Rep. Mary E. Flowers

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1 AMENDMENT TO HOUSE BILL 68

2 AMENDMENT NO. ______. Amend House Bill 68 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Hospital Licensing Act is amended by
5 changing Section 10.4 as follows:

6 (210 ILCS 85/10.4) (from Ch. 111 1/2, par. 151.4)
7 Sec. 10.4. Medical staff privileges.
8 (a) Any hospital licensed under this Act or any hospital
9 organized under the University of Illinois Hospital Act shall,
10 prior to the granting of any medical staff privileges to an
11 applicant, or renewing a current medical staff member's
12 privileges, request of the Director of Professional Regulation
13 information concerning the licensure status, proper
14 credentials, required certificates, and any disciplinary
15 action taken against the applicant's or medical staff member's
16 license, except: (1) for medical personnel who enter a

1 hospital to obtain organs and tissues for transplant from a
2 donor in accordance with the Illinois Anatomical Gift Act; or
3 (2) for medical personnel who have been granted disaster
4 privileges pursuant to the procedures and requirements
5 established by rules adopted by the Department. Any hospital
6 and any employees of the hospital or others involved in
7 granting privileges who, in good faith, grant disaster
8 privileges pursuant to this Section to respond to an emergency
9 shall not, as a result of their acts or omissions, be liable
10 for civil damages for granting or denying disaster privileges
11 except in the event of willful and wanton misconduct, as that
12 term is defined in Section 10.2 of this Act. Individuals
13 granted privileges who provide care in an emergency situation,
14 in good faith and without direct compensation, shall not, as a
15 result of their acts or omissions, except for acts or
16 omissions involving willful and wanton misconduct, as that
17 term is defined in Section 10.2 of this Act, on the part of the
18 person, be liable for civil damages. The Director of
19 Professional Regulation shall transmit, in writing and in a
20 timely fashion, such information regarding the license of the
21 applicant or the medical staff member, including the record of
22 imposition of any periods of supervision or monitoring as a
23 result of alcohol or substance abuse, as provided by Section
24 23 of the Medical Practice Act of 1987, and such information as
25 may have been submitted to the Department indicating that the
26 application or medical staff member has been denied, or has

1 surrendered, medical staff privileges at a hospital licensed
2 under this Act, or any equivalent facility in another state or
3 territory of the United States. The Director of Professional
4 Regulation shall define by rule the period for timely response
5 to such requests.

6 No transmittal of information by the Director of
7 Professional Regulation, under this Section shall be to other
8 than the president, chief operating officer, chief
9 administrative officer, or chief of the medical staff of a
10 hospital licensed under this Act, a hospital organized under
11 the University of Illinois Hospital Act, or a hospital
12 operated by the United States, or any of its
13 instrumentalities. The information so transmitted shall be
14 afforded the same status as is information concerning medical
15 studies by Part 21 of Article VIII of the Code of Civil
16 Procedure, as now or hereafter amended.

17 (b) All hospitals licensed under this Act, except county
18 hospitals as defined in subsection (c) of Section 15-1 of the
19 Illinois Public Aid Code, shall comply with, and the medical
20 staff bylaws of these hospitals shall include rules consistent
21 with, the provisions of this Section in granting, limiting,
22 renewing, or denying medical staff membership and clinical
23 staff privileges. Hospitals that require medical staff members
24 to possess faculty status with a specific institution of
25 higher education are not required to comply with subsection
26 (1) below when the physician does not possess faculty status.

1 (1) Minimum procedures for pre-applicants and
2 applicants for medical staff membership shall include the
3 following:
4 (A) Written procedures relating to the acceptance
5 and processing of pre-applicants or applicants for
6 medical staff membership, which should be contained in
7 medical staff bylaws.
8 (B) Written procedures to be followed in
9 determining a pre-applicant's or an applicant's
10 qualifications for being granted medical staff
11 membership and privileges.
12 (C) Written criteria to be followed in evaluating
13 a pre-applicant's or an applicant's qualifications.
14 (D) An evaluation of a pre-applicant's or an
15 applicant's current health status and current license
16 status in Illinois.
17 (E) A written response to each pre-applicant or
18 applicant that explains the reason or reasons for any
19 adverse decision (including all reasons based in whole
20 or in part on the applicant's medical qualifications
21 or any other basis, including economic factors).
22 (2) Minimum procedures with respect to medical staff
23 and clinical privilege determinations concerning current
24 members of the medical staff shall include the following:
25 (A) A written notice of an adverse decision.
26 (B) An explanation of the reasons for an adverse

1 decision including all reasons based on the quality of
2 medical care or any other basis, including economic
3 factors.
4 (C) A statement of the medical staff member's
5 right to request a fair hearing on the adverse
6 decision before a hearing panel whose membership is
7 mutually agreed upon by the medical staff and the
8 hospital governing board. The hearing panel shall have
9 independent authority to recommend action to the
10 hospital governing board. Upon the request of the
11 medical staff member or the hospital governing board,
12 the hearing panel shall make findings concerning the
13 nature of each basis for any adverse decision
14 recommended to and accepted by the hospital governing
15 board.
16 (i) Nothing in this subparagraph (C) limits a
17 hospital's or medical staff's right to summarily
18 suspend, without a prior hearing, a person's
19 medical staff membership or clinical privileges if
20 the continuation of practice of a medical staff
21 member constitutes an immediate danger to the
22 public, including patients, visitors, and hospital
23 employees and staff. In the event that a hospital
24 or the medical staff imposes a summary suspension,
25 the Medical Executive Committee, or other
26 comparable governance committee of the medical

1 staff as specified in the bylaws, must meet as
2 soon as is reasonably possible to review the
3 suspension and to recommend whether it should be
4 affirmed, lifted, expunged, or modified if the
5 suspended physician requests such review. A
6 summary suspension may not be implemented unless
7 there is actual documentation or other reliable
8 information that an immediate danger exists. This
9 documentation or information must be available at
10 the time the summary suspension decision is made
11 and when the decision is reviewed by the Medical
12 Executive Committee. If the Medical Executive
13 Committee recommends that the summary suspension
14 should be lifted, expunged, or modified, this
15 recommendation must be reviewed and considered by
16 the hospital governing board, or a committee of
17 the board, on an expedited basis. Nothing in this
18 subparagraph (C) shall affect the requirement that
19 any requested hearing must be commenced within 15
20 days after the summary suspension and completed
21 without delay unless otherwise agreed to by the
22 parties. A fair hearing shall be commenced within
23 15 days after the suspension and completed without
24 delay, except that when the medical staff member's
25 license to practice has been suspended or revoked
26 by the State's licensing authority, no hearing

1 shall be necessary.
2 (ii) Nothing in this subparagraph (C) limits a
3 medical staff's right to permit, in the medical
4 staff bylaws, summary suspension of membership or
5 clinical privileges in designated administrative
6 circumstances as specifically approved by the
7 medical staff. This bylaw provision must
8 specifically describe both the administrative
9 circumstance that can result in a summary
10 suspension and the length of the summary
11 suspension. The opportunity for a fair hearing is
12 required for any administrative summary
13 suspension. Any requested hearing must be
14 commenced within 15 days after the summary
15 suspension and completed without delay. Adverse
16 decisions other than suspension or other
17 restrictions on the treatment or admission of
18 patients may be imposed summarily and without a
19 hearing under designated administrative
20 circumstances as specifically provided for in the
21 medical staff bylaws as approved by the medical
22 staff.
23 (iii) If a hospital exercises its option to
24 enter into an exclusive contract and that contract
25 results in the total or partial termination or
26 reduction of medical staff membership or clinical

1 privileges of a current medical staff member, the
2 hospital shall provide the affected medical staff
3 member 60 days prior notice of the effect on his or
4 her medical staff membership or privileges. An
5 affected medical staff member desiring a hearing
6 under subparagraph (C) of this paragraph (2) must
7 request the hearing within 14 days after the date
8 he or she is so notified. The requested hearing
9 shall be commenced and completed (with a report
10 and recommendation to the affected medical staff
11 member, hospital governing board, and medical
12 staff) within 30 days after the date of the
13 medical staff member's request. If agreed upon by
14 both the medical staff and the hospital governing
15 board, the medical staff bylaws may provide for
16 longer time periods.

17 (C-5) All peer review used for the purpose of
18 credentialing, privileging, disciplinary action, or
19 other recommendations affecting medical staff
20 membership or exercise of clinical privileges, whether
21 relying in whole or in part on internal or external
22 reviews, shall be conducted in accordance with the
23 medical staff bylaws and applicable rules,
24 regulations, or policies of the medical staff. If
25 external review is obtained, any adverse report
26 utilized shall be in writing and shall be made part of

1 the internal peer review process under the bylaws. The
2 report shall also be shared with a medical staff peer
3 review committee and the individual under review. If
4 the medical staff peer review committee or the
5 individual under review prepares a written response to
6 the report of the external peer review within 30 days
7 after receiving such report, the governing board shall
8 consider the response prior to the implementation of
9 any final actions by the governing board which may
10 affect the individual's medical staff membership or
11 clinical privileges. Any peer review that involves
12 willful or wanton misconduct shall be subject to civil
13 damages as provided for under Section 10.2 of this
14 Act.
15 (D) A statement of the member's right to inspect
16 all pertinent information in the hospital's possession
17 with respect to the decision.
18 (E) A statement of the member's right to present
19 witnesses and other evidence at the hearing on the
20 decision.
21 (E-5) The right to be represented by a personal
22 attorney.
23 (F) A written notice and written explanation of
24 the decision resulting from the hearing.
25 (F-5) A written notice of a final adverse decision
26 by a hospital governing board.

(G) Notice given 15 days before implementation of an adverse medical staff membership or clinical privileges decision based substantially on economic factors. This notice shall be given after the medical staff member exhausts all applicable procedures under this Section, including item (iii) of subparagraph (C) of this paragraph (2), and under the medical staff bylaws in order to allow sufficient time for the orderly provision of patient care.

(H) Nothing in this paragraph (2) of this subsection (b) limits a medical staff member's right to waive, in writing, the rights provided in subparagraphs (A) through (G) of this paragraph (2) of this subsection (b) upon being granted the written exclusive right to provide particular services at a hospital, either individually or as a member of a group. If an exclusive contract is signed by a representative of a group of physicians, a waiver contained in the contract shall apply to all members of the group unless stated otherwise in the contract.

(3) Every adverse medical staff membership and clinical privilege decision based substantially on economic factors shall be reported to the Hospital Licensing Board before the decision takes effect. These reports shall not be disclosed in any form that reveals the identity of any hospital or physician. These reports

1 shall be utilized to study the effects that hospital
2 medical staff membership and clinical privilege decisions
3 based upon economic factors have on access to care and the
4 availability of physician services. The Hospital Licensing
5 Board shall submit an initial study to the Governor and
6 the General Assembly by January 1, 1996, and subsequent
7 reports shall be submitted periodically thereafter.
8 (4) As used in this Section:
9 "Adverse decision" means a decision reducing,
10 restricting, suspending, revoking, denying, or not
11 renewing medical staff membership or clinical privileges.
12 "Economic factor" means any information or reasons for
13 decisions unrelated to quality of care or professional
14 competency.
15 "Pre-applicant" means a physician licensed to practice
16 medicine in all its branches who requests an application
17 for medical staff membership or privileges.
18 "Privilege" means permission to provide medical or
19 other patient care services and permission to use hospital
20 resources, including equipment, facilities and personnel
21 that are necessary to effectively provide medical or other
22 patient care services. This definition shall not be
23 construed to require a hospital to acquire additional
24 equipment, facilities, or personnel to accommodate the
25 granting of privileges.
26 (5) Any amendment to medical staff bylaws required

1 because of this amendatory Act of the 91st General
2 Assembly shall be adopted on or before July 1, 2001.
3 (c) All hospitals shall consult with the medical staff
4 prior to closing membership in the entire or any portion of the
5 medical staff or a department. If the hospital closes
6 membership in the medical staff, any portion of the medical
7 staff, or the department over the objections of the medical
8 staff, then the hospital shall provide a detailed written
9 explanation for the decision to the medical staff 10 days
10 prior to the effective date of any closure. No applications
11 need to be provided when membership in the medical staff or any
12 relevant portion of the medical staff is closed.
13 (Source: P.A. 96-445, eff. 8-14-09; 97-1006, eff. 8-17-12.)

14 Section 10. The Hospital Report Card Act is amended by
15 changing Section 25 as follows:

16 (210 ILCS 86/25)
17 Sec. 25. Hospital reports.
18 (a) Individual hospitals shall prepare a quarterly report
19 including all of the following:
20 (1) Nursing hours per patient day, average daily
21 census, and average daily hours worked for each clinical
22 service area.
23 (2) Infection-related measures for the facility for
24 the specific clinical procedures and devices determined by

1 the Department by rule under 2 or more of the following
2 categories:
3 (A) Surgical procedure outcome measures.
4 (B) Surgical procedure infection control process
5 measures.
6 (C) Outcome or process measures related to
7 ventilator-associated pneumonia.
8 (D) Central vascular catheter-related bloodstream
9 infection rates in designated critical care units.
10 (3) Information required under paragraph (4) of
11 Section 2310-312 of the Department of Public Health Powers
12 and Duties Law of the Civil Administrative Code of
13 Illinois.
14 (4) Additional infection measures mandated by the
15 Centers for Medicare and Medicaid Services that are
16 reported by hospitals to the Centers for Disease Control
17 and Prevention's National Healthcare Safety Network
18 surveillance system, or its successor, and deemed relevant
19 to patient safety by the Department.
20 (5) Each instance of preterm birth and infant
21 mortality within the reporting period, including the
22 racial and ethnic information of the mothers of those
23 infants.
24 (6) Each instance of maternal mortality within the
25 reporting period, including the racial and ethnic
26 information of those mothers.

1 (7) The number of female patients who have died within
2 the reporting period.
3 (8) The number of female patients admitted to the
4 hospital with a diagnosis of COVID-19 and at least one
5 known underlying condition identified by the United States
6 Centers for Disease Control and Prevention as a condition
7 that increases the risk of mortality from COVID-19 who
8 subsequently died at the hospital within the reporting
9 period.
10 The infection-related measures developed by the Department
11 shall be based upon measures and methods developed by the
12 Centers for Disease Control and Prevention, the Centers for
13 Medicare and Medicaid Services, the Agency for Healthcare
14 Research and Quality, the Joint Commission on Accreditation of
15 Healthcare Organizations, or the National Quality Forum. The
16 Department may align the infection-related measures with the
17 measures and methods developed by the Centers for Disease
18 Control and Prevention, the Centers for Medicare and Medicaid
19 Services, the Agency for Healthcare Research and Quality, the
20 Joint Commission on Accreditation of Healthcare Organizations,
21 and the National Quality Forum by adding reporting measures
22 based on national health care strategies and measures deemed
23 scientifically reliable and valid for public reporting. The
24 Department shall receive approval from the State Board of
25 Health to retire measures deemed no longer scientifically
26 valid or valuable for informing quality improvement or

infection prevention efforts. The Department shall notify the Chairs and Minority Spokespersons of the House Human Services Committee and the Senate Public Health Committee of its intent to have the State Board of Health take action to retire measures no later than 7 business days before the meeting of the State Board of Health.

The Department shall include interpretive guidelines for infection-related indicators and, when available, shall include relevant benchmark information published by national organizations.

The Department shall collect the information reported under paragraphs (5) and (6) and shall use it to illustrate the disparity of those occurrences across different racial and ethnic groups.

(b) Individual hospitals shall prepare annual reports including vacancy and turnover rates for licensed nurses per clinical service area.

(c) None of the information the Department discloses to the public may be made available in any form or fashion unless the information has been reviewed, adjusted, and validated according to the following process:

(1) The Department shall organize an advisory committee, including representatives from the Department, public and private hospitals, direct care nursing staff, physicians, academic researchers, consumers, health insurance companies, organized labor, and organizations

representing hospitals and physicians. The advisory committee must be meaningfully involved in the development of all aspects of the Department's methodology for collecting, analyzing, and disclosing the information collected under this Act, including collection methods, formatting, and methods and means for release and dissemination.

(2) The entire methodology for collecting and analyzing the data shall be disclosed to all relevant organizations and to all hospitals that are the subject of any information to be made available to the public before any public disclosure of such information.

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

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

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

(6) 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 such information and
4 these hospitals have 30 days to make corrections and to
5 add helpful explanatory comments about the information
6 before the publication.

7 (7) 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 (8) Effective safeguards to protect against the
11 unauthorized use or disclosure of hospital information
12 shall be developed and implemented.

13 (9) 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 (10) 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 (11) Only the most basic identifying information from
22 mandatory reports shall be used, and information
23 identifying a patient, employee, or licensed professional
24 shall not be released. None of the information the
25 Department discloses to the public under this Act may be
26 used to establish a standard of care in a private civil

1 action.
2 (d) Quarterly reports shall be submitted, in a format set
3 forth in rules adopted by the Department, to the Department by
4 April 30, July 31, October 31, and January 31 each year for the
5 previous quarter. Data in quarterly reports must cover a
6 period ending not earlier than one month prior to submission
7 of the report. Annual reports shall be submitted by December
8 31 in a format set forth in rules adopted by the Department to
9 the Department. All reports shall be made available to the
10 public on-site and through the Department.
11 (e) If the hospital is a division or subsidiary of another
12 entity that owns or operates other hospitals or related
13 organizations, the annual public disclosure report shall be
14 for the specific division or subsidiary and not for the other
15 entity.
16 (f) The Department shall disclose information under this
17 Section in accordance with provisions for inspection and
18 copying of public records required by the Freedom of
19 Information Act provided that such information satisfies the
20 provisions of subsection (c) of this Section.
21 (g) Notwithstanding any other provision of law, under no
22 circumstances shall the Department disclose information
23 obtained from a hospital that is confidential under Part 21 of
24 Article VIII of the Code of Civil Procedure.
25 (h) No hospital report or Department disclosure may
26 contain information identifying a patient, employee, or

1 licensed professional.
2 (Source: P.A. 101-446, eff. 8-23-19.)".