AN ACT concerning regulation.

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

Section 5. The Emergency Medical Services (EMS) Systems Act is amended by changing Sections 3.116, 3.117, 3.117.5, 3.118, 3.118.5, 3.119, and 3.226 as follows:

(210 ILCS 50/3.116)

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:

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

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

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

"Designation" or "designated" means the Department's recognition of a hospital as a Comprehensive Stroke Center, Primary Stroke Center, or Acute 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.

"Primary Stroke Center Plus" 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. At minimum, the Regional Stroke 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 each level of stroke care, including Comprehensive Stroke Centers within the Region, if any, Thrombectomy Capable Stroke Centers within the Region, if any, Thrombectomy Ready Stroke Centers within the Region, if any, Primary Stroke Centers Plus within

the Region, if any, Primary Stroke Centers within the Region, if any, and Acute Stroke-Ready Hospitals within the Region, if any; one physician from each level of stroke care, including one physician who is a neurologist or who provides advanced stroke care at a Comprehensive Stroke Center in the Region, if any, one physician who is a neurologist or who provides acute stroke care at a Thrombectomy Capable Stroke Center within the Region, if any, a Thrombectomy Ready Stroke Center within the Region, if any, or a Primary Stroke Center Plus in the Region, if any, one physician who is a neurologist or who provides acute stroke care at a Primary Stroke Center in the Region, if any, and one physician who provides acute stroke care at an Acute Stroke-Ready Hospital in the Region, if any; one nurse practicing in each level of stroke care, including one nurse from a Comprehensive Stroke Center in the Region, if any, one nurse from a Thrombectomy Capable Stroke Center, if any, a Thrombectomy Ready Stroke Center within the Region, if any, or a Primary Stroke Center Plus in the Region, if any, one nurse from a Primary Stroke Center in the Region, if any, and one nurse from an Acute Stroke-Ready Hospital in the Region, if any; one representative from both a public and a private vehicle service provider that transports possible acute stroke patients within the Region; the State-designated regional EMS Coordinator; and a fire chief or his or her designee from the EMS Region, if the Region serves a population of more than 2,000,000. The Regional Stroke 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.

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

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

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

(Source: P.A. 102-687, eff. 12-17-21.)

(210 ILCS 50/3.117)

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

(3) A center designated as a Primary Stroke 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 Stroke Data Collection Fund.

(3.5) 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 notify the Department and the Regional EMS Advisory

Committee within 5 business days.

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

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

(2) A hospital certified as a Comprehensive Stroke Center shall send a copy of the Certificate and annual fee to the Department and shall be deemed, within 30 business days of its receipt by the Department, to be a State-designated Comprehensive Stroke Center.

(3) A hospital designated as a Comprehensive Stroke 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 Stroke Data Collection Fund.

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

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

(B) Suspend the hospital's Comprehensive Stroke Center designation, in extreme circumstances in which 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 Comprehensive Stroke Center certification of that previously designated hospital.

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

(5) Comprehensive Stroke Center designation shall remain valid at all times while the hospital maintains its certification as a Comprehensive Stroke Center, in good standing, with the certifying body. The duration of a Comprehensive Stroke Center designation shall coincide with the duration of its Comprehensive Stroke Center certification. Each designated Comprehensive Stroke Center

shall have its designation automatically renewed upon the Department's receipt of a copy of the certifying body's certification renewal.

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

(a-5) The Department shall attempt to designate Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, and Primary Stroke Centers Plus in all areas of the State according to the following requirements:

(1) The Department shall designate as many certified Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, and Primary Stroke Centers Plus as apply for that designation, provided that the body certifying the facility uses certification criteria consistent with the most current nationally recognized and evidence-based stroke guidelines for reducing the occurrence of strokes and the disabilities and death associated with strokes.

(2) A Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus shall send a copy of the certificate of its designation 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 Thrombectomy Capable Stroke Center,

Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus.

(3) A Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus shall pay an annual fee as determined by the Department that shall be no less than $100 and no greater than $500. All fees collected under this paragraph shall be deposited into the Stroke Data Collection Fund.

(4) With respect to a Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus, the Department shall:

(A) suspend or revoke the Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus designation upon receiving notice that the Thrombectomy Capable Stroke Center's, Thrombectomy Ready Stroke Center's, or Primary Stroke Center Plus's certification has lapsed or has been revoked by its certifying body;

(B) in extreme circumstances in which patients may be at risk for immediate harm or death, suspend the Thrombectomy Capable Stroke Center's, Thrombectomy Ready Stroke Center's, or Primary Stroke Center Plus's designation until its certifying body investigates the circumstances and makes a final determination regarding its certification;

(C) restore any previously suspended or revoked

Department designation upon notice to the Department that the certifying body has confirmed or restored the Thrombectomy Capable Stroke Center's, Thrombectomy Ready Stroke Center's, or Primary Stroke Center Plus's certification; and

(D) suspend the Thrombectomy Capable Stroke Center's, Thrombectomy Ready Stroke Center's, or Primary Stroke Center Plus's designation at the request of a facility seeking to suspend its own Department designation.

(5) A Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus designation shall remain valid at all times while the facility maintains its certification as a Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus and is in good standing with the certifying body. The duration of a Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus designation shall be the same as the duration of its Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus certification. Each designated Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus shall have its designation automatically renewed upon the Department's receipt of a copy of the certifying body's

renewal of the certification.

(6) A hospital that no longer meets the criteria for Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, or Primary Stroke Centers Plus, or loses its Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus certification, shall notify the Department and the Regional EMS Advisory Committee of the situation within 5 business days after being made aware of it.

(b) Beginning on the first day of the month that begins 12 months after the adoption of rules authorized by this subsection, the Department shall attempt to designate hospitals as Acute Stroke-Ready Hospitals in all areas of the State. Designation may be approved by the Department after a hospital has been certified as an Acute Stroke-Ready Hospital or through application and designation by the Department. For any hospital that is designated as an Emergent Stroke Ready Hospital at the time that the Department begins the designation of Acute Stroke-Ready Hospitals, the Emergent Stroke Ready designation shall remain intact for the duration of the 12-month period until that designation expires. Until the Department begins the designation of hospitals as Acute Stroke-Ready Hospitals, hospitals may achieve Emergent Stroke Ready Hospital designation utilizing the processes and criteria provided in Public Act 96-514.

(1) (Blank).

(2) Hospitals may apply for, and receive, Acute 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 Acute Stroke-Ready Hospital designation and pays an annual fee.

A hospital designated as an Acute Stroke-Ready Hospital 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 Stroke Data Collection Fund.

(2.5) A hospital may apply for, and receive, Acute Stroke-Ready Hospital designation from the Department, provided that the hospital provides proof of current Acute Stroke-Ready Hospital certification and the hospital pays an annual fee.

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

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

(C) Each designated Acute Stroke-Ready Hospital shall have its designation automatically renewed upon

the Department's receipt of a copy of the certifying body's certification renewal and Application for Stroke Center Designation form.

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

(E) A hospital designated as an Acute Stroke-Ready Hospital 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 Stroke Data Collection Fund.

(3) Hospitals seeking Acute Stroke-Ready Hospital designation that do not have certification shall develop policies and procedures that are consistent with 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 Acute 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;

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

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

(C) designate a Clinical Director of Stroke Care who shall be a clinical member of the hospital staff with training or experience, as defined by the facility, in the care of patients with cerebrovascular disease. This training or experience may include, but is not limited to, completion of a fellowship or other specialized training in the area of cerebrovascular disease, attendance at national courses, or prior experience in neuroscience intensive care units. The Clinical Director of Stroke Care may be a neurologist, neurosurgeon, emergency medicine physician, internist, radiologist, advanced practice registered nurse, or physician's assistant;

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

(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;

(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 Acute Stroke-Ready Hospital;

(H) admit stroke patients to a unit that can provide appropriate care that considers and reflects nationally recognized, evidence-based protocols or guidelines or transfer stroke patients to an Acute Stroke-Ready Hospital, Primary Stroke Center, or Comprehensive Stroke Center, or another facility that can provide the appropriate care that considers and reflects nationally recognized, evidence-based protocols or guidelines; and

(I) demonstrate compliance with nationally recognized quality indicators.

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

(A) Require hospitals applying for Acute 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 an Acute Stroke-Ready Hospital.

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

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

Within 30 business days of the Department's receipt of a hospital's Acute Stroke-Ready Certificate and Application for Stroke Center Designation form that indicates that the hospital is a certified Acute Stroke-Ready Hospital, in good standing, the hospital shall be deemed a State-designated Acute Stroke-Ready Hospital. The Department shall send a designation notice to each hospital that it designates as an Acute Stroke-Ready Hospital and shall add the names of designated Acute Stroke-Ready Hospitals to the website listing immediately upon designation. The Department shall immediately remove the name of a hospital from the website listing when a hospital loses its designation after notice and, if requested by the

hospital, a hearing.

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

The Application for Stroke Center Designation form shall contain a statement that instructs the hospital to "Provide proof of current Acute Stroke-Ready Hospital certification from a nationally recognized certifying body approved by the Department".

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

within 90 days of receipt of the attestation.

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

(D) Issue an Emergency Suspension of Acute Stroke-Ready Hospital designation when the Director, or his or her designee, has determined that the hospital no longer meets the Acute Stroke-Ready Hospital criteria and an immediate and serious danger to the public health, safety, and welfare exists. If the Acute 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 Acute Stroke-Ready Hospital designation. The Acute Stroke-Ready Hospital may appeal the revocation within 15 business 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 Acute Stroke-Ready Hospital designation, when

the Department finds the hospital is not in substantial compliance with current Acute Stroke-Ready Hospital criteria.

(c) The Department shall consult with the State Stroke Advisory Subcommittee for developing the designation, re-designation, and de-designation processes for Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, and Acute Stroke-Ready Hospitals.

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

(Source: P.A. 102-687, eff. 12-17-21.)

(210 ILCS 50/3.117.5)

Sec. 3.117.5. Hospital Stroke Care; grants.

(a) In order to encourage the establishment and retention of Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, and Acute 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 Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, and Acute 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 Comprehensive Stroke Center, Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, Primary Stroke Center Plus, Primary Stroke Center, or Acute Stroke-Ready Hospital, or a hospital seeking certification as a Comprehensive Stroke Center, Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, Primary Stroke Center Plus, Primary Stroke Center, or Acute Stroke-Ready Hospital or designation as an Acute 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 Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers

Plus, Primary Stroke Centers, Acute Stroke-Ready Hospitals, or hospitals seeking certification or designation as a Comprehensive Stroke Center, Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, Primary Stroke Center Plus, Primary Stroke Center, or Acute 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.

(Source: P.A. 102-687, eff. 12-17-21.)

(210 ILCS 50/3.118)

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 Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, and Acute Stroke-Ready Hospitals to all Resource Hospital EMS Medical

Directors in this State and shall post a list of designated Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, and Acute Stroke-Ready Hospitals on the Department's website, which shall be continuously updated.

(c) The Department shall add the names of designated Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, and Acute 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 Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, and Acute Stroke-Ready Hospitals to their certifying body, to fulfill certification requirements. Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, and Acute Stroke-Ready Hospitals may provide data used in submission to their certifying body, to satisfy any Department reporting requirements. The Department may require submission of data elements in a format that is used State-wide. In the event the Department establishes reporting requirements for designated Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, and Acute Stroke-Ready Hospitals, the Department shall permit each designated Comprehensive Stroke Center, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Center, or Acute Stroke-Ready Hospital 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 Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, and Acute Stroke-Ready Hospitals 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.

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

(210 ILCS 50/3.118.5)

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 Comprehensive Stroke Center;

(2.5) a hospital administrator, or designee, from a Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus;

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

(3.5) a hospital administrator, or designee, from an Acute Stroke-Ready Hospital;

(3.10) a registered nurse from a Comprehensive Stroke Center;

(3.15) a registered nurse from a Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus;

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

(5) a registered nurse from an Acute Stroke-Ready Hospital;

(5.5) a physician providing advanced stroke care from a Comprehensive Stroke center;

(5.10) a physician providing stroke care from a Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, or Primary Stroke Center Plus;

(6) a physician providing stroke care from a Primary Stroke Center;

(7) a physician providing stroke care from an Acute Stroke-Ready Hospital;

(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;

(12.5) a representative from a municipal EMS provider; and

(13) a representative from 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 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.

(d-5) Each EMS Regional Stroke Advisory Subcommittee shall submit recommendations for continuing education for pre-hospital personnel to that Region's EMS Medical Directors Committee.

(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 Comprehensive Stroke Center, Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, Primary Stroke Center Plus, Primary Stroke Center, or Acute Stroke-Ready Hospital, unless circumstances warrant otherwise.

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

(210 ILCS 50/3.119)

Sec. 3.119. Stroke Care; restricted practices. Sections in this Act pertaining to Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, and Acute 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.

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

(210 ILCS 50/3.226)

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 Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, and Acute Stroke-Ready Hospitals. All moneys collected by the Department pursuant to its authority to designate Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, and Acute 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:

(1) to hospitals that have been certified as Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, or Acute Stroke-Ready Hospitals;

(2) to hospitals that seek certification or designation or both as Comprehensive Stroke Centers, Thrombectomy Capable Stroke Centers, Thrombectomy Ready Stroke Centers, Primary Stroke Centers Plus, Primary Stroke Centers, or Acute Stroke-Ready Hospitals;

(3) to hospitals that have been designated Acute Stroke-Ready Hospitals;

(4) to hospitals that seek designation as Acute

Stroke-Ready Hospitals; and

(5) 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.

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