

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Tuesday, December 5, 2023

Bolingbrook, Illinois

9:00 a.m.

PRESENT:

DEBRA SAVAGE, Chairwoman

REX BUDDE

KENNETH BURNETT

GARY KAATZ

DAVID KATZ

DR. AUDREY LYNN TANKSLEY

MONICA LeGRAND

DAVID FOX

ALSO PRESENT:

JOHN P. KNIERY, Administrator

RYAN LEE, IDPH Ex-Officio

MICHAEL CONSTANTINO, IDPH Staff

GEORGE ROATE, IDPH Staff

DON JONES, IDPH Staff

MAGNA LEGAL SERVICES

BY: Michael Marciniak, CER

Notary Public

1 P R O C E E D I N G S

2 (Time noted: 9:00 a.m.)

3 CHAIRWOMAN SAVAGE: I now call the Open Meetings
4 Act at section seven. We will have some members
5 attending remotely via Webex. Meeting is not only
6 recorded via the court reporter, but the entire Webex
7 format will be recorded as required. Welcome everyone.
8 And Happy Holidays. So George, would you please call
9 the role.

10 MR. ROATE: Thank you, Madam Chair. Rex Budde.

11 MR. BUDDE: Present.

12 MR. ROATE: Thank you. Kenneth Burnett.

13 MR. BURNETT: Present.

14 MR. ROATE: David Fox.

15 MR. FOX: Present.

16 MR. ROATE: Monica Hendrickson.

17 MS. HENDRICKSON: Present.

18 MR. ROATE: David Katz.

19 (No verbal response.)

20 MR. ROATE: Mr. Katz? Moving on. Gary Kaatz.

21 MR. KAATZ: Present.

22 MR. ROATE: Thank you. And lastly, Deborah
23 Savage.

24 CHAIRWOMAN SAVAGE: Present.

1 MR. ROATE: Thank you. That's six in attendance
2 in-person and three in attendance via Webex.

3 CHAIRWOMAN SAVAGE: Okay. Now may I have a
4 motion to allow board members, Mr. Katz, Mrs. Legrand,
5 and Dr. Tanksley to attend the meeting via Webex for
6 one of the reasons outlined in Section 7A of the Open
7 Meetings Act.

8 MR. KAATZ: I Make the motion.

9 MS. HENDRICKSON: I second.

10 CHAIRWOMAN SAVAGE: Thank you. George, please
11 call the role to allow the seating of these members.

12 MR. ROATE: Mr. Budde?

13 MR. BUDDE: Yes.

14 MR. ROATE: Thank you. Mr. Burnett.

15 MR. BURNETT: Yes.

16 MR. ROATE: Thank you. Mr. Fox.

17 MR. FOX: Yes.

18 MR. ROATE: Thank you. Ms. Hendrickson.

19 MS. HENDRICKSON: Yes.

20 MR. ROATE: Thank you. Mr. Kaatz.

21 MR. KAATZ: Yes.

22 MR. ROATE: Thank you. Chairwoman Savage.

23 CHAIRWOMAN SAVAGE: Yes.

24 MR. ROATE: That's six votes of approval.

1 CHAIRWOMAN SAVAGE: Thank you. That motion was
2 approved. Now we are going to change the format of our
3 traditional agenda today to make accommodations for our
4 rules with items number five and six. We all have made
5 or have heard comments on our rules and we are making a
6 concerted effort to prioritize the modernization of our
7 rules. Also, I would like to remove items 13 and 14
8 from the agenda. We will hold the executive session at
9 our next scheduled meeting. So now may I have a motion
10 to approve the October 3rd, 2023 meeting agenda as
11 amended.

12 MR. BUDDE: So moved.

13 MS. HENDRICKSON: Second.

14 CHAIRWOMAN SAVAGE: Thank you. George, if you
15 could call the roll.

16 MR. ROATE: Thank you. Madam Chair. Mr. Budde.

17 MR. BUDDE: Yes.

18 MR. ROATE: Thank you. Mr. Burnett?

19 MR. BURNETT: Yes.

20 MR. ROATE: Thank you. Mr. Fox.

21 MR. FOX: Yes.

22 MR. ROATE: Thank you. Ms. Hendrickson?

23 MS. HENDRICKSON: Yes.

24 MR. ROATE: Thank you. Mr. Katz?

1 MR. KATZ: Yes.

2 MR. ROATE: Thank you. Mr. Gary Kaatz.

3 CHAIRWOMAN SAVAGE: David Katz.

4 MR. ROATE: I'll move on. Monica Legrand.

5 MS. LEGRAND: Yes.

6 MR. ROATE: Thank. You. Dr. Tanksley.

7 DR. TANKSLEY: Yes.

8 MR. ROATE: Thank you. Chairwoman Savage.

9 CHAIRWOMAN SAVAGE: Yes.

10 MR. ROATE: Thank you. That's eight votes in the
11 affirmative.

12 CHAIRWOMAN SAVAGE: That motion is approved. May
13 I now have a motion to approve July 27th, 2023 meeting
14 transcript; May I have a motion?

15 MR. FOX: I'll move it.

16 MR. KATZ: Second.

17 CHAIRWOMAN SAVAGE: Thank you. Are there any
18 changes or comments?

19 (No verbal response.)

20 CHAIRWOMAN SAVAGE: Okay, hearing none. George,
21 if you could please call the role.

22 MR. ROATE: Thank you, Madam Chair. Mr. Budde?
23 Yes. Thank you. Mr. Burnett? Yes. Thank you. Mr.
24 Fox. Yes. Thank you. Ms. Hendrickson? Yes. Thank

1 you. Mr. Katz? Yes. Thank, thank you. Mr. Gary
2 Katz. David Katz. Second. Mr. Katz.
3 David Katz.
4 Thank you, Madam Chair. Mr. Budde?
5 MR. BUDDE: Yes.
6 MR. ROATE: Mr. Burnett?
7 MR. BURNETT: Yes.
8 MR. ROATE: Mr. Fox?
9 MR. FOX: Yes.
10 MR. ROATE: Thank you. Ms. Hendrickson?
11 MS. HENDRICKSON: Yes.
12 MR. ROATE: Thank you. Mr. Katz -- David Katz.
13 Still no Mr. Katz. Gary Kaatz?
14 MR. KAATZ: Yes.
15 MR. ROATE: Thank you Ms. Legrand?
16 MS. LEGRAND: Yes. Yes.
17 MR. ROATE: Thank you. Dr. Tanksley?
18 DR. TANKSLEY: Yes.
19 MR. ROATE: Thank you. Chairwoman Savage.
20 CHAIRWOMAN SAVAGE: Yes.
21 MR. ROATE: Thank you. That eight votes in the
22 affirmative.
23 CHAIRWOMAN SAVAGE: That motion is approved. So
24 now we're gonad have a discussion of cardiac Cath

1 category of service. So I'll turn it over to you. Mr.
2 Jones.

3 MR. JONES: Thank you Madam Chair. As many of
4 you know the board has requested changes to its cardiac
5 cath rules. Some sections of those rules were
6 promulgated in 1987 and have not been updated since.
7 So board staff has been working for several months to
8 gather information to update these rules in terms of
9 utilization standards, current equipment standards,
10 current staffing standards.

11 Back at the October meeting it was
12 suggested that we reach out to providers that we had
13 been in discussions with during the fall and the summer
14 to get their perspectives. And so we have confirmed
15 the attendance of several providers across the state.
16 The first entity that would like to make presentation
17 is Northwestern Medicine.

18 CHAIRWOMAN SAVAGE: Okay. Say and spell your
19 name for the court reporter, please.

20 MR. DAVIDSON: Sure. Thank you. Thanks for
21 having us. I'm Charles Davidson.

22 MR. COHEN: My name is Dr. Ian Cohen.

23 MR. DAVIDSON: Thank you for having us here
24 today, it is kind of amazing we talked about the last

1 time this was updated. I think back to early in my
2 career. All. We really did in cardiac cath labs,
3 diagnostic coronary -- orders, and we blew up balloons
4 to try to treat blocked arteries; that was pretty much
5 it. No catheter based -- was used for battling heart
6 disease. Coronary stints, which everybody knows about
7 were not even developed, medicated stints development
8 took until about early 2000s. Bowel disease Started to
9 be treated in the last 10 to 15 years. So I want to
10 put some perspective that the cardiovascular labs are
11 very different today than they were back then.

12 More complex procedures that were often
13 thought to be in a surgical arena have now migrated to,
14 to the cath labs. And this is not something that's a
15 static, safe, slow process. Even over the past few
16 years and continues to add from new technologies that
17 have been developed. And patients increasingly want
18 non nonsurgical procedures, right. They want a new
19 non-invasive type of surgery.

20 And I -- I just brought a couple slides
21 just to give you some perspective on, you've all heard
22 of TAVR probably, which is Transcatheter aortic valve
23 replacement replacing an aortic valve from a leg
24 artery. And this is just looking at kind of the last

1 10 years we've been this doing for about 15 years at
2 Northwestern Memorial Hospital. But you can see I
3 don't want go too much detail, but you can see the TAVR
4 back in 2013 when we were doing only 50 of them, we
5 doing 150 open half open heart valve replacements to
6 the aortic valve. Fast forward to about the last five
7 years, as you can see that not only has there been a
8 growth in the number of aortic valve replacements, but
9 the TAVR has now become the predominant player that now
10 makes up close to 70 percent of aortic valve
11 replacements.

12 And that's not just true in Northwestern,
13 but it's a nationwide statistic, I just got better
14 access that we're used to getting at Northwestern. But
15 this has transformed the treatment and that now occurs
16 in the cardiac cath labs routinely as part of a heart
17 team approach. So the surgeons are working in the cath
18 labs routinely with the intervention cardiologists,
19 which I am intervention cardiologist. But it's a much
20 more team based approach in order to find what's the
21 best for what patients. Some patients are still best
22 treated in surgery, but you can see the vast majority
23 are now migrated to that.

24 So the complexity of what we do now and

1 the need for surgical backup if there was a problem,
2 one of these patients is -- is necessary to make sure
3 we provide the best outcomes for these patients. Just
4 one more slide too. So this is looking at one of our
5 facilities, affiliated facilities at Central DuPage
6 Hospital. They are more recent to this world of TAVR.
7 We started with the early studies back over 15 years
8 ago, at Northwestern downtown. But what you can see
9 here is they gone from 88 percent open heart surgery,
10 to replace aortic valves to now 75 percent catheter
11 based catheter system. So this is only one example,
12 Dr. Cohen is going to speak about coronary disease, but
13 there's a bunch of valve programs that we're doing now.
14 There's custom valves, heart -- heart failure
15 therapies, all of those have migrated to this kind of
16 hybrid area within the cardiac cath labs.

17 MR. COHEN: Thank you. Talk to you on, I think
18 that the sea change that urgent terms of what Dr. Ben
19 said was described is clearly demonstrated as well in
20 terms of early intervention. And if you could extend
21 it further into the electro physiology lab, we were
22 doing electrode rhythmic studies lifting a, a
23 significant improvement and lean towards non-surgical
24 therapies. We were very, very limited in those in

1 terms of complications with interventional techniques.
2 And this really started 5.8 percent -- 6 percent of
3 patients needed to be rushed to the operating room.

4 But as skills improve technology
5 improved, complication rates got lower and lower and
6 started to see in probably be, I don't know 15, 16
7 years was a move to start to intervention services at
8 hospitals that did not have surgical onsite data. But
9 that was probably the biggest improvement since 15
10 years ago, probably a lot of years ago, probably 20
11 years to two three, like published over the course of
12 the last 20 years, what's really committed to the
13 chronic Cath level is a strategy of doing certain
14 procedures in body caths that did not have surgical
15 backup.

16 And then transferring patients who had
17 much more complex diseases in the coronary arena to
18 hospital that did have such backup to provide a level
19 of safety that the patients required from complex
20 procedures. The initial guidelines in terms of bone
21 surgical backup were published in 2003, but then
22 updated in 2014 and they just were really attempted in
23 2024 we saw a lot of the change that have been. And
24 schematically the algorithm we have behind you on the

1 slide is really a decision making process to decide
2 what type of procedures should be done and what type of
3 facility by an operator with significant experience,
4 the one commonality of all of this that complex
5 procedures, whether they on onsite or you know, surgery
6 site or certain off sites with more experienced
7 cardiologists, well versed in techniques in early
8 intervention.

9 And so I think to summarize what in the
10 broader sense, I think the biggest change has been
11 modern catheters that's primarily before as a separate
12 silent to get patients to the surgery suites, to have
13 more complex surgical procedures done. And I think the
14 modern catheter is much more hybrid between surgeons
15 and cardiologists to complex procedures, both on the
16 valvular side and coronary side in cath labs. You
17 don't know if it's cardiologists in the operating
18 rooms, but having surgeons in the operating room right
19 now is -- most of it is elect.

20 I think if we understand where we are at
21 in terms of the benefit of the services offered right
22 now, I think it's a perfect time to re-look at
23 strategies and thoughts of how we allow cardiac cath
24 labs either to come online and places that had never

1 had cardiac cath labs, you know, before, as well as to
2 see how you extend the advanced cardiac cath lab offers
3 afterwards that do a lot of complex work but do not
4 have such back up to allow them to really move towards
5 broader approach in terms of providing the cloud
6 services that a local communities trust state.

7 MR. DAVIDSON: What we want to do is provide more
8 access to patients. I think that's going to evolve as
9 technologies have grown. I think out safety and, what
10 we do better. What we want to do also provide is
11 provide access patients to this type of care. I think
12 we're a bit limited in some degree. I want to add to
13 that, that has to have proper quality insurance to
14 implement this program. There are some work, for
15 example -- how many procedures need to be done on the
16 side and how much done on the Cath lab based side
17 option. To open and maintain program members
18 administrators. They want to be able to demonstrate
19 their outcomes.

20 I think if we're -- it's one thing to
21 allow it to occur, we have to be sure that proper
22 quality oversight is, is achieved and the proper volume
23 is achieved to maintain that quality. 'Cause there's
24 still been a hybrid between volume. And I and I, I

1 think that's where maybe some of the earlier rights
2 from, from CA and Sam not really didn't address that.
3 'Cause It was a very different world, which doing
4 fairly simple procedures back then, the technology was
5 not -- in complex procedures. I'll be happy to answer
6 questions on specific areas we can touch on that.

7 CHAIRWOMAN SAVAGE: Any questions from our board
8 members?

9 MR. KAATZ: I have a question. Do you -- for
10 TAVR's that are now performed in the cath lab, is a
11 surgeon always in the cath lab and you foresee that
12 practice to be continuing?

13 MR. DAVIDSON: That's a good question and it is
14 actually CMS who is the surgeon has to be present as
15 well as interventional cardiologists. That was one of
16 the initial improvements paths we have for that. The
17 answer to that is yes. There have been discussions of
18 whether that will continue. But nothing has changed in
19 this country as far as that guidance goes. There are
20 other Cath lab interventionists that

21 MR. KAATZ: Approximately how many of those TAVR
22 procedures migrate to a surgical solution? Unless --
23 other questions? If I may. Are there any established
24 the desired volumes for Some of these elective

1 procedures such as TAVR?

2 MR. DAVIDSON: TAVR is recognized by American
3 College cardiologist and the American Heart Association
4 about guidance? I didn't bring it with us today, make
5 this all the numbers. There's guidance regarding the
6 surgical volume that has to occur in the hospital in
7 order to start the TAVR program. And there's guidance
8 on what -- and it's also part of the probate you have
9 to send all of your data to the National Cardiologist
10 registry which includes your outcomes, that's the
11 benchmark that gets us to --

12 And so again, if we're thinking about this
13 here, it really has to be dialed in, not just how do
14 you develop one, but how do you ensure that the
15 embodiment is of adequate quality in one -- And that's
16 always something that's, you know, been concern of ours
17 is making sure that we could do year after year. We're
18 doing that. Maybe we have one year when one hospital,
19 doesn't have that number, but what is it doing to --

20 MR. KAATZ: And that's apart of the cardiology
21 database.

22 MR. DAVIDSON: Yeah, it's actually the
23 cardiovascular data registry which is highly recognized
24 by cardiologists. It's also supported by the surgical

1 thoracic society combined within. So when it was put
2 together it was done very nice. The whole thing is to
3 the collaboration, this whole heart team occurred
4 around the time when cath labs -- and is now migrated
5 to the coronary world as well. We talked about
6 coronary we have a heart team meeting about transplant
7 versus -- this heart team concept got it operating.

8 MR. COHEN: I'm sorry, just to add on then. I
9 think the message worked from that heart team approach.
10 Now I want to see how that approach applies very much
11 to whether patient surgery, bypass surgery or someone
12 gets multiple stints implanted, a discussion amongst
13 surgeons and cardiologists that the part of the
14 function. So traditionally we would send the patients
15 to non -- surgical basis to see if that can be
16 accomplished successfully. The problem is that in some
17 hospitals who have surgical coverage, we have to
18 transfer the patient from a hospital without surgical
19 coverage, to achieve the procedure being done.
20 Oftentimes the same operators are moving from hospital.
21 So if we really want to make those kind of procedures
22 more available to patients we need coverage that
23 privileged areas sort of best ability to travel. We
24 have to then have the same budget terms of guidelines,

1 software guidelines, digital oversight, quality matrix,
2 we need to allow some of those hospitals the ability to
3 then provide Cath lab procedures. Which then segues
4 into surgical probably not part of discussion, but has
5 continue of really provide applied care.

6 CHAIRWOMAN SAVAGE: Okay. Any other questions?

7 (No verbal response.)

8 CHAIRWOMAN SAVAGE: All Right. Hearing none.
9 Thank you so much, doctors.

10 MR. DAVIDSON: Feel free to follow up with
11 questions. Thank you.

12 MR. JONES: Our next group is Advocate Aurora
13 Healthcare.

14 CHAIRWOMAN SAVAGE: Good morning. Please state
15 and spell your name and then you can get started.

16 MR. JAFFE: Good morning. Dennis Jaffe,
17 D-E-N-N-I-S, last name J-A-F-F-E.

18 MR. RAJU: Mahesh Raju, last name R-A-J-U first
19 M-A-H-E-S-H. Good morning. We appreciate the
20 opportunity to continue this discussion started by our,
21 colleagues at Northwestern Medicine. I'm the
22 cardiologist and I serve as the vice president of the
23 cardiovascular service line at Aurora Health. It's
24 nice to be here. We appreciate the opportunity to

1 participate in this morning's discussion regarding
2 updating of the state rules regarding -- As the largest
3 cardiovascular service line in the upper Midwest,
4 spanning 27 hospitals from South Chicago to.
5 Green Bay.

6 We are actively involved in the national
7 conversation regarding how best serve our patients with
8 a broad range of cardiovascular disorders. Technology,
9 and innovation have been moving quickly as the threat
10 to procedures that will continuing to expand from
11 becoming less invasive and less risky. This is good
12 for our patients, but has forced the cardiovascular
13 community to reevaluate the traditional model and all
14 of these procedures of high cost of beefing up
15 settings.

16 The cardiac cath laboratory was
17 traditionally housed in our -- hospital. We focused
18 primarily on diagnoses, treat Coronary heart diseases
19 at I previously mentioned. In today's department,
20 capitalization, however, we're also now repairing and
21 replacing heart valves. Repairing a non-intensive
22 recipe again means planting the internal finish
23 occlusion devices to prevent strokes closing atrial
24 defect and much more all without making an incision.

1 This rapidly increase in volume procedures has created
2 the need for additional cardiac catheterization
3 laboratories. While being mindful of mitigating the
4 potential rise of healthcare costs.

5 The expansion of the ambulatory surgery
6 center capacity to observe the lower -- and to absorb
7 the lower key lower risk cardiovascular procedures
8 makes good sense. As it will not only make this care
9 more affordable, but in improve patient satisfaction to
10 enhance convenience personalized care. This will need
11 to occur at the same time we maintain our current
12 patient -- ion estimate. So how do we ensure that
13 these facilities will adhere to the same standards as
14 has been applied to any patient catheterization by and
15 tertiary hospitals.

16 While the ASC still P-C-R registry will
17 remain the standard bringing patient cath lab quality,
18 as will be <unintelligible> accreditation process. We
19 expect the new ASC registry to become an excellent tool
20 for the peer review process for ASCs and we'll
21 facilitate the trial with quality and confidence; this
22 discussion will be available in early 2024.

23 Participation is not mandatory. I want to -- CMS for
24 other third party payers. So highlights participating

1 in those -- is as follows.

2 Each of these registries, both for
3 inpatient care and ASCs are very game driven.
4 Facilitate the assurance that patients are receiving
5 the right care at the right time, that is the right
6 sentence. It'll also allow each facility to benchmark
7 their care and patient outcomes against similar
8 facilities and against national standards. And these
9 national standards in benchmarks will be updated
10 quarterly. Each facility will be listed on the ASC
11 patient websites currently the patients with care to
12 watch will have the opportunity to use the find your
13 heart phone tool for information on cardiovascular
14 services.

15 And lastly, each facility will have
16 access to ASC quality improvement for institution tool
17 kits and the resources to help them measure the care
18 and follow approval roles. And now for additional
19 comments I'm going to turn it over to my colleague.

20 MR. JAFFE: Hi, so I'm the director of
21 interventional cardiology, medical director of
22 cardiology and advocate of Good Samaritan Hospital.
23 I've been director for nine to 10 years in
24 interventional structural endovascular procedures.

1 Point has to look at the state boards for definition of
2 cardiac catheterization procedures. It is indeed very
3 broad now taken.

4 So the current definition for cardiac
5 catheter establishment does not take many recent
6 procedures as was described earlier. It mainly has to
7 paraphrase such procedures that this coronary Adrian
8 brighter cath myocardial biopsy, pleural neutropenia
9 fluid catheters somewhat with physiology procedures.

10 As you know, there are a lot more
11 procedures that are done than labs today. So the
12 current definition does not take any of those things in
13 account. We would recommend that the safety of the CMS
14 list of approved procedures as the definition moving
15 forward. Would be beneficial for the definitions to be
16 aligned between CMS and the state will ensure that the
17 definition remains relevant and for payment files to
18 remain aligned. This will allow the state's to add
19 appropriate updates as they occur.

20 By producing data to the states that
21 evaluate as each stage has developed. Besides society
22 and geographic interventions are solid. As also
23 mentioned, follow the CPT codes associated with
24 procedures in determining what can be marked as season

1 one in addition of peer review requirement, states will
2 provide a draft. We also updated the utilization
3 standards to provide that service is adhered to.

4 Specifically the case staff draft states
5 the target utilization should be 800 procedures
6 annually. Currently is 200, within two years after
7 initiation of the service. We understand that these
8 standards are maintained only in additional -- to
9 increase to 800 would be difficult for organizations
10 specifically though that a clinical provider practice
11 at more than one location, which is needed given their
12 expertise providing patients more access to care.
13 These standards are dependent on definition use.

14 Example, if they only include
15 cardiac catheterizations in a cath room for self
16 procedures that such as root implants provides rules
17 should provide more information to this and indicate
18 what our case procedures. This includes the more
19 inclusive definition and the procedure volume
20 requirement increased perhaps 400, but not closer to
21 800 annually by year two. One additional consideration
22 from looking at buying requirements in the state track,
23 is establish a new program. Current standard is no
24 additional kits to be started unless each facility in

1 the planning area offering service operates at 400
2 procedures annually.

3 This suggestion is increased as to
4 1,000 This is all been significant for enrolling
5 programs such as ambulatory site of care out of state.
6 On the trend that is national is going to do more of
7 patient collective Cath lab procedures. So I think
8 it's, it's our role to try to make these rules be
9 aligned with CMS to make this more fluid moving
10 forward, and with that we will take questions.

11 MR. KAATZ: The question in my mind is, is it has
12 changed months. I actually filed a first I state about
13 a wife for <inaudible> about 400 years ago, and
14 questions that I got asked back then were actually
15 really, really interesting. But my questions based on
16 a really recent event in my family's history. My Uncle
17 up in Green Bay just had an ablation done and the
18 catheter went where it wasn't supposed to and had to
19 have this emergency surgery. Had his chest graft and,
20 and fortunately he survived, but it was touch and go.

21 As we expand access and -- and I
22 mean, how do we keep people safe? I realize since the
23 time these things happening, hopefully very, very rare.
24 But I mean that's -- that's -- that's my question. How

1 do we -- we do need to modernize, we do need to reflect
2 the -- the gains in -- in this -- this discipline
3 because remarkable. But how, you know, how do we give
4 people safety?

5 MR. JAFFE: Well, I think we can never eliminate
6 all risk of adverse from any sort of procedure, but I
7 do think we have good data to -- to base decisions make
8 <inaudible> treatment that case. As I mentioned
9 earlier, the risk is going to go down another basic
10 technique. So for example, there's a new technique
11 <unintelligible>. If it's as advertised, it should be
12 much safer for patients and we really anticipate moving
13 a lot of those procedures to the outpatient site I
14 mentioned.

15 So that's just a example. So I think
16 we're never going to want to maybe fall procedures to
17 maybe more an ambulatory settings. Patients are
18 looking for that because We should be better staffed in
19 some of these outpatient facilities. But I do think we
20 can be certain based on the data and certain procedures
21 was mentioned earlier there, there is certainly some
22 really good data to suggest which patients are able to
23 move to, to settings, which can both certain C one
24 requirements.

1 MR. RAJU: That document thing I said sky
2 guidelines, the state recommends I think lot of the
3 ones that the society cardiologist Society recommended
4 this case it was outpatient. Having a plan in place so
5 they're not just saying that we have planned with
6 something to be actually defined. That's what the
7 American Heart Society recommends.

8 MR. KAATZ: Thank you.

9 CHAIRWOMAN SAVAGE: Any other question? You had
10 talked about aneurysms. So what kind of aneurysms do
11 you think can be done at A-S-C?

12 MR. JAFFE: Not very many. I think those are,
13 that, that's an example of a -- of a complex procedure
14 that is not very increasing frequency. Well, but
15 that's the type of procedure that's recently taken
16 without the <inaudible> capacity. So I really don't
17 the data <unintelligible>. I'd love to hear about
18 that. Other questions?

19 (No verbal response.)

20 CHAIRWOMAN SAVAGE: All right. Well thank you so
21 much doctors and have a great day. And we'll move on
22 to our next group, Don.

23 MR. JONES: Our Next group is Seven Illinois
24 Healthcare. They are participating remotely, I

1 believe.

2 MR. AL-DALLOW: Good morning. Thank you very
3 much for the opportunity. We appreciate the chance to
4 participate and give feedback and I'll update to the
5 board. My name is Raed Al-Dallow, I'm an
6 interventional cardiologist at Prairie Cardiovascular
7 here at Memorial Hospital of Carbondale. My colleague
8 Mr. Mirza, Kathy Blythe(ph) and Garret Burton(ph) are
9 on the Webex as well. We are located in region five
10 here as a tertiary care provider for the southern part
11 of the state.

12 We are a hub for a large STEMI
13 program and a vascular care network. And we are also
14 the trauma center south of Springfield, Illinois.
15 We -- we are one of four facilities that provide
16 catheterization laboratories. And over time, we became
17 the first one the -- the only one with open heart
18 surgery on site. Since the other programs have ceased
19 to provide such services. Other presenters have
20 already alluded to the evolution of cardiac
21 catheterization laboratories.

22 Over the past couple of decades,
23 the -- and for a variety of reasons, the level of
24 complexity in the cardiac cath lab has increased

1 dramatically because of structural heart procedures, as
2 well as the fact that advancement in medical therapy
3 has led to focus the treatment of similar levels of
4 disease into the medical therapy arena. And therefore,
5 the complexity in the -- in the cardiac cath lab become
6 more and more therapeutic place rather than a
7 diagnostic place. And also it has become more complex
8 therapies rather than the simpler ones.

9 This basically with regards to the
10 definition of the cardiac catheterization category of
11 service, this makes it a -- a rather perfect time to
12 revisit the previous definition. We do believe that
13 there is a need to update and clarify the definitions
14 for the overall category of service. There also needs
15 to be further definitions about the electrophysiology
16 versus interventional procedures. There's also quite a
17 bit of overlap between the cardiovascular procedures
18 and the endovascular procedures that are being
19 performed more and more commonly in the cardiac
20 catheterization laboratories.

21 So we do believe that a new definition
22 should reflect that evolution that has occurred in the
23 cardiac cath labs over the past couple of decades.
24 Also, for the same reason, and because of the level of

1 complexity, having a rigorous attempt to maintain
2 quality and safety of those procedures is also very
3 reasonable and timely. It -- it is certainly
4 reasonable that a standard peer review process should
5 be implemented. We do feel that the national the NCDR
6 registry is the gold standard for -- for cardiac
7 procedures. We do support that some form of a peer
8 review and NCDR participation should be required.

9 It is to be noted however, that there is
10 a certain cost that is non-trivial that comes with this
11 participation. Not only the cost of subscription, if
12 you would, but also there is FTE cost associated with
13 data extraction. So a mindful selection of what level
14 of involvement in the NCDR database and how extensive
15 the data should be. Some data are needed to maintain
16 quality and safety, and others are probably more geared
17 towards research processes. And in rural areas, the
18 FTE support for the full blown database may need to be
19 looked at in terms of how do we maintain the principle
20 of quality without adding too much cost to the program.

21 Also, regarding utilization
22 standards there is indeed a link between quality and
23 volumes. And therefore we -- we do have a concern that
24 therapeutic procedural quality is directly indeed

1 related to procedural volume, which I assume also is
2 your concern in the setting of physician standards. We
3 agree that should be -- there should be a minimum
4 requirement of about 400 procedures, their lab, and,
5 and that there should be a, probably some sort of a
6 facility minimum at about 800 to a thousand procedures.

7 These minimum utilization standards will
8 establish some sort of guidance in terms of what would
9 be appropriate volume to maintain quality in a lab per
10 lab volume or per facility. And finally regarding the
11 expansion and modernization of, of, of a
12 catheterization laboratory. We certainly feel that for
13 modernization and expansion of existing cardiac
14 catheterization facility the approval should probably
15 be required in association with a certain threshold of
16 a capital expenditure.

17 This could be a new requirement. The
18 idea is to maintain ability to modernize a cath lab or
19 allow some sort of level of recruitment replacement and
20 upgrades without necessarily requiring a CON. A lot of
21 the associated imaging that comes with a
22 catheterization laboratory, a lot of the supportive
23 services and ultrasound access, which has been
24 highlighted in the latest guidelines are actually

1 necessary in caths labs. But whether or not a CON is
2 required to upgrade a caths lab to those level is, is
3 something should be looked at.

4 Thank you for your time and my colleagues
5 and I will be pleased to take any questions.

6 CHAIRWOMAN SAVAGE: Do we have any questions for
7 these doctors?

8 (No verbal response.)

9 CHAIRWOMAN SAVAGE: Okay. Thank you so much,
10 doctors. Don, our next group.

11 MR. JONES: Our next group is Rush University
12 Medical Center.

13 CHAIRWOMAN SAVAGE: Good morning. You could
14 state your name and spell your name for the court
15 reporter. Sure. My name is Faisal Hasan, F-A-I-S-A-L;
16 last name is H-A-S-A-N.

17 CHAIRWOMAN SAVAGE: Go ahead.

18 MR. HASAN: I'm representing Rush. It's a
19 pleasure to be here. I'm an interventional
20 cardiologist by bay and the chief of cardiology at Rush
21 University. I am delighted to be here. It's a
22 pleasure to be invited this forum. Couple of
23 observations. It's -- it's really a pleasure to see
24 approved first physicians from various facilities in

1 Illinois. Saying the same thing I think that we -- we
2 compete with each other and yet when we can get
3 together these forum, we can really bring together.

4 Catheterization as it's been very
5 elegantly said before, has evolved since 1977 when the
6 first percutaneous and now has evolved into structural
7 peripheral and very complex arenas. But we are also
8 seeing a migration of overall healthcare labs also, but
9 also specific to the cardiac catheterization lab out of
10 major hospitals and into ambulatory settings. And I
11 think we are part of this transformational stage and
12 how we play in this arena right now will dictate how we
13 get set rules moving forward.

14 The goal should be to provide excellent
15 healthcare with the utmost safety. I think that was a
16 very good point that was brought up. The most people I
17 know with in the most cost effective way. And so the
18 question that last by my esteem colleague here is it's
19 very well taken. And how do we get around that?
20 Well, there's a couple of -- a couple ways. Phase
21 number one is appropriate patient selection is going to
22 be absolutely key in doing this procedures and an
23 ambulatory setting.

24 The second is that, you know, if you have

1 a patient in a cath lab or a procedure area or in PT
2 lab, admitted into the hospital, and you have to
3 activate a surgical team, it is not an instantaneous
4 activation. That activation itself can take up to two
5 to three hours, even if the patient is at a facility
6 where you have onsite surgical backup. And so that has
7 to be taken into consideration. If you've got
8 appropriate pathways where a patient can, can get
9 transferred from a site without onsite surgical backup
10 to a surgical site in a timely fashion, and those
11 appropriate pathways are well delineated, then
12 potentially these complications can be mitigated and --
13 and -- and handled appropriately appropriately.

14 The overall complication rate is --
15 is substantially lower than 1 percent in the range of
16 0.1 or 0.4 percent for these procedures, which would
17 involve potentially having surgical backup; and the
18 data is very clear about that. I would also like to
19 address that we are discussing here two interrelated,
20 but somewhat distinct points, and we should be very
21 clear about that. The first point very eloquently
22 brought, brought forward by colleagues from
23 Northwestern is procedural expertise or procedures in
24 the cath lab without on onsite surgical backup. That

1 that's one concept. And then as we evolve through that
2 concept and we get into the next stage, well, the next
3 stage is that we do these procedures in an ambulatory
4 Setting; in an ASC setting.

5 Where clearly there is no surgical
6 backup. And I think both of those are very feasible as
7 long as we keep the focus on quality, providing
8 appropriate care to our -- our communities, which Rush
9 very much stands for, we are part of our community.
10 And to do it in a cost effective way without
11 compromising on patient safety. If we keep those high
12 level principles in view, I think that we can create a
13 mechanism to provide care to our patients in their
14 respective abilities and do it in a -- in a very --
15 very -- very good way. Thank you. And I'm happy to
16 take questions.

17 CHAIRWOMAN SAVAGE: Are you in the agreement
18 about 400 procedures might be the amount of procedures
19 to do in an ASTC?

20 MR. HASAN: I think that's a -- that's a great
21 question. I think there's a lot of consideration
22 there, I don't think it should be a very
23 straightforward number for an ASC to just have 400
24 procedures cutoff. I think that you really have to get

1 into the details of how many operators are there what
2 is the experience of the operators? Have they been in
3 practice for several years, which makes a big
4 difference.

5 Or is it a person fresh out of
6 fellowship and coming into doing procedures? What is
7 their cumulative experience over multiple years versus
8 their most recent past one to two years of -- of
9 experience? What we do know is that in a city like
10 Chicago, operators are oftentimes operating in very low
11 volumes. Particularly in the community. And we need
12 to support these operators. It shouldn't be
13 exclusionary. However, it should not be at the cost of
14 compromising patient safety or patient care.

15 So I don't think that I can give you
16 the number right now, but I think if we are thoughtful
17 about it, and if all these themes that, that are here
18 put our minds to it, we can clearly come up with a
19 consensus statement. And as has been mentioned
20 earlier, the side documents, so the society of coronary
21 geography and, and intervention has come up with
22 consistent statements. The first one for ambulatory
23 care centers was in 2020, right after CMS gave me
24 approval in January, 2020.

1 In May was a -- a document which was
2 put forward, which is a -- a fantastic guideline as to
3 what procedures can be done in ASC and still very much
4 by the time contemporary now not -- not out of fact
5 even though it's about three years old. The second
6 document that was put forward by actually a combined
7 group of side American College of Cardiology and the
8 American Heart Association was updated this year. And
9 that brings forward what sort of procedures can be done
10 without surgical backup. And I think we're pushing the
11 envelope on both of these trials.

12 However, there are certain principles
13 that still apply and there are certain patient they
14 just can be divided into patient characteristics and
15 anatomic characteristics. And if we take these in
16 combination, we can say that these are the types of
17 patients which potentially should not be treated in an
18 ambulatory setting and -- and more appropriately
19 treated in -- in an in traditional hospital setting.

20 We have evolved now from mostly femoral
21 access for GA catheterization procedures to regular
22 radioactive, which is an artery in the wrist. And same
23 day discharge for patients now across the country
24 rather than close to a third of the patients. This is

1 still this stale data, but about a third of the
2 patients get discharged same day after a procedure in
3 the hospital. So very feasible that these -- these
4 procedures can be done at the lower cost, potentially
5 at the ambulatory care center with, with the utmost
6 safety. But I think that what we should not compromise
7 upon is a standard of quality and guidelines that --
8 that support what kind of procedures.

9 CHAIRWOMAN SAVAGE: Thank you. Okay. Other
10 questions?

11 MS. HENDRICKSON: So you mentioned patient
12 characteristics and setting aside quality and safety
13 measures, is there a rationale as to ensure that the
14 type of care that's seen at ambulatory also covers
15 individuals that are underinsured or uninsured to take
16 advantage of a low risk and potentially a quicker
17 healing process, so to speak.

18 MR. HASAN: At lower cost? Absolutely. Yeah.
19 You know, at Rush, we struggle with dispartment issues
20 all the time. I think my colleagues at Northwestern
21 have it somewhat easier as far as the despairing. But
22 I -- I think that when we think about these questions,
23 we really have to be mindful that we provide this care
24 to, to all of our populations. I don't think that we

1 should start thinking about exclusionary
2 characteristics as far as pyramids or insurance and
3 things like that. I think in fact, if we do it right,
4 we can potentially provide better care to a much larger
5 population compared to what we are we are doing right
6 now in, in a very -- way.

7 So I think that, I don't have the exact
8 answer to what you're -- what you're asking, but if we
9 do this right, this is a wonderful opportunity to set
10 some of our -- some of the precedent, which I would
11 agree with. I think we can be, make a better -- better
12 thing for our communities.

13 MS. HENDRICKSON: So maybe a follow up would be,
14 we've talked about volume, we've talked about quality
15 measurements and even registering of services that is
16 measurable. Is there value then for coordinating payer
17 mix as the sites?

18 MR. HASAN: As a data point, absolutely. I think
19 it would be -- it would be good to know what -- what
20 kind of patients we are serving. And I think that the
21 city of Chicago is unique because it is if you go by
22 the -- the zip codes, it very much dictates
23 socioeconomic status. But there are a lot of studies
24 that actually have backed that up. The Capricorn

1 database actually has utilized that, and one of our
2 researchers showed that just zip code dictates outcomes
3 in certain patient populations.

4 I think that data will be of tremendous
5 value as we evolve along this path and as we provide
6 care to more patient reports set.

7 MR. FOX: Dr. Hasan, I think you, you mentioned
8 that there are a number of programs in Chicago that are
9 not operating in a minimum of 400 procedures. Can you
10 say a little bit more about that? How many places are
11 there operating in a much lower volume level, and why
12 is that?

13 MR. HASAN: So I don't have the data for what
14 percentage are, are below. I'm sure that that's
15 attainable. The city of Chicago is very unique in --
16 in that, in a very small radius. There are, by last
17 count, about maybe three cardiac cath labs. This is
18 probably more unique than New York City and Los
19 Angeles, which are the two largest cities in the
20 country; and Chicago is number three. Nowhere else,
21 including Boston, do we have such a concentration of
22 cath labs in such small area. So I think just by the
23 nature of the fact that you've got a tremendous amount
24 of cath labs that don't necessarily talk to each other

1 all the time it's a very divided community.

2 Each healthcare system has patient
3 population that wants to hang on to that. I think that
4 is probably the reason why we have relatively low
5 volume operators and relatively low volume cath labs in
6 the city of Chicago. Whether that's a good thing or
7 bad, I think we really don't have data to support that,
8 although generally speaking, it is clear that higher
9 volume proceduralists and higher volume cath labs
10 generally better and their outcomes are, are better
11 than, than with out.

12 MR. KAATZ: I -- I love the presentations today,
13 and I like that the three -- three legged stool patient
14 safety colleague brought up, measured outcomes, and
15 cost. This committee, obviously our charter, this
16 board is responsible for the costs in many ways. And
17 it excites me, but I -- I'm, I'm struggling with what
18 power structures, and I'm trying to think of what --
19 what exists in Illinois now. I think one of -- one
20 other person talked about making this world class.

21 Can we do something advanced, or try to
22 achieve. And in Illinois, as in a couple other states,
23 we have a prenatal unit, right, which has level threes,
24 level twos, level ones, level three standard

1 responsibility for education. We have a comparable
2 issue with Murphy Centers leaving the hospital. And
3 we're struggling with what -- what should the rules be
4 around that. What should the credentials be and what
5 is the quality measurement to be considered.

6 We also have trauma surgery, trauma
7 surgeon, another network, trauma surgeons that requires
8 getting into -- Do you think it's feasible, my first
9 question, Dr. Hasan do you think it's feasible to, we
10 could ever see a cardiac network like we see in those
11 two areas?

12 MR. HASAN: It would be a dream come true. I
13 think that we have on multiple levels demonstrated that
14 when we have brought together and -- and sessions such
15 as this and we put our differences aside, which are
16 almost nonsensical, they are within healthcare, we are
17 all in the same boat, we are all here to take care of
18 patients. We all want best outcomes for our patients.
19 Why would we not be able to come together? I think
20 it's -- it's unfathomable that as physicians we can't
21 come together and -- and create something which is
22 really for our plan.

23 I experienced recently at the American
24 College of Cardiology, Illinois chapter, they

1 specifically invited the chiefs from all the major
2 centers, predominantly academic medical centers, but
3 all major centers across Chicago and a few beyond
4 Chicago. And it was one of the most wonderful sessions
5 that feedback was tremendous because we also sat on the
6 same stage and we were talking to each other and we
7 quote unquote compete with each other, which again
8 makes no sense whatsoever. But if we brought --
9 brought our collective brain power and our collective
10 know-how, and our collective experience to the same
11 table, we would be a force that to recognize.

12 And I don't think that other states
13 have done it in fact. And that is where opportunity
14 lies is to truly collaborate and, and be one unit as
15 far as the dimensional gap community for, for Illinois
16 for that matter. And it can be lead by top leaders in
17 from some of the best centers in the world in Chicago.
18 And and we can create something that is really special.
19 And Europe has done that on multiple levels. They --
20 they don't compete with each other. They combine their
21 sources. Sweden is a very big example, the Netherlands
22 for example. And those are countries, bigger, big
23 countries that have done that. We can certainly

24 MR. BURNETT: Do they have better outcomes than

1 we have.

2 MR. HASAN: They have better monitoring of, of
3 outcomes for sure. And a lot of the data that we have
4 in cardiology actually comes from some of the pivotal
5 studies have taken place.

6 MR. BURNETT: Thank you.

7 CHAIRWOMAN SAVAGE: Other questions.

8 (No verbal response.)

9 CHAIRWOMAN SAVAGE: Hearing done. Thank you so
10 much, doctor.

11 MR. JONES: Our last group is representatives
12 from Corazon Incorporated; they are a cardiac
13 consulting firm here in the United States.

14 CHAIRWOMAN SAVAGE: If you could introduce
15 yourselves and spell your name for the court reporter.

16 MR. SWANSON: Sure. I'm Ross Swanson, R-O-S-S
17 S-W-A-N-S-O-N, Chief Operating Officer for Corazon.

18 MS. WESLEY: And I'm Carol Wesley, C-A-R-O-L
19 W-E-S-L-E-Y, Vice President with Corazon.

20 MR. SWANSON: And we're also very happy to be
21 here today and really appreciate the presentations we
22 heard before, for us really would not want to see
23 anything that was said by the esteem Physicians that
24 went for us. Our goal here today is really just to

1 talk to you about what we see as a national
2 organization. And so we're not really advocating
3 anything. We're, we're here just to basically tell you
4 our experience and share the landscape will.

5 So we did put together a presentation,
6 I know that there's copies in front of the board and I
7 know that it was also produced online for other members
8 to see. For those of you that may need a quick
9 reintroduction, our report is on -- is one of the
10 preeminent national consultancies for cardiovascular
11 service line development. And we've actually assisted
12 with CON regulations in over 20 states. So we're --
13 we're very comfortable talking about cardiovascular
14 regulations at that level.

15 If you actually go to slide three, I think
16 this speaks to a lot of what you've heard with the
17 physicians earlier. There is this rapid timeline of
18 adoption that's occurring, Carol and I are going to be
19 focused today on cardiac cath in coronary intervention.
20 I know EP procedures and other things were mentioned by
21 the prior speakers, but their current regulations
22 really call that out. We're seeing a lot of movement
23 in that area as well, and I know that I've addressed
24 this group before with testimony just at the last

1 meeting. But what I wanted to call out on
2 that slide was that there's such rapid movement as
3 we've seen, and you've heard the prior speakers talk
4 about. Angioplasty with surgery offsite and the
5 movement that has created and really created a, a
6 wonderful barometer to look at as we're opening access
7 to care for these patients. And now you all have been
8 at the forefront for approving procedures to do
9 coronary procedures in the ambulatory surgery treatment
10 setting.

11 So with the safety profile and the
12 technologies that exist with these procedures that the
13 prior procedures -- that the prior speakers talked
14 about, you're certainly going to see rapid movement
15 with that; we just outlined some of that in this slide.
16 I'd really like to stop just for a bit on slide four,
17 which actually is a map with the United States that
18 shows the current state of affairs with angioplasty
19 without surgery on site. And if you went back only
20 eight or nine years, I would call it more of a
21 patchwork quilt.

22 You can see that we only have a few
23 colors on that map now, and Illinois being one of those
24 states that is fairly unregulated when it comes to

1 acute care facilities providing PCI without -- heart
2 surgery. And this map continues to change, recently
3 Maine was a state that was fairly restricted. The only
4 state in the United States that's left that is truly
5 completely prohibitory to our knowledge is Vermont,
6 when it comes to allowing PCI without surgery onsite or
7 not allowing I should say. And your neighbors in Iowa
8 have a little bit of a sticky situation going on there.

9 Because they actually do have in their
10 regulations, they don't allow it. But there's centers
11 that have started that are actually suing the state.
12 They're actually providing the service already, but
13 they're suing to change those regulations. And -- and
14 at any time, we know the format's a little long if you
15 have a question for us please don't hesitate to stop
16 us. The next slide, slide five here really talks about
17 cardiac ASC regulations by state. And you can see that
18 Illinois, this is a band of states with Kentucky, West
19 Virginia, Virginia that has restrictions, but there's
20 approvals that are allowed to take place.

21 And you can see that those states in
22 green are fairly unregulated. There's some states in
23 the southwest where there's really virtually no
24 regulations when it comes to providing those services

1 in an off-site or a non-hospital or acute care setting.
2 There's two states you're going to hear a lot about
3 today, in our talk with just a really hot off the press
4 in terms of recent regulatory change. My home state of
5 Pennsylvania where our company's mails from, as well as
6 Michigan have had some recent changes.

7 And I think we're going to continue to
8 see these progress along for some of these other states
9 in red. For instance, Pennsylvania passed a senate
10 bill earlier this year. That as long as the procedure
11 is on the CMS covered procedure list, it's allowed to
12 be done in advance. The only evaluation that the ASCs
13 go through is a facility departmental survey, if you
14 will, an occupancy survey. And if they need
15 architectural guidelines and requirements, the
16 providers just allow -- they're permitted to actually
17 perform cardiac caths and angioplasty in that facility.

18 Very controversial because it's
19 actually more restrictive for hospital facilities than
20 it is for the ASC, So that's causing a little bit of
21 uproar In our local market. Michigan has passed
22 legislation just this last year, they are a CON state
23 to also allow movement of these procedures to the ASC
24 setting. They have some pretty prohibitive guidelines

1 in terms of volumes as well as quality and
2 accreditation mandates that we're going to talk about
3 later. There was a wonderful question to that
4 gentleman right there Mr. Kaatz about developing
5 something similar to a trauma or the prenatal network.

6 Michigan just passed a law last month,
7 that's a semi rule for heart attack patients that
8 basically sets up that standard of care for STEMI PCI
9 programs and it's going to follow the same quadrants
10 that the trauma programs do, hospitals are going to be
11 designated as their referral or a receiving center.
12 Missouri has legislation -- works would be similar to
13 that. So we really provided this for your records and
14 to let you know that Illinois is not alone. You're not
15 renegades, you're certainly not cowboys, like we say
16 with our folks in the Texas markets.

17 So with that, I'm going to turn it over
18 to Carol who is going to talk a little bit about some
19 of the guidelines that I eluded to earlier.

20 MS. WESLEY: Yes. So if you move on to slide
21 number six sky the society for cardiac intervention
22 that was referenced several times by the other
23 physicians. They have documented their cath line best
24 practices. This focuses on their current consensus,

1 it's very patient focused. It's very evidence-based in
2 terms of the approach to care. And as Dr. Hasan, he
3 was bringing to us to mention, it's really about
4 optimizing quality and outcomes more so than
5 designating particular volume that needs to be done.

6 And that's done through the best
7 practices through registries and through the usage of,
8 you know, the vascular access sites. If you move on to
9 slide number seven, this is really just the highlights
10 of what that sky document from 2023 here the consensus
11 document outlined. So it talks about those levels of
12 service, level one and level two; level two being
13 non-surgery on site that's more defined by level one
14 and two by a volume differentiation. So level one,
15 less than 200, level two greater than 200.

16 And we're talking PCIs here, not
17 necessarily authorization. So I know we provided you
18 with a definition list in terms of the differences
19 between diagnostic catheterizations and then the
20 interventional procedure of PCIs. And they talk about
21 you know, staffing physician requirements, which we're
22 going to get into a little bit more later on. And to
23 inclusion criteria and quality monitoring as well.

24 MR. SWANSON: The one comment I want to make on

1 volume related to that slide is that the document does
2 state that quality can certainly exist in programs that
3 do less than 200. There's just additional scrutiny
4 metrics in place at times. I think two good examples
5 would be New York and New Jersey. They both have a
6 volume threshold within their requirements. Programs
7 are not prohibited or told that they're going to be
8 shut down or go on probation if they fall below those
9 guidelines.

10 They just have to provide additional
11 quality parameters back to the state; they just undergo
12 additional scrutiny.

13 MS. WESLEY: Pennsylvania has that same
14 requirements.

15 MR. SWANSON: Yeah, and they use 200 angioplasty
16 like Pennsylvania's threshold as well. Like I said,
17 we're not advocating these numbers, we're just telling
18 you what's in the reds and, and what we see. On the
19 next slide, slide eight, I wanted to address this
20 because when I was here with the Springfield Clinic
21 pulses for their ASTC, and I was providing testimony on
22 their behalf. There were a lot of questions that came
23 up around appropriateness and safety of the procedures.
24 And I want to stick with appropriateness for just a

1 brief second.

2 So one of the things that came up a bit
3 when we were talking, was about appropriate patients
4 and criteria in ensuring that there wasn't over
5 utilization at particular labs that may have been
6 deemed "inappropriate". And so I just wanted to bring
7 this forward to the group, very briefly here. One of
8 the things that Dr. Tanksley asked me a question about
9 the ischemia trial, which we're going to talk about in
10 next slide. And I went on a little bit of a diatribe
11 about making sure that we're monitoring what you'll
12 hear in the cardiology world as the appropriate use
13 criteria.

14 I know you're hearing that in other
15 clinical specialties as well. This is significant
16 scrutiny in the cardiology community right now, that
17 ACCNCr database that you heard about from all the prior
18 presenters, added appropriate use criteria measures to
19 make sure that the right patients were being selected
20 at the right time. And we weren't inappropriately
21 sending these folks and promoting over utilization.
22 Has been something that has been now been reported in
23 that registry and is under a lot of scrutiny, in states
24 where you have to submit your data, your NCDR to the

1 state body itself for review; that's actually one of
2 the first areas that comes under scrutiny.

3 In that ischemia trial that was brought
4 up in that case and that trial took place in 2020. It
5 was reported that coronary revascularization did not
6 lower cardiovascular event rates among patients with
7 stable ischemic heart disease. But, but there's a big
8 but, it did improve the disease specific health status
9 of patients if they had angina or chest pain, which of
10 course, the predominance of these patients, we're not
11 saying how they get to the facility, but as a
12 presenting symptom, one of the key factors in terms of
13 how those patients present.

14 So they can -- these -- the results of
15 that trial can only be applied to stable patients
16 without Angionox. And coronary revascularization
17 should be considered if they have recurrent symptoms of
18 <unintelligible> high optimal medical therapy. And
19 Carol and I are not physicians who can talk to the
20 folks and that spoke prior related to that. But I
21 would tell you that there is a lot of scrutiny around
22 that over utilization that you're concerned.

23 Now, we really wanted to get to these
24 next few slides that look a bit -- for lack of a

1 better word. And it really is going to talk about what
2 we've seen in your current regs and what we see in
3 other regs that they <unintelligible>.

4 MS. WESLEY: So the next couple slides, we're
5 going to specifically talk about what those
6 professional societal recommendations SKY, ACC, so
7 forth. What are the typical practices that -- that we
8 see across the nation when we go to different
9 facilities, and how do they compare with your current
10 CON requirements today. So you'll see on slide number
11 10, we address duplication of services and then
12 utilization in volumes.

13 So the -- the societal recommendations
14 and, and what we see really throughout when it comes to
15 duplication of services and, and utilization and
16 volumes is really all of that state CON. And I know
17 that's sort of circular talk because you are looking to
18 update your CON. And like you said, a lot of programs
19 are following societal recommendations in terms of the
20 PCI volume number of -- of 200 less than or greater
21 than, but caveating it with it, it has a the quality
22 control component to it.

23 So when you have like Dr. Hasan was
24 saying a facility within Chicago, that -- that you can,

1 you know, throw a penny and, and hit a cath lab, you
2 may not see 200, but does that mean they don't have a
3 quality program. So that -- that's the piece that we
4 want to engrain with this particular piece here. The
5 next slide, slide number 11. The society guidelines
6 breakdown physician requirements and staffing
7 requirements. So they talk about board certification
8 for the physicians in interventional cardiology that
9 are, are doing the procedure in the labs.

10 To ensure that those physicians are
11 quality, physicians have been trained appropriately and
12 so forth. They talk about the physicians performing a
13 minimum number, a lot of physicians will go to several
14 facilities to do procedures, not just be at one -- one
15 facility. So they talk about minimum volumes that
16 those physicians should -- should do over that time.
17 And even address in those training guidelines that if
18 they don't do that number of what can be done to ensure
19 that they're -- they're doing quality.

20 And they talk about being trained in
21 resuscitation and treatment of complications. So when
22 those things do occur on that rare occasion, less than
23 in 0.1 percent, that they know what to do, how to get
24 the patients to appropriate treatment. And then as far

1 as staffing --

2 MR. SWANSON: I just want to read this out of the
3 PA rules I had to pull it up on my phone. When it
4 comes to the physician requirement, the Pennsylvania
5 rules, which are fairly contemporary, talk about the
6 director of the cardio catheterization service shall be
7 board certified in cardiology or pediatric cardio
8 cardiology as appropriate. The medical staff, it talks
9 about the physicians in the lab shall be either board
10 certified on or have obtained pre-board certification
11 status in cardiovascular diseases in specialized
12 training and invasive procedures.

13 Again, we only mention that because
14 very generically now your current rule just talks about
15 specialized training in cardiology. There's no mention
16 of board eligibility requirement.

17 MS. WESLEY: And then staffing wise the societal
18 recommendations talk about minimum staffing
19 requirements. They're not telling cath labs how many
20 they have in there, but there's be minimum of three
21 staff. And they delineate by goals, not necessarily by
22 whether it's RN, a technologist, a -- a rad tech but by
23 roles. So including someone to administer the -- the
24 sedation and manage the airway, which is typically done

1 through your RN. Monitoring a recorder, a circulator
2 these types of roles to be within the cath lab.

3 And we do see that in typical staffing
4 within cath labs are three and four staff members
5 depending on, you know, the cath lab, where it's at,
6 what resources do they have and that type of thing.
7 And then they talk about appropriate training for that
8 staff as well. Professional guidelines say three to
9 five years of experience, but that's not to say that
10 you can't have somebody new come in who has the
11 appropriate training with a mentor or somebody until
12 they get experience. And your CON requirements right
13 now talk about the Rad Tech being highly skilled.

14 Talk about some of the nurse
15 training, but really has some older, not contemporary
16 players in there. Like a dark room, somebody who's
17 going to -- develops the film the dark room. The next
18 slide, slide number 12, we go into some of the imaging
19 requirements, equipment and supplies, and then the
20 rescue and support equipment. So these three, your
21 regulations don't really address specifics on these.
22 They address a minimum utilization standard per -- per
23 room or per year. But they don't really address
24 requirements in terms of -- of imaging being a high

1 quality imaging digital archive system.

2 Fixed imaging rather than mobile
3 is -- is typically recommended, as -- as far as
4 equipment and supplies, there are a lot of pieces of
5 equipment now that provide that safety and that
6 appropriate use piece. So FFR, which is fractional
7 flow reserve, and then IVUS, which is intravascular
8 ultrasound are two pieces of equipment that the
9 cardiologists now use to make sure that -- that
10 appropriate use criteria is being met. And that the
11 patient is getting the procedure done as safely as
12 possible.

13 So those are recommended as well as
14 monitoring the equipment and the appropriate inventory
15 supplies. And then as far as rescue equipment, it is
16 recommended that there is a room pump there in the lab.
17 If you are ASTC -- you would still have that room pump,
18 but that patient, of course would get transferred to
19 the hospital setting. As well as the type of general
20 resuscitation equipment and cupboard stents so that if
21 there is a catastrophic event that the physician would
22 deploy the covered stent and would be able to get to
23 the hospital <unintelligible>.

24 MR. SWANSON: So yes, they're very granular those

1 regulations are -- to get down to these level of detail
2 with this equipment. And we've actually supported that
3 as an organization. 'Cause as we've been seeing this
4 move to the ambulatory environment, can't skip. We
5 have to make sure that these treatments are available
6 regardless if it's in an office setting that now
7 converted to an ASTC and so forth. So we -- we've been
8 supportive of the level of granularity when it comes to
9 this type of equipment discussion being put into
10 regulation.

11 And then finally, if you go to slide
12 13 here, you'll see transfer of transport agreements --
13 and case selection. And there is a requirement in your
14 current -- I'm going to start from the right of the
15 slide versus left, right? You currently have a
16 requirement for transfer agreement, but one thing that
17 is lacking that we typically see in state regulations
18 is that it has to dictate an unconditional acceptance
19 of transfer of that patient by the receiving
20 organization. States like California, the receiving
21 organization has a chance to submit an affidavit to the
22 state saying that they're as a receiving center,
23 they're going to accept all newcomers from that other
24 organization.

1 From a facility standpoint, right
2 now your requirement in the CON talks about just
3 availability of these key services at a very generic
4 level. We do see a lot of recommendations refer to the
5 FGI guidelines that I alluded to when I talked about
6 Pennsylvania's regulations. So those will talk about
7 minimal square footage, requirements of the rooms,
8 isolation of control areas, and things of that nature.
9 And then finally very important, there's no current
10 requirement listed for case selection for patient types
11 that are going to be done within these specific
12 settings. And we have on here SKY societal
13 recommendations.

14 This is another one where I really
15 have to refer to my notes because I want to make sure I
16 get this right. I think Michigan did this very well,
17 Michigan's language states verbatim that, "the facility
18 will adhere to patient selection as outlined in the
19 sky, ACCAHA expert consensus document 2014 update with
20 PCI without surgical backup published in 2014", and I'm
21 going to say this part -- "and it's update for further
22 guideline changes". So they did themselves a real good
23 surface there because now they don't have to update
24 their guidelines every year. And they refer to the SKY

1 document, the Professional Society, and they don't have
2 to re-review it every time a medical professional
3 society comes out with a new recommendation.

4 So that -- that we think is key.
5 There's some other elements on the slide that I may not
6 have addressed that I think are kind of a
7 self-explanatory, like no requirement for EMS transport
8 protocols in your current guidelines, and those are
9 certainly addressed in formal recommendations. If you
10 move on to slide 14, for quality assurance and review.
11 The current Illinois regulation just talks about having
12 a detailed mechanism for adequate peer review. I
13 believe almost every provider that spoke before us
14 talked about participation in the PCC NCPR, so you can
15 see those comparisons with national benchmarks.

16 And you know, we also see items where the
17 quality program and elements of that are actually
18 called out in a lot of the CONs that we review, in
19 terms of internal and external peer review. Having
20 regular audit drills, et cetera, to make sure that
21 safety piece is done. The last piece we put on here
22 our accreditation was mentioned by one of the prior
23 speakers. There's a few states that actually mandate
24 cardiovascular accreditation within their guidelines.

1 And listed those here both Pennsylvania
2 and Michigan, as I mentioned earlier, Georgia requires
3 that for new startup programs. New Jersey does it for
4 programs that aren't meeting their threshold that I
5 talked about earlier. So they fall below that 200
6 marker that lab has to undergo and outside external
7 review of the organization. And then I'll end it with
8 one of the pieces that I thought was particularly
9 interesting was an exception request component of the
10 current CON that is an exception for alleviating
11 existing capacity. And in the current code, I have no
12 issue or -- or don't take any issue or concern with
13 being affiliated with existing programs. The referral
14 transfer agreements we talked about earlier, cost
15 effective of course is, is a key item.

16 The one area that had us -- the antenna
17 went up was existing programming and having more than
18 750 procedures annual per lab. And I know several of
19 the speakers spoke earlier, you know, in the past these
20 procedures were very homogenous in terms of what was
21 being provided. You have people up here talking about
22 structural work procedures like TAV or nitro equipment
23 and so forth. You can get into a real slippery slope
24 and Virginia is experiencing this right now, and

1 they're actually looking how to back out of this with
2 their state regs. When you actually look at procedure
3 requirements per room, most of the contemporary state
4 regulations that we see in New York did this with the
5 modernization of their legs -- regs, looks at the
6 number of procedures per program.

7 So it's per facility, what those are,
8 where the demands are being held. When you think about
9 the fact that these procedures in rooms are actually
10 taking longer in some cases, and you've heard that in
11 some of the prior testimony in the last meeting. That
12 is of significant concern for us, 'cause it can get
13 real dicey when they're looking at that at a non
14 service level. And so, we'll -- we'll end it with, and
15 certainly take questions; that, you know, for us it's
16 when we monitor regs, it's really about the balance of
17 patient provider preference, patient access, and
18 quality and outcomes.

19 CHAIRWOMAN SAVAGE: Thank you. Do any of our
20 members have questions for Mr. Swanson.

21 MR. BURNETT: I have kind of a question. I sort
22 of entered this discussion today in part focusing on
23 numbers, minimum volumes for example. And then also
24 the very important issue of on on-site surgery versus

1 backup surgery. But you've identified a number of
2 criteria in your national search, which are around
3 quality, which were around board certification, which
4 were around compliance with ongoing society standards.
5 And I think it really is a valuable contribution what
6 the CON -- Thank you.

7 CHAIRWOMAN SAVAGE: Other questions? Now, at
8 this time, I would like to invite all of our presenters
9 that presented on Cardiac Cath, if you have any final
10 comments, if you'd like to come up and say anything.

11 MR. SWANSON: We have that one extra comment for
12 Monica, we did not find in any CON anything related to
13 payer Mix directly mentioned. So, I think it was a
14 great question for sure --

15 MS. WESLEY: And, and not to say that you can't
16 be the -- the first state to put something in there.
17 But we don't see any -- of the, the regs or the
18 societal guidelines or anything in regards to that.

19 CHAIRWOMAN SAVAGE: Thank you. Are there other
20 presenters want to come up for any final comments?

21 (No verbal response.)

22 CHAIRWOMAN SAVAGE: All right. Well we thank you
23 so very much for all of your input and we will start
24 looking at this and I'm sure we'll get back with many

1 of you. So thank you again.

2 MR. SWANSON: Thank you very much.

3 CHAIRWOMAN SAVAGE: Okay. So now we're back to
4 Don Jones. Oh, one second. We'll take a five minute
5 break and then we'll be back with rules development on
6 our birth centers and such.

7 (Recess.)

8

9

10 CHAIRWOMAN SAVAGE: For the birthing center
11 update on the process and the rest on the agenda.

12 MR. JONES: Thank you Madam Chair. I just wanted
13 to let the board members know that last Friday on
14 December 1st the Illinois Secretary of State approved
15 your publication for the update to the birth center
16 rules that is now in the Illinois Register. Both part
17 1100 1110 changes that you approved at your October
18 meeting are now referenced here. I wanted to let the
19 board know that the public has 45 days to submit any
20 written comments regarding this proposal.

21 So that would expire on January 15th,
22 2024. Also wanted to let the board know that with the
23 publication in the register, the board and the staff
24 are now bound by ex parte communication provisions

1 under the Administrative Procedure Act. So essentially
2 that means that the board or the staff cannot discuss
3 with the public the substance of this proposal. So for
4 example, if someone in the audience approached you and
5 said, "when is the public comment period over?" You
6 could communicate that to them, but if they came to you
7 and said, "I don't like this proposal and here's the
8 reasons why", your discussion would have to be
9 memorialized and put into the record.

10 And then you would have to notify both
11 the governor's office and <unintelligible> that a ex
12 parte communication occurred, which I would like to
13 avoid if we could. Most likely at the January meeting,
14 any public comments that we receive, I will bring to
15 the board's attention because any comment that we do
16 receive, we have to respond to it. And I'd be happy to
17 answer any questions about that.

18 CHAIRWOMAN SAVAGE: That's pretty clear. Any
19 members have any questions about that?

20 (No verbal response.)

21

22 CHAIRWOMAN SAVAGE: All right. Also, on B there
23 was cardiac catheterization and ASTCs states.

24 MR. JONES: Yes. I was just want to let the

1 board members know that based on today's discussions
2 with these providers, it is unlikely that we will have
3 a draft of comprehensive rule changes ready by the
4 January meeting. There's -- there's items that were
5 presented today that I don't believe the board has
6 considered. And so we would need to look further into
7 that and revise our drafts and most likely that would
8 be something would provide you at the March meeting at
9 the earliest. But hopefully we would have a -- a
10 comprehensive draft to review at that time. And the
11 last item on that portion of the agenda, there is
12 something called a regulatory agenda. Oh, I'm sorry.
13 You have a question?

14 MR. KAATZ: I, I was going to say and, and I'm
15 sorry for going out of order, but I thought the idea to
16 bring in the, the leadership that you did today, the,
17 the following cardiology and thoracic physicians was an
18 excellent idea. And I think we should take as much
19 time, we should take as much time with -- you come up
20 with something that was said by one of the individuals
21 that could be a real example. Not organized by cardiac
22 services <unintelligible>. But I -- I think it was
23 great idea. I thought the presenters were excellent.
24 I learned a lot, I think everybody here did, and I hope

1 we -- we continue working with them as -- as we build
2 final numbers.

3 MR. JONES: And the last item on the agenda
4 regarding rules developments you have a handout,
5 something called the January, 2024 regulatory agenda.
6 This is a requirement by JCAR. What they like for each
7 agency and board commission to do, is to publish an
8 agenda in both January and July of each calendar year.
9 And that is merely to notify the public of possible
10 rulemaking that you might do in the first six months of
11 2024. So John and I and the rest of staff had put that
12 together for you to review. And if you're comfortable
13 with that, if you could approve it and then we would
14 submit that to JCAR to be published in the Illinois
15 Register in the upcoming publication.

16 CHAIRWOMAN SAVAGE: And do we also publish our
17 opposition -- report?

18 MR. JONES: So for public comment?

19 CHAIRWOMAN SAVAGE: No. What we say any JCAR,
20 like if we approve those regulatory, the regulatory
21 agenda, but you said it would be published somewhere.
22 Is that something that our opposition support goes with
23 that or --

24 MR. JONES: No. That that's merely published in

1 the register. It's just a notification to the public
2 and to the industry that you might engage in rule
3 making in this particular area. But we're not bound to
4 do that; it's just a -- a notification to the public
5 that this is something we are considering.

6 CHAIRWOMAN SAVAGE: And they can provide comment.

7 MR. JONES: For an agenda, they cannot.

8 CHAIRWOMAN SAVAGE: No. Any other questions
9 about anything Don has talked about?

10 (No verbal response.)

11 CHAIRWOMAN SAVAGE: Okay. Well thank you so much
12 Mr. Jones. Okay. So now may I have a motion to
13 approve the legislative agenda?

14 MR. BUDDE: So moved.

15 MS. HENDRICKSON: Second.

16 CHAIRWOMAN SAVAGE: Thank you. George, if you
17 can call the role.

18 MR. ROATE: Thank you Madam Chair. Mr. Budde.

19 MR. BUDDE: Yes.

20 MR. ROATE: Thank you. Mr. Burnett.

21 MR. BURNETT: Yes.

22 MR. ROATE: Thank you. Mr. Fox.

23 MR. FOX: Yes.

24 MR. ROATE: Thank you. Ms. Hendrickson.

1 MS. HENDRICKSON: Yes.

2 MR. ROATE: Thank you. Mr. Katz. I don't
3 believe he's on our WebEx. Mr. Kaatz?

4 MR. KAATZ: Yes.

5 MR. ROATE: Thank you. Ms. Legrand.

6 (No audible response.)

7 MR. ROATE: Ms. Legrand.

8 MS. LEGRAND: Yes.

9 MR. ROATE: Okay. Thank you. Dr. Tanksley?

10 (No verbal response.)

11 MR. ROATE: Dr. Tanksley is not with us.

12 CHAIRWOMAN SAVAGE: Dr. Tanksley, can you hear
13 us?

14 MR. ROATE: She's not on the WebEx, ma'am. Madam
15 Chair?

16 CHAIRWOMAN SAVAGE: Yes.

17 MR. ROATE: Okay. Seven votes in the
18 affirmative.

19 CHAIRWOMAN SAVAGE: That motion is approved.

20 MR. CONSTANTINO: I'd like to let the record show
21 that members David Katz and Dr. Tanksley have left the
22 meeting. We still have a quorum present in place.
23 Thank you.

24 CHAIRWOMAN SAVAGE: Thank you. There is no

1 public participation or comment.

2 So now we're going to move on to number
3 eight; items approved by the Chair. So, I have
4 approved the following 20 items on your agenda; please
5 let the record note these items as approved.

6 And now we are going to move on to
7 permit renewal requests.

8 A-01, NANI Sycamore Dialysis Sycamore,
9 Illinois. May I have a motion to approve the nine
10 month permit renewal of project 21-019. It is the
11 second permit renewal request for this project.

12 MR. KAATZ: So moved.

13 MR. BURNETT: Second.

14 CHAIRWOMAN SAVAGE: Okay. If you could please
15 identify yourselves and then you'll be sworn in.

16 MR. MORAVO: Good morning. Juan Moravo Junior;
17 That's J-U-A-N M-O-R-A-V-O Junior.

18 MR. BRENNAN: Good morning. Bill Brennan,
19 B-I-L-L B-R-E-N-N-A-N; Mark Silverman, that's Mark with
20 a "K" Silverman, S-I-L-V-E-R-M-A-N.

21 CHAIRWOMAN SAVAGE: Can you swear them in?
22 (Whereupon:

23 JOHN MORAVO

24 BILL BRENNAN

1 MARK SILVERMAN

2 Were called upon to tell the truth, and did so as
3 follows herein after being duly sworn.)

4 CHAIRWOMAN SAVAGE: George if you could please
5 proceed with the state board Staff report.

6 MR. ROATE: Thank you Madam Chair. On December
7 14th, 2021, the state board approved permit number of
8 21019. This is the second permit renewal request for
9 this project. They have the -- the permit holder is
10 asking for a nine month permit renewal. Thank you
11 Madam Chair.

12 CHAIRWOMAN SAVAGE: Thank you. Please proceed.

13 MR. MORAVO: Sure. Good morning members of the
14 board. We're very happy to be with you here today for
15 this permit renewal request for NANI Sycamore dialysis.
16 With me today is the permit holder representative Bill
17 Brennan, special projects manager for NANI and my
18 partner Mark Silverman. This project was approved by
19 the board in December of 2021, and there's been some
20 updates since we filed our request for this renewal.

21 First, you may recall that this project
22 was brought forth by name following the closure of a
23 facility in the geographic service area and NANI
24 physicians looking for a way to ensure access for their

1 patients. The permit holder identified a undeveloped
2 piece of land in Sycamore, Illinois. For those of you
3 who may not be familiar, that's near DeKalb, Northern
4 Illinois University. And this was raw land that was
5 already zoned for a business park. NANI answered into
6 an OI with the developer of the business park to
7 construct the shell for their facility and then
8 ultimately the goal of policing that space over the
9 long term.

10 Since our request was filed with this
11 board, the project's gone from being 25 percent
12 complete to 30 percent complete. And that's as a
13 result of the completion of the construction of the
14 shell being done. So I'm going to stop there and I'm
15 going to allow Bill Brennan for NANI to share more
16 Substantive update on the delays and status of the
17 project moving forward.

18 MR. BRENNAN: Thank you Board for Hearing our,
19 our delay construction is underway. We've contracts
20 have been lead. There's been a lot of delays that
21 occurred -- occurred outside of our -- our -- our
22 control. We're moving forward, it's just taking longer
23 than we anticipated. There Lot of things that have
24 been going on. There's a lot of development to the

1 south of us. I think that's impacted some of our
2 progress. But overall we're moving forward.

3 MR. SILVERMAN: Members of the board. The only
4 thing I'll add is we wanted to appear before you to let
5 you know the project just continues. We can address
6 any questions that you have that we can as expected and
7 required to vote.

8 MR. KAATZ: Can you finish it at nine months?

9 MR. SILVERMAN: Yes, we shall.

10 MR. KAATZ: That's 30 percent done, roughly?

11 MR. SILVERMAN: Yes.

12 MR. KAATZ: And that's nine months initially from
13 what date?

14 MR. SILVERMAN: That's the nine months from the,
15 sorry, it would be nine months from the project
16 completion date, which was December 1st. So now I think
17 it actually sets it to September.

18 MR. BRENNAN: And Members the wild card, whenever
19 you go with a third party. And that -- that's solving
20 delays here, but we acknowledge sometimes you end up on
21 their timeframe. The one thing we'll acknowledge if
22 something has happened, we will obviously be here
23 before you update. We thought it would be better to
24 give you a realistic date than to set it so far down

1 the road that it wouldn't be a problem. But you also
2 wouldn't have your September 2nd.

3 MR. KAATZ: What's the date?

4 MR. BRENNAN: It's September 2nd.

5 MR. KAATZ: I just want to make sure it can be
6 completed in nine months. So don't have to come back
7 and renew all that. If you need 10 months --

8 MR. BRENNAN: That would be able to give us a
9 little bit more time, but again, no, we're moving
10 forward. We have had that discussion that this is the
11 amount of time we believe it should take. If there is
12 another bump, we may be back. But we also made the
13 determination that it was better to bat up in spirit of
14 the rules than to say that we have 18 months when we
15 think it's going to take longer.

16 CHAIRWOMAN SAVAGE: Other questions by board
17 members?

18 (No verbal response.)

19 CHAIRWOMAN SAVAGE: Hearing none, George if you
20 could call the role.

21 MR. ROATE: Thank you. Madam Chair, please
22 correct me if I have my motions wrong. Motion made by
23 Mr. Kaatz. Seconded by Mr. Fox.

24 MR. FOX: Correct.

1 MR. ROATE: All Right. Thank you. Mr. Budde.

2 MR. BUDDE: Yes.

3 MR. ROATE: Thank you. Mr. Burnett.

4 MR. BURNETT: Yes.

5 MR. ROATE: Thank you. Mr. Fox.

6 MR. FOX: Yes.

7 MR. ROATE: Thank you. Dr. Hendrickson.

8 MS. HENDRICKSON: First of all, thank you for
9 making me a doctor.

10 MR. ROATE: I'm sorry.

11 MS. HENDRICKSON: Based on the provided
12 documentation, yes.

13 MR. ROATE: Thank you. Mr. Katz.

14

15 MR. KATZ: Based on the presentation, yes.

16 MR. ROATE: Thank you. Ms. Legrand.

17 (No verbal response.)

18 MR. ROATE: Okay. I think we've lost Ms.
19 Legrand. I'll come back and revisit. Chairwoman
20 Savage.

21 CHAIRWOMAN SAVAGE: Based on today's presentation
22 of the state board staff report, yes.

23 MR. ROATE: Thank you. That's six votes in the
24 affirmative. Does that carry?

1 CHAIRWOMAN SAVAGE: Motion is approved. Yes.

2 MR. ROATE: Thank you.

3 MR. MORAVO: Thank you so much.

4 CHAIRWOMAN SAVAGE: All right. So next up is
5 going to be A-02 Fresenius Kidney Care Chicago HSA-6,
6 Chicago, Illinois. May I have a motion to approve the
7 five month permit rule of project 19-035, which is the
8 second permit for you to request for this project.

9 MS. HENDRICKSON: So moved.

10 MR. BURNETT: Second.

11 CHAIRWOMAN SAVAGE: Thank you. If you could
12 please introduce yourself, spell your name for the
13 court reporter and he can swear you in.

14 MS. WRIGHT: My name is Gloria Wright,
15 G-L-O-R-I-A W-R-I-G-H-T; The specialist for Fresenius
16 Kidney Care.

17 Whereupon:

18 GLORIA WRIGHT
19 Was called upon to tell the truth, and did so as
20 follows herein after being duly sworn.)

21 CHAIRWOMAN SAVAGE: If you could share the state
22 board staff report.

23 MR. ROATE: In October of 2019. The state board
24 approved permit number 19035, the permit authorized the

1 relocation of an existing 24 station ESRD facility in
2 Chicago, Illinois. State Board staff notes this --
3 this permit is obligated and the current project
4 completion date is December 31st, 2023. Project cost
5 is approximately \$7.4M and the permit holders are
6 asking for a five month permit renewal until May 31st,
7 2024. Thank you Madam Chair.

8 CHAIRWOMAN SAVAGE: Thank you. You can proceed.

9 MS. WRIGHT: This is the central relocation of
10 Jackson Park facility --

11 MR. ROATE: Could you speak closer to the mic?
12 Thank you.

13 MS. WRIGHT: It's the Jackson Park facility and
14 we relocated the new addition near the Chicago Skyway.
15 The original renewal request came to a decision for six
16 rooms as well as Sunday that prepared to add home
17 therapy east to the service area. That required, you
18 know, re planning, looking at the size of the site, a
19 parking addition that was quite expensive. Since that
20 time and construction of university related from the
21 shell, each building permit time took about five months
22 for approval.

23 Shell construction and interior work
24 was also delayed. The ground storage tanks that the

1 property had required had lengthy inspections before
2 they could forward. And then after the construction
3 was finished the city of Chicago was also probably
4 understaffed like everybody else. That took extensive
5 time to have them come out and do their inspections.

6 The facility did -- on October 23rd, and
7 it's in operation now. So if there are more questions.

8 CHAIRWOMAN SAVAGE: So you did get the
9 Chicago approval to move forward.

10 MS. WRIGHT: Oh yes. We're just -- we're just
11 waiting for the CMS inspection and the receipt of CMS
12 letter, which could come before December 31st. But in
13 order to remain in compliance, we want to wait for the
14 inspection receipt.

15 CHAIRWOMAN SAVAGE: Which you are expecting
16 anytime now?

17 MS. WRIGHT: Yeah, it should be -- I don't think
18 months out, but just to be safe so we don't have to come
19 back and ask for an extension.

20 CHAIRWOMAN SAVAGE: Other questions from members?

21 (No verbal response.)

22 CHAIRWOMAN SAVAGE: Okay. Hearing none, George
23 if you could call the roll.

24 MR. ROATE: Thank you Madam Chair. Motion made

1 by Ms. Hendrickson. Seconded by Mr. Burnett. Mr.
2 Budde.

3 MR. BUDDE: Yes. Based on the staff report I
4 vote yes.

5 MR. ROATE: Thank you. Mr. Burnett.

6 MR. BURNETT: Yes. Based on the staff report.

7 MR. ROATE: Thank you. Mr. Fox.

8 MR. FOX: Yes.

9 MR. ROATE: Thank you. Ms. Hendrickson.

10 MS. HENDRICKSON: Based on the information, yes.

11 MR. ROATE: Thank you. Mr. Kaatz?

12 MR. KAATZ: Yes, based on the staff report.

13 MR. ROATE: Thank you. Chairwoman Savage.

14 CHAIRWOMAN SAVAGE: Yes. Based on the staff
15 report and testimony today.

16 MR. ROATE: Thank you. That's six votes in the
17 affirmative.

18 CHAIRWOMAN SAVAGE: Thank you. That motion is
19 approved.

20 MS. WRIGHT: Thank you.

21 CHAIRWOMAN SAVAGE: All right. So now we are
22 going to move on to the Exemption Requests. We have
23 one item and its The University of Chicago at Glendale
24 Heights, Illinois. The University recently acquired

1 Advent Hospitals. May I have a motion to approve the
2 discontinuation of OB services at Advent Health Glen
3 Oaks Hospital.

4 MR. BURNETT: So moved.

5 MR. FOX: Second.

6 CHAIRWOMAN SAVAGE: Thank you. If you all could
7 introduce yourselves, spell your name for the court
8 reporter and you'll be sworn in.

9 MR. RAGIVOJEVS: Good morning. My name is
10 Vladimir Ragivojevs, V-L-A-D-I-M-I-R
11 R-A-G-I-V-O-J-E-V-S.

12 MS. AYANYAN: Hi, good morning. I'm Deborah
13 Ayanyan, A-Y-A-N-Y-A-N. I am the Chief of nursing.

14 MR. AXEL: Chad Axel, A-X-E-L; Axel and
15 Associates.

16 THE REPORTER: Please raise your right hand.
17 Whereupon:

18 VLADIMIR RAGIVOJEVS

19 DEBORAH AYANYAN

20 CHAD AXEL

21 Were called upon to tell the truth, and did so as
22 follows herein after being duly sworn.)

23 CHAIRWOMAN SAVAGE: Thank you. Mike, if you
24 could give us our state board staff report.

1 MR. CONSTANTINO: Thank you. Madam Chair,
2 University of Chicago Medicine, Advent Health Glen Oaks
3 is 140 bed safety net Hospital located in Glendale
4 Heights, Illinois. They propose to discontinue the 15
5 bed obstetric unit at the hospital. There is no cost
6 to the discontinuation and the expected completion date
7 is upon state board approval. The applicant's are
8 before the state board because the application proposes
9 a discontinuation of a category of service. This
10 application for exemption was forwarded to the state
11 board chairwoman for approval. The chairwoman
12 recommended this exemption be submitted to the state
13 board for approval. Thank you Madam Chair.

14 CHAIRWOMAN SAVAGE: Thank you Mike. If you'd
15 like to proceed.

16 MR. RAGIVOJEVS: Thank you Madam Chairperson.
17 Again, my name is Vladimir Ragivojevs and I'm the
18 President and CEO of Chicago Advent Glen Oaks. Thank
19 you for the opportunity to appear for you this morning
20 and our <unintelligible>. We are here to answer any
21 questions you may have about the decision made in July
22 to suspend obstetric services, and subsequently filing
23 of discontinuation of certification section allocation
24 for you today.

1 As noted in your staff report, we
2 found to be in compliance with all of our reviewed
3 material. Glen Oaks is located in the city of Glendale
4 Heights, one of the smallest hospitals within the
5 Chicago suburbs and Archdiocese program. Is
6 experienced steadily declining admissions during 2021
7 and 2022, we arrived less than five <unintelligible> of
8 week an Advent census of just under 2.2 patients.

9 We do not believe our proposed
10 discontinuation will have a material impact on access.
11 Northwestern Central DuPage Hospital and Alexian
12 Brothers medical centers are both located within the
13 HSS RPP designated geographic service area. And
14 together are approved to operate 64 open beds,
15 experience combined rate of 6 percent. Our
16 Average daily census of 2.2 patients is barely noticed.

17 We put policies in place to smooth
18 transition process during the past five months, since
19 suspension we haven't experienced any difficulties nor
20 to the best of our knowledge have a patient
21 historically looked to us for any of their
22 <unintelligible>. With that introduction, we can now
23 answer any questions you would have. And again, thank
24 you for the opportunity for appearing before you today.

1 Mr. Axel, do you have any additional comments?

2 MR. AXEL: My only additional comment is to
3 confirm that this application and all reviewed criteria
4 reviewed by staff.

5 CHAIRWOMAN SAVAGE: I'd like to let the record
6 reflect that Ms. Legrand is back online; board member.
7 I do have a question. So when the University of
8 Chicago took over at Advent Health Hospitals or merged,
9 even though it wasn't noted that you were going to work
10 <unintelligible> at this hospital. So why was that not
11 discussed at the time by the Archdiocese?

12 MR. RAGIVOJEVS: Yeah, we didn't have the
13 intention to close the services at that time when there
14 was that merger. But when time continued, we ran into
15 some difficult situations with staff. We had all
16 the -- all the opportunity to, to work on staffing,
17 just weren't able to find the ability to plug those
18 holes. We have a number of staff that were burned out
19 and staff that left the organization.

20 Even with agency staffing, we weren't
21 able to provide the appropriate staff to arrange a
22 situation where we weren't able to provide safe and
23 adequate care. And so with all those things be
24 considered, in conjunction to position with discussion

1 with our physicians and staff, we made that decision to
2 suspend services.

3 CHAIRWOMAN SAVAGE: Other questions by board
4 members. Yes, Mr. Katz, please.

5 MR. KATZ: What prenatal network are you in right
6 now, Glendale?

7 MS. AYANYAN: Hi, good morning. The UCM worked
8 very closely with Peggy Collins.

9 MR. KATZ: Who is your level three provider?

10 MS. AYANYAN: <Unintelligible> so UCM.

11 MR. KATZ: What's UCM?

12 MS. AYANYAN: University of Chicago Medicine.

13 MR. KATZ: And are you going to drop gynecologic
14 surgery also?

15 MR. AXEL: No, we will continue to provide
16 gynecologic services for inpatient operations.

17 MR. KATZ: That's going to be quite a drive for
18 your primary service area, right? That's used going to
19 Glendale Heights if they have to go to Alexian or
20 Central DuPage.

21 MR. AXEL: It is a six mile drive to Alexian
22 Brothers and about eight mile route to Central DuPage.

23 MR. KATZ: Do you have any OBs on your staff?

24 MR. AXEL: We do have OBs on staff, but they

1 won't be providing any services, they'll just be
2 providing technological services.

3 CHAIRWOMAN SAVAGE: Other questions? You know,
4 this is always IDPH's purview that you do have some
5 training of your ER staff?

6 MR. AXEL: Yes.

7 MS. AYANYAN: We did extensive training and
8 actually we had the OB nurses for eight weeks staff
9 down in our ED area on both the day shift, night shift
10 to support that. So we did didactic and return
11 demonstration, simulation and the required education
12 including hemorrhage and pre amp and also any of the
13 equipment was relocated to make sure that the staff
14 were aware we utilized the equipment. We also made
15 sure that all the medications required were relocated.
16 So that they're right there for the ED staff. And the
17 great opportunity is that the prenatal network will
18 help us continue on an annual basis to keep the staff
19 training on an annual basis. And that is a great
20 relief to us that the nurses that are in the ED and the
21 providers.

22 CHAIRWOMAN SAVAGE: And did you have any
23 deliveries since you've closed in the ER?

24 MS. AYANYAN: We have not had any deliveries. So

1 we did create a transfer algorithm. So immediately if
2 anyone comes to our triage area, we have a varied
3 process, step by step review or assessing the patient,
4 seeing where their stability is, and then get them to
5 the appropriate facility after we see the patient.

6 CHAIRWOMAN SAVAGE: Any other questions by board
7 members? Oh, Mr. Katz.

8 MR. KATZ: Any letters of opposition?

9 MR. RAGIVOJEVS: We have not received any letters
10 about opposition. I personally made phone calls
11 throughout the community, EMS, fire, police,
12 surrounding mayors, member of the villages. We -- we
13 actually, we also posted within our Daily Herald, I've
14 not received any phone calls from anyone. I spoke with
15 other obstetricians and our board members and did not
16 receive any letters of opposition.

17 MR. KATZ: Your board is totally onboard.

18 MR. RAGIVOJEVS: Totally supportive, Yes.

19 CHAIRWOMAN SAVAGE: Like said it's said because
20 it was a beautiful unit. You go ahead.

21 MR. BURNETT: Yeah, I -- I would just add that
22 operating a quality OB unit with an average census of
23 2.2 is a challenge. And certainly would be a challenge
24 to track and maintain staff at those five levels. And

1 of course, it's -- it's extremely cost ineffective to
2 provide <unintelligible> census 2.2.

3 MR. RAGIVOJEVS: It is. We recognize that and as
4 we, as we were looking at the situation of not having
5 enough staff, we recognize that it's difficult to,
6 difficult to maintain competencies. And our staff
7 presented that to us and we did ask staff if they would
8 cover different shifts, those type of things as we did
9 our best staff the unit, but we couldn't get there by a
10 collective decision with our physicians and staff.

11 CHAIRWOMAN SAVAGE: Obstetric aside how is
12 hospitals going otherwise in terms of nursing?

13 MS. AYANYAN: Always a challenge. Especially
14 healthcare post Covid, so it -- it's something that we
15 just, we continue to strive. Retention, recruitment,
16 all those, you know, impact all of our areas. But we
17 are doing okay. And we are looking to decrease in all
18 of our areas. And it's significantly reduced in our,
19 ICU in our med surg departments. We don't have any
20 agency and that's a big accomplishment for us for sure.

21 CHAIRWOMAN SAVAGE: Any other questions?

22 (No verbal response.)

23 CHAIRWOMAN SAVAGE: George, if you could call the
24 roll.

1

2 MR. ROATE: Thank you Madam Chair. Motion made
3 by Mr. Fox, seconded by Mr. Burnett. Mr. Budde.
4 Yes. Based on the staff report and the conversation
5 today I vote yes.

6 MR. ROATE: Thank you. Mr. Burnett.

7 MR. BURNETT: Yes.

8 MR. ROATE: Thank you. Mr. Fox.

9 MR. FOX: Yes. Based on staff report and
10 testimony today.

11 MR. ROATE: Thank you Ms. Hendrickson.

12 MS. HENDRICKSON: Based on the testimony today,
13 yes.

14 MR. ROATE: Thank you. Mr. Katz.

15 MR. KATZ: Based on the staff report and the
16 presentation, I think the presenters are on top of this
17 one. I will vote yes. However, my thinking behind it
18 is that number one, you convert to Chicago medicine, I
19 would expect Glendale Heights to add services not
20 delete, but I do -- I -- I understand your position.
21 And the second issue that I have as a board member, the
22 first issue, and I'm not speaking for anyone else is
23 every now and then we get a presentation for a birthing
24 center. And we're starting to see hospitals close

1 their units. Doesn't make sense. My point is
2 rhetorical I vote yes.

3 MR. ROATE: Thank you. Ms. Legrand.

4 MS. LEGRAND: Can you hear me, George?

5 MR. ROATE: Yes. Yes ma'am.

6 MS. LEGRAND: I vote yes also.

7 MR. ROATE: Thank you. Chairwoman Savage.

8 CHAIRWOMAN SAVAGE: Yes, I vote yes based on
9 today's presentation and state board staff report, but
10 I wish it could stay open.

11 MR. ROATE: Thank you. That's seven votes of the
12 affirmative.

13 CHAIRWOMAN SAVAGE: All Right. That motion is
14 approved. Thank you.

15 MR. AXEL: Thank you.

16 CHAIRWOMAN SAVAGE: Okay. So next up we're going
17 to have declaratory rulings and other business. So we
18 have the E-01, birthing center declaratory ruling.
19 May, I now have a motion to approve the department's
20 request to grandfather the existing and already
21 approved birth centers permits from the alternative
22 Healthcare Delivery Act to the newly established birth
23 centers licensing Act.

24 MS. HENDRICKSON: I take that motion.

1 MR. FOX: Second.

2 CHAIRWOMAN SAVAGE: Thank you. So John could
3 walk us through this request.

4 MR. KNIERY: Thank you Madam Chairwoman and
5 members of the board. Since we met last, the
6 department of Public Health licensing passed the
7 Birthing Center's Licensing Act and put their rules
8 together. Our role is previous <unintelligible> for
9 Birthing centers were under the alternative healthcare
10 birthing Act. As existing facilities have to renew
11 their licenses or as approve two of them, so as we
12 approved, have to become complete c licensure. They
13 now have to fall under the Birthing Center License Act,
14 not Alternative Healthcare Delivery. Please know, that
15 we have four existing facilities and have two that are
16 under construction.

17 So I asked Karen Singer of the
18 Department of Public Health to submit this declaratory
19 ruling change in licensure of assisting facilities is
20 one of the items the declaratory ruling process was
21 defined for. In essence, as you stated, Madam
22 Chairwoman, this request is asking you grandfather
23 these facilities; all new facilities will have to
24 follow a similar process, which we have filed our rules

1 to start that process.

2 CHAIRWOMAN SAVAGE: Thank you John. Don, if you
3 could please give us the state board standard report on
4 this.

5 MR. JONES: Thank you Madam Chair. As John
6 mentioned, the Department of Public Health has
7 submitted a formal request for a declaratory ruling.
8 The reason that was done was that one of the models
9 under the Alternative Healthcare Delivery Act was first
10 in the model. And in 2021, that model moved and was
11 recognized as a licensed healthcare facility under the
12 newly adopted statute of the Birth Center License Act.

13 And then in September of 2023, the
14 department promulgated new rules for the regulation
15 licensing of birth centers known as the birth center
16 licensing code. And when those rules were promulgated
17 and established, the department reached out to John to
18 determine if the six existing facilities that you
19 approved sealed in permits for -- under the Alternative
20 Healthcare Delivery Act, had to come back before the
21 board for new CONs because they were going to be
22 either -- either their existing license would be
23 renewed under the Birth Center Licensing Act or the two
24 facilities that you see on page three of your report.

1 They're not open yet, when they do open
2 they will receive a license under the Birth Center
3 Licensing Act and not under the Alternative Health
4 Delivery Act. And, and the reason this all was started
5 was that under the Health Facilities Planning Act, it
6 states that if the facility is established and receives
7 a license, that is viewed as an establishment of a new
8 facility. So the department questioned the board,
9 questioned us, and wanted to make sure that if they
10 started issuing licenses under the new statute, the
11 board would not view that as establishing a new
12 facility with a new license. Thank you, Madam Chair.

13 CHAIRWOMAN SAVAGE: Thank you, Don. Karen Ms.
14 <Unintelligible> do you have any comments?

15 MS. KAREN: No. Nothing to add. He
16 gave a great explanation.

17 CHAIRWOMAN SAVAGE: Any questions from any board
18 members on this matter?

19 (No verbal response.)

20 CHAIRWOMAN SAVAGE: Okay. Hearing none, George,
21 if you could please call the role.

22 MR. ROATE: Thank you, Madam Chair. Motion made
23 by Ms. Hendrickson, seconded by Mr. Fox. Mr. Budde?

24 MR. BUDDE: Yeah. Based on the staff report, I

1 vote yes.

2 MR. ROATE: Thank you. Mr. Burnett.

3 MR. BURNETT: Yes.

4 MR. ROATE: Thank you. Mr. Fox.

5 MR. FOX: Yes. Based on staff report and staff
6 Comment.

7 MR. ROATE: Thank you Ms. Hendrickson.

8 MS. HENDRICKSON: Yes, based on the Staff's
9 report.

10 MR. ROATE: Thank you. Mr. Kaatz. Based on
11 Staff report I would say yes.

12 MR. ROATE: Thank you, Ms. Legrand.

13 (No audible response.)

14 MR. ROATE: Ms. Legrand, I'll come back.
15 Chairwoman Savage.

16 CHAIRWOMAN SAVAGE: Yes, please. Based on Staff
17 report and testimony today.

18 MR. ROATE: Thank you. Circling back. Ms.
19 Legrand?

20 MS. LEGRAND: I vote yes.

21 MR. ROATE: Thank you. That's seven votes in the
22 affirmative.

23 CHAIRWOMAN SAVAGE: Okay. This declaratory
24 ruling is approved. Okay, so now we are going to move

1 on to Applications Subsequent to initial review. That
2 will be H-01, OSF Saint Joseph Medical Center, in
3 Bloomington, Illinois. May I have a motion to approve
4 23-037 for the expansion of med surg and ICU within the
5 hospital.

6 MR. ROATE: So moved.

7 MS. HENDRICKSON: Second.

8 CHAIRWOMAN SAVAGE: Thank you. As you all get
9 seated, if you could please introduce yourselves, spell
10 your names for the court reporter and he will swear you
11 in.

12 MR. WEBER: Ralph Weber. W-E-B-E-R.

13 MS. FULTON: Lynn Fulton, F-U-L-T-O-N. President
14 OSF Saint Joseph Medical Center.

15 MS. CALLUTA: Sarah Calluta. S-A-R-A-H
16 C-A-L-L-U-T-A; Chief Medical Officer for Saint Joseph.

17 MR. HOHUMIA: M-A-R-K-H-O-H-U-M-I-A. COS for
18 Saint Joseph.

19 THE REPORTER: Please raise your right hands.

20 (Whereupon:

21 RALPH WEBER

22 LYNN FULTON

23 SARAH CALLUTA

24 MARK HOHUMIA

1 Were called upon to tell the truth, and did so as
2 follows herein after being duly sworn.)

3 THE REPORTER: You may proceed.

4 CHAIRWOMAN SAVAGE: Thank you. Mike, if you
5 could share our state board staff report.

6 MR. CONSTANTINO: Thank you. Madam Chair. OSF
7 healthcare system is proposing to have 10 medical
8 surgical beds and 15 intensive care beds at OSF Saint
9 Joseph Medical Center in Bloomington, Illinois at a
10 cost of approximately \$17.8M.

11 The expected completion date is
12 December 31st, 2026. There was no public hearing
13 requested, we did receive letters of support but no
14 opposition letters were received. We did have findings
15 regarding this project. Thank you Madam Chair.

16 CHAIRWOMAN SAVAGE: Thank you Mike. Now if you
17 folks could please get really close to the microphones
18 and speak louder. We're trying to make microphones
19 louder; People can't hear. Okay, proceed.

20 MS. FULTON: All right. Will do. And thank you.
21 And again, Lynn Fulton, the president at OSS Saint
22 Joseph's Medical Center. You know, we're pleased to be
23 here to request approval for the 15 ICU and 10 Med-surg
24 expansion. OS of Saint Joseph, you know, really

through the pandemic transitioned from, what I would say, community hospital to a regional referral center. Over the last three years, we've accommodated close to 3000 transfers for inpatient care.

Over the last two years, we have had to turn down about 228 requests. So we feel we're really in the midst of some tremendous space. Our med surg stays have increased by about 5 percent annually over the eight years. Our ICU days increased by about 98 percent between 2017 and 2022. We've used the 20 bed 10 percent rule several times over the last few years to accommodate both that we could put the beds to the best use for patients.

In July, 2020, I put the cause to reclassify 11 swing beds two med surg; into 2022, we closed our long-term care unit and transitioned those 12 beds to med-surg. And then last summer we added three beds for a total of 121 medical surgical beds. So you might ask in Illinois, what -- what's causing this. And it's really twofold.

Number one is the absence of a specialist in small rural hospitals. You know, at every hospital used to have general surgery, GI, neurology, available and on call and today that's just

not the case today. They're really relying on the regional referral centers to be able to take those patients. And we've even seen that increase over the last 14 months.

And then number two is a little more positive is really the population growth in Bloomington-Normal. Really attributed to building an electric car manufacturer. You know, most recently Dr. Zelig<ph> and I just met with some of their team and they're at over 8,000 employees today at that location in Bloomington. Our economic development group is projecting about 13,000 in population between 21 and 2028. And living in Bloomington-Normal you can't help but see in anecdotally the results of that.

You know, houses do not stay on the market long even in today's rate environment. In my neighborhood, I regularly see license plates, especially from California moving to the Bloomington-Normal market. Our schools -- our largest school in a rural community, They've added tailors to the back of the school to accommodate the increase in students. They also do virtual site halls now to be able to kind of expand their ability to have students.

Retail and our services in the

community also expanded as we've seen the increase in population. So we feel it's really important that we look at this now and we position Saint Joseph Medical Center so that we can continue to care for not only our community, but also the community; Thank you.

MR. WEBER: Thank you. Again. I'm Ralph Weber certificate of need consultant and I will address the negative findings. And first, I want to thank Mike and George for their consult during a pre-application conference on this project as well. And and while we were preparing the permit application it's always appreciated.

The first negative relates to Saint Joseph's Utilization of Medical Surgical and ICU beds. The staff analysis correctly reports that these volumes for the past two years justify fewer than the 15 ICU and 10 medical surgical bed increases that are requested. But our bed increases are based on projections utilizing the experience volume increases that have been cited for the past six to eight years, not just the past two. And ICU patient days have average increase of 20 percent per year during that period of time. And med/surg, is averaging 5.3 percent, taking the numbers that she got in annual.

And the population growth being experienced means that the continuation of this past growth is very likely.

The second negative finding is that our rapid population growth model did not consider birth and death rates. And that is also correct. I wrote the analysis using aggregate population growth driven mostly by the creation of 7,700 new jobs inside of 8,000. So I mean, every month this thing is increasing; new businesses supporting the electric vehicle industry and secondary growth in hospitality, leisure, and services add to this number.

Growth spur is spurring the population increases. I use the HSFRBs data on population distribution by age cohorts. And inpatient hospitalization rates by these aged cohorts, to protect future utilization associated with the population growth. These age cohorts -- cohorts factor in there some deaths. So I did not address births and death. But I did review the birth and death rates from McLean County; that also is fascinating. And because it was raised, I will address the record.

While births had been declining from 2014 to 2018, they have been relatively stable over the past six years. So by stable I mean that they

fluctuated up or down by less than a hundred from year to year, around a current level of 2100 births for this year. For death rates they peaked in 2020, likely due to Covid and have declined since. As a result, deaths, this year are about the same, within a dozen of what they were in 2017, just under 1400 a year.

Comparing now in 2017 pretty much takes out the Covid factor. Deaths this year are down more than 200 below the death count last year. Again, this is for a plain count. As upon this year of births exceeded deaths in the county by about 750.

And incidentally, the average yearly difference for the last six years, I'm sorry, last eight years, it's been 752 per year, births above death. It's a good story that continues and it attests to the population growth.

As to population migration inbound and outbound migration result in the net gain in populations. The source of the data is the US Census Bureau. Census flows mapper presenting U.S. county migration patterns. The census flows mapper presents two factors, inter and intra state migration. Outside migration of almost 4,800 residents from McClean County to two other states in the last five years ending 2020; exceeded the in migration of about 2,600 people from

other states to McLean County. In other words, there were about 2,145 people leaving above those arriving during these five years.

But over the same five years, if you look at migration within Illinois, there were over 9,100 people who moved into McClean County from elsewhere in Illinois, while about 600 left McClean County for other Illinois counties. So, movement within Illinois was a gain of over 3,100 people in this five years. Combining inter an intra state migration, there was a net gain of about 1,000 people; 993, the five years ending 2020.

So when I look at the same data for the five year period ending 2019 instead of 2020, the results were much the same with a net gain of almost 900 people. This shows a <unintelligible> in the positive net migration when a one year later timeframe is used. So in summary, the excess of earth's over deaths and the positive net migration reinforces the population data presented in the permit application.

So finally, the third negative relates to the cost of the project exceeding state standards. The cost of \$561 per square foot for new construction is about \$91 -- \$90 above the RS standard. We reported on

some of the factors explaining the difference above the standard and thank Mike and George for including that in the state board staff report.

To have several factors adding to new construction costs include new construction in a tight courtyard to expand existing space. This requires smaller construction equipment and extra cost tie-ins to the existing of all structures and foundations. And number two, challenging conditions from material delivery and set up approach of the proximity of an adjacent building entrance. The modernization costs of \$419 is about \$90 above the standard for modernization.

Factors adding cost to modernization are the majority of modernization space being converted, that's been non-clinical. So as a result there are significant infrastructure deficits requiring against plumbing, HVAC, electrical, medical gases, and low voltage wire. And secondly, the existing space being modernized has difficult angular spaces, space layouts, columns, configurations requiring special architectural and construction efforts.

I have other comments, but I think we should take questions. As Mike noted, there was no opposition to the project, only letters of support

received from eight hospitals in Central Illinois. And as you thank you for this.

CHAIRWOMAN SAVAGE: Thank you. Our board member have any questions.

MR. BURNETT: I Have a question, I think it's for Ms. Fulton. And did, did you say that you had to -- you had to say no to about 2000 referrals?

MS. FULTON: 228.

MR. BURNETT: 228 or 2,228.

MS. FULTON: 228.

MR. BURNETT: Oh, okay. And that was for, because you had inadequate beds served or ICU beds available?

MS. FULTON: Inadequate beds, as well as a few of whom were for staffing.

MR. BURNETT: Okay. And can you comment on -- on your rationale for requesting 10 additional med surg beds and 15 ICU beds? Why 10, why 15?

MS. FULTON: Well because of the way that we're going to set up the unit, we'll have the 15 ICU and the 10 will be Med/Surg, but they'll serve as a step down capacity. So when a patient leaves that -- the ICU level of care, instead of having to go elsewhere in the building, we'll be able to have that continuity by

being able to move that patient to a med surg bed right there with the seat.

MR. CONSTANTINO: I may, I also, I asked this question when we started working on the permit application. But that's where the use of the 20 bed, 10 percent rule has come in and they've added, I think, 24 medical surgical beds over the last 30 years. So this is catching time for the ICU.

MR. FOX: Will the additional ICU beds be built the contiguous to or part of your existing ICU?

MS. FULTON: No, they, they will not. That's not feasible with the way that the building's laid out. So it will be a separate unit from our --

MR. FOX: And, and is part of the rationale for 15 ICU beds versus 12 or some other number because, because you're located in these beds and to have them there that it makes sense to have a critical mass of those beds for staffing purposes?

MS. CALLUTA: It's really both. For staffing as well as when we look at the projections for what we believe we're going to need for ICU beds, that number seemed to be the right number both for staffing as well as for future utilization.

MR. KAATZ: Will you be adding or expanding any

to your ICU related services? I get that your population is growing, but are you, would you be adding any new services? Do you expect to expand any of your care service?

MS. FULTON: We have been, we are just accommodating more for patients. An example is our OR, you know, in our OR recently met with our OR? General director about 3000 minutes in our OR last month. So our expansion for that is utilizing it more so increasing our hours of operations so that we can serve our patients. And so that's really what we've done throughout the hospital. How can we maximize what we have to be able to take care of the patients coming in for services.

We do have a plan though, you know, as we look and we continue growth, you know, where are those areas that we need to continue rolling, whether that's imaging, OR.

MR. KAATZ: Thank you.

CHAIRWOMAN SAVAGE: Mr. Budde.

MR. BUDDE: What are your projections for ICU beds in 2023.

MR. HOHUMIA: For 2023, the projected what?

MR. BUDDE: ICU bays.

MR. HOHUMIA: ICU bays. 2023. I'm sorry. I have so many numbers in this. I have, I've got three pages of notes and you asked about one it's not on. So 2023 chart ends at 2022.

MR. BUDDE: Yeah, you don't have any information in there, saw a big increase, 22,000 increase. And it's already, so you're down to 60 percent utilization now I'm just wondering what trend line might --

CHAIRWOMAN SAVAGE: When did the electric car company went that town -- to your area?

MS. CALLUTA: The tremendous road within really Rutherford really lasts for the last three years. They have been there, they started they lease the space, that was the Mitsubishi plant before came in at least -- I've been there six years and they had came on shortly after I joined Saint Joe's. And then they started to ramp up subsequently within the last three years that we've seen the biggest bump.

MS. CALLUTA: They have now 8,500 employees and 20,000 family members assisting in their medical needs. So it's a cycle service.

CHAIRWOMAN SAVAGE: Did they ramp up to 8,000 employees more recently, or --

MS. FULTON: We had the, I think 7,500 of the

application that went Dr. Zawa<ph> and I ended up with 'them about how we can continue to increase services try to help us with their members. That's when we get our 80,000

CHAIRWOMAN SAVAGE: That's kind of secret I guess. Moving to, I --

MR. WEBER: I have an answer for Mr. And apologize for not getting into at my fingertips, but there were in 2022 about 3,056 and we are scheduled to increase by about 574 patients a year. So that would put it at about 3600 - 3650 for 2023.

MR. BUDDE: That's reverse of the trend for 2021. 2022, yes. Yes. You're anticipating 500 more ICU bays in 2023?

MR. WEBER: Yes. Thank you.

CHAIRWOMAN SAVAGE: Just one question I would have is based on your increasing volume in med surg you think 10 is enough? I think the younger population are probably going to be working at that plant. Are going to be younger.

MS. FULTON: Which you are correct. We do feel that is adequate for today for our plan to expansion. We do believe that we will need to continue to increase, but we have a stepwise plan on how we want to

accommodate --

CHAIRWOMAN SAVAGE: Like the schools and going trailers.

MS. FULTON: Yes, exactly.

MR. KAATZ: I've noticed your length of stay is increasing. We have been trying to sort through. All the information. We have a growing community, but you, you don't have the admission numbers, which is why you have two negative findings, but you have a, you have a significant lack of stay issue. So I'm trying to figure out if growth being driven by the length of stay by admission. What's going on between the relationship between admissions and length of stay? That's my first question.

MS. CALLUTA: Well, you're correct on the length of stay and that we're not unique to that, that's happening in every facility across the country. It's harder to get patients into post acute care. Dr. Zalink is actually leading a project on reduction of length of stay because that's where we're hoping to generate some access capacity so that we can fill in and thus the requesting of the 10 bed med/surg stage. So we began to kick off that project actually two months ago where we can reduce that.

Now, your second part of that question is about admissions. As we look at the negative findings, really in the short term where we're looking at our growth over the next three to five years. With the population, we feel that we will hit what the state's requirement is, it's just not showing the population in the short term.

MS. FULTON: In addition to that, the -- the population growth is a factor. Also our staff is going to be very similar. So we're growing as a referral center as I said, changing from our previous state of community hospital to really regional referral centers a very important transition for us. And being prepared for that growth is going to be very important. We, again, don't want be a trailer bound.

MR. FOX: Would you have a medical ICU and a surgical ICU?

MS. CALLUTA: That's what we're -- we have not solidified that, but that's what we are looking at there. We're putting that new unit is right next to surgery. So it would make that very convenient for us.

MR. FOX: Do you have intensivists on staff?

MS. CALLUTA: We do. Yes I do.

MR. BURNETT: So about 30 percent of your beds

Would be designated for med/surg; That's a little high isn't it?

MS. CALLUTA: When You look at what's projected though. And when you read any of the literature, it's really for ICU which you see the aging demographic and increase morbidities that we're seeing. And what we see today is really following right along with that. In addition the surgical aspect, we've really grown our own thologic surgery at Saint Joe's. Unfortunately seeing more and more patients coming in with cancer. And treating more and more patients. And with that oncologic surgery you generally see that ICU level of care.

MR. FOX: Thank you. The member Kaatz said the medical surgical bed count would increase to 131 if this project is approved. And so the 30 I that's slightly under 25 percent, so it's really not pushing a third. Maybe that's not a substitute difference, but it's five.

MS. HENDRICKSON: I have a few questions. First and foremost full disclosure I'm from the Peoria area, so I'm very familiar with the location. I think a question I had, I think it was in reference to, is that the Mitsubishi plant, it closed effectively in 2019,

but it was fully operational in 2015. So you're collecting historical data to provide it demonstrates kind of a similar numbering that Caribbean would've had right now in terms of growth.

And so that along with potentially with the Covid spike in numbers, I'm having a hard time wrapping around the, the number of beds that you were adding above what was potentially recommended. And likewise looking 45 minutes the other direction, right? That's the different HSA area is Saint Francis Medical Center; a large area. So I was wondering what is their current, if you know, what their I think it's the percentage occupancy is right now?

MS. CALLUTA: It might take, I'll let Dr. Zai talking in the, in the moment as well. The Mitsubishi Caribbean -- Mitsubishi was really a fraction of what Rian is. They've increased the size and the scope of that facility. It doesn't even look the same if you go out on that campus today. And so I -- I want to say, and this recording Mitsubishi was maybe like 3000 employees. And so when you take that and compare that to Rivian at over 8,000, it is a large difference.

The other piece to that again is the regional referral center. The number of referrals that

we see, and you look at the graph historically at Saint Joe's, I mean, it, it is a, a rather steep line of what we're seeing come in. And so that's why I -- I tried to explain it. It's, it's really too big.

It's population growth, but it's also what we're seeing coming in from that outlining areas. Now, Saint Francis, I will tell you is full. Saint Francis is full almost every day. And so it's really incumbent on us as a sister hospital to be able to take those regional referrals that could come to a hospital our size so we can save Saint Francis for those patients that truly need that pulmonary care.

And Dr. Calluta, please.

MS. CALLUTA: Yeah, I would reiterate that I'm -- I've been the chief medical officer at Saint Joe's for five months, but I've been on staff at OSF Saint Francis Hospital in Peoria for 25 years. And I was their medical staff president so I have a lot of experience there and they are full to Gills. And pre pandemic, I remember we would have census about 99 percent, which is emergency status with no access. And they would try to find beds in any of our other hospitals. And B the, the most -- hospital and near there in our system is incredibly important for us to

have access for those patients. So we are we are not in habit of sending patients for intensive care to Peoria.

We, we will probably take patients that they can't take. So for an important sister hospital there a place that has almost don't have access to.

MS. HENDRICKSON: And then similarly you go the other direction, you hit Champagne-Urbana and what the kind of average occupancy rate of that?

MS. CALLUTA: And to my understanding not the regional referral center that, that we sort of think that, that we we're drawing a very sophisticated referral center that will accommodate patients made of our other regional facilities. And to my understanding, although I don't,.

CHAIRWOMAN SAVAGE: Besides in your general area, where are you drawing patients from then,.

MS. CALLUTA: Well, if you draw a line and look about 90 miles out obviously not from Saint Francis, but that generally within that level it's what we're seeing come in.

CHAIRWOMAN SAVAGE: Into Saint Joes?

MS. CALLUTA: We do see patients come from farther west of Peoria because Peoria is full. So

we'll -- we'll get patients from Galesburg, Keane from the region that would naturally go to Saint Francis geographically. But, but they're full.

MR. KAATZ: I would add that the patient origin table in the permit application shows that the McLean county is the source of 70 percent of the patients. And of that 70 percent, 55 percent come from four counties in the Bloomington Normal area. The other side of that coin is 30 percent of the patients come from outside McLean County, which is a big number. And McLean County is the largest county in Illinois.

And I was surprised to learn that it's almost a couple of square mile. Its the size of Rhode Island island. So coming from outside of McLean county, 30 percent of the people, they're coming a fair way.

CHAIRWOMAN SAVAGE: Other questions?

MR. FOX: How do you explain the cost issue?

MR. WEBER: Cost per square foot for construction and we're, we're \$90 above on new construction and also \$90 above per square foot on modernization. And the modernization is in an area that has a lot of angles. It's not all rectangular 90 degrees. And it's also part of the addition that's being built, the addition that's being built in a courtyard that's actually very small

and I think the new construction is 3000 plus square feet very small. So you got a lot of costs over small one square footage. The modernization of this whole building is also very difficult and that's the bulk of the square footage of the project and it's all nonclinical space. So it has to be upgraded for all of the codes and it's basically business and other nonclinical use right now.

CHAIRWOMAN SAVAGE: Other questions?

(No verbal response.)

CHAIRWOMAN SAVAGE: All right. Hearing none, George, if you could call the roll.

MR. ROATE: Thank you, Madam Chair. Motion made by Mr. Kaatz, seconded by Ms. Hendrickson. Mr. Budde.

MR. BUDDE: Based on the conversation today, I think I have a concern on the size of the ICU requests and doing the math; looks like it brought occupancy to 30-35 percent. So, I would vote no.

MR. ROATE: Thank you. Mr. Burnett.

MR. BURNETT: Yes, please.

MR. ROATE: Thank you. Mr. Fox.

MR. FOX: I'm going to vote yes and based on testimony today and I, I'll just add editorially that it's it's refreshing to have a, a downstate Illinois

applicant building some additional facilities. 'Cause We've seen a lot of places had to have to close down.

MR. ROATE: Thank you. Ms. Hendrickson.

MS. HENDRICKSON: I agree to vote yes based on today's testimony, but I would actually also echo my, my colleague that I think my concern is, while it is good to see the growth. I'm nervous about the size of growth, but yes.

MR. ROATE: Thank you. Mr. Katz

MR. KATZ: I will vote yes based on the presentation of the conversation. I I echo my colleagues as little concerned with the sizing of the project. But I think we we spent it a lot of time talking this, so I vote yes.

MR. ROATE: Thank you. Ms. Legrand.

MS. LEGRAND: I also vote yes, based on what I've heard today.

MR. ROATE: Thank you. Chairwoman Savage.

CHAIRWOMAN SAVAGE: I vote yes as well, based on state board staff report and and testimony today.

MR. ROATE: Thank you. That's six votes in the affirmative. One vote in the negative.

CHAIRWOMAN SAVAGE: This application is approved. Thank you and good luck. On to other business. Other

business and that includes John to talk about the authority summary, financial report of fiscal year 2023 and in the first quarter and fiscal year in the first quarter and fiscal year 2024.

MR. JONES: Thank you, Madam Chair. There are two documents before you today. The just of year end 23, the first quarter, I'd like to focus on just the year. Page one shows that we are well within our budget, we should be as we get those down. Before you go to page two, I direct you your attention to the bottom corporation for recruits seven 1.6 million on DBA support, 1.2 both sides, well not both sides are paid more out. So looking at patients two through four, we'll see that we are involved with both probations.

There will be two new staff members, Sherry and I <unintelligible>. We we're, we're trying to also add a legal counsel to the board. That position's not yet filled. So we'll be seeing the board side increase, have request for fiscal five that increases the corporation's budgets. That has not yet been approved. The department.

The the other thing that item we'd like to do legislatively is also get the board paid. Like upon not that site projecting forward, we

can afford that within our current appropriations. Like I said, a little bit of -- but we cant afford that if we if it is approved . So we are, we, so she have our funds strong at the moment. You always have to be careful that it doesn't get swept and by, by the program. So your I hope that answers your question has been happy. To answer your question, think.

CHAIRWOMAN SAVAGE: One of the things that stuck out me was that the spending costs. Last year was \$94,000; now it's \$90,000 for the first quarter. Where's that coming from?

MR. BUDDE: I believe that is money that I think must have put notices in newspapers. That is something that internally we've talked about many times. The majority of our projects are Change of ownerships. Put those, put those notices in the newspapers, especially in the Chicago market. Additional application, which is on, on several of these projects; It's all we get. So that is something that we are going to look at to pass out, maybe some of those costs or we see the increase additional application. Another possibility we've been discussing is instead of fee, all fees are captive, a hundred thousand dollars, maybe decrease the cap to a 100, 2,025, 50,000. Mm-Hmm, <affirmative>, why

keep affordable not looking to really change if there are any tweaks that <inaudible>.

CHAIRWOMAN SAVAGE: Other questions.

(No verbal response.)

CHAIRWOMAN SAVAGE: All right. Well, hearing none I want to wish everyone a very happy, healthy Holiday season and see you in 2024. So now may I have a motion to adjourn this meeting?

MR. FOX: So moved.

MS. HENDRICKSON: Second.

CHAIRWOMAN SAVAGE: All in favor say aye. Aye.

MR. BUDDE: Aye.

MR. BURNETT: Aye.

MR. KAATZ: Aye.

MR. KATZ: Aye.

MS. LEGRAND: Aye.

CHAIRWOMAN SAVAGE: Okay, good. The meeting is adjourned. Our next meeting is on January 23rd, 2024 here at Bolingbrook Golf Club. Thank you. Happy holidays everybody.

(WHEREUPON, the above-entitled proceedings were adjourned until, January 24, 2024.)

STATE OF ILLINOIS.)

) SS:

COUNTY OF COOK)

I, Michael Marciniak, CER, Notary Public,
electronic reporter doing business in the State of
Illinois; reported the proceedings that were held on
the date, time and place set out on the title page
hereof; and that the foregoing is a true and correct
transcript of report of proceedings so taken aforesaid.

I further certify that I am not related
to any of the parties, and I have no financial interest
in the outcome of this matter.

Michael R. Marciniak

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