SENATE BILL NO. 194

INTRODUCED BY L. NELSON

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING THE LICENSURE OF CRITICAL ACCESS HOSPITALS; PROVIDING DEFINITIONS; REQUIRING DESIGNATION OF ~~THOSE~~ CRITICAL ACCESS HOSPITALS BY THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; REQUIRING THE ADOPTION OF RULES BY THE DEPARTMENT; AMENDING ~~SECTION~~ SECTIONS 7-34-2201, 33-36-103, 39-71-704, 50-5-101, AND 50-6-401, MCA; AND PROVIDING EFFECTIVE DATES."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

SECTION 1. SECTION 7-34-2201, MCA, IS AMENDED TO READ:

"7-34-2201. Erection and management of county health care facilities -- definition -- provision of health care services. (1) The board of county commissioners has jurisdiction and power, under the limitations and restrictions prescribed by law, to erect, furnish, equip, expand, improve, and maintain health care facilities and to provide health care services in those facilities as permitted by law.

(2) The board of county commissioners of a county that has or may acquire title to a site and building or buildings suitable for county health care purposes has jurisdiction and power, under the limitations and restrictions prescribed by law, to erect, furnish, equip, expand, improve, maintain, and operate the building or buildings for health care purposes as provided by this section.

(3) As used in parts 21 and 23 through 25 and this part, unless the context clearly requires otherwise, the term "health care facility" means a hospital, a medical assistance facility, a critical access hospital, a hospice, an end-stage renal dialysis facility, an outpatient center for surgical services, an outpatient center for primary care, a rehabilitation facility, a long-term care facility, or an adult day-care center, as defined in 50-5-101, a public health center, as defined in 7-34-2102, or any combination and related medical facilities, including offices for physicians or other health care professionals providing outpatient, rehabilitative, emergency, nursing, or preventive care."

SECTION 2. SECTION 33-36-103, MCA, IS AMENDED TO READ:

"33-36-103. Definitions. As used in this chapter, the following definitions apply:

(1) "Closed plan" means a managed care plan that requires covered persons to use only participating providers under the terms of the managed care plan.

(2) "Combination plan" means an open plan with a closed component.

(3) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(4) "Covered person" means a policyholder, subscriber, or enrollee or other individual participating in a health benefit plan.

(5) "Department" means the department of public health and human services established in 2-15-2201.

(6) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

(7) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(8) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, medical assistance facility, or critical access hospital, as defined in 50-5-101, or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, ~~or~~ an imaging center, or a rehabilitation or other therapeutic health setting.

(9) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(10) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified pursuant to the laws of this state to perform specified health care services consistent with state law.

(11) "Health care provider" or "provider" means a health care professional or a facility.

(12) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief

of a health condition, illness, injury, or disease.

(13) "Health carrier" means an entity subject to the insurance laws and rules of this state that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a disability insurer, health maintenance organization, or health service corporation or another entity providing a health benefit plan.

(14) "Intermediary" means a person authorized to negotiate, execute, and be a party to a contract between a health carrier and a provider or between a health carrier and a network.

(15) "Managed care plan" means a health benefit plan that either requires or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by a health carrier, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment.

(16) "Medically necessary" means services, medicines, or supplies that are necessary and appropriate for the diagnosis or treatment of a covered person's illness, injury, or medical condition according to accepted standards of medical practice and that are not provided only as a convenience.

(17) "Network" means the group of participating providers that provides health care services to a managed care plan.

(18) "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

(19) "Participating provider" means a provider who, under a contract with a health carrier or with the health carrier's contractor, subcontractor, or intermediary, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

(20) "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and who may be required by the health carrier to initiate a referral for specialty care and to maintain supervision of health care services rendered to the covered person.

(21) "Quality assessment" means the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups, or populations.

(22) "Quality assurance" means quality assessment and quality improvement.

(23) "Quality improvement" means an effort to improve the processes and outcomes related to the provision of health care services within a health plan."

SECTION 3. SECTION 39-71-704, MCA, IS AMENDED TO READ:

"39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates -- fee limitation. (1) In addition to the compensation provided under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the following must be furnished:

(a) After the happening of a compensable injury and subject to other provisions of this chapter, the insurer shall furnish reasonable primary medical services for conditions resulting from the injury for those periods as the nature of the injury or the process of recovery requires.

(b) The insurer shall furnish secondary medical services only upon a clear demonstration of cost-effectiveness of the services in returning the injured worker to actual employment.

(c) The insurer shall replace or repair prescription eyeglasses, prescription contact lenses, prescription hearing aids, and dentures that are damaged or lost as a result of an injury, as defined in 39-71-119, arising out of and in the course of employment.

(d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury only if the travel is incurred at the request of the insurer. Reimbursement must be at the rates allowed for reimbursement of travel by state employees.

(e) Except for the repair or replacement of a prosthesis furnished as a result of an industrial injury, the benefits provided for in this section terminate when they are not used for a period of 60 consecutive months.

(f) Notwithstanding subsection (1)(a), the insurer may not be required to furnish, after the worker has achieved medical stability, palliative or maintenance care except:

(i) when provided to a worker who has been determined to be permanently totally disabled and for whom it is medically necessary to monitor administration of prescription medication to maintain the worker in a medically stationary condition;

(ii) when necessary to monitor the status of a prosthetic device; or

(iii) when the worker's treating physician believes that the care that would otherwise not be compensable under subsection (1)(f) is appropriate to enable the worker to continue current employment or that there is a clear probability of returning the worker to employment. A dispute regarding the

compensability of palliative or maintenance care is considered a dispute over which, after mediation pursuant to department rule, the workers' compensation court has jurisdiction.

(g) Notwithstanding any other provisions of this chapter, the department, by rule and upon the advice of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any medical treatment that the department finds to be unscientific, unproved, outmoded, or experimental.

(2) The department shall annually establish a schedule of fees for medical services not provided at a hospital that are necessary for the treatment of injured workers. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients. The department may require insurers to submit information to be used in establishing the schedule.

(3) (a) The department shall establish rates for hospital services necessary for the treatment of injured workers.

(b) Except as provided in subsection (3)(g), rates for services provided at a hospital must be the greater of:

(i) 69% of the hospital's January 1, 1997, usual and customary charges; or

(ii) the discount factor established by the department that was in effect on June 30, 1997, for the hospital. The discount factor for a hospital formed by the merger of two or more existing hospitals is computed by using the weighted average of the discount factors in effect at the time of the merger.

(c) Except as provided in subsection (3)(g), beginning July 1, 1998, the department shall adjust hospital discount factors so that the rate of payment does not exceed the annual percentage increase in the state's average weekly wage, as defined in 39-71-116.

(d) The department may establish a fee schedule for hospital outpatient services rendered on or after July 1, 1998. The fee schedule must, in the aggregate, provide for fees that are equal to the statewide average discount factors paid to hospitals to provide the same or equivalent procedure to workers' compensation hospital outpatients.

(e) The discount factors established by the department pursuant to this subsection (3) may not be less than medicaid reimbursement rates.

(f) For services available in Montana, insurers are not required to pay facilities located outside Montana rates that are greater than those allowed for services delivered in Montana.

(g) For a hospital licensed as a medical assistance facility or a critical access hospital pursuant to

Title 50, chapter 5, the rate for services is the hospital's usual and customary charge. Fees paid to a hospital licensed as a medical assistance facility are not subject to the limitation provided in subsection (4).

(4) The percentage increase in medical costs payable under this chapter may not exceed the annual percentage increase in the state's average weekly wage, as defined in 39-71-116.

(5) Payment pursuant to reimbursement agreements between managed care organizations or preferred provider organizations and insurers is not bound by the provisions of this section.

(6) Disputes between an insurer and a medical service provider regarding the amount of a fee for medical services must be resolved by a hearing before the department upon written application of a party to the dispute.

(7) (a) After the initial visit, the worker is responsible for 20%, but not to exceed $10, of the cost of each subsequent visit to a medical service provider for treatment relating to a compensable injury or occupational disease, unless the visit is to a medical service provider in a managed care organization as requested by the insurer or is a visit to a preferred provider as requested by the insurer.

(b) After the initial visit, the worker is responsible for $25 of the cost of each subsequent visit to a hospital emergency department for treatment relating to a compensable injury or occupational disease.

(c) "Visit", as used in subsections (7)(a) and (7)(b), means each time that the worker obtains services relating to a compensable injury or occupational disease from:

(i) a treating physician;

(ii) a physical therapist;

(iii) a psychologist; or

(iv) hospital outpatient services available in a nonhospital setting.

(d) A worker is not responsible for the cost of a subsequent visit pursuant to subsection (7)(a) if the visit is an examination requested by an insurer pursuant to 39-71-605."

Section 4. Section 50-5-101, MCA, is amended to read:

"50-5-101. Definitions. As used in parts 1 through ~~4~~ 3 of this chapter, unless the context clearly indicates otherwise, the following definitions apply:

(1) "Accreditation" means a designation of approval.

(2) "Adult day-care center" means a facility, freestanding or connected to another health care

facility, that provides adults, on a regularly scheduled basis, with the care necessary to meet the needs of daily living but that does not provide overnight care.

(3) (a) "Adult foster care home" means a private home or other facility that offers, except as provided in 50-5-216, only light personal care or custodial care to four or fewer disabled adults or aged persons who are not related to the owner or manager of the home by blood, marriage, or adoption or who are not under the full guardianship of the owner or manager.

(b) As used in this subsection (3), the following definitions apply:

(i) "Aged person" means a person as defined by department rule as aged.

(ii) "Custodial care" means providing a sheltered, family-type setting for an aged person or disabled adult so as to provide for the person's basic needs of food and shelter and to ensure that a specific person is available to meet those basic needs.

(iii) "Disabled adult" means a person who is 18 years of age or older and who is defined by department rule as disabled.

(iv) "Light personal care" means assisting the aged person or disabled adult in accomplishing such personal hygiene tasks as bathing, dressing, and hair grooming and supervision of prescriptive medicine administration. The term does not include the administration of prescriptive medications.

(4) "Affected person" means an applicant for a certificate of need, a health care facility located in the geographic area affected by the application, an agency that establishes rates for health care facilities, or a third-party payer who reimburses health care facilities in the area affected by the proposal.

(5) "Capital expenditure" means:

(a) an expenditure made by or on behalf of a health care facility that, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance; or

(b) a lease, donation, or comparable arrangement that would be a capital expenditure if money or any other property of value had changed hands.

(6) "Certificate of need" means a written authorization by the department for a person to proceed with a proposal subject to 50-5-301.

(7) "Chemical dependency facility" means a facility whose function is the treatment, rehabilitation, and prevention of the use of any chemical substance, including alcohol, that creates behavioral or health problems and endangers the health, interpersonal relationships, or economic function of an individual or the public health, welfare, or safety.

(8) "Clinical laboratory" means a facility for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition.

(9) "College of American pathologists" means the organization nationally recognized by that name that surveys clinical laboratories upon their requests and accredits clinical laboratories that it finds meet its standards and requirements.

(10) "Commission on accreditation of rehabilitation facilities" means the organization nationally recognized by that name that surveys rehabilitation facilities upon their requests and grants accreditation status to a rehabilitation facility that it finds meets its standards and requirements.

(11) "Comparative review" means a joint review of two or more certificate of need applications that are determined by the department to be competitive in that the granting of a certificate of need to one of the applicants would substantially prejudice the department's review of the other applications.

(12) "Construction" means the physical erection of a health care facility and any stage of the physical erection, including groundbreaking, or remodeling, replacement, or renovation of an existing health care facility.

(13) "Critical access hospital" means a ~~hospital~~ FACILITY that is located in a rural area, AS DEFINED IN 42 U.S.C. 1395WW(D)(2)(D), and that has been designated by the department as a critical access hospital pursuant to [section ~~2~~ 5].

~~(13)~~(14) "Department" means the department of public health and human services provided for in 2-15-2201.

~~(14)~~(15) "End-stage renal dialysis facility" means a facility that specializes in the treatment of kidney diseases and includes freestanding hemodialysis units.

~~(15)~~(16) "Federal acts" means federal statutes for the construction of health care facilities.

~~(16)~~(17) "Governmental unit" means the state, a state agency, a county, municipality, or political subdivision of the state, or an agency of a political subdivision.

~~(17)~~(18) "Health care facility" or "facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term does not include offices of private physicians, dentists, or other physical

or mental health care workers regulated under Title 37, including chemical dependency counselors. The term includes chemical dependency facilities, critical access hospitals, end-stage renal dialysis facilities, health maintenance organizations, home health agencies, home infusion therapy agencies, hospices, hospitals, infirmaries, long-term care facilities, medical assistance facilities, mental health centers, outpatient centers for primary care, outpatient centers for surgical services, rehabilitation facilities, residential care facilities, and residential treatment facilities.

~~(18)~~(19) "Health maintenance organization" means a public or private organization that provides or arranges for health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or group of providers.

~~(19)~~(20) "Home health agency" means a public agency or private organization or subdivision of the agency or organization that is engaged in providing home health services to individuals in the places where they live. Home health services must include the services of a licensed registered nurse and at least one other therapeutic service and may include additional support services.

~~(20)~~(21) "Home infusion therapy agency" means a health care facility that provides home infusion therapy services.

~~(21)~~(22) "Home infusion therapy services" means the preparation, administration, or furnishing of parenteral medications or parenteral or enteral nutritional services to an individual in that individual's residence. The services include an educational component for the patient, the patient's caregiver, or the patient's family member.

~~(22)~~(23) "Hospice" means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and the patient's family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component. The term includes:

(a) an inpatient hospice facility, which is a facility managed directly by a medicare-certified hospice that meets all medicare certification regulations for freestanding inpatient hospice facilities; and

(b) a residential hospice facility, which is a facility managed directly by a licensed hospice program that can house three or more hospice patients.

~~(23)~~(24) "Hospital" means a facility providing, by or under the supervision of licensed physicians, services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick individuals.

Services provided may or may not include obstetrical care, emergency care, or any other service allowed by state licensing authority. A hospital has an organized medical staff that is on call and available within 20 minutes, 24 hours a day, 7 days a week, and provides 24-hour nursing care by licensed registered nurses. The term includes hospitals specializing in providing health services for psychiatric, mentally retarded, and tubercular patients, but does not include critical access hospitals.

~~(24)~~(25) "Infirmary" means a facility located in a university, college, government institution, or industry for the treatment of the sick or injured, with the following subdefinitions:

(a) an "infirmary--A" provides outpatient and inpatient care;

(b) an "infirmary--B" provides outpatient care only.

~~(25)~~(26) "Intermediate developmental disability care" means the provision of nursing care services, health-related services, and social services for persons with developmental disabilities, as defined in 53-20-102, or for individuals with related problems.

~~(26)~~(27) "Intermediate nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed nurse to patients not requiring 24-hour nursing care.

~~(27)~~(28) "Joint commission on accreditation of healthcare organizations" means the organization nationally recognized by that name that surveys health care facilities upon their requests and grants accreditation status to a health care facility that it finds meets its standards and requirements.

~~(28)~~(29) (a) "Long-term care facility" means a facility or part of a facility that provides skilled nursing care, residential care, intermediate nursing care, or intermediate developmental disability care to a total of two or more individuals or that provides personal care.

(b) The term does not include community homes for persons with developmental disabilities licensed under 53-20-305; community homes for persons with severe disabilities, licensed under 52-4-203; youth care facilities, licensed under 41-3-1142; hotels, motels, boardinghouses, roominghouses, or similar accommodations providing for transients, students, or individuals who do not require institutional health care; or juvenile and adult correctional facilities operating under the authority of the department of corrections.

~~(29)~~(30) "Medical assistance facility" means a facility that meets both of the following:

(a) provides inpatient care to ill or injured individuals before their transportation to a hospital or that provides inpatient medical care to individuals needing that care for a period of no longer than 96 hours

unless a longer period is required because transfer to a hospital is precluded because of inclement weather or emergency conditions. The department or its designee may, upon request, waive the 96-hour restriction retroactively and on a case-by-case basis if the individual's attending physician, physician assistant-certified, or nurse practitioner determines that the transfer is medically inappropriate and would jeopardize the health and safety of the individual.

(b) either is located in a county with fewer than six residents a square mile or is located more than 35 road miles from the nearest hospital.

~~(30)~~(31) "Mental health center" means a facility providing services for the prevention or diagnosis of mental illness, the care and treatment of mentally ill patients, the rehabilitation of mentally ill individuals, or any combination of these services.

~~(31)~~(32) "Nonprofit health care facility" means a health care facility owned or operated by one or more nonprofit corporations or associations.

~~(32)~~(33) "Observation bed" means a bed occupied by a patient recovering from surgery or other treatment.

~~(33)~~(34) "Offer" means the representation by a health care facility that it can provide specific health services.

~~(34)~~(35) "Outpatient center for primary care" means a facility that provides, under the direction of a licensed physician, either diagnosis or treatment, or both, to ambulatory patients and that is not an outpatient center for surgical services.

~~(35)~~(36) "Outpatient center for surgical services" means a clinic, infirmary, or other institution or organization that is specifically designed and operated to provide surgical services to patients not requiring hospitalization and that may include observation beds.

~~(36)~~(37) "Patient" means an individual obtaining services, including skilled nursing care, from a health care facility.

~~(37)~~(38) "Person" means an individual, firm, partnership, association, organization, agency, institution, corporation, trust, estate, or governmental unit, whether organized for profit or not.

~~(38)~~(39) "Personal care" means the provision of services and care for residents who need some assistance in performing the activities of daily living.

~~(39)~~(40) "Personal-care facility" means a facility in which personal care is provided for residents in either a category A facility or a category B facility as provided in 50-5-227.

~~(40)~~(41) "Rehabilitation facility" means a facility that is operated for the primary purpose of assisting in the rehabilitation of disabled individuals by providing comprehensive medical evaluations and services, psychological and social services, or vocational evaluation and training or any combination of these services and in which the major portion of the services is furnished within the facility.

~~(41)~~(42) "Resident" means an individual who is in a long-term care facility or in a residential care facility.

~~(42)~~(43) "Residential care facility" means an adult day-care center, an adult foster care home, a personal-care facility, or a retirement home.

~~(43)~~(44) "Residential psychiatric care" means active psychiatric treatment provided in a residential treatment facility to psychiatrically impaired individuals with persistent patterns of emotional, psychological, or behavioral dysfunction of such severity as to require 24-hour supervised care to adequately treat or remedy the individual's condition. Residential psychiatric care must be individualized and designed to achieve the patient's discharge to less restrictive levels of care at the earliest possible time.

~~(44)~~(45) "Residential treatment facility" means a facility operated for the primary purpose of providing residential psychiatric care to individuals under 21 years of age.

~~(45)~~(46) "Retirement home" means a building or buildings in which separate living accommodations are rented or leased to individuals who use those accommodations as their primary residence.

~~(46)~~(47) "Skilled nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed registered nurse on a 24-hour basis.

~~(47)~~(48) "State health care facilities plan" means the plan prepared by the department to project the need for health care facilities within Montana and approved by the governor and a statewide health coordinating council appointed by the director of the department.

(49) "SWING BED" MEANS A BED APPROVED PURSUANT TO 42 U.S.C. 1395TT TO BE USED TO PROVIDE EITHER ACUTE CARE OR EXTENDED SKILLED NURSING CARE TO A PATIENT."

NEW SECTION. **Section 5. Designation of critical access hospitals -- adoption of rules.** (1) The department may designate as a critical access hospital a ~~hospital~~ FACILITY that:

(a) is:

(i) located more than 35 road miles or, in the case of a ~~hospital~~ FACILITY located in mountainous

terrain or where only secondary roads exist, more than 15 road miles from a hospital or another critical access hospital; or

(ii) a necessary provider of health care services to residents of the area where the ~~hospital~~ FACILITY is located;

(b) provides 24-hour emergency care that is necessary for ensuring access to emergency care services in the area served by the ~~hospital~~ FACILITY;

(c) has no more than 15 acute care inpatient beds or, in the case of a ~~hospital~~ FACILITY with swing beds, 25 acute care inpatient beds, OF WHICH NO MORE THAN 15 ARE USED FOR ACUTE CARE AT ANY ONE TIME, for providing inpatient care for a period not exceeding 96 hours, as determined on an average, annual basis for each patient;

(d) complies with the staffing requirements of 42 U.S.C. 1395i-4(c)(2)(B)(iv); and

(e) operates a quality assessment and performance improvement program and follows appropriate procedures for review of utilization of services as specified in 42 U.S.C. ~~1395i-4(c)(2)(B)(v)~~ 1395X(AA)(2)(I).

(2) The department shall adopt rules to implement this section, INCLUDING THE FOLLOWING:

(A) STANDARDS FOR DETERMINING WHETHER THE FACILITY QUALIFIES AS A NECESSARY PROVIDER PURSUANT TO SUBSECTION (1)(A)(II);

(B) STANDARDS FOR DETERMINING WHETHER THE 24-HOUR EMERGENCY CARE PROVIDED IS NECESSARY TO ENSURE THAT THE AREA SERVED BY THE FACILITY HAS ADEQUATE ACCESS TO EMERGENCY CARE SERVICES; AND

(C) PROCEDURES FOR APPLYING FOR AND RECEIVING DESIGNATION AS A CRITICAL ACCESS HOSPITAL.

SECTION 6. SECTION 50-6-401, MCA, IS AMENDED TO READ:

"50-6-401. Definitions. As used in this part, unless the context clearly requires otherwise, the following definitions apply:

(1) "Department" means the department of public health and human services provided for in Title 2, chapter 15, part 22.

(2) "Emergency medical service" means an emergency medical service as defined by 50-6-302.

(3) "Health care facility" or "facility" means a hospital, critical access hospital, or medical assistance facility as defined in 50-5-101.

(4) "Hospital trauma register" means patient-specific trauma data that is maintained by a health

care facility, in a format prescribed by department rule, and that has the primary purpose of facilitating peer review and quality improvement at the health care facility.

(5) "Quality improvement" means the process of defining trauma care system performance standards, collecting data against which the standards may be applied, using the data to determine compliance with the standards, and using the data and compliance information in a nonpunitive manner, including peer review, that will continuously improve performance and facilitate compliance with the standards.

(6) "State trauma register" means trauma data relating to a specific patient or health care facility that is maintained by the department in an electronic format and that has the primary purpose of facilitating peer review and quality improvement for a health care facility or a trauma care system.

(7) "Trauma" means a severe, abrupt injury to the human body that is caused by mechanical, environmental, thermal, or other physical force.

(8) "Trauma care committee" means the trauma care committee created in 2-15-2216.

(9) "Trauma care system" means a state or regional system for the prevention of trauma and the provision of optimal medical care to trauma victims that includes both provision of appropriate health care services and provision of emergency medical care, equipment, and personnel for effective and coordinated prehospital, hospital, interhospital, and rehabilitative care for trauma patients.

(10) "Trauma facility" means a health care facility designated by the department pursuant to 50-6-410 as providing a specialized program in trauma care with appropriately trained personnel, equipment, and other facility resources that are specifically organized to provide optimal care to a trauma patient at the facility.

(11) "Trauma region" means a geographic area, designated by department rule pursuant to 50-6-402, within which trauma services are coordinated and evaluated through a regional trauma care system."

NEW SECTION. **Section 7. Codification instruction.** [Section ~~2~~ 5] is intended to be codified as an integral part of Title 50, chapter 5, part 2, and the provisions of Title 50, chapter 5, part 2, apply to [section ~~2~~ 5].

NEW SECTION. **Section 8. Effective dates.** (1) Except as provided in subsection (2), [this act]

is effective July 1, 2001.

(2) [Sections ~~2(2) and 3~~ 5(2) AND 7 and this section] are effective on passage and approval.

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