

1 AN ACT concerning public health.

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

4 Section 5. The State Finance Act is amended by adding  
5 Section 5.719 as follows:

6 (30 ILCS 105/5.719 new)

7 Sec. 5.719. The Hospital Stroke Care Fund.

8 Section 10. The Emergency Medical Services (EMS) Systems  
9 Act is amended by changing Sections 3.25, 3.30, 3.130, and  
10 3.200 and by adding Sections 3.116, 3.117, 3.117.5, 3.118,  
11 3.118.5, 3.119, and 3.226 as follows:

12 (210 ILCS 50/3.25)

13 Sec. 3.25. EMS Region Plan; Development.

14 (a) Within 6 months after designation of an EMS Region, an  
15 EMS Region Plan addressing at least the information prescribed  
16 in Section 3.30 shall be submitted to the Department for  
17 approval. The Plan shall be developed by the Region's EMS  
18 Medical Directors Committee with advice from the Regional EMS  
19 Advisory Committee; portions of the plan concerning trauma  
20 shall be developed jointly with the Region's Trauma Center  
21 Medical Directors or Trauma Center Medical Directors

1 Committee, whichever is applicable, with advice from the  
2 Regional Trauma Advisory Committee, if such Advisory Committee  
3 has been established in the Region. Portions of the Plan  
4 concerning stroke shall be developed jointly with the Regional  
5 Stroke Advisory Subcommittee.

6 (1) A Region's EMS Medical Directors Committee shall be  
7 comprised of the Region's EMS Medical Directors, along with  
8 the medical advisor to a fire department vehicle service  
9 provider. For regions which include a municipal fire  
10 department serving a population of over 2,000,000 people,  
11 that fire department's medical advisor shall serve on the  
12 Committee. For other regions, the fire department vehicle  
13 service providers shall select which medical advisor to  
14 serve on the Committee on an annual basis.

15 (2) A Region's Trauma Center Medical Directors  
16 Committee shall be comprised of the Region's Trauma Center  
17 Medical Directors.

18 (b) A Region's Trauma Center Medical Directors may choose  
19 to participate in the development of the EMS Region Plan  
20 through membership on the Regional EMS Advisory Committee,  
21 rather than through a separate Trauma Center Medical Directors  
22 Committee. If that option is selected, the Region's Trauma  
23 Center Medical Director shall also determine whether a separate  
24 Regional Trauma Advisory Committee is necessary for the Region.

25 (c) In the event of disputes over content of the Plan  
26 between the Region's EMS Medical Directors Committee and the

1 Region's Trauma Center Medical Directors or Trauma Center  
2 Medical Directors Committee, whichever is applicable, the  
3 Director of the Illinois Department of Public Health shall  
4 intervene through a mechanism established by the Department  
5 through rules adopted pursuant to this Act.

6 (d) "Regional EMS Advisory Committee" means a committee  
7 formed within an Emergency Medical Services (EMS) Region to  
8 advise the Region's EMS Medical Directors Committee and to  
9 select the Region's representative to the State Emergency  
10 Medical Services Advisory Council, consisting of at least the  
11 members of the Region's EMS Medical Directors Committee, the  
12 Chair of the Regional Trauma Committee, the EMS System  
13 Coordinators from each Resource Hospital within the Region, one  
14 administrative representative from an Associate Hospital  
15 within the Region, one administrative representative from a  
16 Participating Hospital within the Region, one administrative  
17 representative from the vehicle service provider which  
18 responds to the highest number of calls for emergency service  
19 within the Region, one administrative representative of a  
20 vehicle service provider from each System within the Region,  
21 one Emergency Medical Technician (EMT)/Pre-Hospital RN from  
22 each level of EMT/Pre-Hospital RN practicing within the Region,  
23 and one registered professional nurse currently practicing in  
24 an emergency department within the Region. Of the 2  
25 administrative representatives of vehicle service providers,  
26 at least one shall be an administrative representative of a

1 private vehicle service provider. The Department's Regional  
2 EMS Coordinator for each Region shall serve as a non-voting  
3 member of that Region's EMS Advisory Committee.

4 Every 2 years, the members of the Region's EMS Medical  
5 Directors Committee shall rotate serving as Committee Chair,  
6 and select the Associate Hospital, Participating Hospital and  
7 vehicle service providers which shall send representatives to  
8 the Advisory Committee, and the EMTs/Pre-Hospital RN and nurse  
9 who shall serve on the Advisory Committee.

10 (e) "Regional Trauma Advisory Committee" means a committee  
11 formed within an Emergency Medical Services (EMS) Region, to  
12 advise the Region's Trauma Center Medical Directors Committee,  
13 consisting of at least the Trauma Center Medical Directors and  
14 Trauma Coordinators from each Trauma Center within the Region,  
15 one EMS Medical Director from a resource hospital within the  
16 Region, one EMS System Coordinator from another resource  
17 hospital within the Region, one representative each from a  
18 public and private vehicle service provider which transports  
19 trauma patients within the Region, an administrative  
20 representative from each trauma center within the Region, one  
21 EMT representing the highest level of EMT practicing within the  
22 Region, one emergency physician and one Trauma Nurse Specialist  
23 (TNS) currently practicing in a trauma center. The Department's  
24 Regional EMS Coordinator for each Region shall serve as a  
25 non-voting member of that Region's Trauma Advisory Committee.

26 Every 2 years, the members of the Trauma Center Medical

1 Directors Committee shall rotate serving as Committee Chair,  
2 and select the vehicle service providers, EMT, emergency  
3 physician, EMS System Coordinator and TNS who shall serve on  
4 the Advisory Committee.

5 (Source: P.A. 89-177, eff. 7-19-95.)

6 (210 ILCS 50/3.30)

7 Sec. 3.30. EMS Region Plan; Content.

8 (a) The EMS Medical Directors Committee shall address at  
9 least the following:

10 (1) Protocols for inter-System/inter-Region patient  
11 transports, including identifying the conditions of  
12 emergency patients which may not be transported to the  
13 different levels of emergency department, based on their  
14 Department classifications and relevant Regional  
15 considerations (e.g. transport times and distances);

16 (2) Regional standing medical orders;

17 (3) Patient transfer patterns, including criteria for  
18 determining whether a patient needs the specialized  
19 services of a trauma center, along with protocols for the  
20 bypassing of or diversion to any hospital, trauma center or  
21 regional trauma center which are consistent with  
22 individual System bypass or diversion protocols and  
23 protocols for patient choice or refusal;

24 (4) Protocols for resolving Regional or Inter-System  
25 conflict;

1           (5) An EMS disaster preparedness plan which includes  
2           the actions and responsibilities of all EMS participants  
3           within the Region. Within 90 days of the effective date of  
4           this amendatory Act of 1996, an EMS System shall submit to  
5           the Department for review an internal disaster plan. At a  
6           minimum, the plan shall include contingency plans for the  
7           transfer of patients to other facilities if an evacuation  
8           of the hospital becomes necessary due to a catastrophe,  
9           including but not limited to, a power failure;

10           (6) Regional standardization of continuing education  
11           requirements;

12           (7) Regional standardization of Do Not Resuscitate  
13           (DNR) policies, and protocols for power of attorney for  
14           health care; ~~and~~

15           (8) Protocols for disbursement of Department grants;  
16           and -

17           (9) Protocols for the triage, treatment, and transport  
18           of possible acute stroke patients.

19           (b) The Trauma Center Medical Directors or Trauma Center  
20           Medical Directors Committee shall address at least the  
21           following:

22           (1) The identification of Regional Trauma Centers;

23           (2) Protocols for inter-System and inter-Region trauma  
24           patient transports, including identifying the conditions  
25           of emergency patients which may not be transported to the  
26           different levels of emergency department, based on their

1 Department classifications and relevant Regional  
2 considerations (e.g. transport times and distances);

3 (3) Regional trauma standing medical orders;

4 (4) Trauma patient transfer patterns, including  
5 criteria for determining whether a patient needs the  
6 specialized services of a trauma center, along with  
7 protocols for the bypassing of or diversion to any  
8 hospital, trauma center or regional trauma center which are  
9 consistent with individual System bypass or diversion  
10 protocols and protocols for patient choice or refusal;

11 (5) The identification of which types of patients can  
12 be cared for by Level I and Level II Trauma Centers;

13 (6) Criteria for inter-hospital transfer of trauma  
14 patients;

15 (7) The treatment of trauma patients in each trauma  
16 center within the Region;

17 (8) A program for conducting a quarterly conference  
18 which shall include at a minimum a discussion of morbidity  
19 and mortality between all professional staff involved in  
20 the care of trauma patients;

21 (9) The establishment of a Regional trauma quality  
22 assurance and improvement subcommittee, consisting of  
23 trauma surgeons, which shall perform periodic medical  
24 audits of each trauma center's trauma services, and forward  
25 tabulated data from such reviews to the Department; and

26 (10) The establishment, within 90 days of the effective

1 date of this amendatory Act of 1996, of an internal  
2 disaster plan, which shall include, at a minimum,  
3 contingency plans for the transfer of patients to other  
4 facilities if an evacuation of the hospital becomes  
5 necessary due to a catastrophe, including but not limited  
6 to, a power failure.

7 (c) The Region's EMS Medical Directors and Trauma Center  
8 Medical Directors Committees shall appoint any subcommittees  
9 which they deem necessary to address specific issues concerning  
10 Region activities.

11 (Source: P.A. 89-177, eff. 7-19-95; 89-667, eff. 1-1-97.)

12 (210 ILCS 50/3.116 new)

13 Sec. 3.116. Hospital Stroke Care; definitions. As used in  
14 Sections 3.116 through 3.119, 3.130, 3.200, and 3.226 of this  
15 Act:

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

19 "Designation" or "designated" means the Department's  
20 recognition of a hospital as a Primary Stroke Center or  
21 Emergent Stroke Ready Hospital.

22 "Emergent stroke care" is emergency medical care that  
23 includes diagnosis and emergency medical treatment of acute  
24 stroke patients.

25 "Emergent Stroke Ready Hospital" means a hospital that has



1 been designated by the Department as meeting the criteria for  
2 providing emergent stroke care.

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

6 "Regional Stroke Advisory Subcommittee" means a  
7 subcommittee formed within each Regional EMS Advisory  
8 Committee to advise the Director and the Region's EMS Medical  
9 Directors Committee on the triage, treatment, and transport of  
10 possible acute stroke patients and to select the Region's  
11 representative to the State Stroke Advisory Subcommittee. The  
12 Regional Stroke Advisory Subcommittee shall consist of one  
13 representative from the EMS Medical Directors Committee; equal  
14 numbers of administrative representatives, or their designees,  
15 from Primary Stroke Centers within the Region, if any, and from  
16 hospitals that are capable of providing emergent stroke care  
17 that are not Primary Stroke Centers within the Region; one  
18 neurologist from a Primary Stroke Center in the Region, if any;  
19 one nurse practicing in a Primary Stroke Center and one nurse  
20 from a hospital capable of providing emergent stroke care that  
21 is not a Primary Stroke Center; one representative from both a  
22 public and a private vehicle service provider which transports  
23 possible acute stroke patients within the Region; the State  
24 designated regional EMS Coordinator; and in regions that serve  
25 a population of over 2,000,000, a fire chief, or designee, from  
26 the EMS Region.

1       "State Stroke Advisory Subcommittee" means a standing  
2 advisory body within the State Emergency Medical Services  
3 Advisory Council.

4           (210 ILCS 50/3.117 new)

5       Sec. 3.117. Hospital Designations.

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

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

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

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

25           (A) Suspend or revoke a hospital's Primary Stroke

1           Center designation upon receiving notice that the  
2           hospital's Primary Stroke Center certification has  
3           lapsed or has been revoked by the State recognized  
4           certifying body.

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

10           (C) Restore any previously suspended or revoked  
11           Department designation upon notice to the Department  
12           that the certifying body has confirmed or restored the  
13           Primary Stroke Center certification of that previously  
14           designated hospital.

15           (D) Suspend a hospital's Primary Stroke Center  
16           designation at the request of a hospital seeking to  
17           suspend its own Department designation.

18           (4) Primary Stroke Center designation shall remain  
19           valid at all times while the hospital maintains its  
20           certification as a Primary Stroke Center, in good standing,  
21           with the certifying body. The duration of a Primary Stroke  
22           Center designation shall coincide with the duration of its  
23           Primary Stroke Center certification. Each designated  
24           Primary Stroke Center shall have its designation  
25           automatically renewed upon the Department's receipt of a  
26           copy of the accrediting body's certification renewal.

1           (5) A hospital that no longer meets  
2           nationally-recognized, evidence-based standards for  
3           Primary Stroke Centers, or loses its Primary Stroke Center  
4           certification, shall immediately notify the Department and  
5           the Regional EMS Advisory Committee.

6           (b) The Department shall attempt to designate hospitals as  
7           Emergent Stroke Ready Hospitals capable of providing emergent  
8           stroke care in all areas of the State.

9           (1) The Department shall designate as many Emergent  
10           Stroke Ready Hospitals as apply for that designation as  
11           long as they meet the criteria in this Act.

12           (2) Hospitals may apply for, and receive, Emergent  
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 Emergent Stroke Ready Hospital  
18           designation.

19           (3) Hospitals seeking Emergent Stroke Ready Hospital  
20           designation shall develop policies and procedures that  
21           consider nationally-recognized, evidence-based protocols  
22           for the provision of emergent stroke care. Hospital  
23           policies relating to emergent stroke care and stroke  
24           patient outcomes shall be reviewed at least annually, or  
25           more often as needed, by a hospital committee that oversees  
26           quality improvement. Adjustments shall be made as

1 necessary to advance the quality of stroke care delivered.  
2 Criteria for Emergent Stroke Ready Hospital designation of  
3 hospitals shall be limited to the ability of a hospital to:

4 (A) create written acute care protocols related to  
5 emergent stroke care;

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

8 (C) designate a director of stroke care, which may  
9 be a clinical member of the hospital staff or the  
10 designee of the hospital administrator, to oversee the  
11 hospital's stroke care policies and procedures;

12 (D) administer thrombolytic therapy, or  
13 subsequently developed medical therapies that meet  
14 nationally-recognized, evidence-based stroke  
15 guidelines;

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

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

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

23 (4) With respect to Emergent Stroke Ready Hospital  
24 designation, the Department shall have the authority and  
25 responsibility to do the following:

26 (A) Require hospitals applying for Emergent Stroke

1       Ready Hospital designation to attest, on a form  
2       developed by the Department in consultation with the  
3       State Stroke Advisory Subcommittee, that the hospital  
4       meets, and will continue to meet, the criteria for a  
5       Emergent Stroke Ready Hospital.

6           (B) Designate a hospital as an Emergent Stroke  
7       Ready Hospital no more than 20 business days after  
8       receipt of an attestation that meets the requirements  
9       for attestation.

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

17          (D) Issue an Emergency Suspension of Emergent  
18       Stroke Ready Hospital designation when the Director,  
19       or his or her designee, has determined that the  
20       hospital no longer meets the Emergent Stroke Ready  
21       Hospital criteria and an immediate and serious danger  
22       to the public health, safety, and welfare exists. If  
23       the Emergent Stroke Ready Hospital fails to eliminate  
24       the violation immediately or within a fixed period of  
25       time, not exceeding 10 days, as determined by the  
26       Director, the Director may immediately revoke the

1           Emergent Stroke Ready Hospital designation. The  
2           Emergent Stroke Ready Hospital may appeal the  
3           revocation within 15 days after receiving the  
4           Director's revocation order, by requesting an  
5           administrative hearing.

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

12           (c) The Department shall consult with the State Stroke  
13           Advisory Subcommittee for developing the designation and  
14           de-designation processes for Primary Stroke Centers and  
15           Emergent Stroke Ready Hospitals.

16           (210 ILCS 50/3.117.5 new)

17           Sec. 3.117.5. Hospital Stroke Care; grants.

18           (a) In order to encourage the establishment and retention  
19           of Primary Stroke Centers and Emergent Stroke Ready Hospitals  
20           throughout the State, the Director may award, subject to  
21           appropriation, matching grants to hospitals to be used for the  
22           acquisition and maintenance of necessary infrastructure,  
23           including personnel, equipment, and pharmaceuticals for the  
24           diagnosis and treatment of acute stroke patients. Grants may be  
25           used to pay the fee for certifications by Department approved

1 nationally-recognized certifying bodies or to provide  
2 additional training for directors of stroke care or for  
3 hospital staff.

4 (b) The Director may award grant moneys to Primary Stroke  
5 Centers and Emergent Stroke Ready Hospitals for developing or  
6 enlarging stroke networks, for stroke education, and to enhance  
7 the ability of the EMS System to respond to possible acute  
8 stroke patients.

9 (c) A Primary Stroke Center, Emergent Stroke Ready  
10 Hospital, or hospital seeking certification as a Primary Stroke  
11 Center or designation as an Emergent Stroke Ready Hospital may  
12 apply to the Director for a matching grant in a manner and form  
13 specified by the Director and shall provide information as the  
14 Director deems necessary to determine whether the hospital is  
15 eligible for the grant.

16 (d) Matching grant awards shall be made to Primary Stroke  
17 Centers, Emergent Stroke Ready Hospitals, or hospitals seeking  
18 certification or designation as a Primary Stroke Center or  
19 designation as an Emergent Stroke Ready Hospital. The  
20 Department may consider prioritizing grant awards to hospitals  
21 in areas with the highest incidence of stroke, taking into  
22 account geographic diversity, where possible.

23 (210 ILCS 50/3.118 new)

24 Sec. 3.118. Reporting.

25 (a) The Director shall, not later than July 1, 2012,



1 prepare and submit to the Governor and the General Assembly a  
2 report indicating the total number of hospitals that have  
3 applied for grants, the project for which the application was  
4 submitted, the number of those applicants that have been found  
5 eligible for the grants, the total number of grants awarded,  
6 the name and address of each grantee, and the amount of the  
7 award issued to each grantee.

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

14 (c) The Department shall add the names of designated  
15 Primary Stroke Centers and Emergent Stroke Ready Hospitals to  
16 the website listing immediately upon designation and shall  
17 immediately remove the name when a hospital loses its  
18 designation after notice and a hearing.

19 (d) Stroke data collection systems and all stroke-related  
20 data collected from hospitals shall comply with the following  
21 requirements:

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

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

1           (3) Information submitted to the Department shall be  
2           privileged and strictly confidential and shall be used only  
3           for the evaluation and improvement of hospital stroke care.  
4           Stroke data collected by the Department shall not be  
5           directly available to the public and shall not be subject  
6           to civil subpoena, nor discoverable or admissible in any  
7           civil, criminal, or administrative proceeding against a  
8           health care facility or health care professional.

9           (e) The Department may administer a data collection system  
10          to collect data that is already reported by designated Primary  
11          Stroke Centers to their certifying body, to fulfill Primary  
12          Stroke Center certification requirements. Primary Stroke  
13          Centers may provide complete copies of the same reports that  
14          are submitted to their certifying body, to satisfy any  
15          Department reporting requirements. In the event the Department  
16          establishes reporting requirements for designated Primary  
17          Stroke Centers, the Department shall permit each designated  
18          Primary Stroke Center to capture information using existing  
19          electronic reporting tools used for certification purposes.  
20          Nothing in this Section shall be construed to empower the  
21          Department to specify the form of internal recordkeeping. Three  
22          years from the effective date of this amendatory Act of the  
23          96th General Assembly, the Department may post stroke data  
24          submitted by Primary Stroke Centers on its website, subject to  
25          the following:

26               (1) Data collection and analytical methodologies shall

1 be used that meet accepted standards of validity and  
2 reliability before any information is made available to the  
3 public.

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

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

13 (4) Comparative hospital information and other  
14 information that the Department has compiled regarding  
15 hospitals shall be shared with the hospitals under review  
16 prior to public dissemination of the information.  
17 Hospitals have 30 days to make corrections and to add  
18 helpful explanatory comments about the information before  
19 the publication.

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

23 (6) Effective safeguards to protect against the  
24 unauthorized use or disclosure of hospital information  
25 shall be developed and implemented.

26 (7) Effective safeguards to protect against the

1 dissemination of inconsistent, incomplete, invalid,  
2 inaccurate, or subjective hospital data shall be developed  
3 and implemented.

4 (8) The quality and accuracy of hospital information  
5 reported under this Act and its data collection, analysis,  
6 and dissemination methodologies shall be evaluated  
7 regularly.

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

11 (10) The Department shall disclose information under  
12 this Section in accordance with provisions for inspection  
13 and copying of public records required by the Freedom of  
14 Information Act, provided that the information satisfies  
15 the provisions of this Section.

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

20 (12) No hospital report or Department disclosure may  
21 contain information identifying a patient, employee, or  
22 licensed professional.

23 (210 ILCS 50/3.118.5 new)

24 Sec. 3.118.5. State Stroke Advisory Subcommittee; triage  
25 and transport of possible acute stroke patients.

1       (a) There shall be established within the State Emergency  
2 Medical Services Advisory Council, or other statewide body  
3 responsible for emergency health care, a standing State Stroke  
4 Advisory Subcommittee, which shall serve as an advisory body to  
5 the Council and the Department on matters related to the  
6 triage, treatment, and transport of possible acute stroke  
7 patients. Membership on the Committee shall be as  
8 geographically diverse as possible and include one  
9 representative from each Regional Stroke Advisory  
10 Subcommittee, to be chosen by each Regional Stroke Advisory  
11 Subcommittee. The Director shall appoint additional members,  
12 as needed, to ensure there is adequate representation from the  
13 following:

14           (1) an EMS Medical Director;

15           (2) a hospital administrator, or designee, from a  
16 Primary Stroke Center;

17           (3) a hospital administrator, or designee, from a  
18 hospital capable of providing emergent stroke care that is  
19 not a Primary Stroke Center;

20           (4) a registered nurse from a Primary Stroke Center;

21           (5) a registered nurse from a hospital capable of  
22 providing emergent stroke care that is not a Primary Stroke  
23 Center;

24           (6) a neurologist from a Primary Stroke Center;

25           (7) an emergency department physician from a hospital,  
26 capable of providing emergent stroke care, that is not a

1 Primary Stroke Center;

2 (8) an EMS Coordinator;

3 (9) an acute stroke patient advocate;

4 (10) a fire chief, or designee, from an EMS Region that  
5 serves a population of over 2,000,000 people;

6 (11) a fire chief, or designee, from a rural EMS  
7 Region;

8 (12) a representative from a private ambulance  
9 provider; and

10 (13) a representative from the State Emergency Medical  
11 Services Advisory Council.

12 (b) Of the members first appointed, 7 members shall be  
13 appointed for a term of one year, 7 members shall be appointed  
14 for a term of 2 years, and the remaining members shall be  
15 appointed for a term of 3 years. The terms of subsequent  
16 appointees shall be 3 years.

17 (c) The State Stroke Advisory Subcommittee shall be  
18 provided a 90-day period in which to review and comment upon  
19 all rules proposed by the Department pursuant to this Act  
20 concerning stroke care, except for emergency rules adopted  
21 pursuant to Section 5-45 of the Illinois Administrative  
22 Procedure Act. The 90-day review and comment period shall  
23 commence prior to publication of the proposed rules and upon  
24 the Department's submission of the proposed rules to the  
25 individual Committee members, if the Committee is not meeting  
26 at the time the proposed rules are ready for Committee review.

1       (d) The State Stroke Advisory Subcommittee shall develop  
2 and submit an evidence-based statewide stroke assessment tool  
3 to clinically evaluate potential stroke patients to the  
4 Department for final approval. Upon approval, the Department  
5 shall disseminate the tool to all EMS Systems for adoption. The  
6 Director shall post the Department-approved stroke assessment  
7 tool on the Department's website. The State Stroke Advisory  
8 Subcommittee shall review the Department-approved stroke  
9 assessment tool at least annually to ensure its clinical  
10 relevancy and to make changes when clinically warranted.

11       (e) Nothing in this Section shall preclude the State Stroke  
12 Advisory Subcommittee from reviewing and commenting on  
13 proposed rules which fall under the purview of the State  
14 Emergency Medical Services Advisory Council. Nothing in this  
15 Section shall preclude the Emergency Medical Services Advisory  
16 Council from reviewing and commenting on proposed rules which  
17 fall under the purview of the State Stroke Advisory  
18 Subcommittee.

19       (f) The Director shall coordinate with and assist the EMS  
20 System Medical Directors and Regional Stroke Advisory  
21 Subcommittee within each EMS Region to establish protocols  
22 related to the assessment, treatment, and transport of possible  
23 acute stroke patients by licensed emergency medical services  
24 providers. These protocols shall include regional transport  
25 plans for the triage and transport of possible acute stroke  
26 patients to the most appropriate Primary Stroke Center or

1 Emergent Stroke Ready Hospital, unless circumstances warrant  
2 otherwise.

3 (210 ILCS 50/3.119 new)

4 Sec. 3.119. Stroke Care; restricted practices. Sections in  
5 this Act pertaining to Primary Stroke Centers and Emergent  
6 Stroke Ready Hospitals are not medical practice guidelines and  
7 shall not be used to restrict the authority of a hospital to  
8 provide services for which it has received a license under  
9 State law.

10 (210 ILCS 50/3.130)

11 Sec. 3.130. Violations; Plans of Correction. Except for  
12 emergency suspension orders, or actions initiated pursuant to  
13 Sections 3.117(a), 3.117(b), and ~~Section~~ 3.90(b)(10) of this  
14 Act, prior to initiating an action for suspension, revocation,  
15 denial, nonrenewal, or imposition of a fine pursuant to this  
16 Act, the Department shall:

17 (a) Issue a Notice of Violation which specifies the  
18 Department's allegations of noncompliance and requests a plan  
19 of correction to be submitted within 10 days after receipt of  
20 the Notice of Violation;

21 (b) Review and approve or reject the plan of correction. If  
22 the Department rejects the plan of correction, it shall send  
23 notice of the rejection and the reason for the rejection. The  
24 party shall have 10 days after receipt of the notice of



1 rejection in which to submit a modified plan;

2 (c) Impose a plan of correction if a modified plan is not  
3 submitted in a timely manner or if the modified plan is  
4 rejected by the Department;

5 (d) Issue a Notice of Intent to fine, suspend, revoke,  
6 nonrenew or deny if the party has failed to comply with the  
7 imposed plan of correction, and provide the party with an  
8 opportunity to request an administrative hearing. The Notice of  
9 Intent shall be effected by certified mail or by personal  
10 service, shall set forth the particular reasons for the  
11 proposed action, and shall provide the party with 15 days in  
12 which to request a hearing.

13 (Source: P.A. 89-177, eff. 7-19-95.)

14 (210 ILCS 50/3.200)

15 Sec. 3.200. State Emergency Medical Services Advisory  
16 Council.

17 (a) There shall be established within the Department of  
18 Public Health a State Emergency Medical Services Advisory  
19 Council, which shall serve as an advisory body to the  
20 Department on matters related to this Act.

21 (b) Membership of the Council shall include one  
22 representative from each EMS Region, to be appointed by each  
23 region's EMS Regional Advisory Committee. The Governor shall  
24 appoint additional members to the Council as necessary to  
25 insure that the Council includes one representative from each

1 of the following categories:

2 (1) EMS Medical Director,

3 (2) Trauma Center Medical Director,

4 (3) Licensed, practicing physician with regular and  
5 frequent involvement in the provision of emergency care,

6 (4) Licensed, practicing physician with special  
7 expertise in the surgical care of the trauma patient,

8 (5) EMS System Coordinator,

9 (6) TNS,

10 (7) EMT-P,

11 (8) EMT-I,

12 (9) EMT-B,

13 (10) Private vehicle service provider,

14 (11) Law enforcement officer,

15 (12) Chief of a public vehicle service provider,

16 (13) Statewide firefighters' union member affiliated  
17 with a vehicle service provider,

18 (14) Administrative representative from a fire  
19 department vehicle service provider in a municipality with  
20 a population of over 2 million people;

21 (15) Administrative representative from a Resource  
22 Hospital or EMS System Administrative Director.

23 (c) Of the members first appointed, 5 members shall be  
24 appointed for a term of one year, 5 members shall be appointed  
25 for a term of 2 years, and the remaining members shall be  
26 appointed for a term of 3 years. The terms of subsequent

1 appointees shall be 3 years. All appointees shall serve until  
2 their successors are appointed and qualified.

3 (d) The Council shall be provided a 90-day period in which  
4 to review and comment, in consultation with the subcommittee to  
5 which the rules are relevant, upon all rules proposed by the  
6 Department pursuant to this Act, except for rules adopted  
7 pursuant to Section 3.190(a) of this Act, rules submitted to  
8 the State Trauma Advisory Council and emergency rules adopted  
9 pursuant to Section 5-45 of the Illinois Administrative  
10 Procedure Act. The 90-day review and comment period may  
11 commence upon the Department's submission of the proposed rules  
12 to the individual Council members, if the Council is not  
13 meeting at the time the proposed rules are ready for Council  
14 review. Any non-emergency rules adopted prior to the Council's  
15 90-day review and comment period shall be null and void. If the  
16 Council fails to advise the Department within its 90-day review  
17 and comment period, the rule shall be considered acted upon.

18 (e) Council members shall be reimbursed for reasonable  
19 travel expenses incurred during the performance of their duties  
20 under this Section.

21 (f) The Department shall provide administrative support to  
22 the Council for the preparation of the agenda and minutes for  
23 Council meetings and distribution of proposed rules to Council  
24 members.

25 (g) The Council shall act pursuant to bylaws which it  
26 adopts, which shall include the annual election of a Chair and

1 Vice-Chair.

2 (h) The Director or his designee shall be present at all  
3 Council meetings.

4 (i) Nothing in this Section shall preclude the Council from  
5 reviewing and commenting on proposed rules which fall under the  
6 purview of the State Trauma Advisory Council.

7 (Source: P.A. 89-177, eff. 7-19-95; 90-655, eff. 7-30-98.)

8 (210 ILCS 50/3.226 new)

9 Sec. 3.226. Hospital Stroke Care Fund.

10 (a) The Hospital Stroke Care Fund is created as a special  
11 fund in the State treasury for the purpose of receiving  
12 appropriations, donations, and grants collected by the  
13 Illinois Department of Public Health pursuant to Department  
14 designation of Primary Stroke Centers and Emergent Stroke Ready  
15 Hospitals. All moneys collected by the Department pursuant to  
16 its authority to designate Primary Stroke Centers and Emergent  
17 Stroke Ready Hospitals shall be deposited into the Fund, to be  
18 used for the purposes in subsection (b).

19 (b) The purpose of the Fund is to allow the Director of the  
20 Department to award matching grants to hospitals that have been  
21 certified Primary Stroke Centers, that seek certification or  
22 designation or both as Primary Stroke Centers, that have been  
23 designated Emergent Stroke Ready Hospitals, that seek  
24 designation as Emergent Stroke Ready Hospitals, and for the  
25 development of stroke networks. Hospitals may use grant funds

1 to work with the EMS System to improve outcomes of possible  
2 acute stroke patients.

3 (c) Moneys deposited in the Hospital Stroke Care Fund shall  
4 be allocated according to the hospital needs within each EMS  
5 region and used solely for the purposes described in this Act.

6 (d) Interfund transfers from the Hospital Stroke Care Fund  
7 shall be prohibited.