



100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

SB2235

Introduced 10/18/2017, by Sen. Heather A. Steans

SYNOPSIS AS INTRODUCED:

210 ILCS 50/3.116
210 ILCS 50/3.117
210 ILCS 50/3.118

Amends the Emergency Medical Services (EMS) Systems Act. For provisions concerning hospital stroke care, defines "stroke" as brain, spinal cord, or retinal cell death attributable to ischemic or hemorrhagic infarction that is consistent with the most current nationally-recognized, evidence-based stroke definitions. Provides that the Department of Public Health's certification criteria for Primary Stroke Centers shall be consistent with the most current nationally-recognized, evidence-based stroke guidelines that include the use of thrombolytic therapy and anticoagulation reversal medications to reduce (rather than the most current nationally-recognized, evidence-based stroke guidelines related to reducing) the occurrence, disabilities, and death associated with ischemic and hemorrhagic stroke (rather than associated with stroke). Makes similar changes to provisions concerning the criteria for Comprehensive Stroke Centers. Provides that the criteria for the Acute Stroke-Ready Hospital designation of hospitals shall include the ability of a hospital to create written acute care protocols related to emergent ischemic and hemorrhagic stroke care (rather than emergent stroke care) and administer thrombolytic therapy and anticoagulation reversal medications (rather than administer thrombolytic therapy). Provides that the Department shall maintain an educational reference on the Department's website with the most current nationally-recognized and evidence-based guidelines for the management of hemorrhagic stroke and anticoagulation reversal.

LRB100 14695 MJP 29509 b

1 AN ACT concerning regulation.

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

4 Section 5. The Emergency Medical Services (EMS) Systems Act
5 is amended by changing Sections 3.116, 3.117, and 3.118 as
6 follows:

7 (210 ILCS 50/3.116)

8 Sec. 3.116. Hospital Stroke Care; definitions. As used in
9 Sections 3.116 through 3.119, 3.130, 3.200, and 3.226 of this
10 Act:

11 "Acute Stroke-Ready Hospital" means a hospital that has
12 been designated by the Department as meeting the criteria for
13 providing emergent stroke care. Designation may be provided
14 after a hospital has been certified or through application and
15 designation as such.

16 "Certification" or "certified" means certification, using
17 evidence-based standards, from a nationally-recognized
18 certifying body approved by the Department.

19 "Comprehensive Stroke Center" means a hospital that has
20 been certified and has been designated as such.

21 "Designation" or "designated" means the Department's
22 recognition of a hospital as a Comprehensive Stroke Center,
23 Primary Stroke Center, or Acute Stroke-Ready Hospital.

1 "Emergent stroke care" is emergency medical care that
2 includes diagnosis and emergency medical treatment of acute
3 stroke patients.

4 "Emergent Stroke Ready Hospital" means a hospital that has
5 been designated by the Department as meeting the criteria for
6 providing emergent stroke care.

7 "Primary Stroke Center" means a hospital that has been
8 certified by a Department-approved, nationally-recognized
9 certifying body and designated as such by the Department.

10 "Regional Stroke Advisory Subcommittee" means a
11 subcommittee formed within each Regional EMS Advisory
12 Committee to advise the Director and the Region's EMS Medical
13 Directors Committee on the triage, treatment, and transport of
14 possible acute stroke patients and to select the Region's
15 representative to the State Stroke Advisory Subcommittee. At
16 minimum, the Regional Stroke Advisory Subcommittee shall
17 consist of: one representative from the EMS Medical Directors
18 Committee; one EMS coordinator from a Resource Hospital; one
19 administrative representative or his or her designee from each
20 level of stroke care, including Comprehensive Stroke Centers
21 within the Region, if any, Primary Stroke Centers within the
22 Region, if any, and Acute Stroke-Ready Hospitals within the
23 Region, if any; one physician from each level of stroke care,
24 including one physician who is a neurologist or who provides
25 advanced stroke care at a Comprehensive Stroke Center in the
26 Region, if any, one physician who is a neurologist or who

1 provides acute stroke care at a Primary Stroke Center in the
2 Region, if any, and one physician who provides acute stroke
3 care at an Acute Stroke-Ready Hospital in the Region, if any;
4 one nurse practicing in each level of stroke care, including
5 one nurse from a Comprehensive Stroke Center in the Region, if
6 any, one nurse from a Primary Stroke Center in the Region, if
7 any, and one nurse from an Acute Stroke-Ready Hospital in the
8 Region, if any; one representative from both a public and a
9 private vehicle service provider that transports possible
10 acute stroke patients within the Region; the State-designated
11 regional EMS Coordinator; and a fire chief or his or her
12 designee from the EMS Region, if the Region serves a population
13 of more than 2,000,000. The Regional Stroke Advisory
14 Subcommittee shall establish bylaws to ensure equal membership
15 that rotates and clearly delineates committee responsibilities
16 and structure. Of the members first appointed, one-third shall
17 be appointed for a term of one year, one-third shall be
18 appointed for a term of 2 years, and the remaining members
19 shall be appointed for a term of 3 years. The terms of
20 subsequent appointees shall be 3 years.

21 "State Stroke Advisory Subcommittee" means a standing
22 advisory body within the State Emergency Medical Services
23 Advisory Council.

24 "Stroke" means brain, spinal cord, or retinal cell death
25 attributable to ischemic or hemorrhagic infarction that is
26 consistent with the most current nationally-recognized,

1 evidence-based stroke definitions.

2 (Source: P.A. 98-1001, eff. 1-1-15.)

3 (210 ILCS 50/3.117)

4 Sec. 3.117. Hospital Designations.

5 (a) The Department shall attempt to designate Primary
6 Stroke Centers in all areas of the State.

7 (1) The Department shall designate as many certified
8 Primary Stroke Centers as apply for that designation
9 provided they are certified by a nationally-recognized
10 certifying body, approved by the Department, and
11 certification criteria are consistent with the most
12 current nationally-recognized, evidence-based stroke
13 guidelines, including the use of thrombolytic therapy and
14 anticoagulation reversal medications ~~related~~ to reduce
15 ~~reducing~~ the occurrence, disabilities, and death
16 associated with ischemic and hemorrhagic stroke.

17 (2) A hospital certified as a Primary Stroke Center by
18 a nationally-recognized certifying body approved by the
19 Department, shall send a copy of the Certificate and annual
20 fee to the Department and shall be deemed, within 30
21 business days of its receipt by the Department, to be a
22 State-designated Primary Stroke Center.

23 (3) A center designated as a Primary Stroke Center
24 shall pay an annual fee as determined by the Department
25 that shall be no less than \$100 and no greater than \$500.

1 All fees shall be deposited into the Stroke Data Collection
2 Fund.

3 (3.5) With respect to a hospital that is a designated
4 Primary Stroke Center, the Department shall have the
5 authority and responsibility to do the following:

6 (A) Suspend or revoke a hospital's Primary Stroke
7 Center designation upon receiving notice that the
8 hospital's Primary Stroke Center certification has
9 lapsed or has been revoked by the State recognized
10 certifying body.

11 (B) Suspend a hospital's Primary Stroke Center
12 designation, in extreme circumstances where patients
13 may be at risk for immediate harm or death, until such
14 time as the certifying body investigates and makes a
15 final determination regarding certification.

16 (C) Restore any previously suspended or revoked
17 Department designation upon notice to the Department
18 that the certifying body has confirmed or restored the
19 Primary Stroke Center certification of that previously
20 designated hospital.

21 (D) Suspend a hospital's Primary Stroke Center
22 designation at the request of a hospital seeking to
23 suspend its own Department designation.

24 (4) Primary Stroke Center designation shall remain
25 valid at all times while the hospital maintains its
26 certification as a Primary Stroke Center, in good standing,

1 with the certifying body. The duration of a Primary Stroke
2 Center designation shall coincide with the duration of its
3 Primary Stroke Center certification. Each designated
4 Primary Stroke Center shall have its designation
5 automatically renewed upon the Department's receipt of a
6 copy of the accrediting body's certification renewal.

7 (5) A hospital that no longer meets
8 nationally-recognized, evidence-based standards for
9 Primary Stroke Centers, or loses its Primary Stroke Center
10 certification, shall notify the Department and the
11 Regional EMS Advisory Committee within 5 business days.

12 (a-5) The Department shall attempt to designate
13 Comprehensive Stroke Centers in all areas of the State.

14 (1) The Department shall designate as many certified
15 Comprehensive Stroke Centers as apply for that
16 designation, provided that the Comprehensive Stroke
17 Centers are certified by a nationally-recognized
18 certifying body approved by the Department, and provided
19 that the certifying body's certification criteria are
20 consistent with the most current nationally-recognized and
21 evidence-based stroke guidelines, including the use of
22 thrombolytic therapy and anticoagulation reversal
23 medications to reduce ~~for reducing~~ the occurrence of
24 ischemic and hemorrhagic stroke and the disabilities and
25 death associated with ischemic and hemorrhagic stroke.

26 (2) A hospital certified as a Comprehensive Stroke

1 Center shall send a copy of the Certificate and annual fee
2 to the Department and shall be deemed, within 30 business
3 days of its receipt by the Department, to be a
4 State-designated Comprehensive Stroke Center.

5 (3) A hospital designated as a Comprehensive Stroke
6 Center shall pay an annual fee as determined by the
7 Department that shall be no less than \$100 and no greater
8 than \$500. All fees shall be deposited into the Stroke Data
9 Collection Fund.

10 (4) With respect to a hospital that is a designated
11 Comprehensive Stroke Center, the Department shall have the
12 authority and responsibility to do the following:

13 (A) Suspend or revoke the hospital's Comprehensive
14 Stroke Center designation upon receiving notice that
15 the hospital's Comprehensive Stroke Center
16 certification has lapsed or has been revoked by the
17 State recognized certifying body.

18 (B) Suspend the hospital's Comprehensive Stroke
19 Center designation, in extreme circumstances in which
20 patients may be at risk for immediate harm or death,
21 until such time as the certifying body investigates and
22 makes a final determination regarding certification.

23 (C) Restore any previously suspended or revoked
24 Department designation upon notice to the Department
25 that the certifying body has confirmed or restored the
26 Comprehensive Stroke Center certification of that

1 previously designated hospital.

2 (D) Suspend the hospital's Comprehensive Stroke
3 Center designation at the request of a hospital seeking
4 to suspend its own Department designation.

5 (5) Comprehensive Stroke Center designation shall
6 remain valid at all times while the hospital maintains its
7 certification as a Comprehensive Stroke Center, in good
8 standing, with the certifying body. The duration of a
9 Comprehensive Stroke Center designation shall coincide
10 with the duration of its Comprehensive Stroke Center
11 certification. Each designated Comprehensive Stroke Center
12 shall have its designation automatically renewed upon the
13 Department's receipt of a copy of the certifying body's
14 certification renewal.

15 (6) A hospital that no longer meets
16 nationally-recognized, evidence-based standards for
17 Comprehensive Stroke Centers, or loses its Comprehensive
18 Stroke Center certification, shall notify the Department
19 and the Regional EMS Advisory Committee within 5 business
20 days.

21 (b) Beginning on the first day of the month that begins 12
22 months after the adoption of rules authorized by this
23 subsection, the Department shall attempt to designate
24 hospitals as Acute Stroke-Ready Hospitals in all areas of the
25 State. Designation may be approved by the Department after a
26 hospital has been certified as an Acute Stroke-Ready Hospital

1 or through application and designation by the Department. For
2 any hospital that is designated as an Emergent Stroke Ready
3 Hospital at the time that the Department begins the designation
4 of Acute Stroke-Ready Hospitals, the Emergent Stroke Ready
5 designation shall remain intact for the duration of the
6 12-month period until that designation expires. Until the
7 Department begins the designation of hospitals as Acute
8 Stroke-Ready Hospitals, hospitals may achieve Emergent Stroke
9 Ready Hospital designation utilizing the processes and
10 criteria provided in Public Act 96-514.

11 (1) (Blank).

12 (2) Hospitals may apply for, and receive, Acute
13 Stroke-Ready Hospital designation from the Department,
14 provided that the hospital attests, on a form developed by
15 the Department in consultation with the State Stroke
16 Advisory Subcommittee, that it meets, and will continue to
17 meet, the criteria for Acute Stroke-Ready Hospital
18 designation and pays an annual fee.

19 A hospital designated as an Acute Stroke-Ready
20 Hospital shall pay an annual fee as determined by the
21 Department that shall be no less than \$100 and no greater
22 than \$500. All fees shall be deposited into the Stroke Data
23 Collection Fund.

24 (2.5) A hospital may apply for, and receive, Acute
25 Stroke-Ready Hospital designation from the Department,
26 provided that the hospital provides proof of current Acute

1 Stroke-Ready Hospital certification and the hospital pays
2 an annual fee.

3 (A) Acute Stroke-Ready Hospital designation shall
4 remain valid at all times while the hospital maintains
5 its certification as an Acute Stroke-Ready Hospital,
6 in good standing, with the certifying body.

7 (B) The duration of an Acute Stroke-Ready Hospital
8 designation shall coincide with the duration of its
9 Acute Stroke-Ready Hospital certification.

10 (C) Each designated Acute Stroke-Ready Hospital
11 shall have its designation automatically renewed upon
12 the Department's receipt of a copy of the certifying
13 body's certification renewal and Application for
14 Stroke Center Designation form.

15 (D) A hospital must submit a copy of its
16 certification renewal from the certifying body as soon
17 as practical but no later than 30 business days after
18 that certification is received by the hospital. Upon
19 the Department's receipt of the renewal certification,
20 the Department shall renew the hospital's Acute
21 Stroke-Ready Hospital designation.

22 (E) A hospital designated as an Acute Stroke-Ready
23 Hospital shall pay an annual fee as determined by the
24 Department that shall be no less than \$100 and no
25 greater than \$500. All fees shall be deposited into the
26 Stroke Data Collection Fund.

1 (3) Hospitals seeking Acute Stroke-Ready Hospital
2 designation that do not have certification shall develop
3 policies and procedures that are consistent with
4 nationally-recognized, evidence-based protocols for the
5 provision of emergent stroke care. Hospital policies
6 relating to emergent stroke care and stroke patient
7 outcomes shall be reviewed at least annually, or more often
8 as needed, by a hospital committee that oversees quality
9 improvement. Adjustments shall be made as necessary to
10 advance the quality of stroke care delivered. Criteria for
11 Acute Stroke-Ready Hospital designation of hospitals shall
12 be limited to the ability of a hospital to:

13 (A) create written acute care protocols related to
14 emergent ischemic and hemorrhagic stroke care;

15 (A-5) participate in the data collection system
16 provided in Section 3.118, if available;

17 (B) maintain a written transfer agreement with one
18 or more hospitals that have neurosurgical expertise;

19 (C) designate a Clinical Director of Stroke Care
20 who shall be a clinical member of the hospital staff
21 with training or experience, as defined by the
22 facility, in the care of patients with cerebrovascular
23 disease. This training or experience may include, but
24 is not limited to, completion of a fellowship or other
25 specialized training in the area of cerebrovascular
26 disease, attendance at national courses, or prior

1 experience in neuroscience intensive care units. The
2 Clinical Director of Stroke Care may be a neurologist,
3 neurosurgeon, emergency medicine physician, internist,
4 radiologist, advanced practice nurse, or physician's
5 assistant;

6 (C-5) provide rapid access to an acute stroke team,
7 as defined by the facility, that considers and reflects
8 nationally-recognized, evidenced-based protocols or
9 guidelines;

10 (D) administer thrombolytic therapy and
11 anticoagulation reversal medications, or subsequently
12 developed medical therapies that meet
13 nationally-recognized, evidence-based stroke
14 guidelines;

15 (E) conduct brain image tests at all times;

16 (F) conduct blood coagulation studies at all
17 times;

18 (G) maintain a log of stroke patients, which shall
19 be available for review upon request by the Department
20 or any hospital that has a written transfer agreement
21 with the Acute Stroke-Ready Hospital;

22 (H) admit stroke patients to a unit that can
23 provide appropriate care that considers and reflects
24 nationally-recognized, evidence-based protocols or
25 guidelines or transfer stroke patients to an Acute
26 Stroke-Ready Hospital, Primary Stroke Center, or

1 Comprehensive Stroke Center, or another facility that
2 can provide the appropriate care that considers and
3 reflects nationally-recognized, evidence-based
4 protocols or guidelines; and

5 (I) demonstrate compliance with
6 nationally-recognized quality indicators.

7 (4) With respect to Acute Stroke-Ready Hospital
8 designation, the Department shall have the authority and
9 responsibility to do the following:

10 (A) Require hospitals applying for Acute
11 Stroke-Ready Hospital designation to attest, on a form
12 developed by the Department in consultation with the
13 State Stroke Advisory Subcommittee, that the hospital
14 meets, and will continue to meet, the criteria for an
15 Acute Stroke-Ready Hospital.

16 (A-5) Require hospitals applying for Acute
17 Stroke-Ready Hospital designation via national Acute
18 Stroke-Ready Hospital certification to provide proof
19 of current Acute Stroke-Ready Hospital certification,
20 in good standing.

21 The Department shall require a hospital that is
22 already certified as an Acute Stroke-Ready Hospital to
23 send a copy of the Certificate to the Department.

24 Within 30 business days of the Department's
25 receipt of a hospital's Acute Stroke-Ready Certificate
26 and Application for Stroke Center Designation form

1 that indicates that the hospital is a certified Acute
2 Stroke-Ready Hospital, in good standing, the hospital
3 shall be deemed a State-designated Acute Stroke-Ready
4 Hospital. The Department shall send a designation
5 notice to each hospital that it designates as an Acute
6 Stroke-Ready Hospital and shall add the names of
7 designated Acute Stroke-Ready Hospitals to the website
8 listing immediately upon designation. The Department
9 shall immediately remove the name of a hospital from
10 the website listing when a hospital loses its
11 designation after notice and, if requested by the
12 hospital, a hearing.

13 The Department shall develop an Application for
14 Stroke Center Designation form that contains a
15 statement that "The above named facility meets the
16 requirements for Acute Stroke-Ready Hospital
17 Designation as provided in Section 3.117 of the
18 Emergency Medical Services (EMS) Systems Act" and
19 shall instruct the applicant facility to provide: the
20 hospital name and address; the hospital CEO or
21 Administrator's typed name and signature; the hospital
22 Clinical Director of Stroke Care's typed name and
23 signature; and a contact person's typed name, email
24 address, and phone number.

25 The Application for Stroke Center Designation form
26 shall contain a statement that instructs the hospital

1 to "Provide proof of current Acute Stroke-Ready
2 Hospital certification from a nationally-recognized
3 certifying body approved by the Department".

4 (B) Designate a hospital as an Acute Stroke-Ready
5 Hospital no more than 30 business days after receipt of
6 an attestation that meets the requirements for
7 attestation, unless the Department, within 30 days of
8 receipt of the attestation, chooses to conduct an
9 onsite survey prior to designation. If the Department
10 chooses to conduct an onsite survey prior to
11 designation, then the onsite survey shall be conducted
12 within 90 days of receipt of the attestation.

13 (C) Require annual written attestation, on a form
14 developed by the Department in consultation with the
15 State Stroke Advisory Subcommittee, by Acute
16 Stroke-Ready Hospitals to indicate compliance with
17 Acute Stroke-Ready Hospital criteria, as described in
18 this Section, and automatically renew Acute
19 Stroke-Ready Hospital designation of the hospital.

20 (D) Issue an Emergency Suspension of Acute
21 Stroke-Ready Hospital designation when the Director,
22 or his or her designee, has determined that the
23 hospital no longer meets the Acute Stroke-Ready
24 Hospital criteria and an immediate and serious danger
25 to the public health, safety, and welfare exists. If
26 the Acute Stroke-Ready Hospital fails to eliminate the

1 violation immediately or within a fixed period of time,
2 not exceeding 10 days, as determined by the Director,
3 the Director may immediately revoke the Acute
4 Stroke-Ready Hospital designation. The Acute
5 Stroke-Ready Hospital may appeal the revocation within
6 15 business days after receiving the Director's
7 revocation order, by requesting an administrative
8 hearing.

9 (E) After notice and an opportunity for an
10 administrative hearing, suspend, revoke, or refuse to
11 renew an Acute Stroke-Ready Hospital designation, when
12 the Department finds the hospital is not in substantial
13 compliance with current Acute Stroke-Ready Hospital
14 criteria.

15 (c) The Department shall consult with the State Stroke
16 Advisory Subcommittee for developing the designation,
17 re-designation, and de-designation processes for Comprehensive
18 Stroke Centers, Primary Stroke Centers, and Acute Stroke-Ready
19 Hospitals.

20 (d) The Department shall consult with the State Stroke
21 Advisory Subcommittee as subject matter experts at least
22 annually regarding stroke standards of care.

23 (Source: P.A. 98-756, eff. 7-16-14; 98-1001, eff. 1-1-15.)

24 (210 ILCS 50/3.118)

25 Sec. 3.118. Reporting.

1 (a) The Director shall, not later than July 1, 2012,
2 prepare and submit to the Governor and the General Assembly a
3 report indicating the total number of hospitals that have
4 applied for grants, the project for which the application was
5 submitted, the number of those applicants that have been found
6 eligible for the grants, the total number of grants awarded,
7 the name and address of each grantee, and the amount of the
8 award issued to each grantee.

9 (b) By July 1, 2010, the Director shall send the list of
10 designated Comprehensive Stroke Centers, Primary Stroke
11 Centers, and Acute Stroke-Ready Hospitals to all Resource
12 Hospital EMS Medical Directors in this State and shall post a
13 list of designated Comprehensive Stroke Centers, Primary
14 Stroke Centers, and Acute Stroke-Ready Hospitals on the
15 Department's website, which shall be continuously updated.

16 (c) The Department shall add the names of designated
17 Comprehensive Stroke Centers, Primary Stroke Centers, and
18 Acute Stroke-Ready Hospitals to the website listing
19 immediately upon designation and shall immediately remove the
20 name when a hospital loses its designation after notice and a
21 hearing.

22 (c-5) The Department shall maintain an educational
23 reference on the Department's website with the most current
24 nationally-recognized and evidence-based guidelines for the
25 management of hemorrhagic stroke and anticoagulation reversal.

26 (d) Stroke data collection systems and all stroke-related

1 data collected from hospitals shall comply with the following
2 requirements:

3 (1) The confidentiality of patient records shall be
4 maintained in accordance with State and federal laws.

5 (2) Hospital proprietary information and the names of
6 any hospital administrator, health care professional, or
7 employee shall not be subject to disclosure.

8 (3) Information submitted to the Department shall be
9 privileged and strictly confidential and shall be used only
10 for the evaluation and improvement of hospital stroke care.
11 Stroke data collected by the Department shall not be
12 directly available to the public and shall not be subject
13 to civil subpoena, nor discoverable or admissible in any
14 civil, criminal, or administrative proceeding against a
15 health care facility or health care professional.

16 (e) The Department may administer a data collection system
17 to collect data that is already reported by designated
18 Comprehensive Stroke Centers, Primary Stroke Centers, and
19 Acute Stroke-Ready Hospitals to their certifying body, to
20 fulfill certification requirements. Comprehensive Stroke
21 Centers, Primary Stroke Centers, and Acute Stroke-Ready
22 Hospitals may provide data used in submission to their
23 certifying body, to satisfy any Department reporting
24 requirements. The Department may require submission of data
25 elements in a format that is used State-wide. In the event the
26 Department establishes reporting requirements for designated

1 Comprehensive Stroke Centers, Primary Stroke Centers, and
2 Acute Stroke-Ready Hospitals, the Department shall permit each
3 designated Comprehensive Stroke Center, Primary Stroke Center,
4 or Acute Stroke-Ready Hospital to capture information using
5 existing electronic reporting tools used for certification
6 purposes. Nothing in this Section shall be construed to empower
7 the Department to specify the form of internal recordkeeping.
8 Three years from the effective date of this amendatory Act of
9 the 96th General Assembly, the Department may post stroke data
10 submitted by Comprehensive Stroke Centers, Primary Stroke
11 Centers, and Acute Stroke-Ready Hospitals on its website,
12 subject to the following:

13 (1) Data collection and analytical methodologies shall
14 be used that meet accepted standards of validity and
15 reliability before any information is made available to the
16 public.

17 (2) The limitations of the data sources and analytic
18 methodologies used to develop comparative hospital
19 information shall be clearly identified and acknowledged,
20 including, but not limited to, the appropriate and
21 inappropriate uses of the data.

22 (3) To the greatest extent possible, comparative
23 hospital information initiatives shall use standard-based
24 norms derived from widely accepted provider-developed
25 practice guidelines.

26 (4) Comparative hospital information and other

1 information that the Department has compiled regarding
2 hospitals shall be shared with the hospitals under review
3 prior to public dissemination of the information.
4 Hospitals have 30 days to make corrections and to add
5 helpful explanatory comments about the information before
6 the publication.

7 (5) Comparisons among hospitals shall adjust for
8 patient case mix and other relevant risk factors and
9 control for provider peer groups, when appropriate.

10 (6) Effective safeguards to protect against the
11 unauthorized use or disclosure of hospital information
12 shall be developed and implemented.

13 (7) Effective safeguards to protect against the
14 dissemination of inconsistent, incomplete, invalid,
15 inaccurate, or subjective hospital data shall be developed
16 and implemented.

17 (8) The quality and accuracy of hospital information
18 reported under this Act and its data collection, analysis,
19 and dissemination methodologies shall be evaluated
20 regularly.

21 (9) None of the information the Department discloses to
22 the public under this Act may be used to establish a
23 standard of care in a private civil action.

24 (10) The Department shall disclose information under
25 this Section in accordance with provisions for inspection
26 and copying of public records required by the Freedom of

1 Information Act, provided that the information satisfies
2 the provisions of this Section.

3 (11) Notwithstanding any other provision of law, under
4 no circumstances shall the Department disclose information
5 obtained from a hospital that is confidential under Part 21
6 of Article VIII of the Code of Civil Procedure.

7 (12) No hospital report or Department disclosure may
8 contain information identifying a patient, employee, or
9 licensed professional.

10 (Source: P.A. 98-1001, eff. 1-1-15.)