UPDATED VERSION*

OHIO LEGISLATIVE SERVICE COMMISSION

Final Analysis

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(As Passed by the General Assembly)

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Sens. Gardner, Beagle, Jones, Tavares, Cafaro, Brown, Burke, Eklund, Faber, Hackett, Hite, LaRose, Lehner, Manning, Oelslager, Schiavoni, Seitz, Thomas, Uecker, Yuko

Effective date: April 6, 2017

ACT SUMMARY

Advanced practice registered nurses

- Establishes an advanced practice registered nurse (APRN) license that, like the certificate of authority it replaces, authorizes a registered nurse with advanced education and training to practice as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.

- Grants an APRN, other than a certified registered nurse anesthetist, authority to prescribe and furnish most drugs as part of the APRN license, without need for a separate certificate to prescribe or completion of a supervised externship.

- Requires the Board of Nursing to establish an exclusionary drug formulary specifying the drugs an APRN is not authorized to prescribe.

- Increases to five (from three) the number of APRNs with whom a physician or podiatrist may collaborate at the same time in the prescribing component of an APRN's practice.

* This version updates the effective date and reflects a R.C. number change from R.C. 3701.138 to R.C. 3701.139. See https://www.legislature.ohio.gov/download?key=6435&format=pdf.

- Allows an APRN to continue to practice under an existing standard care arrangement without a collaborating physician or podiatrist for not more than 120 days if the physician or podiatrist terminates the collaboration and the nurse notifies the Board of the termination.

Board of Nursing

- Changes the membership and operation of the Board of Nursing.
- Establishes additional grounds for imposing professional discipline on nurses licensed by the Board.
- Establishes new requirements for Board approval of prelicensure nursing education programs and other training programs.

Hyperbaric oxygen therapy

- Authorizes a podiatrist to order and supervise hyperbaric oxygen therapy if specified conditions are met.

Diabetes

- Permits diabetes care in schools to be provided in accordance with orders issued by physician assistants, clinical nurse specialists, and certified nurse practitioners, as well as by physicians.
- Requires certain state agencies to assess the prevalence of diabetes in Ohio.

TABLE OF CONTENTS

CONTENT AND OPERATION

ADVANCED PRACTICE REGISTERED NURSES

Advanced practice registered nurse license

The act establishes an advanced practice registered nurse (APRN) license issued by the Board of Nursing that includes designation as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.[1] The license replaces the certificate of authority that under former law authorized a registered nurse (RN) who completed advanced education and training to practice as one of the four types of APRNs.[2] The APRN license is distinct from an RN license and must be renewed separately.

Standard care arrangement

Law unchanged by the act requires an APRN, other than a certified registered nurse anesthetist, to enter into a standard care arrangement with one or more collaborating physicians or podiatrists and practice in accordance with it.[3] A standard

[1] R.C. 4723.41.

[2] R.C. 4723.01.

[3] R.C. 4723.431.

care arrangement is a written, formal guide for planning and evaluating a patient's health care that is developed by one or more collaborating physicians or podiatrists and a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.[4]

The act eliminates the requirement that the arrangement contain the following:

(1) A procedure for regular review of referrals by the nurse to other health care professionals and the care outcomes for a random sample of all patients seen by the nurse;

(2) A policy for care of infants up to age one and recommendations for collaborating physician visits for children from birth to age three, if the nurse regularly provides services to infants.

Former law required a copy of the nurse's standard care arrangement to be retained on file at each practice site. Following the act, it must instead be retained on file by the nurse's employer.[5]

Practice after termination of collaboration

If a physician or podiatrist terminates collaboration with a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner before their standard care arrangement expires, the act permits the nurse to continue to practice under the existing arrangement without a collaborating physician or podiatrist for not more than 120 days. In that case, all of the following apply:

(1) The collaborating physician or podiatrist must give the nurse written or electronic notice of the termination;

(2) The nurse must notify the Board of Nursing of the termination as soon as practicable by submitting to the Board a copy of the notice of termination;

(3) The 120-day period runs from the date the nurse submits the notice of termination.[6]

If collaboration terminates because of the death of a collaborating physician or podiatrist, the nurse must notify the Board of the death as soon as practicable. The nurse may continue to practice under the existing standard care arrangement without a

[4] R.C. 4723.431.

[5] R.C. 4723.431.

[6] R.C. 4723.431(E) and R.C. 4731.27.

collaborating physician or podiatrist for not more than 120 days after notifying the Board.

Collaboration in the prescribing component of practice

The act increases to five (from three) the number of APRNs with whom a physician or podiatrist may collaborate at the same time in the prescribing component of APRN practice.[7]

Psychiatric clinical nurse specialists

Under former law, a clinical nurse specialist who specialized in mental health or psychiatric mental health but lacked prescriptive authority could practice without a standard care arrangement as long as the nurse practiced in collaboration with one or more physicians. If the nurse had prescriptive authority, the nurse was required to enter into a standard care arrangement with one or more physicians practicing in the same or similar specialty. The standard care arrangement needed to address only the prescribing components of the nurse's practice.[8]

Under the act, each psychiatric clinical nurse specialist must enter into a standard care arrangement with a collaborating physician who specializes in pediatrics, primary care or family practice, or a specialty that is the same as or similar to that of the nurse.[9]

The standard care arrangement for a psychiatric clinical nurse specialist must address each component required for other APRNs, not just the prescribing components of the nurse's practice, as was the case under former law.

Prescriptive authority

The APRN license grants each APRN, other than a certified registered nurse anesthetist, authority to prescribe or personally furnish most drugs and therapeutic devices.[10] Under prior law, an RN holding a certificate of authority as a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner could apply for a certificate to prescribe. A certificate to prescribe authorized the nurse to prescribe or personally furnish drugs or devices, if the following conditions were met:

(1) The drug or device was included in the formulary established by the Board;

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[7] R.C. 4723.431.

[8] R.C. 4723.431(D).

[9] R.C. 4723.431(D).

[10] R.C. 4723.481.

(2) In the case of a schedule II controlled substance, the drug was prescribed only under certain conditions or from specified locations;

(3) In the case of a sample of a drug or device (other than a schedule II controlled substance), the drug or device was personally furnished to a patient in an amount that did not exceed a 72-hour supply;

(4) In the case of a complete or partial supply of a specified drug or device, the drug or device was personally furnished to a patient from a local health department, federally funded primary care clinic, or nonprofit clinic or program only.[11]

The act eliminates the certificate to prescribe, along with the initial externship certificate that required supervision of the nurse's prescribing practices by one or more collaborating physicians or podiatrists.[12] However, it retains, modifies, or eliminates some of the conditions on prescriptive authority as described below.

Limits on prescriptive authority

The act changes the APRN drug formulary from a list of drugs that could be prescribed to an "exclusionary" formulary specifying the drugs or devices that a nurse is not authorized to prescribe or furnish.[13] The formulary cannot permit prescribing or furnishing a drug or device prohibited by state or federal law.

An APRN may prescribe a schedule II controlled substance for a patient with a terminal condition but only under certain conditions. Under prior law, these conditions included that the prescription was initially issued by the collaborating physician and was for an amount that did not exceed that necessary for the patient's use in a single, 24-hour period. The act instead permits the initial prescription to have been issued by any physician and be for an amount for the patient's use in a single, 72-hour period. These conditions do not apply if the prescription is issued from any of certain locations, such as hospitals. The act adds residential care facilities (assisted living facilities) to these locations.[14]

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[11] R.C. 3719.06 and 4723.481.

[12] R.C. 4723.484 (repealed) and 4723.485 (repealed).

[13] R.C. 4723.50.

[14] R.C. 4723.481.

The act eliminates conditions governing a nurse furnishing a sample or a complete or partial supply of a drug that is not a controlled substance.[15]

Pharmacology education

The act continues the requirement that an applicant seeking to practice as an APRN, other than as a certified registered nurse anesthetist, successfully complete a course of study in advanced pharmacology. It extends to five years (from three) the time after completion of the course of study in which an applicant must apply for the APRN license.[16]

APRN license application and renewal

Former law authorized the Board to issue to an RN, upon application, a certificate of authority to practice as one of the following: a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner. The act instead authorizes the Board to issue to an RN, upon application, an APRN license that includes designation as one of the four types of APRNs. It gives the Board 30 days to issue or deny the license. Under prior law, the Board was required to issue or deny a certificate of authority not later than 60 days after receiving the application.

The application fee for an APRN license cannot exceed $150. Under former law, the application fee for a certificate of authority could not be more than $100, while the application fee for a certificate to prescribe could not exceed $50.[17]

Each APRN license and RN license must be renewed separately. Law unchanged by the act requires any license or certificate issued by the Board to be renewed biennially to remain active. For renewal of an APRN license, the act authorizes the Board to impose a fee up to $135. Under prior law, the renewal fee for a certificate of authority could not exceed $85, while the renewal fee for a certificate to prescribe could not exceed $50.

Continuing education

Under the act, 24 hours of continuing education must be completed for an APRN license during a biennial renewal period. These hours are in addition to the continuing education hours required to renew an RN license. Certain continuing education credits

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[15] R.C. 4723.481.

[16] R.C. 4723.482.

[17] R.C. 4723.08.

earned by an APRN to maintain certification by a national certifying organization count as credit for the renewal of both licenses.[18] Former law allowed these credits to count toward renewal of an RN license.

APRN license status

Under the act, if either an RN or APRN license is revoked or suspended, the other license is automatically revoked or suspended. Under prior law, if an RN license was revoked or suspended, the nurse's APRN certificate of authority was automatically suspended.[19]

Unauthorized practice as an APRN

The act prohibits a person from knowingly doing any of the following without a valid, current license to practice nursing as an APRN:

(1) Engaging in the practice of nursing as an APRN for a fee, salary, or other consideration, or as a volunteer;

(2) Representing the person as being an APRN;

(3) Using any title or initials implying that the person is an advanced practice registered nurse.[20]

These prohibitions replace former law prohibiting practicing without the appropriate certificate. Like the former law, a first offense is a fifth degree felony and a subsequent offense a fourth degree felony.[21] The act also prohibits a person who is not otherwise authorized to prescribe or furnish drugs and therapeutic devices from knowingly doing so unless the person holds an APRN license and is designated as a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.[22] A person who knowingly violates this prohibition is guilty of a fifth degree felony on a first offense and a fourth degree felony on each subsequent offense.[23]

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[18] R.C. 4723.24.

[19] R.C. 4723.47.

[20] R.C. 4723.03 and 4723.44.

[21] R.C. 4723.99.

[22] R.C. 4723.03.

[23] R.C. 4723.99.

Insurance and maternity benefits

Prior law required a health insuring corporation policy, policy of sickness and accident insurance, public employee benefit plan, or multiple employer welfare arrangement providing maternity benefits, and the Medicaid program to provide coverage for certain care following a delivery if the care was from a physician-directed source. The act requires coverage of follow-up care directed by either a physician or APRN.[24]

Hospital staff membership or professional privileges

The act prohibits a hospital that is considering and acting on an application for staff membership or professional privileges from discriminating against a qualified person solely because the person is an APRN.[25]

Testimonial privilege

The act extends testimonial privilege to APRNs. In general, an APRN will not be permitted to testify concerning (1) a communication made to the APRN by a patient in the course of their professional relationship or (2) the advice of the APRN to a patient.[26]

Report of death

Continuing law prohibits a person who discovers the body or acquires first knowledge of a person's death from failing to immediately report the death to a physician whom the person knows to be treating the deceased for a condition from which death at such time would not be unexpected. The act permits the report to be made to an APRN under the same circumstances.[27]

Do-not-resuscitate order

In the case of a do-not-resuscitate (DNR) order, prior law allowed just two types of APRNs, certified nurse practitioners and clinical nurse specialists, to take an action that an attending physician could take. This authority is extended by the act to the other two types of APRNs: certified nurse-midwives and certified registered nurse anesthetists. In a corresponding provision, these additional APRNs are granted the

[24] R.C. 1751.67, 3923.63, 3923.64, and 5164.07.

[25] R.C. 3701.351.

[26] R.C. 2317.02.

[27] R.C. 2921.22.

same immunity from civil liability and criminal prosecution that continuing law grants to attending physicians, certified nurse practitioners, and clinical nurse specialists.[28]

Conforming changes

As the act establishes a separate APRN license that includes prescriptive authority, it makes conforming changes to the laws governing APRNs and other health professionals.[29]

BOARD OF NURSING

Board membership

The Board consists of 13 members, eight of whom must be RNs. The act increases, from at least one to at least two, the number of the eight RN members who must be holders of current, valid APRN licenses.[30]

Committee on Prescriptive Governance

The act maintains the Committee on Prescriptive Governance, but reduces its membership from ten to seven: three advanced practice registered nurses, three physicians, and one pharmacist, rather than four nurses, four physicians, and two pharmacists.[31] The pharmacist member is a nonvoting member. The act requires that at least four of the six voting members be present for the Committee to conduct official

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[28] R.C. 2133.211.

[29] R.C. 1.64 (APRN specialty definitions), 2305.113 (commencing medical malpractice action), 2305.234 (volunteer health care professional immunity), 2925.61 (lawful administration of naloxone), 3701.926 (patient centered medical home education pilot project), 3719.121 (suspension of health care professional licensure due to substance abuse), 3923.233 (insurance reimbursement for services performed by a certified nurse-midwife), 3923.301 (insurance reimbursement for services performed by a certified nurse-midwife), 4713.02 (State Board of Cosmetology membership), 4723.06 (Board of Nursing powers and duties), 4723.07 (Board of Nursing rule-making authority), 4723.09 (license application requirements), 4723.151 (prohibit practice of medicine and surgery by nurses), 4723.16 (providing nursing services through authorized business entity), 4723.25 (domestic violence continuing education), 4723.271 (replacement copy of license or certificate), 4723.28 (Board of Nursing disciplinary actions), 4723.32 (practice of nursing by students), 4723.341 (immunity for reporting negligence to Board of Nursing), 4723.432 (cooperation in Medical and Dental Board investigations), 4723.46 (list of approved national certifying organizations), 4723.487 (review of patient information in OARRS), 4723.488 (authority to supply naloxone), 4731.35 (anesthesia administration), 4755.48 (prescription for physical therapy), 4761.17 (respiratory care supervision), and 5120.55 (Department of Rehabilitation and Correction licensed health professional recruitment program).

[30] R.C. 4723.02.

[31] R.C. 4723.49.

business. In the case of a tie, the Board of Nursing casts the deciding vote, but must do so following a Board meeting.

The Committee must meet at least twice per year. It must develop and submit to the Board at least twice per year a recommended exclusionary formulary for the Board's approval. Prior law prohibited the Board from adopting any rule regarding APRN prescriptive authority that did not conform to a recommendation made by the Committee. The act similarly requires the Board to adopt rules consistent with the recommended exclusionary formulary submitted by the Committee. However, as under former law, the Board may ask the Committee to reconsider and resubmit the recommended formulary.[32]

Advisory Committee on Advanced Practice Registered Nursing

The act establishes the Advisory Committee on Advanced Practice Registered Nursing to advise the Board on the practice and regulation of APRNs.[33] It may also make recommendations to the Committee on Prescriptive Governance. The Advisory Committee consists of the following members appointed by the Board:

(1) Four APRNs who are actively practicing in Ohio in clinical settings, at least one of whom is actively engaged in providing primary care, at least one of whom is actively engaged in practice as a certified registered nurse anesthetist, and at least one of whom is actively engaged in practice as a certified nurse-midwife;

(2) Two APRNs who each serve as faculty members of approved programs of nursing education that prepare students for licensure as APRNs;

(3) One member of the Board who is an APRN;

(4) One representative of an entity that employs ten or more APRNs who are actively practicing in Ohio.

Schools of advanced practice registered nursing and organizations representing APRNs practicing in Ohio may submit to the Board recommendations regarding the Committee's membership. In addition to the eight members required by the act, the Board may appoint extra members on the Advisory Committee's recommendation.

Initial appointments must be made by June 5, 2017. Some of the initial appointments are for one year, while others are for two years. Thereafter, each member

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[32] R.C.4723.50.

[33] R.C. 4723.493.

serves a two-year term. Members may be reappointed for one additional term. Five members constitute a quorum.

Advisory Group on Dialysis

The Advisory Group on Dialysis is responsible for advising the Board on matters related to the regulation of dialysis technicians and dialysis technician interns. Prior law required the Board to appoint a physician specializing in nephrology to serve as a member of the group. Under the act, the Board may appoint to the group such a physician or an APRN specializing in nephrology who is recommended by the Board.[34]

Professional discipline – all nurses

The act establishes both of the following as grounds for professional discipline by the Board:

(1) Revocation, suspension, restriction, reduction, or termination of clinical privileges by the U.S. Department of Defense or Department of Veterans Affairs;

(2) Termination or suspension of a certificate of registration to prescribe drugs by the Drug Enforcement Administration of the U.S. Department of Justice.[35]

Notice of overdose death

Under the act, a coroner may notify the Board of Nursing and State Dental Board of a drug overdose death. This notice may include any information relating to the drug that resulted in the overdose, including whether it was obtained by prescription and if so, the name of its prescriber. Law unchanged by the act permits a coroner to notify the State Medical Board of an overdose death and to provide to the Medical Board the name of the physician who prescribed the drug.[36]

Prelicensure nursing education programs and other training programs

Continuing law requires a person or entity seeking to operate a prelicensure nursing education program or a training program for medication aides, dialysis technicians, or community health workers to obtain approval from the Board of Nursing. The act authorizes the Board to deny approval if the program is controlled by a person who controls or previously controlled a program that had its approval

[34] R.C. 4723.71.

[35] R.C. 4723.28.

[36] R.C. 313.212.

withdrawn, revoked, suspended, or restricted by the Board or a board of another jurisdiction that is a member of the National Council of State Boards of Nursing.[37] If the Board proposes to deny approval, it must do so pursuant to an adjudication conducted under the Administrative Procedure Act (R.C. Chapter 119.).

Control of a program is defined as any of the following:

(1) Holding 50% or more of the outstanding voting securities or membership interest of the program;

(2) In the case of an unincorporated program, having the right to 50% or more of the program's profits or, in the event of a dissolution, 50% or more of the program's assets;

(3) In the case of a program that is a corporation, having the contractual authority presently to designate 50% or more of its directors;

(4) In the case of a program that is a trust, having the contractual authority presently to designate 50% or more of its trustees;

(5) Having the authority to direct the management, policies, or investments of the program.

Adjudication

When the Board acts to deny or grant approval to a program and that action must be taken pursuant to an adjudication conducted under the Administrative Procedure Act, the act authorizes the Board to enter into a consent agreement to resolve the matter. The agreement is in lieu of an adjudication hearing. A consent agreement, when ratified by a vote of a quorum of the board, constitutes the findings and order of the Board with respect to the matter addressed in the agreement. However, if the board refuses to ratify a consent agreement, the admissions and findings contained in the agreement are of no effect.[38]

Under the act, in any instance in which the Board must give a program notice of an opportunity for a hearing, the Board is not required to hold the hearing if the program does not timely request it. Instead of the hearing, the Board may adopt, by a vote of a quorum, a final order that contains the Board's findings.[39]

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[37] R.C. 4723.06, 4723.66, 4723.74, and 4723.87.

[38] R.C. 4723.06, 4723.66, 4723.74, and 4723.87.

[39] R.C. 4723.06, 4723.66, 4723.74, and 4723.87.

Permanent action

Whenever the Board denies, suspends, refuses to renew, revokes, or withdraws approval of a program, the Board may specify that its action is permanent. A program subject to permanent action is forever ineligible for approval and the Board must not accept an application for the program's reinstatement or approval.[40]

LPN licensure – educational requirements

The act allows an applicant for a license to practice as a licensed practical nurse (LPN) to meet educational requirements by successfully completing a practical nursing course offered or approved by the U.S. Army. This is an alternative to completing a nursing education program approved by either the Board or a board that is a member of the National Council of State Boards of Nursing, as permitted by continuing law.[41]

LPN administration of adult intravenous therapy – training requirements

Under former law, to obtain authority from the Board of Nursing to administer intravenous therapy, an LPN must have successfully completed both an approved course of study in the safe performance of the therapy and a minimum of 40 hours of training that included the following elements:

(1) A curriculum established by the Board in rules;

(2) Training in the anatomy and physiology of the cardiovascular system, signs and symptoms of local and systemic complications in the administration of fluids and antibiotic additives, and guidelines for the management of those complications;

(3) A testing component that requires the nurse to perform a successful demonstration of intravenous procedures, including all skills needed to perform them safely;

(4) Any other training or instruction the Board considers appropriate.

The act instead requires the LPN to complete either (1) a course of study approved by the Board or an agency in another state with similar requirements or (2) a continuing education course or program approved by the Board that contains each of

[40] R.C. 4723.06, 4723.66, 4723.74, and 4723.87.

[41] R.C. 4723.09.

the four elements described above. It eliminates the requirement that a minimum of 40 hours be completed.[42]

Dialysis technicians

Under the act, a person who is required by law to register as a sex offender is ineligible for a Board-issued certificate to practice as a dialysis technician or dialysis technician intern.[43]

HYPERBARIC OXYGEN THERAPY

The act authorizes a podiatrist to order and supervise hyperbaric oxygen therapy if the podiatrist meets the following conditions:

(1) Is board-certified or board-qualified by the American Board of Foot and Ankle Surgery or the American Board of Podiatric Medicine;

(2) Orders the therapy only for treatment within the scope of practice of podiatry;

(3) Has consulted with a physician who has been authorized to perform the therapy by the facility in which the oxygen room or chamber is located;

(4) Is certified in advanced cardiovascular life support by a certifying organization recognized by the State Medical Board;

(5) Has documentation of having completed, at a minimum, a 40-hour introductory course in hyperbaric medicine recognized by the American Board of Foot and Ankle Surgery or the Undersea and Hyperbaric Medical Society.

On the request of the Medical Board, the podiatrist must submit to the Board evidence demonstrating that the podiatrist is certified in advanced cardiovascular life support and has completed the required course in hyperbaric medicine.

When supervising hyperbaric oxygen therapy, the podiatrist must be immediately available while the therapy is performed and a physician must be readily available for consultation in the event a complication occurs that is outside the scope of practice of podiatry.[44]

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[42] R.C. 4723.18.

[43] R.C. 4723.75 and 4723.76.

[44] R.C. 4731.51, 4731.511, and 4761.11.

Hyperbaric oxygen therapy is defined by the act as the administration of pure oxygen in a pressurized room or chamber.

DIABETES

Diabetes care in schools

Law unchanged by the act requires a school district or chartered nonpublic school governing authority to ensure that each student who has diabetes receives appropriate and needed diabetes care. Prior law required this care to be provided in accordance with an order signed by the student's treating physician. The act permits the care to be provided in accordance with orders issued by physician assistants, clinical nurse specialists, and certified nurse practitioners, as well as physicians.[45]

Diabetes prevalence assessments

The act requires the Director of Health to convene meetings with staff of the Departments of Health, Medicaid, and Administrative Services, and the Commission on Minority Health to do all of the following:[46]

--Assess the prevalence of all types of diabetes in Ohio, including disparities in that prevalence among various demographic populations and local jurisdictions;

--Establish and reevaluate goals for each agency to reduce that prevalence;

--Identify how to measure the progress achieved toward attaining the goals;

--Establish and monitor the implementation of plans to reduce the prevalence of diabetes, improve diabetes care, and control complications associated with the disease among the populations of concern to each agency;

--Consider any other matter associated with reducing the prevalence of diabetes that the Director determines to be appropriate; and

--Collect the information needed to prepare the biennial reports the act requires.

Meetings are to be convened at the Director's discretion, but must be held not less than twice each calendar year.

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[45] R.C. 3313.7112.

[46] R.C. 3701.139(A) and (B).

Biennial reports

Not later than January 31 of each even-numbered year beginning in 2018, the Director of Health must submit to the General Assembly a report addressing or containing the following for the two-year period preceding its submission:[47]

--The results of required assessments;

--The progress each agency has made toward achieving and implementing diabetes-related goals and plans;

--An assessment of the health and financial impact of diabetes on the state, local jurisdictions, and each agency covered by the act (see "**Agency-specific assessments**," below);

--A description of agency efforts to coordinate programs intended to prevent, treat, and manage diabetes and associated complications;

--Recommendations for legislative policies to reduce the impact of diabetes, pre-diabetes, and complications from the disease, including proposed action steps, expected outcomes of the action steps, and benchmarks for measuring progress toward achieving outcomes;

--A budget proposal that identifies resources needed to implement the recommendations, as well as estimates of implementation costs; and

--Any other information concerning diabetes prevention, treatment, or management the Director determines to be appropriate.

Agency-specific assessments

An assessment of the impact of diabetes on each agency covered by the act must include the following:[48]

--A list and description of each diabetes prevention or control program the agency administers, the number of individuals, including dependents, impacted by each program, the expenses associated with program administration, and the funds appropriated for each program by funding source;

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[47] R.C. 3701.139(C).

[48] R.C. 3701.139(D).

--A comparison of diabetes prevention or control program expenses with expenses incurred administering programs to reduce the prevalence of other chronic diseases and conditions; and

--An evaluation of the benefits resulting from each diabetes prevention or control program.

No requirement to establish new programs

The act specifies that none of its provisions require the agencies to establish programs for diabetes prevention, treatment, and management that had not been initiated or funded before the act's effective date.[49]

HISTORY

ACTION	DATE
Introduced	05-18-15
Reported, H. Health & Aging	05-25-16
Passed House (96-1)	05-25-16
Reported, S. Health & Human Services	11-30-16
Passed Senate (32-0)	12-07-16
House concurred in Senate amendments (92-1)	12-08-16

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[49] R.C. 3701.139(E).