour emergency department) if that can be achieved prior to the arrival of air medical transport.

   e. Traumatic cardiac arrest due to blunt trauma is not appropriate for air transport.

2. Reasons to Consider a Call for Air Transport:

   a. Prolonged extrication

   b. Multiple victims/trauma patients

   c. Time/distance factors:
   If the transportation time to a trauma center by ground is greater than 30 minutes AND the transport time by ground to the nearest trauma center is greater than the total transport time* to a trauma center by helicopter. ***Total transport time includes any time at scene waiting for helicopter and transport time to trauma center.**

   d. In the rural environment, immediate transfer with severely traumatized patients by air medical transport may be appropriate and should be encouraged if it does not significantly delay intervention for immediate life-threatening injuries.

21 May, 2001
JCK

APPENDIX F: Draft Registry Risk Adjustment & Confidentiality

DRAFT

General Principals being considered by the Trauma Registry Advisory Committee discusses rules language for the registry mandates in HB 138

This information is posted for comments and feedback from parties interested in the Ohio State Trauma Registry. Recently enacted legislation requires the EMS Board to adopt rules that address risk-adjustment and confidentiality of registry data. This process is being discussed by the members of the Trauma Registry Advisory Committee. Comments, and questions can be directed to Mike Glenn, RN, Trauma Coordinator at (614) 728-6853 or mglenn@dps.state.oh.us

This is a draft only and not necessarily the exact language that would be submitted for rules.

Risk Adjustment of Trauma Registry Data

1. Mortality should be the outcome that is risk adjusted.
2. TRISS should be the primary methodology used to risk adjust trauma registry data.
3. Major Trauma Outcome Study (MTOS) equations and co-efficient should be used TRISS allows for risk adjustment of mortality utilizing the following factors;
   - Physiologic (systolic BP, respiratory rate, Glasgow Coma Scale score)
   - Anatomic (Injury Severity Score)
   - Age (older or younger than 55)
   - Trauma Type (blunt or penetrating injury)
4. Other risk adjustment methodologies should be evaluated by the Trauma Registry Advisory Committee (TRAC) and recommendations made to the Trauma Committee and EMS Board on their potential use. (i.e. NISS, ASCOT, ICISS)
5. The TRAC will evaluate the possibilities of creating Ohio specific co-efficients, based upon the Ohio data set, to utilize with the TRISS methodology, and when appropriate these equations should be utilized. Additionally, other appropriate state databases should be evaluated for use in developing specific co-efficients.
6. The TRAC should utilize a variety of acceptable techniques for providing statistical analysis of risk-adjusted data (examples: Z-scores, M statistics and W statistics)
7. In addition to TRISS, mortality should be risk adjusted by sex and age providing specific attention to age groupings that appropriately identify pediatric patients. (TRISS only discriminates between groups older and younger than 55 year old).
8. The TRAC will evaluate and report to the Trauma Committee and EMS Board on the feasibility of adjusting mortality on other risk factors, (Ethnicity, presence of co-morbid conditions, geographic regions, etc.)
9. The TRAC will evaluate and report to the Trauma Committee and EMS Board on the feasibility of risk adjusting other outcomes (i.e. complications, functional outcomes, length of stay, cost, etc)

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10. ODPS may contract with individuals and or organizations with specific expertise in risk-adjustment and statistical analysis of medical data.

Confidentiality of Deliberations of Employees/Contractors performing Risk-Adjustment

1. All employees and contractors performing risk-adjustment on Ohio trauma registry data should be required to sign and adhere to statements of confidentiality and conflicts of interest.
2. The EMS Board, with the advise of the Trauma Committee and TRAC shall approve individuals who will have access to data, or involvement with the process of data review, regarding trauma data risk adjustment. These individuals may include Trauma Registry Advisory Committee members, Trauma committee members or EMS Board members.
3. All TRAC meetings containing discussions involving non-risk adjusted outcome data from individual hospital or groups of hospitals, shall be considered confidential and not subject to Ohio's open meetings act.
4. All minutes, recordings, and documents, electronic and paper, that contain non-risk adjusted outcome data from individual hospitals or groups of hospitals shall be considered confidential and not subject to Ohio's public records act.
5. Any meeting at which the discussion, review or display of outcome data for the purpose of risk adjustment will be utilized shall be a meeting closed to the public.
6. Executive sessions may/may not *(this still needs legal interpretation)* be used to discuss risk adjustment and/or review data in which individual providers are identifiable, at meetings that would otherwise be open meetings.

Confidentiality of data that is not to be made public

1. All reports that contain non-risk-adjusted outcomes must be presented in an aggregate form to a degree that individual hospitals and individual patients are not identified.
2. Individual Hospitals may request data reports on their own hospitals data, and these reports shall remain confidential, for the exclusive use of the hospital only for support of its trauma quality assurance program as required by ORC 3727.09 B (4).
3. The TRAC and hospitals will work out a process for the formatting, structure and frequency of confidential trauma QA reports.
4. All entities submitting data to the state trauma registry must do so in accordance with policies and procedures adopted by the TRAC and approved by the Board.

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5. The TRAC should develop policies and procedures that specifically address how requests for data from the state trauma registry are handled and the creation of reports with TRAC review prior to release.

6. The following data fields, individually would identify an individual recipient of trauma care, and thus are considered not public data.
   - SS#
   - Medical Record Number

7. The following data fields, collectively, may identify an individual recipient of trauma care, and thus must be strictly reviewed by the TRAC prior to publication as public data.
   - Patients date of birth
   - Race/ethnicity
   - Date injury occurred
   - ICD-9-CM Diagnosis codes
   - Time of arrival at ED
   - Gender
   - Zip code of residence
   - County in which injury occurred
   - E-Code description of injury
   - Others? _____

8. The following data fields, individually would, identify an individual provider of trauma care, and thus are considered not public data.
   - Hospital code

9. The following data fields, collectively, may identify an individual provider of trauma care, and thus must be strictly reviewed by the TRAC prior to publication as public data.
   - Date injury occurred
   - County in which injury occurred
   - ICD-9-CM Diagnosis codes
   - Others? _____
   - Site at which injury occurred
   - E-code description of injury

10. The following data points are outcome oriented and must be reported in aggregate format unless risk-adjusted.
    - Total days in ICU
    - Complications
    - Discharge status
    - Length of stay in hospital
    - Ventilator support days
    - FIM scores upon discharge
    - Billed hospital charges
    - Others? _____

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Informational Review of Risk Adjustment

The trauma registry was created by ORC 4765.06 (B) specifically to "provide for the reporting of adult and pediatric trauma-related deaths, identification of adult and pediatric trauma patients, monitoring of adult and pediatric trauma patient care data, determination of the total amount of uncompensated adult and pediatric trauma care provided annually by each facility that provides care to trauma victims, and collection of any other information specified by the board"

Meaningful comparisons of patients' outcomes, across the state, require adjustment for patient risks. Risk-adjustment "levels the playing field" by accounting for factors that the patient brings to a healthcare encounter that could affect their outcome. Risk adjustment facilitates "apples to apples' comparisons, sorting patients by similar characteristics so that like is compared to like. Risk adjustment is a way to remove or reduce the effects of confounding factors in the study of a group of patients

Additional considerations in risk-adjustment (these may not necessarily need to be written in rule.

Selection bias – the patient groups reported on must be reviewed in great detail to control for selection bias (ex. Inclusion or exclusion of dead on arrival patients, patients transferred from another facility vs. directly from the scene, etc.)

Coding differences – manual AIS coding variances between trauma centers, manual coding vs. software generated coding. Coding done with and without autopsy data.

Missing data - TRISS analysis requires certain minimum data, large numbers of records with missing data can skew reporting.

Confounding factors – co-morbidities, prolonged or inconsistent pre-hospital care are significant factors that are difficult to control

Steps in Risk Adjustment

The first step in risk adjustment is to decide which outcome you are evaluating. The Trauma Registry database has several potential outcomes that could be evaluated using risk adjusted methodologies. Mortality is the most common outcome that is risk adjusted. Through consensus of the TRAC members present and the expertise of the non-voting members, it was agreed that initially, mortality should be the outcome measure subjected to risk adjusted reporting.

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The next step in the risk adjustment process is to determine which risk factors need to be adjusted for. A wide variety of factors could be considered such as age, sex, race, ethnicity, acute clinical stability, extent and severity of co-morbidities, physical functional

status, etc. To a great degree, risk adjustment on data in the trauma registry will be limited by the information available in the data set itself. By electing to use the TRISS methodology, the following factors of risk will be adjusted for: physiologic stability on arrival to the ED, severity of anatomic injury, age and injury type blunt or penetrating.

The third step is to define the methodology that will be applied to the variables in order to produce risk adjusted data. The TRISS methodology is used most consistently in published trauma literature and effectively serves as the gold standard against which other trauma mortality risk adjustment methodologies are compared. Its limitations are well documented and although not a perfect tool, it should serve adequately to begin evaluating trauma mortality in Ohio.

TRISS utilizes information from the Revised Trauma Score (RTS), the Injury Severity Score (ISS), patient age and injury type. TRISS provides a revised probability of survival given the factors used to create the TRISS score (physiologic instability as measured by the RTS, the first set of vital signs in the emergency department, anatomic injuries, as coded on patient discharge using the Abbreviated Injury Score (AIS) which is used to calculate the Injury Severity Score). The physiologic components of the RTS, systolic blood pressure, respiratory rate and coded values from the glasgow coma scale are all currently collected as part of the trauma registry. The patient's age and injury type (blunt or penetrating) are also collected routinely.

The anatomic injury information that is used must be supplied in the format of an injury severity score (ISS). The ISS ranges from 1-75 and is calculated using the Abbreviated Injury Scale (AIS). AIS scores are assigned for each anatomic injury, and range from 1-6. Injury Severity Scores are calculated by identifying the three highest AIS scores from six different body regions. These three AIS scores are squared and summed, giving you an ISS. The current trauma registry does not collect AIS scores on individual injuries, although we do collect ICD-9-CM diagnosis codes. Software exists which will "map" AIS codes to the existing ICD-9 codes in the trauma database. It is current practice at all ACS verified trauma centers in Ohio to code patient injuries using AIS. Due to the specific nature of AIS coding for trauma center use and the training required to use this process, AIS coding will not become standard practice at non-trauma center hospitals. Thus, ICD-9 mapping is the only currently viable alternate to AIS coding of large ICD-9 data sets. The limitations of ICD-9 mapping are well established and can be controlled for when reviewing data. Future revisions of the Trauma Registry data set should include collection of trauma center AIS coding.

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TRISS produces a probability of survival using the following formula

$Ps = 1/(1+e^{-b})$ where $b = b_0 + b_1 (RTS) + b_2 (ISS) + b_3 (A)$

(A) is the symbol for the patients age. If the age is 54 years or less, A is equal to 0, If the patient is 55 years old or more, A is equal to 1

$b_{0...3}$ are coefficients derived from regression analysis applied to the Major Trauma Outcome Study. The constant e is equal to 2.718282

Coefficients for Revised Trauma Score blunt and penetrating injury types

	b_0 (constant)	b_1 (RTS)	b_2 (ISS)	b_3 (age)
Blunt	-1.2470	0.9544	-0.0768	-1.9052
Penetrating	-0.6029	1.1430	-0.1516	-2.6676

GCS	Systolic BP	Respiratory Rate	Coded Value
13-15	>89	10-29	4
9-12	76-89	>29	3
6-8	50-75	6-9	2
4-5	1-49	1-5	1
3	0	0	0

Weights	
GCS	0.9368
Systolic BP	0.7326
Respiratory Rate	0.2908

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APPENDIX G

DRAFT GUIDELINES FOR THE OPERATION OF AIR MEDICAL SERVICES: June 13, 2001

AIR AMBULANCES

Definitions

The Following definitions apply throughout this article:

1) "Air Medical Program" means to furnish, operate, conduct, maintain, advertise, promote, or otherwise engage in providing emergency medical services, as a rotorcraft or fixed-wing ambulance service provider as part of a regular course of doing business.
2) "Air medical personnel" means a person who is licensed and/or certified by the State of Ohio as a paramedic, a registered nurse, or physician with an unlimited license to practice medicine.
3) "Medical director of an air medical program" means a licensed physician within an air ambulance service who is ultimately responsible for patient care during each transport. The Medical Director shall have an active role in the delivery of emergency care and has knowledge of air medical transport and flight physiology. The medical director is responsible for directly overseeing and assuring that appropriate air-medical personnel, and equipment are provided for each patient transported by the air medical program within the air-medical services as well as the clinical performance of air medical personnel.
4) "Rotorcraft ambulance" means a helicopter or other aircraft capable of vertical take offs and landings with the capability of hovering.
5) "A rotorcraft ambulance service provider" means a service provider , based in the State of Ohio or providing transport services within the State of Ohio, that utilizes rotorcraft aircraft to respond directly to the scene of a medical emergency and are utilized to air lift critically ill or injured patients directly to or between definitive care facilities or to a point of transfer with another more appropriate form of transportation and has a minimum staff of at least one RN and a second licensed and /or certified medical crew member which may be physician, nurse, paramedic, or respiratory therapist.
6) "Fixed-wing ambulance" means a propeller driven or jet airplane with appropriately licensed and or certified medical personnel as determined by the medical director.
7) " Fixed-wing ambulance service provider" means a service provider, based in the State of Ohio or providing transport services within the State of Ohio, that utilizes fixed-wing aircraft to provide airport to airport transports where the patient(s) involved requires a stretcher or cot and are being transported to or from a definitive care medical setting.
8) "Licensed" or "licensure" means authorization in written form issued by the State of Ohio to an air medical program.
9) "CAMTS" means the Commission on Accreditation of Medical Transport Systems.
10) "14 CFR, Part 135 & 119" means air carriers with reference to Federal Aviation Regulations, Part 135 & 119, and holding a current FAA Air Carrier certificate, with approved "Air Ambulance Operations-Helicopter," or "Air Ambulance Operations-Airplane" operations specifications.
11) "F.A.A." means the Federal Aviation Administration.
12) "F.A.R." means the Federal Aviation Regulations including but not limited to Title 14 CFR.
13) "Base of operation" means a location at which an aircraft and crew are stationed to respond to transport requests.
14) "Mutual aid" means an agreement between two or more air medical programs to respond to the scene of an emergency or interfacility transport when the original service requested is unable to respond.
15) "Flight Physiology" means the physiological stress of flight encountered during air medical operations to include, but not be limited to, the Boyle's, Charles', Dalton's, Henry's, and Universal Gas Laws, and stressors of barometric pressure changes, hypoxia, thermal and humidity changes, gravitational forces, noise, vibration, and fatigue.

Rotorcraft Ambulance Service Provider

Sec. 1.

1) **Who needs to be licensed as a rotorwing provider?**
   a) Base of operations in Ohio, or
   b) Program providing, or seeking to provide rotorcraft ambulance services within the State of Ohio, or
   c) Responding directly to the scene of a medical emergency in the State of Ohio,
2) **Licensure not needed for the following:**
   a) Assisting in a major catastrophe, disaster, when existing emergency medical services are insufficient are unable to cope with the situation.
   b) An air medical program responding in a mutual aid capacity
   c) An agency or instrumentality of the United States.
3) **Other aviation requirements:**
   a) Meet all applicable parts of F.A.A regulation, and shall
   b) Hold a valid 14 CFR , Part 135 Air Carrier certificate, or shall have a contract with the holder of a 14 CFR Part 135 Air Carrier certificate to provide aviation services under their certificate.
   c) Either must also have current FAA approved Air Ambulance Operations-Helicopter specifications.
4) **Rotorcraft ambulance service provider organizations will have:**
   a) Continuing education
   b) Audit and review
   c) Scene response utilization consistent with the American College of Surgeons as defined in Resources for Optimal Care of the Injured Patient.
   d) Performance Improvement
   e) Qualified Medical control and direction
   f) Safety and survival programs and education.
5) **Medical Director requirments:**
   a) Ohio licensed medical director with a current unlimited Ohio License.
   b) The duties and responsibilities of the medical director include, but are not limited to:
      (i) Assuming medical authority over any and all patients treated and transported by the rotorcraft ambulance service.
      (ii) Providing liaison with physicians.
      (iii) Assuring that the drugs, medications, supplies, and equipment are appropriate
      (iv) Monitoring and evaluating overall clinical operations.
      (v) Assisting in the coordination and provision of clinical continuing education.
      (vi) Participating in a quarterly audit and review of cases treated by air medical personnel.
      (vii) Attesting to the competency of air medical personnel affiliated with the rotorcraft ambulance service provider organization.
6) **Responsibility for in-service training** – program will designate one (1) person licensed and/or certified as a paramedic, a registered nurse, or a licensed physician, and have appropriate knowledge of patient care during air ambulance transport.
7) **Public Safety** - service will not engage in conduct or practices detrimental to the health and safety of emergency patients or to members of the general public while in the course of business or service as a rotorcraft ambulance service provider.
8) **Coordination with EMS and Law enforcement** - will have area wide plan to provide safety education and coordinate rotorcraft ambulance service with emergency medical services rescue, law enforcement, and mutual aid back-up systems
9) **Required personnel resources** - adequate number of trained personnel and aircraft to routinely provide continuous twenty-four (24) hour services.
10) **Safety committee to include:**
   a) Pilot(s)
   b) Air-medical personnel
   c) Aircraft maintenance technician(s)
   d) Communications personnel.
   e) The safety committee shall meet at least quarterly and may be concurrent and in conjunction with the audit/review committee.
11) **Who can request rotorcraft?**
   a) hospitals and health care facilities,
   b) emergency medical services organizations,
   c) fire departments and
   d) law enforcement agencies
   e) industrial safety departments.

12) Destinations

a) Appropriate medical facility in accordance with protocols approved by the Air Medical Program Medical Director.
b) Trauma patients meeting triage criteria will be transported to an appropriate Level I or II Trauma Center.

Sec. 2.

1) Application requirements:

a) Aircraft types and identification numbers.
b) A listing of all personnel, and their qualifications by category, who will regularly serve as pilots, and air medical personnel.
c) A copy of the patient care transport record to be utilized on each transport.
d) Documentation of medical education as approved by the Medical Director
e) A listing of all on-board life support and medical communications equipment available, including a list of drugs and medications to be carried on each aircraft.
f) A copy of all treatment protocols and standing orders (if applicable) under which all non-physician personnel operate.
g) Documentation of appropriate aircraft liability coverage in accordance with State guidelines.
h) Insurance coverage for each and every aircraft owned and/or operated
i) valid for a period of two (2) years

Sec. 3.

1) **Rotorcraft ambulance characteristics**:

a) equipment and operations
   i) performance inherent in the type of aircraft selected by the rotorcraft ambulance service provider
   ii) aircraft and its equipment and operations shall be in compliance with prevailing F.A.R for the type of aircraft in question and flying conditions under which the aircraft will be operated as specified in the 14 CFR, Part 135 air carrier certificate of the air ambulance service provider.
b) Capable of carrying a minimum of one (1) patient on a litter in a horizontal position located so as not to obstruct the pilot's vision or interfere with the performance of any member of the flight crew or required air medical personnel.
c) Means of securing each litter and attached patient securely to either the floor (deck), walls (bulkhead), seats, or specific litter rack or any combination thereof which will comply with an acceptable method using either approved data from the aircraft manufacturer or data approved by the F.A.A. If data approved by the F.A.A. is required, a field approval or, supplemental type certificate (STC) shall be obtained.
d) Demonstrable unobstructed vertical space at the head and thorax areas of the upper surface of a litter(s) to allow for performance of advanced life support cardiac care.
e) Both the head and thorax of a secured patient shall be accessible by a minimum of two (2) air-medical personnel at one (1) time.
f) Lighting available for patient observation (a minimum of forty (40) foot-candles at the level of the patient is recommended). Lighting shall be such as to not interfere with the pilots vision and will be focused, shielded, diffused, or colored illumination.
g) Temperature regulation to assure the comfort of all persons on board.
h) Door access demonstrably large enough for ease of patient litter loading and unloading in the supine position.
i) Electrical system of the aircraft capable of supporting all of the ancillary equipment without the threat of overload or systems failure.
j) Other specialized equipment may be required to conduct certain operations. The installation of this equipment shall comply with an acceptable method using either approved data from the aircraft manufacturer or data approved by the F.A.A. If data approved by the F.A.A. is required, a field approval or, supplemental type certificate (STC) shall be obtained.
k) Searchlight rated as a minimum of four hundred thousand (400,000) candlepower or greater, manipulated by the pilot with a minimum movement of ninety (90) degrees vertical and one hundred eighty (180) degrees horizontal with the capability of illuminating the proposed landing site.
l) air to ground communication capability to allow the pilot to communicate with all of the following ground personnel:
   i) Law enforcement,
   ii) Fire/rescue,
   iii) Ambulances,
   iv) Hospital(s).
m) Adequate patient restraint(s) to preclude interference with the crew or aircraft flight controls.
n) Intercommunications system.

Sec. 4.

1) Documentation:

a) Maintain accurate records concerning the emergency care provided to each patient within the state.
b) Participate in Ohio EMS Run reporting and the Ohio Trauma Registry as required.
c) Premises maintained, suitable to the conduct of a rotorcraft ambulance service, with provision for adequate storage, and/or maintenance of rotorcraft ambulances and the on-board equipment.
d) Have a periodic maintenance program as outlined for each specific aircraft in compliance with F.A.A. guidelines and manufacturer's service recommendations (MSR) as a minimum to assure that each rotorcraft ambulance, including equipment, is maintained in good, safe working condition and that rigid sanitation conditions and procedures are in effect at all times.
e) Premises, records, hangars, padding, and tie-down facilities, and rotorcraft ambulances will be made available for inspection
f) A determination of non-compliance with F.A.R. may result in immediate suspension of licensure as a rotorcraft ambulance service provider.
g) Each rotorcraft ambulance service provider shall make available for inspection at place of operation during regular business hours any manual of operations required under F.A.R.
h) Licensure as a rotorcraft ambulance service provider may be terminated upon the date specified in the notice.
i) establish equipment checklist procedures to insure the following:
j) Electronic and mechanical equipment are in proper operating condition.
k) Rotorcraft ambulances shall be maintained in safe operating conditions at all times.
l) Emergency patient care equipment maintained in minimum quantities either directly on board the rotorcraft ambulance or available at the time of patient transport.
m) Insure that rigid sanitation conditions and procedures are in effect at all times.
n) The interior and the equipment within the aircraft are clean and maintained in good working order at all times.
o) Freshly laundered linens are used on all litters, and pillows and linen shall be changed after each patient is transported.
p) When the aircraft has been utilized to transport a patient known to have a communicable disease, the aircraft must be cleansed and all contact surfaces be disinfected.
q) Provider may operate, for a period not to exceed one hundred eighty (180) consecutive days, a temporary replacement rotorcraft ambulance if the temporary replacement rotorcraft ambulance is used to replace a certified rotorcraft ambulance that has been temporarily taken out of service for repair or maintenance, providing the following:
r) The replacement rotorcraft ambulance must meet all certification requirements of this article.

Sec. 5.

1) Staffing

a) will be staffed by no less than three (3) people and include the following requirements:
b) The first person must be a properly certified pilot who shall complete an orientation program covering flight, and air medical operations as prescribed by the holder of the 14 CFR Part 135 Air Carrier certificate under which the Air Medical Program operates.
c) The second person shall be an Ohio-licensed registered nurse with air-medical oriented training as prescribed by the program medical director
d) The third person shall be any appropriate, licensed or certified medical personnel required to properly care for the medical needs of the patient at the discretion of the program medical director.
e) The air medical personnel on board the aircraft must be trained in air transport issues and flight physiology.
f) notify in writing within thirty (30) days of any change in the services provided.

Sec. 6.

1) Equipment

a) Portable suction with appropriate catheters and tips capable of a minimum of three hundred
b) (300) mm mercury.
c) Orophyrangeal airways (adult, child, and infant sizes)
d) Nasophyrangeal airways (small, 20-24 french; medium, 26-30 french; large, 30 french or
e) greater)
f) 1 adult, & 1 child/infant bag, with adult, child, infant, and neonate masks.
g) Portable oxygen w/appropriate cannulas, or mask, etc.
h) Blood pressure cuffs (adult, child, and infant sizes)
i) Stethoscope (carried in the aircraft or by air medical personnel)
j) Bandages and dressings to include, but not limited to the following:
k) Sterile gauze pads (4x4).

l) Airtight dressings.
m) Tape/bandage shears (shears may be carried in aircraft or by air-medical personnel).
n) Rigid extrication collars in pediatric, small, medium, and large (or adjustable to fit the sizes indicated) for each patient transported.
o) Portable defibrillator with self-contained cardiac monitor and E.C.G. strip writer with adult and pediatric paddles, or hands-free adapter which will not interfere with the aircraft's electrical and radio system
p) Endotracheal intubation equipment to include laryngoscopes with spare batteries and bulbs, with laryngoscope blades, and endotracheal tubes in adult, child, and infant sizes.
q) Medications, intravenous fluids, administration sets, syringes, and needles will be specified by the air-medical director identifying types and quantities

2) Controlled drugs shall not be left on unattended aircraft unless adequate security precautions have been taken.

Sec. 7.

1) Communications – rotorcraft provider will have maintain the following:
a) communications equipment required under 14 CFR Part 135 for the type of aircraft and service provided
b) radio communications equipment that allows it to communicate directly with Ohio hospitals and EMS.
c) Transmitters are to operate with an output power not to exceed ten (10) watts as applicable to F.C.C. rules and regulations.
d) A dispatch and tactical communications system with the capability to provide a coordinated voice communications linkage within the flying area of the rotorcraft ambulance service provider.

Rotorcraft Ambulance Service Provider Licensure Application with Accreditation by CAMTS (Commission for Accreditation of Medical Transport Systems).

Sec. 1.

1) Deemed status - CAMTS Accreditated programs
a) Required info:
i) Base of operations and a level of care to be provided.
ii) A description and general location of each aircraft to be used as an air ambulance, including the make, model, year of manufacture, insignia, name or monogram, or other distinguishing characteristics.
iii) Documentation of appropriate aircraft liability coverage in accordance with State guidelines.
iv) The insurance coverage specified shall be for each and every aircraft owned and/or operated by or for the fixed wing ambulance service provider.
v) Proof of current critical care transport accreditation by the Commission for Accreditation of Medical Transport Systems (CAMTS), including the date of accreditation expiration.
vi) Other information as requested .
b) will be licensed by the commission for a period of up to three (3) years, or the expiration date of the CAMTS accreditation (whichever occurs first), and a certificate will be issued.
c) must comply with all applicable F.A.A regulation(s), and
d) hold a valid 14 CFR Part 135 Air Carrier certificate, or
e) have a contract with the holder of a 14 CFR Part 135 Air Carrier certificate, to provide aviation services under their certificate.
f) hold a current FAA approved EMS Operations Specifications certificate.

Fixed Wing Ambulance Service Provider

Sec. 1.

1) **Who needs to be licensed as a Fixed Wing Provider?**
   a) base of operations in Ohio, or a program
   b) providing, or seeking to provide fixed wing ambulance services within the State of Ohio,
2) **Licensure not required for the following:**
   a) assisting in a major catastrophe, disaster, when existing emergency medical services are insufficient or are unable to cope with the situation.
   b) an air medical program responding in a mutual aid capacity
   c) an agency or instrumentality of the United States.
3) **Other Aviation Requirements:**
   a) meet all applicable parts of F.A.A regulation, and
   b) hold a valid 14 CFR , Part 135 Air Carrier certificate, or
   c) have a contract with the holder of a 14 CFR Part 135 Air Carrier certificate to provide aviation services under their certificate.
   d) Either must also have current FAA approved Air Ambulance Operations-Helicopter specifications.
4) **Fixed wing ambulance service provider organizations will have:**
   a) Continuing education
   b) Audit and review
   c) Performance Improvement
   d) Qualified Medical control and direction
   e) Safety and survival programs and education.
5) **Medical Director requirements:**
   a) Ohio licensed medical director with a current unlimited Ohio License.
   b) The duties and responsibilities of the medical director include, but are not limited to:
   c) Assuming medical authority over any and all patients treated and transported by the fixed wing ambulance service.
   d) Providing liaison with physicians.
   e) Assuring that the drugs, medications, supplies, and equipment are appropriate
   f) Monitoring and evaluating overall clinical operations.
   g) Assisting in the coordination and provision of clinical continuing education.
   h) Participating in a quarterly audit and review of cases treated by air medical personnel.
   i) Attesting to the competency of air medical personnel affiliated with the fixed wing ambulance service provider organization.
6) **Responsibility for in-service training** - will designate one (1) person licensed and/or certified as a paramedic, a registered nurse, or a licensed physician, and have appropriate knowledge of patient care during air ambulance transport.
7) **Public safety**
   a) service provider will not engage in conduct or practices detrimental to the health and safety of emergency patients or to members of the general public while in the course of business or service as a fixed wing ambulance service provider.
8) **Safety committee to include:**
   a) Pilot(s)
   b) Air-medical personnel
   c) Aircraft maintenance technician(s)
   d) Will meet at least quarterly and may be concurrent and in conjunction with the audit/review committee.
9) **Patient Destination:**
   a) Transport to an appropriate medical facility in accordance with protocols approved by the Air Medical Program Medical Director.

Sec. 2.

1) **Application Requirements:**
   2) Aircraft types and identification numbers.
   3) A listing of all personnel, and their qualifications by category, who will regularly serve as pilots, and air medical personnel.
   4) A copy of the patient care transport record to be utilized on each transport.
   5) Documentation of medical education as approved by the Medical Director
   6) A listing of all on-board life support and medical communications equipment available, including a list of drugs and medications to be carried on each aircraft.
   7) A copy of all treatment protocols and standing orders (if applicable) under which all non-physician personnel operate.
   8) Documentation of appropriate aircraft liability coverage in accordance with State guidelines.

9) Insurance coverage specified shall be for each and every aircraft owned and/or operated by or for the fixed wing ambulance service provider.
10) valid for a period of two (2) years from the date of issue

Sec. 3.
Fixed Wing ambulance characteristics:

1) Equipment and operations

a) Performance characteristics inherent in the type of aircraft selected by the fixed wing ambulance service provider.
b) Equipment and operations shall be in compliance with prevailing F.A.R for the type of aircraft in question and flying conditions under which the aircraft will be operated as specified in the 14 CFR, Part 135 air carrier certificate of the air ambulance service provider.
c) Capable of carrying a minimum of one (1) patient on a litter in a horizontal position located so as not to obstruct the pilot's vision or interfere with the performance of any member of the flight crew or required air medical personnel.
d) Means of securing each litter and attached patient securely with an acceptable method using either approved data from the aircraft manufacturer or data approved by the F.A.A. If data approved by the F.A.A. is required, a field approval or, supplemental type certificate (STC) shall be obtained and kept on file.
e) Demonstrable unobstructed vertical space at the head and thorax areas of the upper surface of a litter(s) to allow for performance of advanced life support cardiac care.
f) Both the head and thorax of a secured patient shall be accessible by a minimum of two (2) air-medical personnel at one (1) time.
g) lighting available for patient observation (a minimum of forty (40) foot-candles at the level of the patient is recommended). Lighting shall be such as to not interfere with the pilots vision and will be focused, shielded, diffused, or colored illumination.
h) Temperature regulation to assure the comfort of all persons on board.
i) door access demonstrably large enough for ease of patient litter loading and unloading in the supine position.
j) The electrical system of the aircraft capable of supporting all of the ancillary equipment without the threat of overload or systems failure.
k) Other specialized equipment may be required to conduct certain operations.
l) The installation of this equipment shall comply with an acceptable method using either approved data from the aircraft manufacturer or data approved by the F.A.A. If data approved by the F.A.A. is required, a field approval or, supplemental type certificate (STC) shall be obtained.
m) Equipped with adequate patient restraint(s) to preclude interference with the crew or aircraft flight controls.
n) The aircraft must have air to ground communications capabilities to allow medical personnel to communicate with medical control.

Sec. 4.

1) Maintain accurate records concerning the medical care provided to each patient within the state.
2) Premises will be maintained, suitable to the conduct of a fixed wing ambulance service, with provision for adequate storage, and/or maintenance of fixed wing ambulances and the on-board equipment.
3) Have a periodic maintenance program as outlined for each specific aircraft in compliance with F.A.A. guidelines and manufacturer's service recommendations (MSR) as a minimum to assure that each fixed wing ambulance, including equipment, is maintained in good, safe working condition and that rigid sanitation conditions and procedures are in effect at all times.
4) Premises, records, hangars, padding, and tie-down facilities, and fixed wing ambulances will be made available for inspection by the director or the director's authorized representative at any time during regularly scheduled business hours.
5) A determination of non-compliance with F.A.R. may result in immediate suspension of licensure as a fixed wing ambulance service provider.
6) Each fixed wing ambulance service provider will make available for inspection at place of operation during regular business hours any manual of operations required under F.A.R.
7) Licensure as a fixed wing ambulance service provider may be terminated upon the date specified in the notice.
8) establish equipment checklist procedures to insure the following:
9) Electronic and mechanical equipment are in proper operating condition.
10) Fixed wing ambulances shall be maintained in safe operating conditions at all times.
11) Emergency patient care equipment required for fixed wing ambulance certification is maintained in minimum quantities either directly on board the fixed wing ambulance or available at the time of patient transport.
12) insure that rigid sanitation conditions and procedures are in effect at all times. The following sanitation standards apply to all fixed wing ambulances:
13) The interior and the equipment within the aircraft are clean and maintained in good working order at all times.
14) Freshly laundered linens are used on all litters, and pillows and linen shall be changed after each patient is transported.

15) When the aircraft has been utilized to transport a patient known to have a communicable disease, the aircraft must be cleansed and all contact surfaces be disinfected.

Sec. 5.
Fixed Wing Staffing

1) Staffed by no less than three (3) people and include the following requirements:
2) The first person must be a properly certified pilot who shall complete an orientation program covering flight, and air medical operations as prescribed by the holder of the 14 CFR Part 135 Air Carrier certificate under which the Air Medical Program operates.
3) Minimum of 2 appropriate, licensed or certified medical personnel required to properly care for the medical needs of the patient at the discretion of the program medical director.
4) The air medical personnel on board the aircraft must be trained in air transport issues and flight physiology.

Sec. 6.
Equipment

1) Required on all flights:
   a) Portable suction with appropriate catheters and tips capable of a minimum of three hundred
   b) (300) mm mercury.
   c) Orophyrangeal airways (adult, child, and infant sizes)
   d) Nasophyrangeal airways (small, 20-24 french; medium, 26-30 french; large, 30 french or
   e) greater)
   f) 1 adult, & 1 child/infant bag, with adult, child, infant, and neonate masks as appropriate for the flight.
   g) Portable oxygen w/appropriate cannulas, or mask, etc.
   h) Blood pressure cuffs (adult, child, and infant sizes)
   i) Stethoscope (carried in the aircraft or by air medical personnel)
   j) Bandages and dressings to include, but not limited to the following:
   k) Sterile dressings
   l) Airtight dressings.
   m) Tape/bandage shears (shears may be carried in aircraft or by air-medical personnel).
   n) Rigid extrication collars in pediatric, small, medium, and large (or adjustable to fit the sizes indicated) for each patient transported.
   o) Minimum of AED must be carried on transports.

2) Equipment based on mission/patient condition
   a) alternative to the AED is Portable defibrillator which may be used by appropriately trained medical persnnel as specified by the medical director. Monitor should include self-contained cardiac monitor and E.C.G. strip writer with adult and pediatric paddles, or hands-free adapter which will not interfere with the aircraft's electrical and radio system
   b) (12) Endotracheal intubation equipment to include laryngoscopes with spare batteries and bulbs, with laryngoscope blades, and endotracheal tubes in adult, child, and infant sizes.
   c) (13) Medications, intravenous fluids, administration sets, syringes, and needles will be specified by the air-medical director identifying types and quantities

3) Controlled drugs shall not be left on unattended aircraft unless adequate security precautions have been taken.
4) Additional equipment/supplies as specified by the medical director based on crew medical training and patient need.
5) Medical equipment will not interfere with aircraft electrical and radios system.

Sec. 7.

1) Communications:
   a) all communications equipment required under 14 CFR Part 135 for the type of aircraft and service provided
   b) radio communications equipment that allows it to communicate directly with medical control.
   c) Transmitters are to operate with an output power in accordance with applicable F.C.C. rules and regulations.

Fixed wing Ambulance Service Provider Licensure Application with Accreditation by CAMTS (Commission for Accreditation of Medical Transport Systems).

Sec. 1.
Deemed status - CAMTS Accreditated programs

1) Required info:
   a) Base of operations and a level of care to be provided.
   b) A description and general location of each aircraft to be used as an air ambulance, including the make, model, year of manufacture, insignia, name or monogram, or other distinguishing characteristics.
   c) Documentation of appropriate aircraft liability coverage in accordance with State guidelines.
   d) The insurance coverage specified shall be for each and every aircraft owned and/or operated by or for the fixed wing ambulance service provider.
   e) Proof of current critical care transport accreditation by the Commission for Accreditation of Medical Transport Systems (CAMTS), including the date of accreditation expiration.
   f) Other information as requested .
2) will be licensed by the commission for a period of up to three (3) years, or the expiration date of the CAMTS accreditation (whichever occurs first), and a certificate will be issued.
3) must comply with all applicable F.A.A regulation(s), and
4) hold a valid 14 CFR Part 135 Air Carrier certificate, or
5) have a contract with the holder of a 14 CFR Part 135 Air Carrier certificate, to provide aviation services under their certificate.
6) hold a current FAA approved EMS Operations Specifications certificate.

THE SIREN

It's About Safety

A Newsletter of the Division of Emergency Medical Services and the State Emergency Medical Services Board
1970 W. Broad Street • Columbus, Ohio 43223
1-(800)-233-0785

September/October 2001

Laura Tiberi, Executive Director

We have implemented several new online services on our Web site. It is hoped that the Emergency Medical Services (EMS) Web site and the new online features will serve as an alternative mode of communication for visitors and a one-stop center for current EMS related information. I hope everyone will take the opportunity and familiarize themselves with the new online system. It will provide a more value-added Web site for the EMS and fire community.

New online services that were recently implemented include:

1) **Training Facility Look-up-** Viewers can look up either accredited training facilities or approved continuing education sites by county, school name, city or ZIP code;

2) **Exam calendar-** Offers a listing of all scheduled exam dates through the end of the year. The benefit of this online system is that all exam dates that are entered in the database automatically appear, eliminating the need to frequently update printed exam calendars;

3) **Certification Verification-** Certifications can be verified by entering either a social security number or certification number; and

4) **New and Improved Online Test Registration-** This version will require those registering for tests to update their personal information that is fed directly into EMS database records. This will assist the Division in keeping accurate records. Try out the new online services by visiting the Division of EMS Web site at: http://www.state.oh.us/odps Click on Emergency Medical Services.

Ohio Task Force One Aids New York After Terrorist Attacks

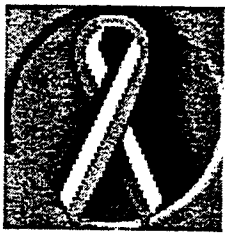
Within hours of the September terrorist attack on the World Trade Center in New York on September 11th, 72 members of Ohio's Urban Search and Rescue Task Force One were on their way to assist in the recovery effort coordinated by our Emergency Management Agency (EMA) division.

Commanded by Michael Muhl, the Ohio Task Force is one of 27 such units in the United States and was one of nine dispatched to New York and Washington, D.C. following the terrorist attacks. The Ohio Task Force carried with it four trained canines along with a large array of specialty equipment, including sensitive listening devices, miniature TV cameras connected with fiber optics for insertion into tiny spaces, heavy lift and extraction equipment and its own medical support. All the equipment is worth about $1.2 million.

It was the second deployment of the Task Force, which is comprised of highly trained and equipped volunteers from across the state. The Task Force, based at Wright-Patterson Air Force Base near Dayton, became operational in April 2000 and first was deployed as part of the recovery effort in Xenia following a tornado a year ago.

Many Ohio fire departments kept a volunteer list following the terrorist attacks in case more were needed to go search the rubble. But federal officials said their need was not immediate.

The training and support finances for the Task Force come from state and federal funds.



Many organizations distributed red, white and blue ribbons to people in exchange for donations to the relief efforts.

Disciplinary & Administrative Action

September 19, 2001

Scott Whitcomb, EMT Applicant
Violation: Felony conviction for Corruption of a Minor
Sanction: Denial of EMT-Basic certificate to practice

Anthony Allegrini, EMT Cert#18537
Violations: Committed fraud, misrepresentation, or deception in applying for or securing any certificate – Not satisfying the requirements for certification to practice for the level sought in a renewal application – Not completing the continuing education requirements to renew as a paramedic
Sanction: $500 fine, EMT certificate to practice suspended for six months, must complete the continuing education requirements within this six month period. If not in compliance at the completion of the six month suspension, then will result in the revocation of EMT-Paramedic certificate to practice

Stacey McGuire, EMT Cert#88116
Violation: Practicing beyond the scope of an EMT-Paramedic
Sanction: Written reprimand and two year probation

Edison Cook, Jr., EMT Cert#7909
Violation: Conviction for misdemeanor involving moral turpitude to wit domestic violence
Sanction: Written reprimand, three year probation, and successful completion of anger management course within nine months

Chris LaDue, EMT Cert#95798
Violation: Conviction for misdemeanor involving moral turpitude to wit domestic violence
Sanction: Written reprimand, three year probation, and successful completion of anger management course within nine months

Kenneth Allison, EMT Cert#95680
Violation: Conviction for misdemeanor involving moral turpitude to wit domestic violence
Sanction: Written reprimand, three year probation, and successful completion of anger management course within nine months

Annette McKissic, EMT Applicant
Violation: Felony convictions for Theft and Food Stamp Trafficking
Sanction: Issue EMT-Basic Certificate, 3 year probation and within six months must supply the Division of EMS with a complete criminal history check

A Note from Doctor D.

State Medical Director Dr. John Drstvensek

C. Q. I.

In manufacturing plants, service industries and medical centers, organizations around the world are using continuous quality improvement (CQI) as their strategy to bring about dramatic changes in their operations.

Today, organizations need to meet or exceed customer expectations while maintaining a cost competitive position. CQI is a systematic, organization wide approach for improving all processes that deliver quality products and services and is the strategy to meet today's challenges and to prepare for the future.

In pursuing CQI, the organization will use four principles:
1. Develop a strong customer focus
2. Continually improve all processes
3. Involve employees
4. Mobilize data and team knowledge to improve decision–making

The Regional Physician Advisory Boards (RPAB) are preparing a sample CQI packet to share with the EMS providers and EMS medical directors in an effort to help all areas of this diverse state meet the needs of the patients in their communities.

CQI courses are available around the state and country. Talk to your EMS medical director about using this important tool to improve the health care in your area.

Ohio Families to Receive 25,000 Free Booster Seats

Boost America! a $30 million child passenger safety program that gives one million booster seats to low-income families nationwide, gave its 250,000th free booster seat to an Ohio family on August 24, 2001, at the St. Stephens Community Center in Columbus. In all, 25,000 booster seats will be given to Ohio families. United Way and the Ohio Department of Public Safety are handling the distribution of the seats.

A new survey indicates 84 percent of Ohio children ages four through eight run an increased risk of injury or death in car crashes because they are not in booster seats.

A booster seat raises a small child higher in a car, allowing a safety belt to properly cross at the shoulder and at the waist, as recommended by safety belt and auto manufacturers. If improperly restrained, during a crash, a child is more likely to suffer critical or even fatal injuries.

Lt. Governor Maureen O'Connor helped craft HB 334 with Representative Kevin DeWine to require children under 80 pounds and under 8-years-old be properly restrained in life-saving booster seats. HB 334 is currently in committee.

Bystander Involvement Encouraged

The Ohio Department of Public Safety Emergency Medical Services Division (EMS) encourages educated bystander involvement to help prevent motor vehicle fatalities. According to the National Highway Traffic Safety Administration (NHTSA), every American will be in or witness a motor vehicle crash every ten years.

The campaign, "First There, First Care" includes these five actions for bystander care:

• Stop to help • Call for help • Assess the victim • Start the breathing • Stop the bleeding

The chances of being in a life-threatening crash are greatest in rural areas, which is partially attributed to the significant time delay from when a crash occurs to when it is first reported to Emergency Medical Services (EMS). It also takes longer for EMS to respond in rural areas, due to the distances they must travel to reach injured crash victims.

Many highway fatalities result from blood loss and airway obstruction. Both are treatable conditions if care is given soon after the injuries occur. Thus, many rural highway fatalities may be attributed to the lack of early intervention.

We know that every second counts in an emergency. Therefore, individuals trained to perform bystander care at a roadway emergency can make the difference between life and death—but only if they get involved and take action!

To receive more information on the "First there, First Care" bystander care for the injured campaign, visit www.nhtsa.dot.gov/people/injury/ems. Also, to become more involved, contact your local emergency medical service.

IT'S EMS BIKE PATROL

In Toledo, the Whitehouse fire department has been using bikes to help save lives. They have a converted police mountain bike and nine bicycles to assist. The new Emergency Medical Services (EMS) bike carries more than $3,000 worth of equipment, which includes an oxygen tank, portable heart defibrillator, IV set up and a first-aid kit.

Paramedics with the city of Toledo's fire and rescue division began riding bikes in 1999. The bikes are equipped with 30 pounds of gear. The obvious difference is that they can't transport people to hospitals. The bikes are only used at special events such as parades, firework shows, running races and festivals so they can respond to people and problems in congested areas.

The bike unit has taken an additional 32 hours of training to cover such topics as bike maintenance, how to maneuver through crowds and how to go up and down stairs on a bike that is carrying an oxygen tank and other heavy equipment. The paramedics also promote bike safety.

Several other EMS providers in Ohio also offer bike service for festivals and other events.

(Source: Toledo Blade)

EMS Staff

...Up Close & Personal

Carol MacDowell
E-mail: clmacdowell@dps.state.oh.us

- ★ Responsible for coordinating and assisting with the activities of the 10 regional physician advisory boards
- ★ Provides a vital link between the regional physician advisory boards, the state trauma committee, EMS board, and state medical director
- ★ Attends regional physician advisory board meetings
- ★ Member of the Business Advisory Committee of Goodwill Rehabilitation
- ★ Graduated from Columbus State Community College in 1998 with a degree in Health Information Management
- ★ Is certified as a Registered Health Information Technician
- ★ Worked as a manager in the Health Information Management Department at Columbus Children's Hospital, 1998
- ★ Served as Trauma Registrar at Mt. Carmel Health System, 1998-2000
- ★ Is an adjunct faculty member at Columbus State Community College, where she currently teaches Advanced Medical Terminology

Michaele Von Ville-Feuillerat
E-mail: mvonville-feuillerat@dps.state.oh.us

- ★ Attended The Ohio State University and graduated with a Bachelor of Science in Physical Education K-12 in August of 1989
- ★ Accepted to the Columbus Division of Fire Training Academy and graduated in December of 1989 with a 240 hour Firefighter and EMT-Basic certification
- ★ Gained Paramedic status in 1996 and became an EMS Instructor
- ★ Obtained a Masters of Science in Human Services Management from Franklin University
- ★ Also trained as a Heavy Rescue Technician
- ★ Began career with the Ohio Division of EMS in February 2001
- ★ Is the EMS Education Coordinator, responsible for the accreditation of all training programs in the state, handles the initial certification of all instructors and serves as staff liaison to the Education Committee of the EMS Board
- ★ Interests are in family, profession, horseback riding and soccer

Meetings @ a Glance

EMS Board Meetings
November 14, 2001*
Dublin Wyndham Hotel
*Note date and location change due to Thanksgiving Holiday
January 16, 2002
Location TBA

Trauma Committee
November 7, 2001
10 a.m. – 12:30 p.m.
Holiday Inn North
(Note date/time change due to Thanksgiving holiday)

December 12, 2001
12:30 p.m. – 3:00 p.m.
Location TBA

Trauma Subcommittees
December 12, 2001
10 a.m. - noon:
1. Hospital/Clinical
   Location TBA
2. Pre-hospital
   Location TBA
3. Air Medical
   Location TBA

Trauma Registry Advisory Committee
October 25, 2001
1:00-4:00 p.m.
ODPS, Room 134

R.P.A.B.
R.P.A.B. General Meeting
November 13, 2001
10 a.m.
ODPS, Room 134

Please visit our Web site for a comprehensive listing of meeting dates and information www.state.oh.us/odps

Editor: Lynne McBee

THE SIREN

Layout & Design: Kris Marple

Focus on EMS Board Members...

In this issue, we will continue to introduce you to Ohio EMS Board members. More profiles will be included in the next issue of the *Siren*.

Ohio EMS Board Member—Martin Mace

E-mail: mmace@apk.net

Position on EMS Board: Full-time paramedic nominated by Northern Ohio Firefighters

Brief biography

- Full–time paid Paramedic in state of Ohio for 25 years
- 13 years with Lakewood EMS, a hospital based third municipal service
- 12 years with City of Bay Village Fire Dept. as Firefighter/Paramedic
- -Currently involved in the Dive Rescue Team for the Fire Department
- Personal interest in law that led to Paralegal training

Interest/involvement and/or association with EMS:

- Chairman of Legislative Committee
- Co-Chair of Education Committee
- Have worked in Private and Public sector including teaching throughout career
- Served as representative of the EMS Board on the Rules Committee at Board of Health for the 1999 DNR Legislation

Ohio EMS Board Member—Mark Mankin

E-mail: MM5241@aol.com

Position on EMS Board: Firefighter, EMT instructor nominated by Ohio State Firefighters Association

Brief biography

- Capt./EMS Coordinator City of Worthington Division of Fire
- EMS. EMT-P for 17 years
- Started as a volunteer FF/EMT 1980
- Became full-time EMT-P instructor in 1983

Interest/involvement and/or association with EMS:

- Serves on EMS Systems Management Committee

OHIO PUBLIC SAFETY
EDUCATION · SERVICE · PROTECTION

Division of Emergency Medical Services
P.O.Box 182073
Columbus Ohio 43218-2073

Bob Taft, Governor
Lt. Governor Maureen O'Connor, Director
Laura Tiberi, Executive Director

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