ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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MEETING MINUTES
Hospital Licensing Board Meeting
October 14, 2021 - 10:00 A.M.

WebEx Meeting Access Information:

https://illinois.webex.com/illinois/j.php?MTID=m5839b1d50d671e0c0dd2f8b7f343cddf

WebEx Meeting Number (Access Code): 2455 287 1704

Meeting Password: HLB102021

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mobile device: 1-415-655-0002,24552871704##

Phone: 1-415-655-0002

Call to Order

Members Present: Lyndean Brick (Chair), Brad Hughes, MD, Mark (Ed) Cunningham, Kim K. Tee, DPM, Gabrielle Cummings, Evert (EJ) Kuiper, Rob Connor, and Kimberly Landers

Members Absent: Cheryl Wolfe, James Girardy, Charli Smith

Department Staff: Karen Senger, Elaine Huddleston, IDPH Attorney, Ellen Bruce, Beck Dragoo, Deputy Director, IDPH Atty Seulgi Han, Sara Wilcockson, IDPH Staff Rukhaya Alikhan

Guests: Lance Kovacs, IHA

Introduction of Committee Members and Guests

Karen Senger, Division Chief of Division of Health Care Facilities & Programs called the meeting to order at 10:32 a.m. an announced that this is the Hospice and Palliative Care Advisory Committee Meeting with today's date is August 12th.

Karen Senger reminded Members and Guests that this meeting is being conducted via WebEx and gave a brief explanation of the protocols for conducting this meeting. This is a public meeting, and it is subject to the Open Meetings Act (OMA) and a recording of this meeting is permitted. Today's meeting is being conducted via WebEx, which allows audio and other information said during the session to be recorded. By joining this session, you are automatically consenting to such recordings and if you do not consent to be recorded, then you should not join this session. This introduction statement is being read so everyone is aware that this meeting is being recorded.

Since we are conducting this meeting from the Springfield conference room via WebEx, you will need to please mute your phone or computer when you are not speaking so we do not get the echo feedback from members and quests of the public that wish to speak. Members of the Public and others wishing to speak will be recognized by the chair during public comment period, which we will open the floor at the end of the meeting for open discussion/comments.

An introduction of Board members was conducted to establish a quorum. After a roll call was conducted, a quorum was established at this time and the meeting was called to order.

Approval of Draft Minutes for February 18, 2020 (VOTE)

The draft minutes of the February 18, 2021, meeting were reviewed and discussed by the Board. A motion was made by Board Member, Ed Cunningham to approve the minutes, 2nd motion made by Board Member, Brad Hughes and unanimously approved as presented.

NEW BUSINESS

Vote for Chairperson and Vice Chairperson

Karen Senger presented the following agenda item for Board on identifying new Chairperson and a Vice Chairperson according to the Hospital By-Laws. Karen Senger commented that she will need a recommendation for Lyndean Brick to continue as chair, or a nomination for a replacement. We will also need a recommendation for a motion and 2nd to vote Lyndean Brick as Chairperson for the Hospital Licensing Board. Board member, EJ Kuiper made a motion to continue Lyndean Brick as Chair for this Board, and Board member Kimberly Landers 2nd with all in favor and one unanimous vote. Karen Senger commented Lyndean Brick was revoted in as Chairperson for the Hospital Licensing Board

Karen Senger then remarked that the Hospital Licensing Board now needed a recommendation for a nomination for Vice- Chairperson that would fill in for the Chair whenever that person is not available to Chair the Board meeting. This Vice-Chairperson is needed to replace former Board member, Catherine Neuman who has now resigned membership. Board Member Ed Cunningham commented he would volunteer to accept the position of Vice-Chair unless someone else was interested in the position. Board member, Gabrielle Cummings supported the motion to elect Ed Cunningham for position of Vice-Chairperson, and Board Member, Brad Hughes 2nd the nomination with all in favor. Board member, Ed Cunningham was unanimously elected as Vice- Chairperson for the Hospital Licensing Board.

Board Approval required of 250.240, 250.260, 250.1820, 250.1840 (PA 100-0099; 101-0091; 101-0445)

Karen Senger presented the next agenda item for Board Approval of draft Administrative Code Regulations for Section 250. Karen Senger commented that we have a few regulations that need to be approved for Section 250. 240, 250.260, 250.1820 and Section 250.1840 and were all based off three Public Acts that were passed quite some time ago. Board members were given a handout of the proposed Amendments and copy of three Public Acts (100.0099, 101.0091 and 101-0445) for review. The three Public Acts were implemented effective January 1, 2020, are the changes to the proposed Regulations that the Department has put together for review by the Board. The Board conduct a review of each section and Public Acts for discussion and recommended a formal vote at the end of review:

a. Section 250.240 – Admission and Discharge (PA 100-0099).
   i. Letter d) page 12 – This proposed section of the regulations is in relationship to PA 101-0099, which identifies that a Hospital license under the Hospital Licensing Act shall not refer someone for services that is not a licensed Home Health Agency.

   ii. Language was written to identify an overall Hospital discharging procedures to include permission against discharging or referring a patient to any facility for further Health Care Services that is unlicensed, uncertified, or unregistered to be able to address the public.

b. Section 250.260 – Patients' Rights (PA 101-0445),
   a. Letter e) page 20 – This proposed section of the regulations is in relationship to PA 101-0445, which identify patient rights for women, pregnancy, and childbirth concerns.
      i. One of the mandates implemented to this section was that the Department also had to post the patient rights information on the Departments Website, which this has been done.
      ii. Second of the mandates identifies what a Hospital must do with the posting of the patient rights information and that they must be posted on their Hospitals Website and shall include the information related to the Patient Medical Rights Act.
      iii. The posting information on Patients' Rights will be posted within the facility (Hospital) and on their Hospital website based on this Public Act.

c. Section 250.1820 – Obstetric and Neonatal Service (Perinatal Service) (PA 101-0091)
    a. Letter a) number 4) bottom of page 20 – This proposed section of the regulations is in relationship to PA 101-0091, which identifies that the proper instrument is available for taking a pregnant woman's blood pressure.
    b. Letter b) Number 2) page 21 - This sentence was added to clarify the language that Obstetric and Neonatal facilities be located within the Hospital that prevents traffic to any other part of the Hospital.

d. Section 250.1840 - Discharge of Newborn Infants from Hospital,
    a. Letter d) page 29 – This proposed section of the regulations was to clarify the discharge of a newborn to any person other than the biological mother, which is confirmed through an identification band.
    b. The Hospital request proof of the person's identity per government issued photo ID, signature, and receipt for the newborn in the Hospital.
    c. Require proof of identity of the biological mother before discharging the newborn if the newborn is discharged from the biological mother prior to that.
    d. Language was changed to make it more specific and clearer in identifying that if the mother's being discharged with the newborn, they are already banned, and we do not need the mother's photo ID. Then a photo ID is needed if the mother is discharged prior to that newborn or if then to anyone else.
    e. Request for proposed ruling came about from the industry wanting some clarification to ensure safety of discharge of a newborn.

Karen Senger commented those are the amended rule changes that need to be voted on and asked if there were any questions or concerns with any one of these sections before we take a formal vote.

Chair, Lyndean Brick commented hearing none, asked for a motion to approve the amended changes as presented. Board Member, EJ Kuiper made a Motion for approval of the proposed regulations, 2nd by Board Member, Kimberly Landers with all in favor for approval of amended changes.

Hospital Emergency Rules (Informational only)

Karen Senger presented the next few agenda items on the Hospital Emergency Rules for informational purposes. Karen Senger reminded the Board about the original executive order that was issued when the Hospital Board was suspended during this time when the Department needed to process emergency rules and to be able to deal with them since this is a Licensing Board and must approve any rule changes. Since this executive order has been lifted, and the Licensing Board reinstated, just wanted to make the Board aware of the existing Emergency Amendment rules that are still out there. The Board was given a handout of the following Emergency rules that the Department is seeking to extend for another 150 days for informational purposes. The Emergency Rules are as follows:

a. **New Section 250.1: COVID-19 Emergency Provisions for Hospitals (Eff 6/20/21; Exp 11/16/21) EMERGENCY - 45 Ill. Reg. 8503***

This new section of the regulations is in relationship to Section 250.1-COVID-19 on Emergency Provisions for Hospitals Emergency that allows Hospitals to expand their beds without having to go through the formal process over temporarily converting some of their observation beds in the Med Surge Beds by converting Med Surge Beds throughout the Hospital. The pandemic Hospitals needed to expand their bed capacity, so this emergency rule allowed this process and then the Hospital would have to notify the Department once those beds came back operational. This was one of those Emergency rules that was put into place to help the Hospital through this pandemic. Karen Senger asked if there were any questions or comments to this section.

Board Member, EJ Kuiper asked if it required both approval in converting to ICU beds, and then converting back to Med Surge Beds. Karen Senger responded yes and commented that once the Department approved the Bed conversation the Hospital would need to notify the Department once it was back to its normal operational status. Some of the Hospitals have kept the Department up to date each month and some appear to wait until the end to notify the Department. The facility will need to notify the Department within 30 days after the temporarily bed increase capacity decision discontinues, and the facility's (Hospital) normal bed capacity is resumed.

b. **New Section 250.3: COVID-19 Emergency Provisions - At-Home Patient Care (Eff 6/7/21; Exp 11/3/21) EMERGENCY - 45 Ill. Reg. 7544**

Karen Senger presented the next section of the regulations in relationship to Section 250.3-COVID-19 on Emergency Provisions for At-Home Patient Care. This section responded to COVID-19, where a Hospital is kind of a Hospital at- Home patient care. This Emergency ruling is in relationship to Medicare's request that allows Hospitals to provide inpatient care in the Home. This is a hospital individual waiver, and it is not a blanket CMS waiver that is under the Hospital policies that can perform this task. The Hospital will always have to apply and be approved noting what the process will be. There are two Hospitals in Illinois that have been approved by Medicare to be able to provide this type of service. This is St. Francis and the other one is Northwestern Memorial.

Neither one of these institutions, at this point, is fully operational to provide this type of at home service. The Department did put this language in the Emergency Rule listing what we would like them to be able to do and identify them from a licensed standpoint since this is not part of our normal licensing process This is informational right now and imagine this process would end once the Federal Public Health Emergency no longer requires this waiver. Since the Department only has two Hospitals that are implementing and starting this process, will probably extend this Emergency Waiver.

Karen Senger asked if anyone had any questions to this topic and if someone wants this information you can go to the CMS Medicare website. This Website is excellent on what that process covers and very detailed with questions and answers on the process and what that would mean for the types of patients this service would benefit from.

c. **New Section 250.4: N95 Masks (Eff 6/15/21; Exp 11/11/21) EMERGENCY - 45 Ill. Reg. 8096**

Karen Senger presented the next section of the regulations in relationship to Section 250.4-COVID-19 on Emergency Provisions; N95 Masks. This Emergency policy requires the N95 Masks to be made available to individuals/staff and any other employees or contractual workers who provide direct patient care to have such a mask to safely provide direct patient care within a hospital setting.

d. **New Section 250.455 COVID-19 Vaccination of Hospital Personnel (Effective 9/17/21; Expires 2/13/22) EMERGENCY - 45 Ill. Reg. 11907 (Emergency Executive Order Section 250.455)**

Karen Senger presented the next section of the regulations in relationship to Section 250.455-COVID-19 on Emergency Provisions on vaccination of Hospital Personnel. This Emergency ruling is effective September 17th of 2021 and expires February 13th, 2022. This is the latest emergency ruling that was put into place and this mandate was extended per the Executive order when they reinstated the Hospital Licensing Board. At this point within the Emergency Rules, the executive order declared that during the declaration of the governmental disaster proclamation, the requirement that the Hospital Licensing Department must receive prior approval from the Hospital Licensing Board before adopting a rule is suspended. They did suspend that portion of the rule from the public from the Hospital Licensing Act. The Department can still have a Board Meeting for the Department to continue to put this Emergency Rule out in relationship to the vaccination.

Karen Senger opened the meeting for discussion or if there are any concerns about this mandate that all Hospital Staff must be vaccinated. If the staff are not vaccinated than they must either identify their reason for exemption, whether that is a medical or religious reason. If they are not going to get vaccinated, they then would be required to have to test to continue to work within the Health Care facility.

Board member, Gabrielle Cummings asked since these are emergency orders, does that mean that they are in effect for 150 days, and then they will need to be revisited or discussed at the end of that 150-day term, assuming that the emergency orders are still in effect.

Karen Senger commented that is correct, and there is a lot of the Health System facilities that are already mandating this regulation even before this emergency order came out and were mandating that their employees to be vaccinated and this ruling is emphasizing those issues.

Board Member, Kimberly Landers asked after reading the section under letter "b", where would you locate subsection (c) that was noted at the end of the sentence. Karen Senger responded that individual would need to show proof of being vaccinated or exemption of this section. This subsection is on the next page under letter "c" with the language starting as "Beginning September 19, 2021". Kimberly Landers further commented on this language that covers fully being vaccinated weekly at a minimum and mentioned religious and medical exemptions language anywhere in this section. This question was being asked as their facility is going through this requirement right now and trying to understand exactly what the language says. In addition, do you foresee the Department asking for these records or proof of staff/employees that are fully vaccinated, tested or exempt at any point?

Lance Kovac with IHA responded that this language can be found on page 8 under letter b) numbers (5), (6), and (7) and letter (c) covers this mandate.

Karen Senger responded that the only time the Department would review this mandate would be from a survey perspective situation such as based on a complaint, or a concern related to this type of situation and that the Department would go on site to investigate or address this situation and not when the Department is doing a routine/general survey of the Hospital.

Karen Senger asks if there were any other comments or concerns with this agenda item (Attachment 3) before we moved on to the next agenda item. These attachments were for informational purposes.

No other questions or comments were made to this agenda item

Executive Order 2021-22 No. 88 – Vaccination Health Care Workers (Informational Only)

Karen Senger presented the next agenda item Executive Order 2021-22 No. 88 on Vaccination Health Care Workers. Board members were given a copy of this Executive Order for informational purposes. Karen Senger commented that this overall Executive Order ultimately had to do with the emergency rules that the Board just covered previously under Emergency Rule Section 250.455. The Board was reminded that this Executive Order does not just address Hospitals, but other Health Care Facilities on having staff to be vaccinated per Section 7 on page 8 of this handout about suspending the formal approval for the Hospital Licensing Board. Karen Senger asked if the Board felt they needed to write an emergency rule on this mandate and this section goes along with the Executive Order under Emergency Rule Section 250.455.

Board member Gabrielle Cummings asked about the vaccination amendment and testing requirement and was there were any verbiage if an employee decides that they do not want to go through the testing that protects or prevents the Health Care Organization from being responsible if the employee gets vaccinated and refuses to get tested. Or, if this is the Hospital responsibility or the person's responsibility to ensure they are following the Emergency Order. We have experienced several individuals who are vaccinated but refuse to get tested weekly.

Deputy Director, Becky Dragoo commented that it is the facilities responsibility to ensure testing in the facilities.

No other questions or comments were made to this agenda item.

Medicare Vaccination Requirements for Health Care Settings (Informational Only)

Karen Senger presented the following agenda item on the federal document that went out from Biden-Harris administration to Expand Vaccination Requirements for Health Care Settings. Board members were given a handout on this press release for informational purposes on what will be forthcoming. Karen Senger commented that Medicare is also looking at mandating very similar to what the state has as far as healthcare providers mandating the vaccinations. This mandate should be coming out this month with more details and how that will be tied to the Medicare conditions of participation. Karen Senger informed the

Board that she will know more details within the next month and how this mandate will be tied to the Medicare Conditions of Participation and more of a discussion about directing this for our rules.

Board Member Ed Cunningham shared some information from the Biden Administration stating that the Federal Government was going to do a mandate for Hospitals like the Nursing Homes to where everybody had to be vaccinated or they could not work and then they backed off to what the governor said. So, are we expecting a mandate from the Federal Government requiring everyone to have a vaccination or do you have any information on this mandate currently?

Karen Senger responded that she did not know of anymore information of this topic, but this is something we are monitoring.

Karen Senger asked if there were any other questions or concerns with any of the information before we move on to the next agenda items. No other questions or comments were made to this agenda item.

Public Act requiring rule making discussion to assist in drafting rules:

Karen Senger presented the a few new Public Acts (PA) requiring Rule making for discussion in drafting rules as follows:

a. PA 102-0533 Surgical Smoke Plume Evacuation

Karen presented the first Public Act on Surgical Smoke Plume Evacuation. This PA affects both the Hospitals and Ambulatory Surgery Centers and looking at some guidance out there in relationship to OSHA. There is not a formal process as when we address this, because the policy in the Amendatory Act itself is straight forward saying that the facility must have this system in place if they are going to be doing procedures that are going to generate surgical smoke to protect Healthcare workers and the patients in the room.

Karen Senger commented that one of the items she was looking at is from a regulatory standpoint is that the Board adopt rules that would ensure that the Facilities that have these equipment's have policies in place, their staff are properly trained, and they are wearing appropriate protective coverage whenever those types of procedures will be utilized and then making sure they follow the normal process for reporting to the Department. In addition, the facilities will need to let the Department know when they have all these systems in place, and we are not going to ask to approve their policies, but to be able to have some guidance with the rules than just mirroring and copying the statute. The Department felt that the facilities had to have a committee of some kind to maybe develop which types of procedures would not be mandated for that type of device to be utilized and then the staff are trained on how to operate the equipment and wearing the appropriate protective coverage. They would also need to have a policy procedure developed on how to use the device, and whichever device they are going to come up with.

Karen Senger asked if the Board had any questions or concerns or something that you might already be utilizing in your families now. If this was too much information to be added, and if we needed to have that level of details on what we are expecting from the facility then just leaving you have a policy in place.

Board Member, Gabrielle Cummings asked to help understand this Amendatory Act you have named the University of Illinois Hospital Act. This there a certain reason why it is specific to one Hospital of it this Act to that Hospital? Or is this Act specifically for that Hospital System? Karen Senger responded that the University of Illinois is not licensed under the Hospital Licensing Act, because it is a State-run Hospital, which is exempt under the Hospital Licensing Act itself. This Hospital must have their own licensing rules as they follow under the Medicare Conditions of Participation as a Hospital, but hey are not licensed under the Hospital License Act, as they are exempt.

Karen Senger commented that this Act is for all three types of facilities to include the University of Illinois Hospital, Licensed Hospitals and Ambulatory Surgical Treatment Centers. Karen Senger responded will draft some rules to include that the facilities will have to have a committee in place to develop a policy procedure in more details on training the staff and making sure they have a system in place instead of writing to say they have a policy and will bring back at the next meeting.

The Board agreed and no other comments were made to this agenda item.

b. PA 102-0641 Nurse Staffing Improvement Act

Karen Senger presented the next agenda item on Nurse Staffing Improvement Act (Public Act 102-0641) which amends the section within the Hospital Licensing Act that deals with nursing staffing. The Board was given a handout of this Public Act (PA) for informational purposes. This Act did not get into the ratios, but the Department can impose fines if a hospital does not follow their written Hospital-wide staffing plan. The Hospitals shall implement a Hospital-wide staffing plan and assign nursing personnel to each impatient caregiver, including inpatient emergency departments in accordance with the staffing plan. The Board will obviously need to write rules for this section as it expands to the nursing committee. This staffing plan is already in place in the rules, and they outline what those committees should take into consideration for their own view.

Karen Senger asked if there was anything as Board members you would like the Department to focus on in the rulemaking relationship to add this to our own rules. Chair, Lyndean Brick reached out to Lance Kovacs with IHA on his opinion on this topic.

Lance Kovacs with IHA responded that this Public Act was an initiative response to the Nurse staffing ratios. We worked with legislation and pushed it as a compromise to improve input from all nurses in the operation instead of ratio.

Board member, Ed Cunningham asked that this is fine based on not following your staffing plan and there is a fine charged if you do not have the committee meetings on a regular basis. This Act requires a committee, make up of fifty percent staff members that must be nursing personnel.

Board Member, Kimberly Landers responded yes, and the number is fifty-five percent of nurses that have direct care. I helped work on this Public Act (PA) and would like to see some clarity on the nursing care committee on the second to last page of the document under letter (5) that reads on “written report at least annually to the hospital governing board that addresses items including, but not limited to: the items described in paragraph (3)” on changes and impact”. Kimberly Landers responded that there should be a little more language written in the rules about what the annual board report must include?

Karen Senger responded if any of the Board members had any other ideas on the areas they would like to see changed or expanded on to send her an email so we can work on these rules to expand them out and not just mirror the statutory language. We can try and work on these rules to bring back to the February meeting.

Karen Senger asked if there were any other questions or concerns with any of the information before we move on to the next agenda items. No other questions or comments were made to this agenda item.

c. <u>PA 102-0004 Legionella</u>

Karen Senger presented the next agenda item on Legionella (Public Act 102-0004) and the Board was given a handout of this Public Act (PA) for informational purposes. Karen Senger commented that this Public Act is a quite lengthy document (55-70 pages) so she only sent the Board some of the pages that only implied for the Hospitals.

A lot of this document changes notifications (Article 15) that must be posted within a hospital and where things must be now electronic and not necessarily physically posted on the walls. Karen Senger commented that most the changes was with the PA on the N95 Masks Emergency Rules and there are changes in relationship to the original requirements, which are many electronic changes. On page 14, Article 90, covers the section that requires Hospitals need to develop a policy for testing for the Legionella bacteria. The Department wanted to recommend that we mirror CDC’s policy and guidance. When we draft the rules that we spell out and not just say they must have a policy but should be following CDC areas on environmental that deal with this monitoring and testing the types of systems and that are in place, and they must have a policy. Karen Senger further commented that she had started a draft rule on this language and have been going with the CDC requirements and we can expand on having that more elaborate.

The other change with this rule set, which will not be impacted within our rule, but will impact Hospitals, under Article 95, has to do with the Boards major action on applications for discontinuing a hospital license that is pending before the Board. This rule change is more with discontinuation of a hospital, and this is something that would impact us, but not something we would need to put within our licensing rues.

Karen Senger commented she has just covered the major rule changes that came about from this Public Act from this ruling where the other ones were just notification updates. She asked if there were any other questions or concerns with any of the information before we move on to the next agenda items. No other questions or comments were made to this agenda item.

d. PA 101-390 OB Hemorrhage Education & Postpartum Education Update SB 0967

Karen Senger presented this last Public Act (PA 101-0390) on OB Hemorrhage Education and Senate Bill (SB 0967) on Postpartum Education update on Obstetric, Hemorrhage and Hypertension training. Board members were given a handout on this Public Act that covered a mandate where a hospital or Hospital Birthing Facility must ensure that they conduct continuing education yearly for providers and staff of obstetric medicine and of emergency department and other staff that care for pregnant or postpartum women. The Education training must include yearly educational modules regarding management of severe maternal hypertension and obstetric hemorrhage. We need to make sure these rules are incorporated both within our rules to ensure that this education mandate is identified. We will need to work with both rules to make sure we are capturing everything to do with the education training part of this mandate.

Lance Kovacs, IHA commented that Senate Bill 0967 just actually got certified and there were further changes made to this section. Therefore, you may want to review this section again before working on any proposed rules around the current changes.

Karen Senger responded yes, and there will be some other changes from that and other updated legislation (PA 101-0390) and will work on drafting these rules and bring back by the next meeting in February 2022 for a formal review and vote to get these Acts implemented.

Karen Senger asked if there were any other questions or concerns with any of the information before we move on to the next agenda items. No other questions or comments were made to this agenda item.

IHA proposed changes to related Pediatric services (250.310)

Lance Kovac, Illinois Health and Hospital Association (IHA) presented the next agenda item for board discussion on the IHA proposed changes to related Pediatric Services Section 250.310. Lance Kovacs updated the Board on some proposed changes related to Pediatric Services. The Board had asked IHA couple of years ago (2017) to look at the issue of pediatric beds and how as Hospitals have dropped Pediatric Beds but are still caring for pediatric patients. The Board was interested in what regulations, if necessary, should be in place to govern those Hospitals that are still carrying for Pediatric patients without those beds. IHA put together a work group on this issue and has met over 5 times over a period of a year. This workgroup looked at various data and current regulations around this issue.

Lance Kovac commented that both he and Board Member, Gabriele Cummings were on this work group, and they did develop some recommendations that they did end up proposing to the Board of Trustees. The Board of Trustees did finally get a chance to review these proposals at their September 2020 meeting and approved these recommendations. The recommendations take into a balance of making sure the Pediatric patient has the right care in place and the right staff to deal with any situation they may have. Also, considering that there is a lot of studies that show pediatric patients recover better when they are closer to home, closer to family and trying to find that balance. These recommendations are not to trigger automatic transfer of a pediatric patient but to provide a more formalized process by really looking at it as a case-by-case basis and have some peer- to – peer consultation in place. The recommendation is based on a notion of a hospital that does not have licensed pediatric beds or does not have a Board-certified report eligible pediatrician in the Hospital 24/7.

The basic principle is that the Hospital would have to enter into a written agreement with a Children's Hospital or a Hospital with a pediatric unit. The written agreement must have certain parameters, including consultation, education, communication frequency, equipment, education, transfers, case reviews and the utilization of an early warning system. The workgroup believes that a hospital should engage in multiple agreements across several other Hospitals with pediatric units to ensure there is several options for transfers if necessary. The primary transfer agreement should be in place for education, consultations, education equipment due to the geography, these agreements should not be limited to hospitals within the state of Illinois and consistent with policies under the state's perinatal levels of care. IHA believes that hospitals should have the ability to have an agreement between two institutions that a consulting hospital may charge a fee to the hospital without pediatric beds if there are provisions to ensure that the patient or their parents are not billed for that consulting service. Finally, IHA recommended the hospitals these

hospitals have 12 months to put together these agreements and have them in place in terms of triggering the consultation.

Based on research and discussion it seems like putting an observation or inpatient status would be out of the emergency department or post-operative. First, consultation occurs before a patient has moved to the medical critical unit for observation or in patient care. When that is not possible, the recommendation was that it be done within one hour of the patient being moved. The record of these consultation should be maintained in some form as outlined between the consultation agreement. As we cover the section on reporting components there are two different sites the hospital without pediatric beds would report to the Department. The number of pediatric patients admitted or kept for observation and any information on patient mortality that are ultimately transferred and then breakdown of those patients that were transferred via a different avenue post-procedure on the consulting hospital side, the recommendation was to report the number of consultations provided at any cost incurred for providing the consultation. The Purposes of conformity would be very helpful that any of this data collected done with any other sort of data collection department is doing to implement as seamlessly as possible.

The work group did recommend that the reporting be done twice a year for the first two years to ensure there are no major issues, and then after to be moved to an annual basis in terms of an implementation strategy. The rules the work group thought as a good place to start would be under the medical staff section (Section 250.310) where they talk about requirements for medical staff taking care of all patients within the hospital as well as consultations and having the capabilities of auxiliary equipment. This information is where the workgroup thought would be the best fit, and the best approach, based on the concerns raised by both the Department and the Licensing Board.

Board Member, Kimberly Landers asked for more clarification on the sixty-minute transfer, because getting any transfer out in sixty minutes is nearly impossible with the shortages so admission to a bed and then transferred out. Lance Kovacs responded that ideally the consultation of a patient with a hospital without pediatric beds is to put a pediatric patient either in for observation or inpatient status in a medical surgical bed. The goal would then be that the consultation with their pediatric hospital would occur prior to the transfer. If the transfer must happen beforehand, the idea would be that the consultation would occur with your pediatric hospital within an hour after that patent has been placed in that medical surgical bed. Karen Senger commented or at least be transferred within the Hospital itself.

Lance Kovac further commented that the patient must be transferred within the hospital and not outside of the Hospital and gave a brief example of a child getting their tonsils taken out and how to handle the situation. Ideally the recommendation from the work group is that consultation would occur post-op before they are moved to the medical surgical bed. The case would be where that is not possible, such as you are overrun, and you need that post-surgical bed. Once that child is placed in for whatever medical surgical bed you are going to do your observation in would have to call and do your consultation within 60 minutes of that movement. Kimberly Landers commented the physician would call. Lance Kovac responded correct.

Karen Senger commented there are a lot of Hospitals obviously that have eliminated their pediatric units due to low volume and not having pediatric positions in their community. So, this recommendation will keep children in their individual locations without having to be transferred but have that expertise or consultation to state this patient cannot remain and needs to be transferred to a higher level of care. Or transfer a patient to a facility that has more of the required staff and having the capabilities of auxiliary equipment that are necessary.

Board Member Gabrielle Cummings commented that she and Board Member Ed Cunningham were both on the working committee or a comprehensive group of hospital leaders across the state that got together to really have a discussion and challenge each other on this rule making project.

Ed Cunningham complemented Lance Kovac on his effort and research he has conducted putting this project together and did a fine job on this policy. This policy turned out great and will protect the children and make it safe for them to stay close to home, so it is not difficult for the parents. This is an avenue to keep it safe and not a hardship to the family.

Seulgi Han, IDPH Legal Department questioned the section that says that hospitals are encouraged to have multiple agreements and wondering are the primary agreement with the hospital only for the purposes of consultation and education or is the other agreements with the hospital for transfers after the initial treatment for the child? Is this transfer going to be to a pediatric hospital and not a hospital without pediatric units? Lance Kovac responded correct. The goal of having multiple transfer agreements is twofold with one that

there could be a census issue at your primary hospital where you do your consultation, and they are just not enough space. The second thing is that from a parent child perspective there could be a choice they may not want to go to Hospital A and instead would want to go to hospital B. It is important to have those additional relationships to give the parent a choice if a transfer is needed that they can go a hospital they want for their child. The corrected transfer agreement would have to be with either children's hospital, a pediatric hospital or a hospital with a pediatric unit, there would one without pediatric beds that would have to designate their primary relationship for that consultation agreement.

Chair, Lyndean Brick thanked everybody that worked on this project and was glad we were able to pull something together. Lance Kovacs commented was glad we were able to pull together and look forward to finalizing these rules.

Karen Senger asked if there were any other questions or concerns with any of the information before we move on to the next agenda items by Lance Kovacs about Outpatient Medical Orders. No other questions or comments were made to this agenda item.

Outpatient Medical orders Section 250.330

Lance Kovacs presented the next agenda item on Outpatient Medical Orders Section 250.330 for board discussion. The Board was given a handout with proposed language on Section 250.330 Orders for Medications and Treatments. This topic has been brought up by several members over the years, but quite recently during the pandemic. This topic was brought up also with physical therapy issues that the Board addressed a couple of years ago. Because of the specific language and this section there is not really a workaround it. There are cases where a hospital have an outpatient facility and right now medication and treatment for certain services that was brought up like infusion therapy that can only be ordered by a member of the medical staff of the hospital. The case is particularly in rural parts of the state where the hospital might be the only place to get things type of therapy. Patient are traveling from quite a distance with orders from a physician that is not necessarily a part of the medical staff to provide this service and hospitals are not allowed to provide that service for these patients.

Lance Kovacs commented that we are attempting to with the Board and the Department's approval to carve out a capability for the Hospital board and medical staff to create an outpatient medication and treatment plan for physicians that are not part of the medical staff with some minimum standard. These minimum standards are outlined in the handout on Section 250.330, under number 3 of this proposal would be the minimum standards for this policy. This proposal is somewhat consistent with CMS that it allows something similar for what we are trying to accomplish to keep this issue consistent but give some greater flexibility to hospitals to allow these situations. I am also told that some of these new treatments get approved and put in place that are require outpatient therapy and this would be another area where this might be helpful. Lance Kovacs commented we are presenting this suggested language and will be happy to discuss or fine tune to make sure it is appropriately covering the concerns that was made by several members of the hospital community on this for additional flexibility.

Karen Senger commented on if the Board had any concerns on this topic and if this is something that the board would like the Department to start getting into a more formal rulemaking process. Board members agreed and recommended we proceed with the rule making process.

Chair Lyndean Brick asked if the physicians became members of the medical staff in their own category.

Lance Kovacs responded not necessarily, and do not think this was the goal of this proposed ruling and there would just be a path for a physician that is not a member of the medical staff to simple fill. I think it is not as simple as someone filling a prescription, but it is something in line with that. Your position that is fifty miles away from the hospital and not necessarily on the medical staff, but there is no other place for their patient to get this treatment/service. And how does that patient then must go to this other position within that hospital for treatment. This ruling is kind of where the flexibility would be, and do not know if Kimberly Landers would want to speak on this topic but does not think this would cover the idea that this would be a medical staff member. This would just be some flexibility that there would be enough checks and balances in place to allow the medical staff to feel comfortable with a non-medical staff member prescribing treatment/service.

Board Members, Kimberly Landers, commented on the non-medical staff member topic and about some of the new therapies, whether it is for some of the auto immunes, and how when the patient must go to a center that is willing to administer treatment for this patient. For example, our facility is rural, and all those

physicians are not on staff, and we would like to be able to take those orders written by other physicians and treat those patients without having them go to the rheumatologist or somebody else to get another order.

Board member, Gabrielle Cummings asked if there were any concerns about those positions that are on medical staff following, or not following the medical staff bylaws for the facilities? Is this a concern in this instance?

Lance Kovacs responded that he had not heard from the members that brought this topic up for discussion. Because this is a permissive issue, and as you know the Hospital Board and medical staff oversee developing the rules. I believe the Hospital can develop these rules in a way to ensure their level of comfort with not knowing what is permitted and what requirements these positions would need to meet. These rules being hospital specific to a certain extent and would hope to get some level of comfort to the medical staff in the Hospital Board of that institution.

Board member Kimberly Landers responded that she knew of one other thing that came up during the conversation about what would happen if they had some sort of an emergency and they do not have a physician on staff and the patient is in the infusion center getting therapy. The decision would be to treat the situation like a rapid response and would have the normal response team or code team respond. This code response team would go to the emergency room and then care would be rendered as per normal, whether people have a position or not in this area.

Karen Senger responded that you could look at this situation as an emergency privilege process. You would ask for certain documentation and that could be something that each individual hospital would identify what would be the required documentation to ensure that individual was competent and capable of ordering that type of service. Karen Senger further commented this is going to have to come down to each individual bylaw for their hospital, or what they are wanting to have detailed outside of the actual license that would be appropriate for what we are identifying. Beyond this scope would have to be hospital driven, and we can identify that the rules should include strict criteria within their hospital bylaws and if they are going to extend this to what would be included in the credentialing process because they are not going to become members of the medical staff.

Board Member Brad Hughes commented for those individuals who do not have specific privileges and are not part of the medical staff you can certainly develop a set of specific clinical privileges credentials just for that purpose and have them be adjunct to staff or non-voting members on the medical staff. This way you can provide this type of services on what your bylaws say by having a set of specific privileges that are outlined for them would be beneficial. Brad Hughes offered to take this information or input back and try and make a little bit more sense of this information. You also referenced Medicare as also having this list as a part of their process and their condition of coverall for this type of patient.

Lance Kovacs confirmed and responded he would check with his contacts and make sure to see if he can get the Medicare reference and will send this information to him.

Karen Senger commented that she would put something together and bring back to the board so we can have more detailed information to elaborate on as to what we have all kind of talked about here as key points.

Lance Kovac thanked everyone for their input and appreciate their help.

Karen Senger asked if there were any other questions or concerns with any of the information before we move on to the next agenda No other questions or comments were made to this agenda item.

Medicare Hospital Price Transparency (Informational Only)

Karen Senger presented the next agenda item to the Board for informational purposes. Board members were given a handout on Part 180 - Medicare Hospital Price Transparency that became effective January 1, 2021. This handout is more informational and just wanted to make the Board was aware of this new Medicare Federal Law requirement for hospitals and that is out there. This new section of the Federal Law requires that each hospital operating within the United States, must post yearly their hospital's standard charges for items and services provided by the hospital under the Medicare Hospital Price Transparency. Under this Medicare ruling, Medicare can charge penalties to the Hospital if these postings are not implemented under their price transparency.

Karen Senger asked if there were any other questions or concerns with any of the information before we move on to the next agenda items. No other questions or comments were made to this agenda item.

Medicare and Licensure Survey Statistic (Presented in November meeting)

Karen Senger commented on the next agenda item will need to postpose the survey statistics information until the next meeting in November.

Revised Bylaws (Present in the November meeting)

Karen Senger commented on this agenda item on the Department is going through and looking at all the bylaws for all the advisory and licensing boards. Will bring updated bylaws to the next meeting in November for review and discussion, and then to possibly vote on at the February 2022 meeting. So, this information will be on the November Agenda.

OLD BUSINESS

Proposed Regulatory Change 250.630 Radiology- Discussion

Karen Senger presented the next agenda item for discussion with the Board. The Board was given a handout on proposed regulatory changes to the Hospital Code Section 250.630 under Radiology. The board talked about this agenda item at their last meeting (Section 250.630 – Radiology) and we had some inquiries from other entities about this process and wanting to expand on the section of the radiology rules. Currently the rules are limited to just physicians who can do fluoroscopy procedures. And this section should be added to the rules as an individual due to their full authoritative scope of practice. Larry Children's Hospital has contacted her on some concerns about also trying to implement these changes in relations to getting this change in line and address to be able to perform fluoroscopy service. So, I am opening this topic up for discussion.

Board Member, Gabrielle Cummings, asked is that the current guidelines, or current policy or is the rules more stringent than another organization, and are we looking to make our rules a little more expansive to be in line with the rules.

Karen Senger commented under section 260.360, letter e, clearly states that only a physician whose credentials can do fluoroscopy within the current Hospital Licensing Rules under the emergency part 360, which is under the emergency management. This section is authorized by the Illinois Emergency Management Agency Requirements under the act. The X-ray section for us would be under that section, and they do allow this procedure under letter (n), Operator Restrictions on the last page of the handout. This section says no personnel cannot operate a fluoroscope that is not licensed to practice medicine that includes dental or a licensed podiatrist and is certified by an accredited medical Radiological program by the American Board of Radiology or the American Osteopathic Board of Radiology. The personnel may operate a fluoroscope as directed by and who always has direction under direct supervision of a licensed practitioner of the radiological services. This section does not expand out to just a physician that is under direct supervision.

Karen Senger further commented that she had also received requests that they would like to see this change in lieu of position. Karen Senger asked if this is something that you want to work on in the rules to expand out to be in compliant with and in line with our other state agencies under the Illinois Emergency Management Agency Rules and then also with the Nurse Practice Act in allowing with full practice authority to have a little more flexibility.

Karen Senger opened the topic up for discussion as to what direction the Board would like to take.

Board Member Gabrielle Cummings agreed with looking at expanding and thought it reasonable to put the hospital guidelines in line with the other governing bodies. There are some challenges we are having around clinicians being able to find people/staff to do all the various work in hospitals and it makes more sense to have multiple providers to have the ability to provide this service. Chair, Lyndean Brick agreed with this as well.

Karen Senger commented there is apparently a Senate Bill (SB1949) that is in the works in relationship to addressing this topic and might be coming forward. I am not sure where it is at in the process and will work on getting some rules to expand aligning these guidelines together and bring back to the Board.

Karen Senger asked if there were any other questions or concerns with any of the information before we move on to the next agenda items. No other questions or comments were made to this agenda item.

C-Section and Submission to Pathology (on hold no update)

Karen Senger commented this agenda item is on hold with no updates at this time and will bring back to the next meeting for discussion.

Medical Cannabis (on hold no update)

Karen Senger commented this agenda item is on hold with no updates at this time and will bring back to the next meeting for discussion.

IHA Update

Lance Kovacs shared IHA updates on a few items of concerns with the Board for informational purposes:
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1) One item of concern is back at the end of 2020 as part of a Federal Appropriation Act, the Federal Government is authorized under Federal CMS to create a new status for certain hospitals called Rural Emergency Hospitals. This would basically be for any hospital currently designated as a Critical Access Hospital (CAH) or a hospital with less than 50 beds to basically remove their in-patient beds and be a free-standing emergency hospital without patient services and be paid at the outpatient rate to date. We have checked with many of our constituency sections, and we do not see any hospitals really interested in this. It seems to be more of something that will be a focus in other states and think a lot of I has to do with the payment involved with this as being one of the requirements that the facility is registered and licensed as a hospital in the given state. In the coming months this goes into effect January 1st of 2023, and we wanted to put this topic on the radar, and the licensing Board, because there will need to be some sort of statutory change to incorporate what a real emergency hospital would be here in Illinois or any hospital site to go down that path.

Karen Senger commented that this was an item that she was going to bring up to the next board meeting because it will require a legislative change and our hospitals would want to see the Act itself at this point. The Departments Legal section is looking at this item, and we will need to decide what route we want to go with that Federal Change.

2) Second item of concern is the notion that has arisen since the Bursty Health Micro Hospital, but there is another application out there (Quincy Medical Hospital) and it has been received and intent to deny of a small format hospital less than 100 Beds and what bed size and bed count really means in the future Hospital. We have had a discussion with Lyndean Brick about this in the past and think the fact that the Quincy Medical Group put together this application and that somehow the HHS kind of permitted this hospital to be owned with a license with a nonprofit entity where the sole member of the non-profit seems to be work around a physician owned hospital concept. We will also be working with the planning board on about this concern about bed counts and this type of ownership. This concern is something we will also need to be under consideration of this board as well.

3) Another item of concern is how equity and the creation of a committee on health disparities. Gabrielle Cummings has been very involved in this concern as we have also taken a closer look on the issue of Obstetric Units and doing a member survey on what is the leading causes of hospitals dropping their units. For those hospital that are keeping their units, I have completed some survey data that we compiled over the summer that I am presenting to the Prenatal Advisory Committee this afternoon and would be happy to share at the next Board Meeting.

Karen Senger commented would be very interested in these IHA concerns, because there is a lot of hospitals closing their services to what some of those issues are. Karen Senger also shared an item for the Board information on a new law that was passed (210.170), which is about development of a Burn hospital

license. Currently there are burn centers licensed under the Alternative Healthcare, which are limited to be for the state. There is going to be a separate state license category for a burn center that there is no limit on the number or where they can be located This law just got passed so we are currently writing rules to be able to address these new Burn Center licenses. This will be an impact in relationship to burn facilities across the state that are within the hospital. This is something that will need to be addressed by the Board. Karen Senger commented that the other item Lance Kovacs mentioned was on the bed counts that is also something that is covered within our licensing rules. We are very silent on what we consider to be the types of beds or the bigger categories for an acute care in a general hospital. We have our pediatric and rehab, but then what most hospital do with a combination of all these services is something that has come up with other hospitals. What we have that is coming into play is trying to really consider to be a general acute care bed count, and what types of, or number of beds should be included with that count. This is something that we need to think about as a Board in relationship, because there are a lot of combinations that are coming up and not just the normal standard bed count ratios that we have seen in the past.

Lance Kovac agreed and commented that the change in the healthcare delivery system is very rapid and what is needed for inpatient care is just not what it once was and making those adjustments and making sure the regulations stay up to date with them. These changes are important and happy to work with the Board on these issues.

Chair, Lyndean Brick responded that the Board appreciated all of Lances and IHAs hard work and help with these concerns.

Karen Senger asked if there were any other questions or concerns with any of the information before we move on to the next agenda items. No other questions or comments were made to this agenda item.

Board Membership Update

Karen Senger presented this update on Board Membership:

1. Membership vacancies – Three (3) Board members that have resigned their positions
   a. Catherine Neuman – Appointee for position representing Nurses (Voting Member) resigned effective 05/2020; nominee none
   b. Reverend, Dr. Nathaniel L. Edmond – Appointee for position representing General Public (Voting Member) resigned effective 8/2021. Nominee none
   c. Kishore Belani, DDS, - Appointee for position representing Dentists (voting member) resigned effective 09/2021; nominee none

2. New membership – Two (2) new membership was appointed at this time.
   a. Robert Connor – newly appointee position representing State Representative DHS (voting member) to replace position held by Jayne Antonacci effective 03/2020.
   b. Charli W. Smith, Jr. – newly appointee for position representing Physician (voting member) to replace position held by Nancy Roberts effective 06/30/2020.
3. Reappointments – None

Karen Senger introduced and welcomed newly appointed Board Members, Robert Connor and Charli Smith, Jr. at today's meeting. Newly appointed member Charli Smith, Jr was not able to make today's meeting. Karen Senger commented that the Board has three recent vacancies that are needed to meet full membership. Board Members were for any recommendations for any one of these three categories to please send an email of the name of an individual and their contact information for the Department to reach out to for further information.

Board Member, Ed Cunningham asked if there were any updates from the Governor's office on re-appointment of memberships for members whose terms have expired. This process has been awhile, and members have not heard if they have been removed or appointed.

Karen Senger commented, the Department is currently working with the Governor's office staff on approval on the remaining re-appointments of Board Memberships. The Department will keep in

touch with the Board of any new updates or status of Board membership reappointments approval by the Governor's office. Board members were reminded that members can continue to serve on the Board until you receive notification that you have been approved, replaced or you resign your membership.

Board member, Kimberly Landers asked if there was a way, she could move her position to replace the nurse position that was vacated by Catherine Neuman since she is a Nurse. Karen Senger commented that she will address this and will get back to the member on her recommendation.

The Board has 14 members and were reminded that the Board needs 8 members to meet a quorum to conduct a meeting under the Open Meetings Act (OMA). Karen Senger reminded members to mark their calendars and plan on attending for the Board to meet a quorum.

Board Membership 2021 Mandatory Annual Training

Karen Senger reminded the Board members of the Mandatory Annual Training for 2021 that they will be getting an email from the Department about the upcoming Mandatory Training required of Board members. This mandatory training will include the 2021 Ethics and HIPPA training. Please respond to my staff, Elaine Huddleston with any questions to this request.

Public Comment Period

Karen Senger commented that she was opening the meeting up for Public Comment and asked if anyone had any comments they would like to share. She then asked do we have any other concerns from Board members and was there anything that we did not address or concerns that you want to add to the next meeting to be able to continue through our discussions. Hearing none we will move on to the next agenda topic.

Future Meeting Dates 2022 Schedule

Member were given a copy of the tentative meeting schedule for the rest of 2021 and Draft meeting schedule for 2022 for informational purposes. The Department is currently working on scheduling these dates, times, and meeting locations for next year (2022). Members were asked to mark their calendar accordingly and plan to attend.

Next Meeting:

1) The next Board Meeting is scheduled for November 16, 2021 in the Springfield, Chicago meeting locations. Due to the Public Health Emergency and Governor ordinance for social distancing that has been issued, this meeting will tentatively be held via WebEx.
2) Board Members were given a copy of the Board Meeting Schedule for the rest of 2021 and 2022 and were asked to mark their calendars accordingly and plan on attending.

Closing remarks

Chair, Lyndean Brick asked Board members if there were any other closing comments hearing none, she wanted to thank everyone for joining the call and their input for discussion for the next meeting scheduled for November 16th.

If there was nothing else to address or comment on, she would need a motion to adjourn the meeting. Board Member, Rob Connor made a motion to adjourn, 2nd by Board Member, Ed Cunningham and with all in favor the meeting was adjourned.

Meeting Adjourned at 11:54 am