AN ACT concerning health.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Department of Human Services Act is amended by changing Section 10-15 as follows:

(20 ILCS 1305/10-15)

Sec. 10-15. Pregnant women with a substance use disorder. The Department shall develop guidelines for use in non-hospital residential care facilities for pregnant women who have a substance use disorder with respect to the care of those clients.

The Department shall administer infant mortality and prenatal programs, through its provider agencies, to develop special programs for case finding and service coordination for pregnant women who have a substance use disorder.

The Department shall ensure access to substance use disorder services statewide for pregnant and postpartum women, and ensure that programs are gender-responsive, are trauma-informed, serve women and young children, and prioritize justice-involved pregnant and postpartum women.

(Source: P.A. 100-759, eff. 1-1-19.)

Section 10. The Department of Public Health Powers and

Duties Law of the Civil Administrative Code of Illinois is amended by adding Section 2310-223 as follows:

(20 ILCS 2310/2310-223 new)

Sec. 2310-223. Maternal care.

(a) The Department shall establish a classification system for the following levels of maternal care:

(1) basic care: care of uncomplicated pregnancies with the ability to detect, stabilize, and initiate management of unanticipated maternal-fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until the patient can be transferred to a facility at which specialty maternal care is available;

(2) specialty care: basic care plus care of appropriate high-risk antepartum, intrapartum, or postpartum conditions, both directly admitted and transferred to another facility;

(3) subspecialty care: specialty care plus care of more complex maternal medical conditions, obstetric complications, and fetal conditions; and

(4) regional perinatal health care: subspecialty care plus on-site medical and surgical care of the most complex maternal conditions, critically ill pregnant women, and fetuses throughout antepartum, intrapartum, and postpartum care.

(b) The Department shall:

(1) introduce uniform designations for levels of maternal care that are complimentary but distinct from levels of neonatal care;

(2) establish clear, uniform criteria for designation of maternal centers that are integrated with emergency response systems to help ensure that the appropriate personnel, physical space, equipment, and technology are available to achieve optimal outcomes, as well as to facilitate subsequent data collection regarding risk-appropriate care;

(3) require each health care facility to have a clear understanding of its capability to handle increasingly complex levels of maternal care, and to have a well-defined threshold for transferring women to health care facilities that offer a higher level of care; to ensure optimal care of all pregnant women, the Department shall require all birth centers, hospitals, and higher-level facilities to collaborate in order to develop and maintain maternal and neonatal transport plans and cooperative agreements capable of managing the health care needs of women who develop complications; the Department shall require that receiving hospitals openly accept transfers;

(4) require higher-level facilities to provide training for quality improvement initiatives, educational support, and severe morbidity and mortality case review for lower-level hospitals; the Department shall ensure that,

in those regions that do not have a facility that qualifies as a regional perinatal health care facility, any specialty care facility in the region will provide the educational and consultation function;

(5) require facilities and regional systems to develop methods to track severe maternal morbidity and mortality to assess the efficacy of utilizing maternal levels of care;

(6) analyze data collected from all facilities and regional systems in order to inform future updates to the levels of maternal care;

(7) require follow-up interdisciplinary work groups to further explore the implementation needs that are necessary to adopt the proposed classification system for levels of maternal care in all facilities that provide maternal care;

(8) disseminate data and materials to raise public awareness about the importance of prenatal care and maternal health;

(9) engage the Illinois Chapter of the American Academy of Pediatrics in creating a quality improvement initiative to expand efforts of pediatricians conducting postpartum depression screening at well baby visits during the first year of life; and

(10) adopt rules in accordance with the Illinois Administrative Procedure Act to implement this subsection.

Section 15. The Emergency Medical Services (EMS) Systems Act is amended by changing Section 3.20 as follows:

(210 ILCS 50/3.20)

Sec. 3.20. Emergency Medical Services (EMS) Systems.

(a) "Emergency Medical Services (EMS) System" means an organization of hospitals, vehicle service providers and personnel approved by the Department in a specific geographic area, which coordinates and provides pre-hospital and inter-hospital emergency care and non-emergency medical transports at a BLS, ILS and/or ALS level pursuant to a System program plan submitted to and approved by the Department, and pursuant to the EMS Region Plan adopted for the EMS Region in which the System is located.

(b) One hospital in each System program plan must be designated as the Resource Hospital. All other hospitals which are located within the geographic boundaries of a System and which have standby, basic or comprehensive level emergency departments must function in that EMS System as either an Associate Hospital or Participating Hospital and follow all System policies specified in the System Program Plan, including but not limited to the replacement of drugs and equipment used by providers who have delivered patients to their emergency departments. All hospitals and vehicle service providers participating in an EMS System must specify their level of participation in the System Program Plan.

(c) The Department shall have the authority and responsibility to:

(1) Approve BLS, ILS and ALS level EMS Systems which meet minimum standards and criteria established in rules adopted by the Department pursuant to this Act, including the submission of a Program Plan for Department approval. Beginning September 1, 1997, the Department shall approve the development of a new EMS System only when a local or regional need for establishing such System has been verified by the Department. This shall not be construed as a needs assessment for health planning or other purposes outside of this Act. Following Department approval, EMS Systems must be fully operational within one year from the date of approval.

(2) Monitor EMS Systems, based on minimum standards for continuing operation as prescribed in rules adopted by the Department pursuant to this Act, which shall include requirements for submitting Program Plan amendments to the Department for approval.

(3) Renew EMS System approvals every 4 years, after an inspection, based on compliance with the standards for continuing operation prescribed in rules adopted by the Department pursuant to this Act.

(4) Suspend, revoke, or refuse to renew approval of any EMS System, after providing an opportunity for a hearing, when findings show that it does not meet the minimum

standards for continuing operation as prescribed by the Department, or is found to be in violation of its previously approved Program Plan.

(5) Require each EMS System to adopt written protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center, which provide that a person shall not be transported to a facility other than the nearest hospital, regional trauma center or trauma center unless the medical benefits to the patient reasonably expected from the provision of appropriate medical treatment at a more distant facility outweigh the increased risks to the patient from transport to the more distant facility, or the transport is in accordance with the System's protocols for patient choice or refusal.

(6) Require that the EMS Medical Director of an ILS or ALS level EMS System be a physician licensed to practice medicine in all of its branches in Illinois, and certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine, and that the EMS Medical Director of a BLS level EMS System be a physician licensed to practice medicine in all of its branches in Illinois, with regular and frequent involvement in pre-hospital emergency medical services. In addition, all EMS Medical Directors shall:

(A) Have experience on an EMS vehicle at the highest level available within the System, or make

provision to gain such experience within 12 months prior to the date responsibility for the System is assumed or within 90 days after assuming the position;

(B) Be thoroughly knowledgeable of all skills included in the scope of practices of all levels of EMS personnel within the System;

(C) Have or make provision to gain experience instructing students at a level similar to that of the levels of EMS personnel within the System; and

(D) For ILS and ALS EMS Medical Directors, successfully complete a Department-approved EMS Medical Director's Course.

(7) Prescribe statewide EMS data elements to be collected and documented by providers in all EMS Systems for all emergency and non-emergency medical services, with a one-year phase-in for commencing collection of such data elements.

(8) Define, through rules adopted pursuant to this Act, the terms "Resource Hospital", "Associate Hospital", "Participating Hospital", "Basic Emergency Department", "Standby Emergency Department", "Comprehensive Emergency Department", "EMS Medical Director", "EMS Administrative Director", and "EMS System Coordinator".

(A) (Blank).

(B) (Blank).

(9) Investigate the circumstances that caused a

hospital in an EMS system to go on bypass status to determine whether that hospital's decision to go on bypass status was reasonable. The Department may impose sanctions, as set forth in Section 3.140 of the Act, upon a Department determination that the hospital unreasonably went on bypass status in violation of the Act.

(10) Evaluate the capacity and performance of any freestanding emergency center established under Section 32.5 of this Act in meeting emergency medical service needs of the public, including compliance with applicable emergency medical standards and assurance of the availability of and immediate access to the highest quality of medical care possible.

(11) Permit limited EMS System participation by facilities operated by the United States Department of Veterans Affairs, Veterans Health Administration. Subject to patient preference, Illinois EMS providers may transport patients to Veterans Health Administration facilities that voluntarily participate in an EMS System. Any Veterans Health Administration facility seeking limited participation in an EMS System shall agree to comply with all Department administrative rules implementing this Section. The Department may promulgate rules, including, but not limited to, the types of Veterans Health Administration facilities that may participate in an EMS System and the limitations of participation.

(12) Ensure that EMS systems are transporting pregnant women to the appropriate facilities based on the classification of the levels of maternal care described under subsection (a) of Section 2310-223 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois.

(Source: P.A. 97-333, eff. 8-12-11; 98-973, eff. 8-15-14.)

Section 99. Effective date. This Act takes effect upon becoming law.