Sen. Heather Steans

Filed: 3/9/2009

AMENDMENT TO SENATE BILL 1516

AMENDMENT NO. _____. Amend Senate Bill 1516 by replacing everything after the enacting clause with the following:

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

(30 ILCS 105/5.719 new)

Sec. 5.719. The Hospital Stroke Care Fund.

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

(210 ILCS 50/3.25)

Sec. 3.25. EMS Region Plan; Development.

(a) Within 6 months after designation of an EMS Region, an

EMS Region Plan addressing at least the information prescribed in Section 3.30 shall be submitted to the Department for approval. The Plan shall be developed by the Region's EMS Medical Directors Committee with advice from the Regional EMS Advisory Committee; portions of the plan concerning trauma shall be developed jointly with the Region's Trauma Center Medical Directors or Trauma Center Medical Directors Committee, whichever is applicable, with advice from the Regional Trauma Advisory Committee, if such Advisory Committee has been established in the Region. Portions of the Plan concerning stroke shall be developed jointly with the Regional Stroke Advisory Subcommittee.

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

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

(b) A Region's Trauma Center Medical Directors may choose to participate in the development of the EMS Region Plan

through membership on the Regional EMS Advisory Committee, rather than through a separate Trauma Center Medical Directors Committee. If that option is selected, the Region's Trauma Center Medical Director shall also determine whether a separate Regional Trauma Advisory Committee is necessary for the Region.

(c) In the event of disputes over content of the Plan between the Region's EMS Medical Directors Committee and the Region's Trauma Center Medical Directors or Trauma Center Medical Directors Committee, whichever is applicable, the Director of the Illinois Department of Public Health shall intervene through a mechanism established by the Department through rules adopted pursuant to this Act.

(d) "Regional EMS Advisory Committee" means a committee formed within an Emergency Medical Services (EMS) Region to advise the Region's EMS Medical Directors Committee and to select the Region's representative to the State Emergency Medical Services Advisory Council, consisting of at least the members of the Region's EMS Medical Directors Committee, the Chair of the Regional Trauma Committee, the EMS System Coordinators from each Resource Hospital within the Region, one administrative representative from an Associate Hospital within the Region, one administrative representative from a Participating Hospital within the Region, one administrative representative from the vehicle service provider which responds to the highest number of calls for emergency service within the Region, one administrative representative of a

vehicle service provider from each System within the Region, one Emergency Medical Technician (EMT)/Pre-Hospital RN from each level of EMT/Pre-Hospital RN practicing within the Region, and one registered professional nurse currently practicing in an emergency department within the Region. Of the 2 administrative representatives of vehicle service providers, at least one shall be an administrative representative of a private vehicle service provider. The Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's EMS Advisory Committee.

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

(e) "Regional Trauma Advisory Committee" means a committee formed within an Emergency Medical Services (EMS) Region, to advise the Region's Trauma Center Medical Directors Committee, consisting of at least the Trauma Center Medical Directors and Trauma Coordinators from each Trauma Center within the Region, one EMS Medical Director from a resource hospital within the Region, one EMS System Coordinator from another resource hospital within the Region, one representative each from a public and private vehicle service provider which transports trauma patients within the Region, an administrative

representative from each trauma center within the Region, one EMT representing the highest level of EMT practicing within the Region, one emergency physician and one Trauma Nurse Specialist (TNS) currently practicing in a trauma center. The Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's Trauma Advisory Committee.

Every 2 years, the members of the Trauma Center Medical Directors Committee shall rotate serving as Committee Chair, and select the vehicle service providers, EMT, emergency physician, EMS System Coordinator and TNS who shall serve on the Advisory Committee.

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

(210 ILCS 50/3.30)

Sec. 3.30. EMS Region Plan; Content.

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

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

(2) Regional standing medical orders;

(3) Patient transfer patterns, including criteria for determining whether a patient needs the specialized

services of a trauma center, along with protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center which are consistent with individual System bypass or diversion protocols and protocols for patient choice or refusal;

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

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

(6) Regional standardization of continuing education requirements;

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

(8) Protocols for disbursement of Department grants; and ~~.~~

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

(b) The Trauma Center Medical Directors or Trauma Center

Medical Directors Committee shall address at least the following:

(1) The identification of Regional Trauma Centers;

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

(3) Regional trauma standing medical orders;

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

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

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

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

(8) A program for conducting a quarterly conference which shall include at a minimum a discussion of morbidity and mortality between all professional staff involved in

the care of trauma patients;

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

(10) The establishment, within 90 days of the effective date of this amendatory Act of 1996, of an internal disaster plan, which shall include, at a minimum, contingency plans for the transfer of patients to other facilities if an evacuation of the hospital becomes necessary due to a catastrophe, including but not limited to, a power failure.

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

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

(210 ILCS 50/3.116 new)

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

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

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

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

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

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

"Regional Stroke Advisory Subcommittee" means a subcommittee formed within each Regional EMS Advisory Committee to advise the Director and the Region's EMS Medical Directors Committee on the triage, treatment, and transport of possible acute stroke patients and to select the Region's representative to the State Stroke Advisory Subcommittee. The Regional Stroke Advisory Subcommittee shall consist of one representative from the EMS Medical Directors Committee; equal numbers of administrative representatives, or their designees, from Primary Stroke Centers within the Region, if any, and from hospitals that are capable of providing emergent stroke care that are not Primary Stroke Centers within the Region; one neurologist from a Primary Stroke Center in the Region, if any; one nurse practicing in a Primary Stroke Center and one nurse

from a hospital capable of providing emergent stroke care that is not a Primary Stroke Center; one representative from both a public and a private vehicle service provider which transports possible acute stroke patients within the Region; the State designated regional EMS Coordinator; and in regions that serve a population of over 2,000,000, a fire chief, or designee, from the EMS Region.

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

(210 ILCS 50/3.117 new)

Sec. 3.117. Hospital Designations.

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

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

(2) A hospital certified as a Primary Stroke Center by a nationally-recognized certifying body approved by the Department, shall send a copy of the Certificate to the

Department and shall be deemed, within 30 days of its receipt by the Department, to be a State-designated Primary Stroke Center.

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

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

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

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

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

(4) Primary Stroke Center designation shall remain valid at all times while the hospital maintains its

certification as a Primary Stroke Center, in good standing, with the certifying body. The duration of a Primary Stroke Center designation shall coincide with the duration of its Primary Stroke Center certification. Each designated Primary Stroke Center shall have its designation automatically renewed upon the Department's receipt of a copy of the accrediting body's certification renewal.

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

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

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

(2) Hospitals may apply for, and receive, Emergent Stroke Ready Hospital designation from the Department, provided that the hospital attests, on a form developed by the Department in consultation with the State Stroke Advisory Subcommittee, that it meets, and will continue to meet, the criteria for Emergent Stroke Ready Hospital designation.

(3) Hospitals seeking Emergent Stroke Ready Hospital

designation shall develop policies and procedures that consider nationally-recognized, evidence-based protocols for the provision of emergent stroke care. Hospital policies relating to emergent stroke care and stroke patient outcomes shall be reviewed at least annually, or more often as needed, by a hospital committee that oversees quality improvement. Adjustments shall be made as necessary to advance the quality of stroke care delivered. Criteria for Emergent Stroke Ready Hospital designation of hospitals shall be limited to the ability of a hospital to:

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

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

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

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

(E) conduct brain image tests at all times;

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

(G) maintain a log of stroke patients, which shall

be available for review upon request by the Department or any hospital that has a written transfer agreement with the Emergent Stroke Ready Hospital.

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

(A) Require hospitals applying for Emergent Stroke Ready Hospital designation to attest, on a form developed by the Department in consultation with the State Stroke Advisory Subcommittee, that the hospital meets, and will continue to meet, the criteria for a Emergent Stroke Ready Hospital.

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

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

(D) Issue an Emergency Suspension of Emergent Stroke Ready Hospital designation when the Director, or his or her designee, has determined that the

hospital no longer meets the Emergent Stroke Ready Hospital criteria and an immediate and serious danger to the public health, safety, and welfare exists. If the Emergent Stroke Ready Hospital fails to eliminate the violation immediately or within a fixed period of time, not exceeding 10 days, as determined by the Director, the Director may immediately revoke the Emergent Stroke Ready Hospital designation. The Emergent Stroke Ready Hospital may appeal the revocation within 15 days after receiving the Director's revocation order, by requesting an administrative hearing.

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

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

(210 ILCS 50/3.117.5 new)

Sec. 3.117.5. Hospital Stroke Care; grants.

(a) In order to encourage the establishment and retention

of Primary Stroke Centers and Emergent Stroke Ready Hospitals throughout the State, the Director may award, subject to appropriation, matching grants to hospitals to be used for the acquisition and maintenance of necessary infrastructure, including personnel, equipment, and pharmaceuticals for the diagnosis and treatment of acute stroke patients. Grants may be used to pay the fee for certifications by Department approved nationally-recognized certifying bodies or to provide additional training for directors of stroke care or for hospital staff.

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

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

(d) Matching grant awards shall be made to Primary Stroke Centers, Emergent Stroke Ready Hospitals, or hospitals seeking certification or designation as a Primary Stroke Center or designation as an Emergent Stroke Ready Hospital. The

Department may consider prioritizing grant awards to hospitals in areas with the highest incidence of stroke, taking into account geographic diversity, where possible.

(210 ILCS 50/3.118 new)

Sec. 3.118. Reporting.

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

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

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

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

data collected from hospitals shall comply with the following requirements:

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

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

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

(e) The Department may administer a data collection system to collect data that is already reported by designated Primary Stroke Centers to their certifying body, to fulfill Primary Stroke Center certification requirements. Primary Stroke Centers may provide complete copies of the same reports that are submitted to their certifying body, to satisfy any Department reporting requirements. In the event the Department establishes reporting requirements for designated Primary Stroke Centers, the Department shall permit each designated Primary Stroke Center to capture information using existing electronic reporting tools used for certification purposes.

Nothing in this Section shall be construed to empower the Department to specify the form of internal recordkeeping. Three years from the effective date of this amendatory Act of the 96th General Assembly, the Department may post stroke data submitted by Primary Stroke Centers on its website, subject to the following:

(1) 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.

(2) 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.

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

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

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

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

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

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

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

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

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

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

(210 ILCS 50/3.118.5 new)

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

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

(1) an EMS Medical Director;

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

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

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

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

(6) a neurologist from a Primary Stroke Center;

(7) an emergency department physician from a hospital, capable of providing emergent stroke care, that is not a Primary Stroke Center;

(8) an EMS Coordinator;

(9) an acute stroke patient advocate;

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

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

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

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

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

(c) The State Stroke Advisory Subcommittee shall be provided a 90-day period in which to review and comment upon all rules proposed by the Department pursuant to this Act

concerning stroke care, except for emergency rules adopted pursuant to Section 5-45 of the Illinois Administrative Procedure Act. The 90-day review and comment period shall commence prior to publication of the proposed rules and upon the Department's submission of the proposed rules to the individual Committee members, if the Committee is not meeting at the time the proposed rules are ready for Committee review.

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

(e) Nothing in this Section shall preclude the State Stroke Advisory Subcommittee from reviewing and commenting on proposed rules which fall under the purview of the State Emergency Medical Services Advisory Council. Nothing in this Section shall preclude the Emergency Medical Services Advisory Council from reviewing and commenting on proposed rules which fall under the purview of the State Stroke Advisory Subcommittee.

(f) The Director shall coordinate with and assist the EMS

System Medical Directors and Regional Stroke Advisory Subcommittee within each EMS Region to establish protocols related to the assessment, treatment, and transport of possible acute stroke patients by licensed emergency medical services providers. These protocols shall include regional transport plans for the triage and transport of possible acute stroke patients to the most appropriate Primary Stroke Center or Emergent Stroke Ready Hospital, unless circumstances warrant otherwise.

(210 ILCS 50/3.119 new)

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

(210 ILCS 50/3.130)

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

(a) Issue a Notice of Violation which specifies the

Department's allegations of noncompliance and requests a plan of correction to be submitted within 10 days after receipt of the Notice of Violation;

(b) Review and approve or reject the plan of correction. If the Department rejects the plan of correction, it shall send notice of the rejection and the reason for the rejection. The party shall have 10 days after receipt of the notice of rejection in which to submit a modified plan;

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

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

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

(210 ILCS 50/3.200)

Sec. 3.200. State Emergency Medical Services Advisory Council.

(a) There shall be established within the Department of Public Health a State Emergency Medical Services Advisory

Council, which shall serve as an advisory body to the Department on matters related to this Act.

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

(1) EMS Medical Director,

(2) Trauma Center Medical Director,

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

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

(5) EMS System Coordinator,

(6) TNS,

(7) EMT-P,

(8) EMT-I,

(9) EMT-B,

(10) Private vehicle service provider,

(11) Law enforcement officer,

(12) Chief of a public vehicle service provider,

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

(14) Administrative representative from a fire department vehicle service provider in a municipality with

a population of over 2 million people;

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

(c) Of the members first appointed, 5 members shall be appointed for a term of one year, 5 members shall be appointed for a term of 2 years, and the remaining members shall be appointed for a term of 3 years. The terms of subsequent appointees shall be 3 years. All appointees shall serve until their successors are appointed and qualified.

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

(e) Council members shall be reimbursed for reasonable travel expenses incurred during the performance of their duties

under this Section.

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

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

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

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

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

(210 ILCS 50/3.226 new)

Sec. 3.226. Hospital Stroke Care Fund.

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

(b) The purpose of the Fund is to allow the Director of the Department to award matching grants to hospitals that have been certified Primary Stroke Centers, that seek certification or designation or both as Primary Stroke Centers, that have been designated Emergent Stroke Ready Hospitals, that seek designation as Emergent Stroke Ready Hospitals, and for the development of stroke networks. Hospitals may use grant funds to work with the EMS System to improve outcomes of possible acute stroke patients.

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

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