AN ACT concerning regulation.

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

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

(210 ILCS 85/10.4) (from Ch. 111 1/2, par. 151.4)

Sec. 10.4. Medical staff privileges.

(a) Any hospital licensed under this Act or any hospital organized under the University of Illinois Hospital Act shall, prior to the granting of any medical staff privileges to an applicant, or renewing a current medical staff member's privileges, request of the Director of Professional Regulation information concerning the licensure status<u>, proper credentials, required certificates,</u> and any disciplinary action taken against the applicant's or medical staff member's license, except: (1) for medical personnel who enter a hospital to obtain organs and tissues for transplant from a donor in accordance with the Illinois Anatomical Gift Act; or (2) for medical personnel who have been granted disaster privileges pursuant to the procedures and requirements established by rules adopted by the Department. Any hospital and any employees of the hospital or others involved in granting privileges who, in good faith, grant disaster

privileges pursuant to this Section to respond to an emergency shall not, as a result of their acts or omissions, be liable for civil damages for granting or denying disaster privileges except in the event of willful and wanton misconduct, as that term is defined in Section 10.2 of this Act. Individuals granted privileges who provide care in an emergency situation, in good faith and without direct compensation, shall not, as a result of their acts or omissions, except for acts or omissions involving willful and wanton misconduct, as that term is defined in Section 10.2 of this Act, on the part of the person, be liable for civil damages. The Director of Professional Regulation shall transmit, in writing and in a timely fashion, such information regarding the license of the applicant or the medical staff member, including the record of imposition of any periods of supervision or monitoring as a result of alcohol or substance abuse, as provided by Section 23 of the Medical Practice Act of 1987, and such information as may have been submitted to the Department indicating that the application or medical staff member has been denied, or has surrendered, medical staff privileges at a hospital licensed under this Act, or any equivalent facility in another state or territory of the United States. The Director of Professional Regulation shall define by rule the period for timely response to such requests.

No transmittal of information by the Director of Professional Regulation, under this Section shall be to other

than the president, chief operating officer, chief administrative officer, or chief of the medical staff of a hospital licensed under this Act, a hospital organized under the University of Illinois Hospital Act, or a hospital operated by the United States, or any of its instrumentalities. The information so transmitted shall be afforded the same status as is information concerning medical studies by Part 21 of Article VIII of the Code of Civil Procedure, as now or hereafter amended.

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

(1) Minimum procedures for pre-applicants and applicants for medical staff membership shall include the following:

(A) Written procedures relating to the acceptance and processing of pre-applicants or applicants for medical staff membership, which should be contained in medical staff bylaws.

(B) Written procedures to be followed in determining a pre-applicant's or an applicant's qualifications for being granted medical staff membership and privileges.

(C) Written criteria to be followed in evaluating a pre-applicant's or an applicant's qualifications.

(D) An evaluation of a pre-applicant's or an applicant's current health status and current license status in Illinois.

(E) A written response to each pre-applicant or applicant that explains the reason or reasons for any adverse decision (including all reasons based in whole or in part on the applicant's medical qualifications or any other basis, including economic factors).

(2) Minimum procedures with respect to medical staff and clinical privilege determinations concerning current members of the medical staff shall include the following:

(A) A written notice of an adverse decision.

(B) An explanation of the reasons for an adverse decision including all reasons based on the quality of medical care or any other basis, including economic factors.

(C) A statement of the medical staff member's right to request a fair hearing on the adverse decision before a hearing panel whose membership is mutually agreed upon by the medical staff and the

hospital governing board. The hearing panel shall have independent authority to recommend action to the hospital governing board. Upon the request of the medical staff member or the hospital governing board, the hearing panel shall make findings concerning the nature of each basis for any adverse decision recommended to and accepted by the hospital governing board.

(i) Nothing in this subparagraph (C) limits a hospital's or medical staff's right to summarily suspend, without a prior hearing, a person's medical staff membership or clinical privileges if the continuation of practice of a medical staff member constitutes an immediate danger to the public, including patients, visitors, and hospital employees and staff. In the event that a hospital or the medical staff imposes a summary suspension, the Medical Executive Committee, or other comparable governance committee of the medical staff as specified in the bylaws, must meet as soon as is reasonably possible to review the suspension and to recommend whether it should be affirmed, lifted, expunged, or modified if the suspended physician requests such review. A summary suspension may not be implemented unless there is actual documentation or other reliable

information that an immediate danger exists. This documentation or information must be available at the time the summary suspension decision is made and when the decision is reviewed by the Medical Executive Committee. If the Medical Executive Committee recommends that the summary suspension should be lifted, expunged, or modified, this recommendation must be reviewed and considered by the hospital governing board, or a committee of the board, on an expedited basis. Nothing in this subparagraph (C) shall affect the requirement that any requested hearing must be commenced within 15 days after the summary suspension and completed without delay unless otherwise agreed to by the parties. A fair hearing shall be commenced within 15 days after the suspension and completed without delay, except that when the medical staff member's license to practice has been suspended or revoked by the State's licensing authority, no hearing shall be necessary.

(ii) Nothing in this subparagraph (C) limits a medical staff's right to permit, in the medical staff bylaws, summary suspension of membership or clinical privileges in designated administrative circumstances as specifically approved by the medical staff. This bylaw provision must

specifically describe both the administrative circumstance that can result in a summary suspension and the length of the summary suspension. The opportunity for a fair hearing is required for any administrative summary suspension. Any requested hearing must be commenced within 15 days after the summary suspension and completed without delay. Adverse decisions other than suspension or other restrictions on the treatment or admission of patients may be imposed summarily and without a hearing under designated administrative circumstances as specifically provided for in the medical staff bylaws as approved by the medical staff.

(iii) If a hospital exercises its option to enter into an exclusive contract and that contract results in the total or partial termination or reduction of medical staff membership or clinical privileges of a current medical staff member, the hospital shall provide the affected medical staff member 60 days prior notice of the effect on his or her medical staff membership or privileges. An affected medical staff member desiring a hearing under subparagraph (C) of this paragraph (2) must request the hearing within 14 days after the date

he or she is so notified. The requested hearing shall be commenced and completed (with a report and recommendation to the affected medical staff member, hospital governing board, and medical staff) within 30 days after the date of the medical staff member's request. If agreed upon by both the medical staff and the hospital governing board, the medical staff bylaws may provide for longer time periods.

(C-5) All peer review used for the purpose of credentialing, privileging, disciplinary action, or other recommendations affecting medical staff membership or exercise of clinical privileges, whether relying in whole or in part on internal or external reviews, shall be conducted in accordance with the medical staff bylaws and applicable rules, regulations, or policies of the medical staff. If external review is obtained, any adverse report utilized shall be in writing and shall be made part of the internal peer review process under the bylaws. The report shall also be shared with a medical staff peer review committee and the individual under review. If the medical staff peer review committee or the individual under review prepares a written response to the report of the external peer review within 30 days after receiving such report, the governing board shall

consider the response prior to the implementation of any final actions by the governing board which may affect the individual's medical staff membership or clinical privileges. Any peer review that involves willful or wanton misconduct shall be subject to civil damages as provided for under Section 10.2 of this Act.

(D) A statement of the member's right to inspect all pertinent information in the hospital's possession with respect to the decision.

(E) A statement of the member's right to present witnesses and other evidence at the hearing on the decision.

(E-5) The right to be represented by a personal attorney.

(F) A written notice and written explanation of the decision resulting from the hearing.

(F-5) A written notice of a final adverse decision by a hospital governing board.

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

bylaws in order to allow sufficient time for the orderly provision of patient care.

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

(3) Every adverse medical staff membership and clinical privilege decision based substantially on economic factors shall be reported to the Hospital Licensing Board before the decision takes effect. These reports shall not be disclosed in any form that reveals the identity of any hospital or physician. These reports shall be utilized to study the effects that hospital medical staff membership and clinical privilege decisions based upon economic factors have on access to care and the availability of physician services. The Hospital Licensing Board shall submit an initial study to the Governor and the General Assembly by January 1, 1996, and subsequent reports shall be submitted periodically thereafter.

(4) As used in this Section:

"Adverse decision" means a decision reducing, restricting, suspending, revoking, denying, or not renewing medical staff membership or clinical privileges.

"Economic factor" means any information or reasons for decisions unrelated to quality of care or professional competency.

"Pre-applicant" means a physician licensed to practice medicine in all its branches who requests an application for medical staff membership or privileges.

"Privilege" means permission to provide medical or other patient care services and permission to use hospital resources, including equipment, facilities and personnel that are necessary to effectively provide medical or other patient care services. This definition shall not be construed to require a hospital to acquire additional equipment, facilities, or personnel to accommodate the granting of privileges.

(5) Any amendment to medical staff bylaws required because of this amendatory Act of the 91st General Assembly shall be adopted on or before July 1, 2001.

(c) All hospitals shall consult with the medical staff prior to closing membership in the entire or any portion of the medical staff or a department. If the hospital closes membership in the medical staff, any portion of the medical staff, or the department over the objections of the medical

staff, then the hospital shall provide a detailed written explanation for the decision to the medical staff 10 days prior to the effective date of any closure. No applications need to be provided when membership in the medical staff or any relevant portion of the medical staff is closed.

(Source: P.A. 96-445, eff. 8-14-09; 97-1006, eff. 8-17-12.)

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

(210 ILCS 86/25)

Sec. 25. Hospital reports.

(a) Individual hospitals shall prepare a quarterly report including all of the following:

(1) Nursing hours per patient day, average daily census, and average daily hours worked for each clinical service area.

(2) Infection-related measures for the facility for the specific clinical procedures and devices determined by the Department by rule under 2 or more of the following categories:

(A) Surgical procedure outcome measures.

(B) Surgical procedure infection control process measures.

(C) Outcome or process measures related to ventilator-associated pneumonia.

(D) Central vascular catheter-related bloodstream infection rates in designated critical care units.

(3) Information required under paragraph (4) of Section 2310-312 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois.

(4) Additional infection measures mandated by the Centers for Medicare and Medicaid Services that are reported by hospitals to the Centers for Disease Control and Prevention's National Healthcare Safety Network surveillance system, or its successor, and deemed relevant to patient safety by the Department.

(5) Each instance of preterm birth and infant mortality within the reporting period, including the racial and ethnic information of the mothers of those infants.

(6) Each instance of maternal mortality within the reporting period, including the racial and ethnic information of those mothers.

(7) The number of female patients who have died within the reporting period.

(8) The number of female patients admitted to the hospital with a diagnosis of COVID-19 and at least one known underlying condition identified by the United States Centers for Disease Control and Prevention as a condition that increases the risk of mortality from COVID-19 who

subsequently died at the hospital within the reporting period.

The infection-related measures developed by the Department shall be based upon measures and methods developed by the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, the Joint Commission on Accreditation of Healthcare Organizations, or the National Quality Forum. The Department may align the infection-related measures with the measures and methods developed by the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, the Joint Commission on Accreditation of Healthcare Organizations, and the National Quality Forum by adding reporting measures based on national health care strategies and measures deemed scientifically reliable and valid for public reporting. The Department shall receive approval from the State Board of Health to retire measures deemed no longer scientifically valid or valuable for informing quality improvement or infection prevention efforts. The Department shall notify the Chairs and Minority Spokespersons of the House Human Services Committee and the Senate Public Health Committee of its intent to have the State Board of Health take action to retire measures no later than 7 business days before the meeting of the State Board of Health.

The Department shall include interpretive guidelines for

infection-related indicators and, when available, shall include relevant benchmark information published by national organizations.

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

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

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

(1) The Department shall organize an advisory committee, including representatives from the Department, public and private hospitals, direct care nursing staff, physicians, academic researchers, consumers, health insurance companies, organized labor, and organizations representing hospitals and physicians. The advisory committee must be meaningfully involved in the development of all aspects of the Department's methodology for collecting, analyzing, and disclosing the information collected under this Act, including collection methods, formatting, and methods and means for release and dissemination.

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

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

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

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

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

(7) Comparisons among hospitals shall adjust for

patient case mix and other relevant risk factors and control for provider peer groups, when appropriate.

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

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

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

(11) Only the most basic identifying information from mandatory reports shall be used, and information identifying a patient, employee, or licensed professional shall not be released. 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.

(d) Quarterly reports shall be submitted, in a format set forth in rules adopted by the Department, to the Department by April 30, July 31, October 31, and January 31 each year for the previous quarter. Data in quarterly reports must cover a period ending not earlier than one month prior to submission of the report. Annual reports shall be submitted by December

31 in a format set forth in rules adopted by the Department to the Department. All reports shall be made available to the public on-site and through the Department.

(e) If the hospital is a division or subsidiary of another entity that owns or operates other hospitals or related organizations, the annual public disclosure report shall be for the specific division or subsidiary and not for the other entity.

(f) 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 such information satisfies the provisions of subsection (c) of this Section.

(g) 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.

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

(Source: P.A. 101-446, eff. 8-23-19.)