HB4121

LRB09905550RPS25586b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB4121

by Rep. Robyn Gabel

SYNOPSIS AS INTRODUCED:

See Index

Amends the Emergency Medical Services (EMS) Systems Act and the State Finance Act. Provides that the Department of Public Health may designate a hospital as a STEMI Receiving Center or a STEMI Referring Center. Defines "STEMI" as a ST-elevated myocardial infarction. Provides certain requirements for designation as a STEMI Receiving Center. Establishes a State Acute Cardiac Event Advisory Subcommittee. Establishes Regional Acute Cardiac Event Advisory Subcommittees within each Regional EMS Advisory Committee. Creates the Acute Cardiac Event Data Collection Fund and provides that the moneys in the fund shall be used to support the collection of certain data and provides that any surplus fund shall be used to support the salary of the Department Stroke and Acute Cardiac Event Coordinator or for certain other purposes. In a provision concerning the Stroke Data Collection Fund, provides that any surplus funds shall be used by the Department to support the salary of the Department Stroke and Acute Cardiac Event Coordinator (instead of the Department Stroke Coordinator) or for certain other purposes. Contains provisions concerning definitions; rulemaking; annual fees for designation as a STEMI Receiving Center; suspension and revocation of a hospital's STEMI Receiving Center designation; and reporting of certain data. Makes other changes. Effective July 1, 2015.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning regulation.

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

Section 5. The State Finance Act is amended by adding Section 5.866 as follows:

(30 ILCS 105/5.866 new)

Sec. 5.866. The Acute Cardiac Event Data Collection Fund.

Section 10. The Emergency Medical Services (EMS) Systems Act is amended by changing Sections 3.25, 3.30, and 3.117.75 and by adding Sections 3.121.1, 3.121.2, 3.121.3, 3.121.4, 3.121.5, and 3.121.6 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. Portions of the Plan concerning ST-elevated myocardial infarction shall be developed jointly with the Regional Acute Cardiac Event 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 individual from each level of license provided in Section 3.50 of this Act, one Pre-Hospital Registered Nurse 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 EMS personnel 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 EMR, EMD, EMT, EMT-I, A-EMT, Paramedic, ECRN, or PHRN representing the highest level of EMS personnel 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, EMS personnel, emergency physician, EMS System Coordinator and TNS who shall serve on the Advisory Committee.

(Source: P.A. 98-973, eff. 8-15-14.)

(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;

(8) Protocols for disbursement of Department grants; and

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

(10) Protocols for the triage, treatment, identification, and transport of possible ST-elevated myocardial infarction patients to STEMI Receiving Centers

or STEMI Referring Centers as defined in Section 3.121.1 of this Act.

(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. 96-514, eff. 1-1-10.)

(210 ILCS 50/3.117.75)

Sec. 3.117.75. Stroke Data Collection Fund.

(a) The Stroke Data Collection Fund is created as a special fund in the State treasury.

(b) Moneys in the fund shall be used by the Department to support the data collection provided for in Section 3.118 of this Act. Any surplus funds beyond what are needed to support the data collection provided for in Section 3.118 of this Act shall be used by the Department to support the salary of the Department Stroke and Acute Cardiac Event Coordinator or for other stroke-care initiatives, including administrative oversight of stroke care.

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

(210 ILCS 50/3.121.1 new)

Sec. 3.121.1. Hospital acute cardiac event care; definitions. As used in the Sections following this Section and preceding Section 3.125:

"Acute cardiac event" means any acute cardiovascular condition, including acute myocardial infarction and sudden cardiac arrest.

"Catheterization lab" means an examination room in a hospital or clinic with diagnostic imaging equipment used to visualize the arteries of the heart and the chambers of the heart and treat any stenosis or abnormality found.

"Designation" or "designated" means the Department's recognition of a hospital as a STEMI Receiving Center or a STEMI Referring Center.

"Regional Acute Cardiac Event Advisory Subcommittee" means a subcommittee established under Section 3.121.2 of this Act.

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

"STEMI" means ST-elevated myocardial infarction.

"STEMI Receiving Center" means a hospital that has been accredited by a Department-approved, nationally recognized accrediting body and designated as such by the Department.

"STEMI Referring Center" means a hospital that has not been accredited as a STEMI Receiving Center by a Department-approved, nationally recognized accrediting body and has been designated by the Department as a STEMI Referring Center.

(210 ILCS 50/3.121.2 new)

Sec. 3.121.2. Regional Acute Cardiac Event Advisory Subcommittee. There shall be a subcommittee formed within each Regional EMS Advisory Committee to advise the Director and the Region's EMS Medical Directors Committee on the identification, triage, treatment, and transport of possible STEMI patients and to select the Region's representative to the State Acute Cardiac Advisory Subcommittee. At minimum, the Regional Acute Cardiac Advisory Subcommittee shall consist of: one representative from the EMS Medical Directors Committee; one EMS coordinator from a Resource Hospital; one administrative representative, or his or her designee, from a STEMI Receiving Center within the Region, if any; one

administrative representative, or his or her designee, from a STEMI Referring Center within the Region, if any; one physician from a STEMI Receiving Center within the Region, if any, and one physician from a STEMI Referring Center within the Region, if any, one of whom shall be an interventional cardiologist; one catheterization lab nurse from a STEMI Receiving Center within the Region, if any; one representative from a public vehicle service provider that transports possible STEMI patients within the Region; one representative from a private vehicle service provider that transports possible STEMI patients within the Region; the State-designated regional EMS Coordinator; and one fire chief, or his or her designee, from the EMS Region if the EMS Region serves a population of more than 2,000,000. The Regional Acute Cardiac Event Advisory Subcommittee shall establish bylaws to ensure equal membership that rotates and clearly delineates committee responsibilities and structure. Of the members first appointed, one-third shall be appointed for a term of one year, one-third 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.

(210 ILCS 50/3.121.3 new)

Sec. 3.121.3. State Acute Cardiac Event Advisory Subcommittee; triage and transport of possible STEMI 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 Acute Cardiac Event 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 STEMI patients. Membership on the Committee shall be as geographically diverse as possible and include one representative from each Regional Acute Cardiac Event Advisory Subcommittee, to be chosen by each Regional Acute Cardiac Event 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 his or her designee, from a STEMI Receiving Center;

(3) a hospital administrator, or his or her designee, from a STEMI Referring Center;

(4) a registered nurse from a STEMI Receiving Center;

(5) a registered nurse from a STEMI Referring Center;

(6) an interventional cardiologist from a STEMI Receiving Center;

(7) a cardiologist from a STEMI Referring Center;

(8) an EMS Coordinator;

(9) an acute cardiac event patient advocate;

(10) a fire chief, or his or her designee, from an EMS Region that serves a population of more than 2,000,000

people;

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

(12) a representative of a private ambulance provider;

(13) a representative of a municipal EMS provider; and

(14) a representative of the State Emergency Medical Services Advisory Council.

(b) Of the members first appointed, 9 members shall be appointed for a term of one year, 9 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 Acute Cardiac Event 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 STEMI 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 Subcommittee members, if the Subcommittee is not meeting at the time the proposed rules are ready for Subcommittee review.

(d) Nothing in this Section shall preclude the State Acute Cardiac Event 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 Acute Cardiac Event Advisory Subcommittee.

(e) The Director shall coordinate with and assist the EMS System Medical Directors and Regional Acute Cardiac Event Advisory Subcommittee within each EMS Region to establish protocols related to the assessment, treatment, and transport of possible acute cardiac event patients by licensed emergency medical services providers. These protocols shall include regional transport plans for the triage and transport of possible STEMI patients to the most appropriate STEMI Receiving Center, unless circumstances warrant otherwise.

(210 ILCS 50/3.121.4 new)

Sec. 3.121.4. Hospital designations; STEMI Receiving Centers.

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

(1) The Department shall designate as many accredited STEMI Receiving Centers as apply for that designation provided they are accredited by a nationally recognized accrediting body and approved by the Department, and the accreditation criteria are consistent with the most current nationally recognized, evidence-based STEMI

guidelines related to reducing the occurrence, disabilities, and death associated with STEMI.

(2) A hospital accredited as a STEMI Receiving Center by a nationally recognized accrediting body approved by the Department shall send a copy of the accreditation certificate and annual fee to the Department and shall be deemed, within 30 business days after its receipt by the Department, to be a State-designated STEMI Receiving Center.

(3) A hospital designated as a STEMI Receiving Center shall pay an annual fee as determined by the Department that shall be no less than $100 and no greater than $500. All fees shall be deposited into the Acute Cardiac Event Data Collection Fund.

(4) With respect to a hospital that is a designated STEMI Receiving Center, the Department shall have the authority and responsibility to do the following:

(A) Suspend or revoke a hospital's STEMI Receiving Center designation upon receiving notice that the hospital's STEMI Receiving Center accreditation has lapsed or has been revoked by the State-recognized accrediting body.

(B) Suspend a hospital's STEMI Receiving Center designation in extreme circumstances where patients may be at risk for immediate harm or death until such time as the accrediting body investigates and makes a

final determination regarding accreditation.

(C) Restore any previously suspended or revoked Department designation upon notice to the Department that the accrediting body has confirmed or restored the STEMI Receiving Center accreditation of that previously designated hospital.

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

(5) STEMI Receiving Center designation shall remain valid at all times while the hospital maintains its accreditation as a STEMI Receiving Center, in good standing, with the accrediting body. The duration of a STEMI Receiving Center designation shall coincide with the duration of its STEMI Receiving Center accreditation. Each designated STEMI Receiving Center shall have its designation automatically renewed upon the Department's receipt of a copy of the accrediting body's STEMI Receiving Center accreditation renewal.

(6) A hospital that no longer meets nationally recognized, evidence-based standards for STEMI Receiving Centers or loses its STEMI Receiving Center accreditation shall notify the Department and the Regional EMS Advisory Committee within 5 business days.

(b) The Department shall consult with the State Acute Cardiac Event Advisory Subcommittee for developing the

designation, re-designation, and de-designation processes for STEMI Receiving Centers.

(c) The Department shall consult with the State Acute Cardiac Event Advisory Subcommittee as subject matter experts at least annually regarding STEMI standards of care.

(210 ILCS 50/3.121.5 new)

Sec. 3.121.5. Acute Cardiac Event Data Collection Fund.

(a) The Acute Cardiac Event Data Collection Fund is created as a special fund in the State treasury.

(b) Moneys in the fund shall be used by the Department to support the data collection provided for in Section 3.121.6 of this Act. Any surplus funds beyond what are needed to support the data collection provided for in Section 3.121.6 of this Act shall be used by the Department to support the salary of the Department Stroke and Acute Cardiac Event Coordinator or for other STEMI and acute cardiac event-care initiatives, including administrative oversight.

(210 ILCS 50/3.121.6 new)

Sec. 3.121.6. Reporting; STEMI Receiving Centers.

(a) By July 1, 2016, the Director shall send the list of designated STEMI Receiving Centers to all Resource Hospital EMS Medical Directors in this State and shall post a list of designated STEMI Receiving Centers on the Department's website, which shall be continuously updated.

(b) The Department shall add the names of designated STEMI Receiving Centers to the website listing immediately upon designation and shall immediately remove the name when a hospital loses its designation after notice and a hearing.

(c) STEMI data collection systems and all STEMI-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 STEMI care. STEMI 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.

(d) The Department may administer a data collection system to collect data that is already reported by designated STEMI Receiving Centers to their accrediting body, to fulfill accreditation requirements. STEMI Receiving Centers may provide data used in submission to their accrediting body to satisfy any Department reporting requirements. The Department

may require submission of data elements in a format that is used Statewide. In the event the Department establishes reporting requirements for designated STEMI Receiving Centers, the Department shall permit each designated STEMI Receiving Center to capture information using existing electronic reporting tools used for accreditation purposes. Nothing in this Section shall be construed to empower the Department to specify the form of internal recordkeeping. Beginning 3 years after the effective date of this amendatory Act of the 99th General Assembly, the Department may post STEMI data submitted by STEMI Receiving 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.

Section 99. Effective date. This Act takes effect July 1, 2015.

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