July 1, 2022

Tracey Trigillo
Rules Coordinator
Illinois Department of Public Health
Lincoln Plaza, 524 South 2nd Street, 6th Floor
Springfield, IL 62701

Re: Emergency Rule Amending 77 Ill. Adm. Code 515 – Emergency Medical Services (EMS) Systems Transport

Dear Ms. Trugillo,

On behalf of the Illinois Health and Hospital Association's (IHA) more than 200 member hospitals and nearly 40 health systems, we appreciate the opportunity to submit comments regarding the Proposed Rule (PR) amending 77 Ill. Adm. Code 515.315 and 330, published in the Illinois Register on June 3. IHA appreciates the efforts of the Illinois Department of Public Heath (IDPH) to formalize further guidance in the area of Emergency Medical Services (EMS) system transport. As currently drafted, we remain concerned with two key areas of the Proposed Rule and Emergency Rule (re-issued on June 10). We would like to reiterate our concerns shared with IDPH in our **May 9, 2022 comment letter** (*copy attached*), and urge your consideration of these recommendations to support safe patient throughput in our healthcare delivery system.

1. ***Section 515.315 Bypass or Resource Limitation Status Review***

Section 515.315 creates a **new** requirement during a declared local or state disaster, which would limit bypass approvals to **2 to 4 hours** (pp. 1184-1185). Hospitals have expressed concerns that the abbreviated time period is not adequate. The circumstances necessitating the request to be placed on bypass are often not easily addressed within such a truncated window. In order to address patient safety needs in some disaster situations, clinical staff shortages may require staff redeployment to surge areas or off-duty staff reporting to the hospital. Seeking bypass re-approval every two hours may add additional staffing and resource strain during a declared disaster. If approved for a 2-hour bypass period, a hospital will need to almost immediately begin the process for re-approval, while at the same time working to address the issues which caused the initial request.

While we understand the urgency for hospitals to reengage their Emergency Departments as rapidly as possible after going on bypass status, **we propose that if a limited window needs to be stipulated in rule that it be set at 8 to 12 hours, to correspond to the typical staffing shift change. Requiring re-approval twice per day, versus the 6 times currently required by the proposed rules, would greatly relieve the administrative burden and allow the hospital to spend the added time resolving the initial issues, instead of engaged in additional burdensome administrative processes.**

2. *Section 515.330: EMS System Program Plan*

IHA commends IDPH for developing, by implementing the flexibilities envisioned in Public Act 102-0623, the requirement of an EMS System policy that permits the expansion of EMS transport to alternative healthcare facilities beyond hospitals. Hospitals continue to support the concept of EMS transport to the closest **appropriate alternative healthcare facility**, but have expressed concerns that the current language "***any*** *licensed healthcare facility*" in Section 515.330(h)(5) of the ER (p.1188) appears to be in conflict with Section 3.155(i) of the EMS Systems Act (210 ILCS 50/). There are three key areas of concern with the current language in the ER.

First, the current ER permits bypass or diversion of the closest emergency department to a much broader scope of facilities than identified in PA 102-0623, which permits "*transport to the closest or appropriate EMS System-approved mental health facility…EMS System-approved urgent care or immediate care facility*." **IHA encourages IDPH to align alternative healthcare facility transport with those facilities that are permitted in the EMS Systems Act.**

Second, hospitals have expressed concerns that inferring patients are to be transported to "***any*** *licensed mental health facility"* may inadvertently and substantially increase patient throughput directly to hospitals with inpatient beds for acute mental illness, rather than the closest, appropriate alternative receiving healthcare facility or EMS System-approved mental health facility. This outcome appears contrary to the goal of the transport flexibilities in PA 102-0623, to ensure that individuals experiencing mental health crises who do not require hospitalization are instead linked to available community services, as appropriate. **IHA encourages IDPH to clarify and encourage the use of *appropriate alternative healthcare facilities*, specifically in appropriate instances as described in 210 ILCS 50/3.155(i), to support implementation of PA 102-0623's intent to link patients to available crisis stabilization or community services, instead of inpatient hospitalization.**

In addition, limiting mental health facilities to "*a* ***licensed*** *mental health care facility*" would seem to exclude mental health facilities **certified** by the Illinois Department of Human Services (IDHS), including Certified Community Mental Health Centers and Certified Behavioral Health Clinics. It has been our understanding that the intent expressed in PA 102-0623, which specifies that a transport policy may be permitted for an "*EMS System-approved mental health facility,*" would have included some of the providers **certified** by IDHS. The inclusion of certified mental health facilities as an alternative care site for EMS transports will also assist EMS Systems in aligning with the provisions set forth in the Community Emergency Services and Support Act (PA 102-0580).

Third, clarification is necessary to differentiate hospital participation in an EMS System (or region) for purposes of transport to **crisis stabilization units (CSU)**, versus traditional emergency departments (ED). Proposed this year by the Illinois Dept. of Healthcare and Family Services with Medicaid programmatic requirements and funding approved by the current 1115

Waiver [1](p. 22), hospital-based CSUs can divert patients from emergency departments and provide short-term crisis stabilization services when medically appropriate, with direct CSU admissions occurring via transport or walk-in. **Requiring EMS Systems to develop alternative transport agreements specifically for hospital-based CSUs would clearly distinguish facility participation for ED and CSU transport within the EMS System Plan**, while creating appropriate guardrails to protect patient safety and throughput. **Required alternative transport agreements should also limit participation within the facility's designated EMS systems, unless participation is agreed upon by the facility.** Limiting alternative transport agreements to individual EMS Systems will ensure the new CSU designation and service does not inadvertently and substantially increase patient throughput directly to hospital-based CSUs, when there is a closer and more appropriate alternative healthcare facility or EMS System-approved mental health facility.

To summarize, IHA recommends the following changes:

1. **Expand the permitted bypass window from 2 to 4 hours to 8 to 12 hours to ensure patient throughput issues can be adequately addressed, reduce unnecessary administrative burden, and align with typical shift changes.**
2. **Clarify the use of specific alternative healthcare facilities, in appropriate circumstances, to link patients to available community services and divert away from hospitalization.**
3. **Clarify the use of licensed mental healthcare providers to include providers certified by IDHS.**
4. **Differentiate hospital participation in an EMS System, by requiring alternative transport agreements for CSUs.**

Thank you for your consideration. I look forward to working with you to address this issue in a manner that meets the needs of all stakeholders. If you have any questions or comments, please contact me at awilhelmi@team-iha.org or 630-276-5444 or Lia Daniels at ldaniels@team-iha.org or 630-276-5461.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association

Attch: *May 9, 2022 Comment Letter on January, 2022 Emergency Rules*

Cc: Jordan Powell, Senior Vice President, Health Policy and Finance, IHA
Joe Holler, Vice President, Finance, IHA

[1] Illinois Behavioral Health Transformation Waiver