IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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Meeting Minutes
Hospital Licensing Board Meeting
May 20, 2025 - 10:00-12:00 P.M.

Conference locations:
525 W. Jefferson, 4th Floor, Springfield
5415 North University St., Peoria
3 Westbrook Corporate Center, Bldg. 3, 3rd Floor, Westchester

Webex Meeting Access Information:
Meeting link: https://illinois.webex.com/illinois/j.php?MTID=mf490931c082d76c48094345ec4f3fcc2
Meeting number: 2869 799 0257
Password: zbRBj3fw7Y2
Join by video system: Dial 28697990257@illinois.webex.com
You can also dial 173.243.2.68 and enter your meeting number
Video System Dial +1-312-535-8110 United States Toll (Chicago) or +1-415-655-0002 US Toll

Call to Order

Members Present:	Donell Barnett, Matthew Kolb, O. Erin Reitz, Kelly Park, Gagandeep Goyal, Kimberly Landers, Kim K. Tee, Patricia Hudson
Members Absent:	Chris Klay
Department Staff:	Sheila Baker, Sean Daily, Leandra Diaz, Sara Ettinger, Stephanie Glenn, Rebecca Gold, Annette Hodge, Jackie Richmond, Karen Senger
Guests:	Lance Kovacs (IHA)

Introduction of Committee Members and Guests
Matthew Kolb, Co-Chair, called the meeting to order at (10:01 a.m.) announcing this is the Hospital Licensing Board Meeting with today's date being May 20, 2025.

Kimberly Landers 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. By joining this session, you are automatically consenting to be recorded and if you do not consent to be recorded, you should not join this session.

Members of the public and others wishing to speak will be recognized by the chair during public comment period, which will open the floor at the end of the meeting for discussion/comments.

An introduction of Board members was conducted to establish a quorum. After roll call was conducted, a quorum was established at this time and the meeting was called to order. New member Patricia Hudson, Deputy Director of Facility Management of Dept. of Human Services, was introduced.

Approval of the Draft Minutes for the November 19, 2024 (VOTE} {Exhibit 1}
The approval of the draft minutes for November 19, 2024, and February 18, 2025, were submitted for approval. All members voted in favor of approval.

OLD BUSINESS

None

NEW BUSINESS

Vote regulations per Board's Review Licensing Requirements sections 250.105; 250.525; 250.725; 250.730; 250.740; 250.1210; 250.1220; 250.1240; 250.1250; 250.1260; 250.1290; 250.1300, 250.1305; 250.1310; 250.1320; 250.1410; 250.1510; 250.1520; 250.1670; 250.1720; 250.2110; 250.2120; 250.2130; 250.2410 {Exhibit 2}

These sections of the rules have been separated out, with all of us board members taking certain sections to work on for an update. We're just going through each section after these changes. We'll start on page 15 (Section 250.105), updating incorporated references with the corrected links. We added the NIOSH to that reference. This is just basic technical cleanup. We also added in the federal documentation related to what we have to report as communicable. The bigger changes start on page 24 (Section 250.525) for the blood donor program. We struck out a lot of the language and referred them back to the clinical laboratory Blood Bank Act and the process which outlines donations. The next section (Section 250.725), on page 27, was related to emergency personnel. There were a lot of changes in here due to the statutory that we've referenced in this IMS Emergency Systems Act. We mirrored the appropriate sections to respond and report to EMS of there is a notification of communicable disease by a patient that had been transferred there or is transferring back out via EMS. Instead of listing all the individual diseases, we're referring to the NIOSH publication. The notification is now required by statute no later than 48 hours confirming diagnosis. Section 250.7030, which was renamed Emergency Preparedness Plan, previously called Community Area Wide Planning, along with the next section 250.7040, Disaster and Mass Casualty Program, we are repealing and putting this all together under one section, which states that the hospital must follow Medicare conditions participation for emergency preparedness at 42 CFR 482.15, and that they must submit their plan to the regional designated hospital resource so that everyone is aware of their plans in the resource center. Next is 250.2010 under Surgery, which clarifies some language in there and adds that a member of the hospital's medical staff shall direct the surgical services and shall be qualified by training experience, preferable board certified by the American Board of Surgery and approved by the hospital's medical staff. This also clarifies identifying appropriate allied health personnel, the supervisory nurse. 250.2040 Surgical Privileges and 250.1250 Surgical Emergency care both just clarify some language. 250.1270, surgical patients have a bigger change. We took out section "D" and incorporated it into "E", all infections of surgical procedure, including but not limited to those reportable by NIOSH shall be reported and recorded to the administration inspection control committee. The committee shall report this data to the board at least annually. Under 250.1300b)1 and 2), regarding the flow of patients, personnel and material in a surgical area being controlled. The semi-restricted and restricted areas of the coverings used, such as personal cloth head coverings, should be laundered by the hospital to ensure sterilization. Some facilities do use cloth, which is not preferred. We removed, due to duplication, the gloves used when participating in surgery, being removed and discarded prior to leaving the operating room. We added some clarification under 250.1305, regarding members of the medical staff and persons with additional privileges such as a student observer or those with a patient under the age of 18, or a guardian for someone that is intellectually disabled. 250.1310 under Cleaning, we added individual nurses, surgical technician, assistant surgeons and anesthesia and removed contaminated gowns. Then we added under, b) the infection control committee's guidelines for cleaning room after person with a contamination case (individual was infected with an organism requiring non-routine decontamination and cleaning materials). 250.1320 related to post anesthesia care unit, we removed some language from 3) and made a number 4) to break out all patients with contagious conditions that we covered in phase one isolation room or in the operation room. 250.1410 Anesthesia, the change is under c) the physician or certified registered nurse anesthetist shall supervise the work of all non-medical personnel working in the anesthesia service. With 250.1510 Medical Records, we clarified that the retention of records is ten years. Around page 54, 250.1520 Reports made a clarification on the breakdown of pediatric patients admitted under observation regarding the origin of the patients from the emergency department, post-procedure or from direct admission as an inpatient or observation status setting that were transferred. Changes under 250.1670 Food Preparation and Service on page 55, removes c) regarding dining rooms. Page 56, 250.1720 Garbage, Refuse and Solid Waste Handling and Disposal clarifies some terminology. Section 250.2110 Service Requirements on page 58 updates some pharmacy information including updating to the current standards of practice, removing "vending machines", updating packaging of medications. It also updates who is under the direct supervision of the registered pharmacist. 250.2140 Pharmacy and Therapeutics Committee updates some of the verbiage from "drugs and medicines" to "drugs and biologicals". There is not much after these changes, but Karen will bring what is left to the next meeting. There was a motion to approve from Kimberly Landers and was seconded by Matthew Kolb. All others agree.

Workplace Violence (Hold for ongoing discussions)

Report quarterly data pediatric consultation per 250.310 {Exhibit 3}
This document shows information regarding pediatric patients admitted or placed under observation during the third and fourth quarter of 2024 and the first quarter of 2025. The biggest hospitals are Ottawa and Saint Elizabeth. Most of the hospitals are zero. We had no mortalities. The third quarter only had sixteen and the fourth had eighteen. I think we need to continue to monitor these numbers and see if we have any outliers. Karen will remove those on the list that no longer have an agreement so that it will be a little clearer. Lance offered his help with outreach if needed.

Hospital Care at Home update{Exhibit 4}
Karen collected date from various hospitals who have Hospital Care at Home. Right now, it is still active, even though it expired under Medicare as of December 31, 2024. At this point, all patients in the program must either be discharged to return to the hospital by September (Dec) 30, 2025 in absence unless Congress extends the action. The form shows the hospitals approved, the date of their approval into the program, and how many were admitted. It also shows, the number of admissions as of 1/18/2024, the total number since approval, then a breakout of the numbers from ED, inpatient, transfer back to inpatient, the mortalities and the date we received the information. Also, note that University of Illinois Hospital and Clinics at Chicago never responded. Karen asked Lance if he could reach out to U of I regarding this information. We will find out the status by August, as to if this will continue or not. Most just came on board so the numbers are all zero. OSF Saint Frances was the largest with a total of 703 care at home patients. 135 were from ED. 568 from inpatient and 47 were transferred back and they had 3 mortalities. This information is from a time just shy of a year. Blessing had 249 and Saint Anthony's in Chicago had 121. Northwestern Lake Forest had 31.
The common diagnoses that they are utilizing are COPD, CHF and pneumonia. We really need to see the federal side of this to consider volume of patients.

Legal discussion on provisional license and discontinuation of beds
Rebecca Gold notes that there are a few issues that legal has been dealing with that she wanted to bring up for the Board's consideration/thoughts.
There have been several hospitals lately discontinuing beds and services. As you know, certain services need to go before the HFSRB to discontinue those services. Our rules require approval by the department prior to discontinuing any service, under 250.120k)2). The enforcement mechanism for this provision, except for adverse license or action, which would include suspension or revocation. Do we want to continue with this or make our regulations stronger? Is this an HFSRB issue really, that IDPH doesn't need to be a part of? Karen clarifies that we do request information as to why they discontinue, what other hospital are close by, and if they've informed their patients. As an example, Morris Hospital is surrounded by one hospital shutting down their pediatrics. Another local hospital just shut down their trauma and their obstetrics. Yet another hospital (all these hospitals are 20-25 miles away) is shutting down their ICU and their med surg. Kimberly Landers says that, as a small hospital, we cannot absorb it, and it impacts that community. Matthew Kolb agrees and notes that, as a safety net hospital for a growing region where they are seeing a contraction of services, he's not sure that a regulatory body can compel a hospital to keep a unit open. Donnell Barnett would also like to throw mental health beds into this conversation. In many cases, the private sector closes beds, and the state must absorb it, but they can't keep up with the growing demand. Lance Kovacs offered that IHA could put a member memo out reminding facilities of their responsibilities to submit discontinuous service notices. Karen noted that HFS is good about alerting IDPH who is next on their agenda for discontinuation. Then we reach out for clarification.
Rebecca also wanted to remind everyone of the provisional license, it is a rule but not in the statutory language. We do provide for the issuance of a provisional license for a hospital that is not in substantial compliance with the Act, if they're undertaking changes and corrections, that upon completion, will render the hospital in substantial compliance. We give them the requirements when we issue the provisional license, noting that they must meet compliance during the provisional period prior to reopening. The issue here is that some are in this situation, just keeping their license open, just to sell it immediately. That's not the intent of the provision but it is happening more frequently. Matthew asks if we need to add language to strengthen the notice requirement if there is a change in services, irrespective of whether that's related to a HFSRB? Karen replies that, no, the issue would be that if a hospital says they're going to suspend their operations due to an issue, but they are actively seeking a buyer and cease operations. We need to investigate this further and bring back for discussion at the next meeting.

IHA Update
IHA are wrapping up the legislative session next week. This has been one of the more challenging sessions that I can remember. Two of our initiatives are still in play. The top priority is our 340b Pharmacy initiative. We are trying to do what other states have done, so far successfully, is to maintain the 340b program as it was originally address in Congress and not allow pharmaceutical companies to pull certain medication. The other initiative that Lance is more actively engages in is creating a health care workforce task force to address the impact of issues such as workplace violence to improving workforce pipeline in the state and anything in between. We are also finalizing our agreement with HFS on the updated hospital assessment program. We need that approved before the legislature adjourns so that it can make it to federal CMS for approval. The current tax bill proposal in Washington could make some significant changes to hospital assessment programs. We are monitoring a federal issue regarding critical access hospitals, that it is hard to provide OB services while keeping within the 25-bed limit. A bipartisan bill is in Congress now that will permit critical access hospitals to maintain their status but not have licensed obstetric beds count against their 25 beds. That's in early stages but we are tracking it.

Board Membership Update
Current vacancies: 1 physician, 1 administrator, 1 dentist and 2 governing board. If you have any suggestions for new members, please let us know.

Public Comment Period – None.

Future Meeting Dates for 2025 Schedule {Exhibit 5}
Next Meeting Schedule August 19, 2025

Adjourn at 10:57 a.m.