No. 130042

In the Supreme Court of Illinois

DONALD JAMES, as Executor of the Estate of Lucille Helen James, Deceased, MARK R. DONESKE, as Executor of the Estate of Rose H. Doneske, Deceased, FRANCES G. DEFRANCESCO, as Executor of the Estate of Jack P. DeFrancesco, Deceased, PATRICIA VELICH, as Executor of the Estate of Marion May Heotis, Deceased, FAITH HEIMBRODT, as Independent Administrator of the Estate of Carol Orlando, Deceased Plaintiffs-Appellants, v. GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company d/b/a BRIA HEALTH SERVICES OF GENEVA, Defendant-Appellee.	Appeal from the Appellate Court of Illinois, Second District, No. 2-22-0180 There Heard on Appeal from the Circuit Court of the 16th Judicial Circuit, Kane County, Illinois Case Nos.: 2020 L 247; 2020 L 259; 2020 L 260; 2020 L 264; 2020 L 273. Hon. Susan Boles Judge Presiding.

AMICI CURIAE BRIEF OF THE ILLINOIS HEALTH AND HOSPITAL ASSOCIATION AND THE ILLINOIS STATE MEDICAL SOCIETY

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No. 130042

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DONALD JAMES, as Executor of the Estate of Lucille Helen James, Deceased,	)	Appeal from the Appellate Court of Illinois, Second District, No. 2-22-0180
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FAITH HEIMBRODT, as Independent Administrator of the Estate of Carol Orlando, Deceased	)	2020 L 264; 2020 L 273.
Plaintiffs-Appellants,	)	Hon. Susan Boles Judge Presiding.
v.	)	
GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company d/b/a BRIA HEALTH SERVICES OF GENEVA,	)	
Defendant-Appellee.	)	

AMICI CURIAE BRIEF OF THE ILLINOIS HEALTH AND HOSPITAL ASSOCIATION AND THE ILLINOIS STATE MEDICAL SOCIETY

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STATEMENT OF INTEREST OF THE AMICI CURIAE

The Illinois Health and Hospital Association ("IHA") is a state-wide, not-for-profit organization. IHA's purpose is to ensure that all individuals and communities have access to high-quality health care at the right time and in the right setting. IHA represents over 200 Illinois hospitals and nearly 40 Illinois health systems. For over 80 years, IHA has served as a representative and advocate for its members, addressing the social, economic, political and legal issues affecting the delivery of high-quality health care in Illinois. It has a profound interest in the immunity issue in this case as all of its members were impacted by the COVID-19 pandemic, all fall within the definition of "Health Care Facilities" set forth in the Governor's Executive Order 2020-19 (A. 4-7)[1], and most made heroic efforts to render assistance to the State by providing health care services in response to the COVID-19 outbreak as set forth in that Executive Order. (A. 27-29). Those services, for which negligence immunity was granted, included the postponing and canceling of elective surgeries, increasing the number of beds, preserving personal protective equipment, accepting transfer of COVID-19 patients from other Hospitals that did not have the capacity or the capability to treat such patients and otherwise preparing to treat patients with COVID-19. See Executive Orders 2020-19 and 2020-33 (A. 4-7) (A. 8-13).

The Illinois State Medical Society ("ISMS") is comprised of over 9,000 participating physicians, residents, and medical students, including pediatric specialists. ISMS's mission is to promote the science and art of medicine, the protection of public health and the betterment of the medical profession. ISMS has a profound interest in this case because Executive Order 2020-19's grant of immunity to "Health Care

[1] All A.___ references are to the Appendix hereto.

Facilities" and "Health Care Professionals" during the start of the COVID-19 pandemic was necessary to ensure the levels of care necessary to respond to this novel outbreak, and as a result countless patients were treated by ISMS' members for both COVID-19 and non-COVID-19 related illnesses based upon that understanding of immunity.

Thus, IHA and ISMS and its members have a direct interest in seeing that the negligence immunity granted in Executive Order 2020-19 to those Health Care Facilities and those Health Care Professionals who provided COVID-19 service to the State is enforced as written and intended to apply to all negligence claims "for any injury or death alleged to have been caused by any act or omission" without regard to whether the claim involved an injury or death related to the diagnosis, transmission, or treatment of COVID-19.

Mindful that it is a privilege and not a right to appear as an amicus curiae before this Court, IHA and ISMS are grateful for the opportunity to do so in this case. Based upon the COVID-19 experience of many of their members statewide, IHA and ISMS respectfully submit that they bring to the Court a front-line perspective and analysis that will assist the Court in properly interpreting the immunity granted by the Governor in Executive Order 2020-19.

ARGUMENT

I. The Governor's Grant of Immunity in Executive Order 2020-19 Immunized All Health Care Facilities, Health Care Professionals, and Health Care Volunteers Who Rendered COVID-19Assistance From All Negligence Claims Without Regard to Whether the Claim Was Related to COVID-19 Care.

A. The Governor Reacts to the Crisis at Hand.

On April 1, 2020, in the face of a state-wide pandemic crisis, Governor Pritzker issued Executive Order 2020-19 (EO-19) (A. 4-7). Previously, on March 9, 2020, the Governor, pursuant to the provisions of Section 7 of the Illinois Emergency Management Agency Act (IEMA Act), 20 ILCS 3305/7, had issued a disaster proclamation finding that the COVID-19 pandemic had caused a disaster within the State of Illinois and declaring all counties in the State a disaster area. (A.1-3). As a March 30, 2020 study concluded: "COVID-19 patients are projected to overwhelm Illinois hospitals." (A. 20). The same study estimated that Illinois Hospitals statewide could have to render ICU care to twice as many COVID-19 patients as the number of ICU beds available. (A. 22).

To fight the pandemic, EO-19 directed all "Health Care Facilities," "Health Care Professionals," and "Health Care Volunteers" to render assistance in support of the State's response to the COVID-19 outbreak. (A. 6). For hospitals and other Health Care Facilities, this "rendering assistance" requirement had to include canceling or postponing elective surgeries and procedures, increasing the number of beds, preserving personal protective equipment, taking necessary steps to prepare to treat patients with COVID-19 (A. 6), and subsequently in Executive Order 2020-33, (EO-33) (A. 8-13), accepting transfer of COVID-19 patients from other hospitals who did not have the capacity or the capability

necessary to treat COVID-19 patients. (A. 11). For physicians and other Health Care Professionals, "rendering assistance" in support of the State's response meant "providing health care services at a Health Care Facility in response to the COVID-19 outbreak, or working under the direction of IEMA or DPH in response to the Gubernatorial Disaster Proclamations." (EO-19) (A. 6).

Reports of heroic, frontline, all-hands-on-deck efforts by hospitals, physicians, and other Health Care Facilities, Health Care Professionals, and Health Care Volunteers working at risk to their own health abounded:

- "Hospitals do best to prep for worst: If infection rates are not slowed, system could be overwhelmed," *Chicago Tribune*, March 19, 2020, p. 4 (A. 27);
- "How hospitals answer life, death questions in crisis," noting that "hospitals will be severely tested in the coming days, weeks and months," *Chicago Tribune,* March 18, 2020, p. 4 (A. 33);
- "Gut-wrenching decisions await when hospitals fill up," noting that "there is a very strong likelihood that despite heroic efforts by hospitals, we will run out of ICU beds and ventilators," *Chicago Tribune*, March 31, 2020, p. 15 (A. 35);
- '"Outgunned, outmanned, and underfunded': Inside Roseland hospital's battle against the coronavirus," noting "[w]e are literally on the front lines and we are being bombarded from every angle," *Chicago Tribune*, April 19, 2020, p. 1 (A. 39);
- "Hospital woes are also heating up in coronavirus cold zones," *Chicago Tribune,* April 24, 2020, p. 16 (A. 46);

- "What it's like to treat a COVID-19 patient: Springfield nurse explains the process, *Chicago Tribune*, April 8, 2020, p. 6 (A. 49);
- "12 nurses at University of Illinois Hospital in Chicago test positive," *Chicago Tribune*, March 29, 2020, p. 11 (A. 53);
- "Hospital workers at risk: Like doctors and nurses, other employees face elevated exposure to coronavirus," *Chicago Tribune*, May 20, 2020, p. 1 (A. 55);
- "Chicago hospital prepares for surge of COVID-19 patients," *Fox 32 Chicago*, March 26, 2020 (A. 59);
- '"It's really a hard time right now,' says Chicago nurse looking after COVID-19 patients," *MedicalNewsToday*, April 28, 2020. (A. 61).

In recognition of these sacrifices made by hospitals, physicians, and other Health Care Facilities and Health Care Professionals and Health Care Volunteers throughout the State in rendering service to the State by providing health care services in response to COVID-19 outbreak, the Governor, in accordance Section 21(c) of the IEMA Act, 20 ILCS 3305/21(c), included the following grants of immunity in EO-19 for Health Care Facilities, Health Care Professionals, and Health Care Volunteers.

> **" Section 3.** Pursuant to Sections 15 and 21(b)-(c) of the IEMA Act, 20 ILCS 3305/15 and 21(b)-(c), I direct that during the pendency of the Gubernatorial Disaster Proclamation, Health Care Facilities, as defined in Section 1 of this Executive Order, shall be immune from civil liability for any injury or death alleged to have been caused by any act or omission by the Health Care Facility, which injury or death occurred at a time when a Health Care Facility was engaged in the course of rendering assistance to the State by providing health care services in response to the COVID-19 outbreak, unless it is established that such injury or death was caused by gross negligence or willful misconduct of such Health Care Facility, if 20 ILCS

> 3305/15 is applicable,[2] or by willful misconduct, if 20 ILCS 3305/21 is applicable.[3]
>
> **Section 4**. Pursuant to Sections 15 and 21(b)-(c) of the IEMA Act, 20 ILCS 3305/15 and 21(b)-(c), I direct that during the pendency of the Gubernatorial Disaster Proclamations, Health Care Professionals, as defined in Section 1 of this Executive Order, shall be immune from civil liability for any injury or death alleged to have been caused by any act or omission by the Health Care Professional, which injury or death occurred at a time when a Health Care Professional was engaged in the course of rendering assistance to the State by providing health care services in response to the COVID-19 outbreak, unless it is established that such injury or death was caused by gross negligence or willful misconduct of such Health Care Professional, if 20 ILCS 3305/15 is applicable, or by willful misconduct, if 20 ILCS 3305/21 is applicable.
>
> **Section 5**. Pursuant to Section 21(c) of the IEMA Act, 20 ILCS 3305/21(c), and the Good Samaritan Act, 745 ILCS 49, I direct that during the pendency of the Gubernatorial Disaster Proclamation, any Health Care Volunteer, as defined in Section 1 of this Executive Order, shall be immune from civil liability for any injury or death alleged to have been caused by any act or omission by such Health Care Volunteer in the course of rendering assistance to the State by providing services, assistance, or support in response to the COVID-19 outbreak, unless it is established that such injury or death was caused by willful misconduct of such Health Care Volunteer." (A. 6).

This broad immunity grant for all negligent conduct was not an "absurd result" (AG Amicus Br. 15), but a realistic reflection that: 1) the burdensome and overarching demand placed on hospitals, physicians, and other Health Care Facilities and health care workers to provide COVID-19 care and the resulting strain on hospitals' and other Health Care Facilities' resources and personnel could affect the care rendered to all patients, not just COVID-19 patients; and 2) the financial impact on hospitals and physicians forced to

[2] 20 ILCS 3305/15 pertains to the State or political subdivision of the State.

[3] 20 ILCS 3305/21 applies to private persons, firms or corporations and their employees or agents.

cancel or postpone all elective surgeries would be severe. See "Rush hospital system latest to make cuts: Amid financial struggles executives take a pay cut, yearly raises being withheld," noting: "The Illinois Health and Hospital Association has estimated that the state's hospitals are losing $1.4 billion a month" in devoting their time, resources, and efforts to the COVID-19 crisis. *Chicago Tribune*, May 15, 2020, p. 1. (A.77); "Hospitals far busier, taking hit financially: Losing $1.4 billion with surgeries cancelled." *Chicago Tribune*, April 19, 2020, p. 1. (A. 72).

B. Plaintiff's and the AG's Narrow Interpretation of the Indemnity Grant Is Contrary to the Plain Language of EO-19 and the IEMA Act Itself.

Plaintiffs and the Attorney General (AG) seek to rewrite the immunity provision in EO-19 to limit the negligence immunity granted therein so that only those acts or omissions resulting in injuries or death "related" to COVID-19 are immune. (AG Amicus Br. 9) (Pl. Br. 14). That would rewrite the language of EO-19 providing that "Health Care Facilities," "Health Care Professionals," and "Health Care Volunteers" "shall be immune from civil liability for any injury or death alleged to have been caused by any act or omission" by a Health Care Facility or Health Care Professional or Health Care Volunteer as long as the "injury or death occurred at a time when [a Health Care Facility, Health Care Professional] was engaged in the course of rendering assistance to the State by providing health care services in response to the COVID-19 outbreak." (A. 6).

Indeed, this broad grant of negligence immunity "for civil liability for *any injury or death*" alleged to have been caused by "*any act or omission*" (emphasis added) without regard to whether those injuries or deaths were related to COVID-19 is consistent with the Preamble to EO-19 – expressly recognizing that those Health Care Facilities, Health Care Professionals, and Health Care Volunteers rendering assistance to the State in response to

the COVID-19 outbreak would still have to treat "patients afflicted with other maladies" and "provide care to all who need it." (A. 4). Furthermore, as the Appellate Court held (Opinion ¶¶ 17-25), such a narrow "related-to-COVID-19" reading of the immunity grant would also be inconsistent with the enabling statutory authority in Section 21(c) of the IEMA Act, 20 ILCS 3305/21(c), providing:

> "Any private person, firm or corporation, and any employee or agent of such person, firm or corporation, who renders assistance or advice at the request of the State, or any political subdivision of the State under this Act during an actual or impending disaster, shall not be civilly liable for causing the death of, or injury to, any person or damage to any property except in the event of willful misconduct."

Thus, giving the immunity granted in EO-19 the narrow interpretation urged by plaintiffs and the AG would violate the fundamental proposition that courts are not allowed to read restrictions into statutory language when the legislature "did not do so." *People ex rel. LeGout v. Decker*, 146 Ill. 2d 389, 395 (1992). "Where a statutory enactment is clear and unambiguous, a court is not at liberty to depart from the plain language and meaning of the statute by reading into it exceptions, limitations or conditions that the legislature did not express." *Wilkins v. Williams*, 2013 IL 114310, ¶ 22. Accord *Skokie Castings Inc. v. Illinois Ins. Guar. Fund*, 2013 IL 113873, ¶ 38.

C. The Governor's Subsequent Executive Orders Confirm that the Immunity Granted in EO-19 Was Intended to Apply to All Negligence Claims Against a Health Care Facility, Health Care Professional, or Health Care Volunteer Who Rendered Assistance to the State in Response to the COVID-19 Outbreak.

EO-19, issued on April 1, 2020, was effective for a period of 30 days. (A. 5). On April 30, 2020, the Governor issued Executive Order 2020-33. (EO-33) (A. 8-13). EO-33 reissued Executive Order EO-19, including the requirement that all Health Care Facilities and Health Care Professionals and Health Care Volunteers render assistance to support the

State's response to the COVID-19 outbreak with the same grant of immunity "from civil liability for any injury or death alleged to have been caused by any act or omission by" such a Health Care Facility, Health Care Professional, or Health Care Volunteer. (A. 10-11). However, on May 13, 2020, the Governor issued a third Executive Order, Executive Order 2020-37 (EO-37) (A. 14-18), in which he narrowed the immunity for Health Care Facilities and Health Care Professionals, except for Health Care Volunteers and those Hospitals and Health Care Professionals who continued to cancel all elective surgeries and procedures. Thus, EO-37 contains **two** separate and independent immunity grants as follows:

> "**Section 3**. Pursuant to Sections 15 and 21(b)-(c) of the IEMA Act, 20 ILCS 3305/15 and 21(b)-(c), I direct that during the pendency of the Gubernational Disaster Proclamations, *Hospitals that continue to cancel or postpone all elective surgeries* or procedures in order to respond to the COVID-19 outbreak, or Health Care Professionals providing service in such a Hospital, *shall be immune from civil liability for any injury or death alleged to have been caused by any act or omission by the Hospital or Health Care Professional*, which injury or death occurred at a time when a Hospital or Health Care Professional was rendering assistance to the State in response to the COVID-19 outbreak by providing health care services consistent with current guidance issued by IDPH. This section is inapplicable if it is established that such injury or death was caused by gross negligence or willful misconduct of such Hospital or Health Care Professional, if 20 ILCS 3305/15 is applicable, or by willful misconduct, if 20 ILCS 3305/21 is applicable.
>
> **Section 4**. Pursuant to Sections 15 and 21(b)-(c) of the IEMA Act, 20 ILCS 3305/15 and 21(b)-(c), I direct that during the pendency of the Gubernational Disaster Proclamations, *Hospitals that conduct elective surgeries or procedures beginning on or after May 11, 2020*, or Health Care Professionals providing services in such a Hospital, *shall be immune from civil liability for any injury or death relating to the diagnosis, transmission, or treatment of COVID-19* alleged to have been caused by any act or omission by the Hospital or the Health Care Professional, which injury or death occurred at a time when a Hospital or Health Care Professional was rendering

> assistance to the State in response to the COVID-19 outbreak by providing health care services consistent with current guidance issued by IDPH. This section is inapplicable if it is established that such injury or death was caused by gross negligence or willful misconduct of such Hospital or Health Care Professional, if 20 ILCS 3305/15 is applicable, or by willful misconduct, if 20 ILCS 3305/21 is applicable.
>
> **Section 5.** Pursuant to Sections 15 and 21(b)-(c) of the IEMA Act, 20 ILCS 3305/15 and 21(b)-(c), I direct that during the pendency of the Gubernatorial Disaster Proclamations, Health Care Facilities or Health Care Professionals providing services in a Health Care Facility, *shall be immune from civil liability for any injury or death relating to the diagnosis, transmission, or treatment of COVID-19* alleged to have been caused by any act or omission by the Health Care Facility or the Health Care Professional, which injury or death occurred at a time when a Health Care Facility or Health Care Professional was rendering assistance to the State in response to the COVID-19 outbreak by providing health care services consistent with current guidance issued by IDPH. This section is inapplicable if it is established that such injury or death was caused by gross negligence or willful misconduct of such Health Care Facility or Health Care Professional, if 20 ILCS 3305/15 is applicable, or by willful misconduct, if 20 ILCS 3305/21 is applicable.
>
> **Section 6**. Pursuant to Section 21(c) of the IEMA Act, 20 ILCS 3305/21(c), and the Good Samaritan Act, 745 ILCS 49, I direct that during the pendency of the Gubernatorial Disaster Proclamations, any Health Care Volunteer, as defined in Section 1 of this Executive Order, *shall be immune from civil liability for any injury or death alleged to have been caused by any act or omission by such Health Care Volunteer*, which injury or death occurred at a time when the Health Care Volunteer was rendering assistance to the State in response to the COVID-19 outbreak by providing services, assistance, or support consistent with current guidance issued by IDPH. This section is inapplicable if it is established that such injury or death was caused by willful misconduct of such Health Care Volunteer." (Emphasis added). (A. 17-18).

Pursuant to these four separate sections of EO-37, the broad negligence immunity for "any injury or death alleged to have been caused by any act or omission" provided by EO-19 still applied to Hospital Volunteers and those Hospitals and Health Care

Professionals who continued to cancel or postpone revenue-producing elective surgeries permitted by the IDPH as of May 11, 2020. However, for all other Health Care Facilities and Health Care Professionals, the immunity provision was narrowed to apply only to "civil liability for any injury or death *relating to the diagnosis, transmission, or treatment of Covid-19*." (emphasis added).

Obviously, if the Governor intended the broad immunity conferred by EO-19 and reiterated in Sections 3 and 6 of EO-37 (for Hospital Volunteers and those Hospitals and Health Care Professionals who continued to postpone or cancel elective surgeries) to be the same narrow immunity set forth in Sections 4 and 5 of EO-37 (for Hospitals that did commence elective surgeries and other Health Care Facilities and Health Care Professionals), then the narrower immunity language in Sections 4 and 5 of EO-37 would be rendered meaningless surplusage – violating another fundamental rule of statutory construction. *People v. Wick*, 107 Ill.2d 62, 67 (1985) (rejecting a statutory construction that "would render all of the language of the aggravated-arson statute that proceeds its subsections meaningless surplusage" and noting that "[t]he rule of statutory construction followed by this court is that the presence of surplusage will not be presumed"); *Arnold v. Board of Trustees of County Emp. Annuity and Benefit Fund of Cook County*, 84 Ill.2d 57, 63 (1981) ("a presumption of surplusage is impermissible under the traditional rules of statutory construction") (citation); *Ultsch v. Illinois Mun. Retirement Fund,* 226 Ill.2d 169, 187 (2007) (provisions in a statute should be "interpreted in light of other relevant portions of the statute so that, if possible, no term is rendered superfluous or meaningless.") (citation).

In short, the Governor was fully aware of how to draft an immunity provision that would apply only to negligence claims against a Health Care Facility or Health Care Professional that were related to COVID-19 care. He did so in EO-37 with respect to those Hospitals that chose to begin performing elective surgeries and other Health Care Facilities and Health Care Professionals. Clearly then, he did not do so in EO-19 which conferred negligence immunity on Health Care Facilities and Health Care Professionals "from civil liability for any injury or death alleged to have been caused by any act or omission" – and was *not* limited to "civil liability for any injury or death relating to the diagnosis, transmission or treatment of COVID-19."

CONCLUSION

For the reasons set forth herein and in the Appellee's Brief, the Illinois Health and Hospital Association and the Illinois State Medical Society respectfully request that the Appellate Court's affirmative answer to the certified issue be affirmed.

Respectfully submitted,

THE ILLINOIS HEALTH AND HOSPITAL ASSOCIATION and
THE ILLINOIS STATE MEDICAL SOCIETY

By: */s/ Hugh C. Griffin*
Hugh C. Griffin, their attorney

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Supreme Court Rule 341(c) Certification of Compliance

Pursuant to Supreme Court Rule 341(c), I certify that this Amici Curiae's Brief conforms to the requirements of Rules 341(a), (b) and Rule 345. The length of this brief, excluding the pages containing the Rule 341(d) cover, the Rule 341(h)(1) table of contents and statement of points and authorities, the Rule 341(c) certificate of compliance, the certificate of service and the matters contained in the Appendix, is **12** pages.

Respectfully submitted,

THE ILLINOIS HEALTH AND HOSPITAL ASSOCIATION and
THE ILLINOIS STATE MEDICAL SOCIETY

By: */s/ Hugh C. Griffin*
Hugh C. Griffin, their attorney

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APPENDIX

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GUBERNATORIAL DISASTER PROCLAMATION

WHEREAS, in late 2019, a new and significant outbreak of Coronavirus Disease 2019 (COVID-19) emerged in China; and,

WHEREAS, COVID-19 is a novel severe acute respiratory illness that can spread among people through respiratory transmissions and present with symptoms similar to those of influenza; and,

WHEREAS, certain populations are at higher risk of experiencing more severe illness as a result of COVID-19, including older adults and people who have serious chronic medical conditions such as heart disease, diabetes, or lung disease; and,

WHEREAS, we are continuing our efforts to prepare for any eventuality given that this is a novel illness and given the known health risks it poses for the elderly and those with serious chronic medical conditions; and,

WHEREAS, the World Health Organization declared COVID-19 a Public Health Emergency of International Concern on January 30, 2020, and the United States Secretary of Health and Human Services declared that COVID-19 presents a public health emergency on January 27, 2020; and,

WHEREAS, the World Health Organization has reported 109,578 confirmed cases of COVID-19 and 3,809 deaths attributable to COVID-19 globally as of March 9, 2020; and,

WHEREAS, in response to the recent COVID-19 outbreaks in China, Iran, Italy and South Korea, the Centers for Disease Control and Prevention ("CDC") has deemed it necessary to prohibit or restrict non-essential travel to or from those countries; and,

WHEREAS, the CDC has advised older travelers and those with chronic medical conditions to avoid nonessential travel, and has advised all travelers to exercise enhanced precautions; and,

WHEREAS, the CDC currently recommends community preparedness and everyday prevention measures be taken by all individuals and families in the United States, including voluntary home isolation when individuals are sick with respiratory symptoms, covering coughs and sneezes with a tissue, washing hands often with soap and water for at least 20 seconds, use of alcohol-based hand sanitizers with at least 60% alcohol if soap and water are not readily available, and routinely cleaning frequently touched surfaces and objects to increase community resilience and readiness for responding to an outbreak; and,

WHEREAS, a vaccine or drug is currently not available for COVID-19; and,

WHEREAS, in communities with confirmed COVID-19 cases, the CDC currently recommends mitigation measures, including staying at home when sick, when a household

member is sick with respiratory disease symptoms or when instructed to do so by public health officials or a health care provider and keeping away from others who are sick; and,

WHEREAS, despite efforts to contain COVID-19, the World Health Organization and the CDC indicate that it is expected to spread; and,

WHEREAS, there are currently 11 confirmed cases of COVID-19 and an additional 260 persons under investigation in Illinois; and,

WHEREAS, one of the confirmed cases of COVID-19 in Illinois has not been linked to any travel activity or to an already-confirmed COVID-19 case, which indicates community transmission in Illinois; and,

WHEREAS, based on the foregoing, the circumstances surrounding COVID-19 constitute a public health emergency under Section 4 of the Illinois Emergency Management Agency Act; and,

WHEREAS, it is the policy of the State of Illinois that the State will be prepared to address any disasters and, therefore, it is necessary and appropriate to make additional State resources available to ensure that the effects of COVID-19 are mitigated and minimized and that residents and visitors in the State remain safe and secure; and,

WHEREAS, this proclamation will assist Illinois agencies in coordinating State and Federal resources, including the Strategic National Stockpile of medicines and protective equipment, to support local governments in preparation for any action that may be necessary related to the potential impact of COVID-19 in the State of Illinois; and,

WHEREAS, these conditions provide legal justification under Section 7 of the Illinois Emergency Management Agency Act for the issuance of a proclamation of disaster;

NOW, THEREFORE, in the interest of aiding the people of Illinois and the local governments responsible for ensuring public health and safety, I, JB Pritzker, Governor of the State of Illinois, hereby proclaim as follows:

Section 1. Pursuant to the provisions of Section 7 of the Illinois Emergency Management Agency Act, 20 ILCS 3305/7, I find that a disaster exists within the State of Illinois and specifically declare all counties in the State of Illinois as a disaster area.

Section 2. The Illinois Department of Public Health and the Illinois Emergency Management Agency are directed to coordinate with each other with respect to planning for and responding to the present public health emergency.

Section 3. The Illinois Department of Public Health is further directed to cooperate with the Governor, other State agencies and local authorities, including local public health authorities, in the development of strategies and plans to protect the public health in connection with the present public health emergency.

Section 4. The Illinois Emergency Management Agency is directed to implement the State Emergency Operations Plan to coordinate State resources to support local governments in disaster response and recovery operations.

Section 5. To aid with emergency purchases necessary for response and other emergency powers as authorized by the Illinois Emergency Management Agency Act, the provisions of the Illinois Procurement Code that would in any way prevent, hinder or delay necessary action in coping with the disaster are suspended to the extent they are not required by federal law. If necessary, and in accordance with Section 7(1) of the Illinois Emergency Management Agency Act, 20 ILCS 3305/7(1), the Governor may take appropriate executive action to suspend additional statutes, orders, rules, and regulations.

Section 6. Pursuant to Section 7(3) of the Illinois Emergency Management Agency Act, 20 ILCS 3305/7(3), this proclamation activates the Governor's authority, as necessary, to transfer the direction, personnel or functions of State departments and agencies or units thereof for the purpose of performing or facilitating emergency response programs.

Section 7. The Illinois Department of Public Health, Illinois Department of Insurance and the Illinois Department of Healthcare and Family Services are directed to recommend, and, as appropriate, take necessary actions to ensure consumers do not face financial barriers in accessing diagnostic testing and treatment services for COVID-19.

Section 8. The Illinois State Board of Education is directed to recommend, and, as appropriate, take necessary actions to address chronic absenteeism due to transmission of COVID-19 and to alleviate any barriers to the use of e-learning during the effect of this proclamation that exist in the Illinois School Code, 105 ILCS 5/1-1 et. seq.

Section 9. Pursuant to Section 7(14) of the Illinois Emergency Management Agency Act, 20 ILCS 3305/7(14), increases in the selling price of goods or services, including medical supplies, protective equipment, medications and other commodities intended to assist in the prevention of or treatment and recovery of COVID-19, shall be prohibited in the State of Illinois while this proclamation is in effect:

Section 10. This proclamation can facilitate a request for Federal emergency and/or disaster assistance if a complete and comprehensive assessment of damage indicates that effective recovery is beyond the capabilities of the State and affected local governments.

Section 11. This proclamation shall be effective immediately and remain in effect for 30 days.

Issued by the Governor March 9, 2020
Filed by the Secretary of State March 9, 2020

STATE OF ILLINOIS

EXECUTIVE DEPARTMENT

SPRINGFIELD, ILLINOIS

FILED

APR 01 2020

SECRETARY OF STATE

April 1, 2020 Executive Order 2020-19

EXECUTIVE ORDER IN RESPONSE TO COVID-19
(COVID-19 EXECUTIVE ORDER NO. 17)

WHEREAS, I, JB Pritzker, Governor of Illinois, declared all counties in the State of Illinois as a disaster area on March 9, 2020 (First Gubernatorial Disaster Proclamation) in response to the outbreak of Coronavirus Disease 2019 (COVID-19); and,

WHEREAS, I again declared all counties in the State of Illinois as a disaster area on April 1, 2020 (the Second Gubernatorial Disaster Proclamation, and, together with the First Gubernatorial Disaster Proclamation, the Gubernatorial Disaster Proclamations) in response to the exponential spread of COVID-19; and,

WHEREAS, in a short period of time, COVID-19 has rapidly spread throughout Illinois, necessitating updated and more stringent guidance from federal, state, and local public health officials; and,

WHEREAS, for the preservation of public health and safety throughout the entire State of Illinois, and to ensure that our healthcare delivery system is capable of serving those who are sick, I find it necessary to take additional measures consistent with public health guidance; and,

WHEREAS, ensuring the State of Illinois has adequate bed capacity, supplies, and providers to treat patients afflicted with COVID-19, as well as patients afflicted with other maladies, is of critical importance; and,

WHEREAS, eliminating obstacles or barriers to the provision of supplies and health care services is necessary to ensure the Illinois healthcare system has adequate capacity to provide care to all who need it; and,

WHEREAS, the Illinois Department of Financial and Professional Regulation and the Illinois Department of Public Health (DPH) have taken measures, and continue to take measures, to enable inactive and out-of-state health care workers to come back to work in the State of Illinois through proclamations, emergency rules and variances; and,

WHEREAS, DPH has taken measures, and continues to take measures, to enable hospitals to increase bed capacity and provide levels of care necessary to respond to the COVID-19 outbreak; and,

WHEREAS, Section 6(c)(1) of the Illinois Emergency Management Agency Act (IEMA Act), 20 ILCS 3305/6, provides that the Governor is authorized to "make, amend, and rescind all lawful necessary orders, rules, and regulations to carry out the provisions of this Act within the limits of the authority conferred upon the Governor"; and,

WHEREAS, Section 15 of the IEMA Act, 20 ILCS 3305/15, provides that "Neither the State, any political subdivision of the State, nor, except in cases of gross negligence or willful misconduct, the Governor, the Director, the Principal Executive Officer of a political

subdivision, or the agents, employees, or representatives of any of them, engaged in any emergency management response or recovery activities, while complying with or attempting to comply with this Act or any rule or regulations promulgated pursuant to this Act is liable for the death of or any injury to persons, or damage to property, as a result of such activity"; and,

WHEREAS, Section 21(b) of the IEMA Act, 20 ILCS 3305/21, provides that "Any private person, firm or corporation and employees and agents of such person, firm or corporation in the performance of a contract with, and under the direction of, the State, or any political subdivision of the State under the provisions of this Act shall not be civilly liable for causing the death of, or injury to, any person or damage to any property except in the event of willful misconduct"; and,

WHEREAS, Section 21(c) of the IEMA Act, 20 ILCS 3305/21, provides that "Any private person, firm or corporation, and any employee or agent of such person, firm or corporation, who renders assistance or advice at the request of the State, or any political subdivision of the State under this Act during an actual or impending disaster, shall not be civilly liable for causing the death of, or injury to, any person or damage to any property except in the event of willful misconduct"; and,

WHEREAS, Section 3.150(a) of the Emergency Medical Services (EMS) Systems Act, 210 ILCS 50/3.150, provides that persons "who in good faith provide[] emergency or non-emergency medical services during a Department [of Public Health] approved training course, in the normal course of conducting their duties, or in an emergency, shall not be civilly liable as a result of their acts or omissions in providing such services unless such acts or omissions, including the bypassing of nearby hospitals or medical facilities in accordance with the protocols developed pursuant to this Act, constitute willful and wanton misconduct"; and,

WHEREAS, the Good Samaritan Act, 745 ILCS 49, provides that "the generous and compassionate acts of its citizens," specifically health care professionals, "who volunteer their time and talents to help others" should be exempt from civil liability unless such acts demonstrate willful or wanton misconduct;

THEREFORE, by the powers vested in me as the Governor of the State of Illinois, and pursuant to Sections 7(1), 7(2), 7(3), 7(12), 15, and 21 of the IEMA Act, 20 ILCS 3305, I hereby order the following, effective April 1, 2020 and for the remainder of the duration of the Gubernatorial Disaster Proclamations, which currently extends through April 30, 2020:

Section 1. For purposes of this Executive Order, the following terms are defined as set forth below:

(a) "Health Care Facilities" means:

i. Facilities licensed, certified, or approved by any State agency and covered by the following: 77 Ill. Admin. Section 1130.215(a)-(f); University of Illinois Hospital Act, 110 ILCS 330; Alternative Health Care Delivery Act, 210 ILCS 3/35(2)-(4); Emergency Medical Services (EMS) Systems Act, 210 ILCS 50; or Department of Veterans' Affairs Act, 20 ILCS 2805;

ii. State-operated Developmental Centers certified by the federal Centers for Medicare and Medicaid Services and licensed State-operated Mental Health Centers created pursuant to the Mental Health and Developmental Disabilities Administrative Act, 20 ILCS 1705/4;

iii. Licensed community-integrated living arrangements as defined by the Community-Integrated Living Arrangements Licensing and Certification Act, 210 ILCS 135/2;

iv. Licensed Community Mental Health Centers as defined in the Community Services Act, 405 ILCS 30;

v. Federally qualified health centers under the Social Security Act, 42 U.S.C. § 1396d(l)(2)(B); and

vi. Any government-operated site providing health care services established for the purpose of responding to the COVID-19 outbreak.

"Health Care Facility" is the singular form of the plural "Health Care Facilities."

(b) "Health Care Professional" means all licensed or certified health care or emergency medical services workers who (i) are providing health care services at a Health Care Facility in response to the COVID-19 outbreak and are authorized to do so; or (ii) are working under the direction of the Illinois Emergency Management Agency (IEMA) or DPH in response to the Gubernatorial Disaster Proclamations.

(c) "Health Care Volunteer" means all volunteers or medical or nursing students who do not have licensure who (i) are providing services, assistance, or support at a Health Care Facility in response to the COVID-19 outbreak and are authorized to do so; or (ii) are working under the direction of IEMA or DPH in response to the Gubernatorial Disaster Proclamations.

Section 2. Pursuant to Sections 15 and 21(b)-(c) of the IEMA Act, 20 ILCS 3305/15 and 21(b)-(c) and the Good Samaritan Act, 745 ILCS 49, I direct all Health Care Facilities, Health Care Professionals, and Health Care Volunteers, as defined in Section 1 of this Executive Order, to render assistance in support of the State's response to the disaster recognized by the Gubernatorial Disaster Proclamations (COVID-19 outbreak). For Health Care Facilities, "rendering assistance" in support of the State's response must include cancelling or postponing elective surgeries and procedures, as defined in DPH's COVID-19 – Elective Surgical Procedure Guidance, if elective surgeries or procedures are performed at the Health Care Facility. In addition, for Health Care Facilities, "rendering assistance" in support of the State's response must include measures such as increasing the number of beds, preserving personal protective equipment, or taking necessary steps to prepare to treat patients with COVID-19. For Health Care Professionals, "rendering assistance" in support of the State's response means providing health care services at a Health Care Facility in response to the COVID-19 outbreak, or working under the direction of IEMA or DPH in response to the Gubernatorial Disaster Proclamations. For Health Care Volunteers, "rendering assistance" in support of the State's response means providing services, assistance, or support at a Health Care Facility in response to the COVID-19 outbreak, or working under the direction of IEMA or DPH in response to the Gubernatorial Disaster Proclamations.

Section 3. Pursuant to Sections 15 and 21(b)-(c) of the IEMA Act, 20 ILCS 3305/15 and 21(b)-(c), I direct that during the pendency of the Gubernatorial Disaster Proclamation, Health Care Facilities, as defined in Section 1 of this Executive Order, shall be immune from civil liability for any injury or death alleged to have been caused by any act or omission by the Health Care Facility, which injury or death occurred at a time when a Health Care Facility was engaged in the course of rendering assistance to the State by providing health care services in response to the COVID-19 outbreak, unless it is established that such injury or death was caused by gross negligence or willful misconduct of such Health Care Facility, if 20 ILCS 3305/15 is applicable, or by willful misconduct, if 20 ILCS 3305/21 is applicable.

Section 4. Pursuant to Sections 15 and 21(b)-(c) of the IEMA Act, 20 ILCS 3305/15 and 21(b)-(c), I direct that during the pendency of the Gubernatorial Disaster Proclamations, Health Care Professionals, as defined in Section 1 of this Executive Order, shall be immune from civil liability for any injury or death alleged to have been caused by any act or omission by the Health Care Professional, which injury or death occurred at a time when a Health Care Professional was engaged in the course of rendering assistance to the State by providing health care services in response to the COVID-19 outbreak, unless it is established that such injury or death was caused by gross negligence or willful misconduct of such Health Care Professional, if 20 ILCS 3305/15 is applicable, or by willful misconduct, if 20 ILCS 3305/21 is applicable.

Section 5. Pursuant to Section 21(c) of the IEMA Act, 20 ILCS 3305/21(c), and the Good Samaritan Act, 745 ILCS 49, I direct that during the pendency of the Gubernatorial Disaster Proclamation, any Health Care Volunteer, as defined in Section 1 of this Executive Order, shall be immune from civil liability for any injury or death alleged to have been caused by any act or omission by such Health Care Volunteer in the course of rendering assistance to the State by providing services, assistance, or support in response to the COVID-19 outbreak, unless it is

established that such injury or death was caused by willful misconduct of such Health Care Volunteer.

Section 6. Nothing in this Executive Order shall be construed to preempt or limit any applicable immunity from civil liability available to any Health Care Facility, Health Care Professional, or Health Care Volunteer.

Section 7. If any provision of this Executive Order or its application to any person or circumstance is held invalid by any court of competent jurisdiction, this invalidity does not affect any other provision or application of this Executive Order, which can be given effect without the invalid provision or application. To achieve this purpose, the provisions of this Executive Order are declared to be severable.

JB Pritzker, Governor

Issued by the Governor April 1, 2020
Filed by the Secretary of State April 1, 2020

FILED
INDEX DEPARTMENT
APR 01 2020
IN THE OFFICE OF
SECRETARY OF STATE

STATE OF ILLINOIS

EXECUTIVE DEPARTMENT

SPRINGFIELD, ILLINOIS

April 30, 2020

CORRECTED
Executive Order 2020-33

EXECUTIVE ORDER IN RESPONSE TO COVID-19
(COVID-19 EXECUTIVE ORDER NO. 31)

WHEREAS, protecting the health and safety of Illinoisans is among the most important functions of State government; and,

WHEREAS, Coronavirus Disease 2019 (COVID-19) is a novel severe acute respiratory illness that has spread among people through respiratory transmissions, the World Health Organization declared COVID-19 a Public Health Emergency of International Concern on January 30, 2020, and the United States Secretary of Health and Human Services declared that COVID-19 presents a public health emergency on January 27, 2020; and,

WHEREAS, as the virus has progressed through Illinois, the crisis facing the State has developed and now requires an evolving response to ensure hospitals, health care professionals and first responders are able to meet the health care needs of all Illinoisans and in a manner consistent with CDC guidance that continues to be updated; and,

WHEREAS, I declared all counties in the State of Illinois as a disaster area on April 30, 2020 because the current circumstances in Illinois surrounding the spread of COVID-19, including the devasting impacts to the health and lives of people throughout the State, the threatened shortages of hospital beds, ICU beds, ventilators, and PPE, and the critical need for increased COVID-19 testing capacity, constitute an epidemic emergency and a public health emergency; and,

WHEREAS, in response to the epidemic emergency and public health emergency described above, I find it necessary to re-issue Executive Orders 2020-03, 2020-04, 2020-05, 2020-06, 2020-07, 2020-08, 2020-09, 2020-11, 2020-12, 2020-13, 2020-14, 2020-15, 2020-16, 2020-17, 2020-19, 2020-20, 2020-21, 2020-22, 2020-23, 2020-24, 2020-25, 2020-26, 2020-27, 2020-28, 2020-29, 2020-30, and 2020-31, and hereby incorporate the WHEREAS clauses of those Executive Orders;

THEREFORE, by the powers vested in me as the Governor of the State of Illinois, pursuant to the Illinois Constitution and Sections 7(1), 7(2), 7(3), 7(8), 7(9), and 7(12) of the Illinois Emergency Management Agency Act, 20 ILCS 3305, and consistent with the powers in public health laws, I hereby order the following, effective April 30, 2020:

Part 1: Re-Issue of Executive Orders.

Executive 2020-03, 2020-04, 2020-05, 2020-06, 2020-07, 2020-08, 2020-09, 2020-11, 2020-12, 2020-13, 2020-14, 2020-15, 2020-16, 2020-17, 2020-19, 2020-20, 2020-21, 2020-22, 2020-23, 2020-24, 2020-25, 2020-26, 2020-27, 2020-28, 2020-29, 2020-30, and 2020-31 hereby are re-issued by this Executive Order 2020-33 as follows:

Executive Order 2020-04 (Closure of James R. Thompson Center; Waiver of Sick Leave Requirement for State Employees):

Sections 2 and 3 of Executive Order 2020-04 are re-issued and extended through **May 29, 2020.**

Executive Orders 2020-05 and 2020-06 (School Closures):

Executive Orders 2020-05 and 2020-06 are re-issued in their entirety and extended through **May 29, 2020.**

Executive Order 2020-07 (Suspension of on-premises consumption at restaurants and bars; Unemployment insurance; Open Meetings Act):

Sections 1, 3, 4, 5, and 6, as amended below, of Executive Order 2020-07 are re-issued and extended through **May 29, 2020.**

Section 6. During the duration of the Gubernatorial Disaster Proclamation and through May 29, 2020, the provisions of the Open Meetings Act, 5 ILCS 120, requiring or relating to in-person attendance by members of a public body are suspended. Specifically, (1) the requirement in 5 ILCS 120/2.01 that "members of a public body must be physically present" is suspended; and (2) the conditions in 5 ILCS 120/7 limiting when remote participation is permitted are suspended. The provision of the Illinois Finance Authority Act that "[a]ll meetings shall be conducted at a single location within the State with a quorum of members physically present at this location," 20 ILCS 3501/801-25, is suspended through May 29, 2020. The provision of the Illinois Administrative Code that a meeting of the Concealed Carry Licensing Review Board that a requires a "quorum is in attendance at a meeting" as a condition for when "Commissioners may attend telephonically or electronically," 20 Ill. Admin. Code 2900.110(c), is suspended through May 29, 2020.

Public bodies, including those listed specifically above, are encouraged to postpone consideration of public business where possible. When a meeting is necessary, public bodies are encouraged to provide video, audio, and/or telephonic access to meetings to ensure members of the public may monitor the meeting, and to update their websites and social media feeds to keep the public fully apprised of any modifications to their meeting schedules or the format of their meetings due to COVID-19, as well their activities relating to COVID-19.

Executive Order 2020-08 (Secretary of State Operations):

Executive Order 2020-08 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-09 (Telehealth):

Executive Order 2020-09 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-11 (Revisions to prior Executive Orders; Department of Corrections notification period):

Sections 3 and 4 of Executive Order 2020-11 are re-issued and extended through **May 29, 2020.**

Executive Order 2020-12 (Health care worker background checks; Department of Juvenile Justice notification period; Coal Mining Act):

Executive Order 2020-12 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-13 (Suspending Department of Corrections admissions from county jails):

Executive Order 2020-13 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-14 (Notary and witness guidelines):

Executive Order 2020-14, as amended below, is re-issued in its entirety and extended through **May 29, 2020.**

Section 2. During the duration of the Gubernatorial Disaster Proclamation related to the outbreak of COVID-19, any act of witnessing required by Illinois law may be completed remotely by via two-way audio-video communication technology, provided that:

a. The two-way audio-video communication technology must allow for direct, contemporaneous interaction between the individual signing the document ("the signatory") and the witness by sight and sound;
b. The two-way audio-video communication technology must be recorded and preserved by the signatory or the signatory's designee for a period of at least three years;
c. The signatory must attest to being physically located in Illinois during the two-way audio-video communication;
d. The witness must attest to being physically located in Illinois during the two-way audio-video communication;
e. The signatory must affirmatively state on the two-way audio-video communication what document the signatory is signing;
f. Each page of the document being witnessed must be shown to the witness on the two-way audio-video communication technology in a means clearly legible to the witness and initialed by the signatory in the presence of the witness;
g. The act of signing must be captured sufficiently up close on the two-way audio-video communication for the witness to observe;
h. The signatory must transmit by overnight mail, fax, or electronic means a legible copy of the entire signed document directly to the witness no later than the day after the document is signed;
i. The witness must sign the transmitted copy of the document as a witness and transmit the signed copy of the document back via overnight mail, fax, or electronic means to the signatory within 24 hours of receipt; and,
j. If necessary, the witness may sign the original signed document as of the date of the original execution by the signatory provided that the witness receives the original signed document together with the electronically witnessed copy within thirty days from the date of the remote witnessing.

Executive Order 2020-15 (Suspending provisions of the Illinois School Code):

Executive Order 2020-15 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-16 (Repossession of vehicles; suspension of classroom training requirement for security services):

Executive Order 2020-16 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Orders 2020-03 and 2020-17 (Cannabis deadlines and applications):

Executive Orders 2020-03 and 2020-17, as modified by Executive Order 2020-18, are re-issued and shall remain in effect as specified by Executive Order 2020-18.

Executive Order 2020-19 (Immunity from civil liability for health care facilities, professionals, and volunteers):

Executive Order 2020-19, as amended below, is re-issued in its entirety and extended through **May 29, 2020.**

Section 1. For purposes of this Executive Order, the following terms are defined as set forth below:

a. "Health Care Facilities" means:

i. Facilities licensed, certified, or approved by any State agency and covered by the following: 77 Ill. Admin. Section 1130.215(a)-(f); University of Illinois Hospital Act, 110 ILCS 330; Alternative Health Care Delivery Act, 210 ILCS 3/35(2)-(4); Emergency Medical Services (EMS) Systems Act, 210 ILCS 50; or Department of Veterans' Affairs Act, 20 ILCS 2805;
ii. State-operated Developmental Centers certified by the federal Centers for Medicare and Medicaid Services and licensed State-operated Mental Health Centers created pursuant to the Mental Health and Developmental Disabilities Administrative Act, 20 ILCS 1705/4;
iii. Licensed community-integrated living arrangements as defined by the Community-Integrated Living Arrangements Licensing and Certification Act, 210 ILCS 135/2;
iv. Licensed Community Mental Health Centers as defined in the Community Services Act, 405 ILCS 30;
v. Federally qualified health centers under the Social Security Act, 42 U.S.C. § 1396d(l)(2)(B); ~~and~~
vi. Any government-operated site providing health care services established for the purpose of responding to the COVID-19 outbreak;
vii. Supportive living facilities certified by the Illinois Department of Healthcare and Family Services pursuant to the Illinois Public Aid Code, 305 ILCS 5/5-5.01(a); and,
viii. Assisted living establishments and shared housing establishments licensed by the DPH pursuant to the Assisted Living and Shared Housing Act, 210 ILCS 9.

"Health Care Facility" is the singular form of the plural "Health Care Facilities."

b. "Health Care Professional" means all licensed or certified health care or emergency medical services workers who (i) are providing health care services at a Health Care Facility in response to the COVID-19 outbreak and are authorized to do so; or (ii) are working under the direction of the Illinois Emergency Management Agency (IEMA) or DPH in response to the Gubernatorial Disaster Proclamations.
c. "Health Care Volunteer" means all volunteers or medical or nursing students who do not have licensure who (i) are providing services, assistance, or support at a Health Care Facility in response to the COVID-19 outbreak and are authorized to do so; or (ii) are working under the direction of IEMA or DPH in response to the Gubernatorial Disaster Proclamations.

Section 8. For purposes of Section 2, rendering assistance by hospitals licensed pursuant to the Illinois Hospital Licensing Act, 210 ILCS 85, must also include accepting a transfer of a COVID-19 patient from another hospital, including hospital inpatients, and state-operated entities (collectively, "transferring entities") that do not have the capacity and capability necessary to provide treatment for a COVID-19 patient. The receiving hospital shall accept such transfer of a COVID-19 patient if it has sufficient capacity and capability necessary to provide treatment for the COVID-19 patient. In determining whether a hospital has sufficient capacity and capability necessary to provide treatment for a COVID-19 patient, the hospital shall consider, at a minimum, its ability to provide safe and effective treatment consistent with current public health recommendations and available supplies, staffing, and medical bed capacity.

Executive Order 2020-20 (Public assistance requirements):

Executive Order 2020-20 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-21 (Furlough of Illinois Department of Corrections inmates):

Executive Order 2020-21 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-22 (Township meetings; Funeral Directors and Embalmers Licensing Code; placements under the Child Care Act of 1969; fingerprint submissions under Health Care Worker Background Check Act):

Executive Order 2020-22 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-23 (Actions by the Illinois Department of Financial and Professional Regulation for licensed professionals engaged in disaster response):

Executive Order 2020-23 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-24 (Illinois Department of Human Services Forensic Treatment Program; investigations of Illinois Department of Human Services employees):

Executive Order 2020-24 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-25 (Garnishment and wage deductions):

Executive Order 2020-25 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-26 (Hospital capacity):

Executive Order 2020-26 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-27 (Cadavers testing positive for COVID-19):

Executive Order 2020-27 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-28 (Industrial radiography certifications):

Executive Order 2020-28 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-29 (In-person education or exams for professional insurance licenses):

Executive Order 2020-29 is re-issued in its entirety and extended through **May 29, 2020.**

Executive Order 2020-30 (Filing of residential eviction actions; enforcement of non-residential eviction orders; expired consular identification documents; electronic filings for the Illinois Human Rights Commission):

Executive Order 2020-30, as amended below, is re-issued in its entirety and extended through **May 29, 2020.**

Section 3. All state, county, and local law enforcement officers in the State of Illinois are instructed to cease enforcement of orders of eviction for residential and non-residential premises, unless the tenant has been found to pose a direct threat to the health and safety of other tenants, an immediate and severe risk to property, or a violation of any applicable building code, health ordinance, or similar regulation. Nothing in this Executive Order shall be construed as relieving any individual or entity of the obligation to pay rent, to make mortgage payments, or comply with any other obligation that an individual or entity may have pursuant to a lease, or rental agreement, or mortgage. The continued need for this directive shall be evaluated upon issuance of any new Gubernatorial Disaster Proclamation.

Executive Order 2020-31 (Educator licensure and student graduation requirements):

Executive Order 2020-31 is re-issued in its entirety and extended through **May 29, 2020.**

Part 2: Savings Clause. If any provision of this Executive Order or its application to any person or circumstance is held invalid by any court of competent jurisdiction, this invalidity does not affect any other provision or application of this Executive Order, which can be given effect without the invalid provision or application. To achieve this purpose, the provisions of this Executive Order are declared to be severable.

JB Pritzker, Governor

Issued by the Governor April 30, 2020
Filed by the Secretary of State April 30, 2020

STATE OF ILLINOIS

EXECUTIVE DEPARTMENT

SPRINGFIELD, ILLINOIS

May 13, 2020 Executive Order 2020-37

EXECUTIVE ORDER IN RESPONSE TO COVID-19
(COVID-19 EXECUTIVE ORDER NO. 35)

WHEREAS, Coronavirus Disease 2019 (COVID-19), a novel severe acute respiratory illness, has rapidly spread throughout Illinois in a short period of time, necessitating stringent guidance from federal, state, and local public health officials and significant measures to respond to the increasing public health disaster; and,

WHEREAS, COVID-19 spreads among people through respiratory transmissions and presents with symptoms similar to those of influenza; and,

WHEREAS, on March 9, 2020, I, JB Pritzker, Governor of Illinois, declared all counties in the State of Illinois as a disaster area (the First Gubernatorial Disaster Proclamation) in response to the outbreak of COVID-19; and,

WHEREAS, on April 1, 2020, I declared all counties in the State of Illinois as a disaster area (the Second Gubernatorial Disaster Proclamation) as a result of the exponential spread of COVID-19; and,

WHEREAS, on April 30, 2020, due to the expected continuing spread of COVID-19 and the resulting health impacts across the State, as well as the need to address the potential shortages of hospital beds, ICU beds, ventilators, personal protective equipment and materials for testing for the virus, I declared all counties in the State of Illinois as a disaster area (the Third Gubernatorial Disaster Proclamation, and, together with the First and Second Gubernatorial Disaster Proclamations, the Gubernatorial Disaster Proclamations); and,

WHEREAS, as the virus has spread through Illinois, the crisis facing the State has progressed and requires an evolving response to ensure hospitals, health care professionals, and first responders are able to meet the health care needs of all Illinoisans in a manner consistent with continually updated guidance from the Illinois Department of Public Health (IDPH) and the federal Centers for Disease Control and Prevention (CDC); and,

WHEREAS, ensuring the State of Illinois has adequate bed capacity, supplies, and providers to treat patients afflicted with COVID-19, as well as patients afflicted with other maladies, is of critical importance; and,

WHEREAS, eliminating obstacles or barriers to the provision of supplies and health care services is necessary to ensure the Illinois health care system has adequate capacity to provide care to all who need it; and,

WHEREAS, the Illinois Department of Financial and Professional Regulation and IDPH have taken measures, and continue to take measures, to enable inactive and out-of-state health care workers to work in Illinois through proclamations, emergency rules, and variances; and,

WHEREAS, IDPH has taken measures, and continues to take measures, to enable hospitals to increase bed capacity and provide levels of care necessary to respond to the COVID-19 outbreak; and,

WHEREAS, on March 16, 2020, IDPH issued guidance recommending cancelling all elective or non-emergent surgeries and procedures to immediately decompress the health care system during the COVID-19 response; and,

WHEREAS, IDPH issued revised guidance, effective May 11, 2020, that allows hospitals and ambulatory surgical treatment centers to resume elective surgeries and procedures provided that certain requirements are met relating to surveillance of epidemiologic trends, regional hospital utilization, the hospital's own capacity, case setting and prioritization, preoperative testing for COVID-19, personal protective equipment, infection control procedures, and availability of support services, as well as other requirements; and,

WHEREAS, resumption of elective surgeries and procedures is important to the continued health and safety of the people of the State of Illinois, while at the same time ensuring that Illinois hospitals maintain the ability to accommodate a renewed surge of COVID-19 patients if necessary; and,

WHEREAS, in order to ensure that COVID-19 patients receive proper medical care, it is essential that hospitals and other types of health care facilities accept transfers of COVID-19 patients if they have the capacity and capability necessary to provide treatment for COVID-19 patients; and,

WHEREAS, IDPH has taken measures, and continues to take measures, to enable emergency medical systems to accommodate and prepare for transportation and care of COVID-19 patients; and,

WHEREAS, on April 9, 2020, IDPH issued guidelines requesting emergency medical services systems prepare for transportation of patients to non-traditional destinations, such as alternate care facilities; and,

WHEREAS, Section 6(c)(1) of the Illinois Emergency Management Agency Act (IEMA Act), 20 ILCS 3305/6, provides that the Governor is authorized to "make, amend, and rescind all lawful necessary orders, rules, and regulations to carry out the provisions of this Act within the limits of the authority conferred upon the Governor"; and,

WHEREAS, Section 15 of the IEMA Act, 20 ILCS 3305/15, provides that "Neither the State, any political subdivision of the State, nor, except in cases of gross negligence or willful misconduct, the Governor, the Director, the Principal Executive Officer of a political subdivision, or the agents, employees, or representatives of any of them, engaged in any emergency management response or recovery activities, while complying with or attempting to comply with this Act or any rule or regulations promulgated pursuant to this Act is liable for the death of or any injury to persons, or damage to property, as a result of such activity"; and,

WHEREAS, Section 21(b) of the IEMA Act, 20 ILCS 3305/21, provides that "Any private person, firm or corporation and employees and agents of such person, firm or corporation in the performance of a contract with, and under the direction of, the State, or any political subdivision of the State under the provisions of this Act shall not be civilly liable for causing the death of, or injury to, any person or damage to any property except in the event of willful misconduct"; and,

WHEREAS, Section 21(c) of the IEMA Act, 20 ILCS 3305/21, provides that "Any private person, firm or corporation, and any employee or agent of such person, firm or corporation, who renders assistance or advice at the request of the State, or any political subdivision of the State under this Act during an actual or impending disaster, shall not be civilly liable for causing the death of, or injury to, any person or damage to any property except in the event of willful misconduct"; and,

WHEREAS, Section 3.150(a) of the Emergency Medical Services (EMS) Systems Act, 210 ILCS 50/3.150, provides that persons "who in good faith provide[] emergency or non-emergency medical services during a Department [of Public Health] approved training course, in the normal course of conducting their duties, or in an emergency, shall not be civilly liable as a result of their acts or omissions in providing such services unless such acts or omissions, including the bypassing of nearby hospitals or medical facilities in accordance with the protocols developed pursuant to this Act, constitute willful and wanton misconduct"; and,

WHEREAS, the Good Samaritan Act, 745 ILCS 49, provides that "the generous and compassionate acts of its citizens," specifically health care professionals, "who volunteer their time and talents to help others" should be exempt from civil liability unless such acts demonstrate willful or wanton misconduct; and,

WHEREAS, for the preservation of public health and safety throughout the entire State of Illinois, and to ensure that our health care delivery system is capable of serving those who are sick, I find it necessary to take additional measures consistent with public health guidance;

THEREFORE, by the powers vested in me as the Governor of the State of Illinois, and pursuant to Sections 7(1), 7(2), 7(3), 7(12), 15, and 21 of the IEMA Act, 20 ILCS 3305, for the duration of the Gubernatorial Disaster Proclamations, I hereby order the following:

Section 1. For purposes of this Executive Order, the following terms are defined as set forth below:

(a) "Hospitals" means facilities licensed or approved by the Hospital Licensing Act, 210 ILCS 85, or the University of Illinois Hospital Act, 110 ILCS 330.

(b) "Health Care Facilities" means:

i. Facilities licensed, certified, or approved by any State agency and covered by the following: 77 Ill. Adm. Code 1130.215(a), (c)-(f); Alternative Health Care Delivery Act, 210 ILCS 3/35(2)-(4); Emergency Medical Services (EMS) Systems Act, 210 ILCS 50; or Department of Veterans' Affairs Act, 20 ILCS 2805;

ii. State-operated Developmental Centers certified by the federal Centers for Medicare and Medicaid Services and licensed State-operated Mental Health Centers created pursuant to the Mental Health and Developmental Disabilities Administrative Act, 20 ILCS 1705/4;

iii. Licensed community-integrated living arrangements as defined by the Community-Integrated Living Arrangements Licensure and Certification Act, 210 ILCS 135/2;

iv. Licensed Community Mental Health Centers as defined in the Community Services Act, 405 ILCS 30;

v. Federally qualified health centers under the Social Security Act, 42 U.S.C. § 1396d(l)(2)(B);

vi. Alternate Care Facilities licensed by IDPH;

vii. Supportive living facilities certified by the Illinois Department of Healthcare and Family Services pursuant to the Illinois Public Aid Code, 305 ILCS 5/5-5.01(a); and,

viii. Assisted living establishments and shared housing establishments licensed by IDPH pursuant to the Assisted Living and Shared Housing Act, 210 ILCS 9.

"Health Care Facility" is the singular form of the plural "Health Care Facilities."

(c) "Health Care Professional" means all licensed or certified health care workers or emergency medical services personnel who (i) are providing health care services at a Hospital or Health Care Facility in response to the COVID-19 outbreak and are authorized to do so; or (ii) are working under the direction of the Illinois Emergency Management Agency (IEMA) or IDPH in response to the Gubernatorial Disaster Proclamations.

(d) "Health Care Volunteer" means all volunteers or medical or nursing students who do not have licensure who (i) are providing services, assistance, or support at a Hospital or Health Care Facility in response to the COVID-19 outbreak and are authorized to do so; or (ii) are working under the direction of IEMA or IDPH in response to the Gubernatorial Disaster Proclamations.

Section 2. Pursuant to Sections 15 and 21(b)-(c) of the IEMA Act, 20 ILCS 3305/15 and 21(b)-(c) and the Good Samaritan Act, 745 ILCS 49, I direct all Hospitals, Health Care Facilities,

Health Care Professionals, and Health Care Volunteers to render assistance in support of the State's response to the disaster recognized by the Gubernatorial Disaster Proclamations (COVID-19 outbreak).

(a) Hospitals and Health Care Facilities.

i. For Hospitals and Health Care Facilities, "rendering assistance" in support of the State's response must include measures such as increasing the number of beds, preserving and properly employing personal protective equipment, conducting widespread testing, and taking necessary steps to provide medical care to patients with COVID-19 and to prevent further transmission of COVID-19.

ii. For Hospitals conducting elective surgeries or procedures, "rendering assistance" in support of the State's response must also include compliance with IDPH's current guidance on conducting elective surgeries and procedures.

iii. For Hospitals, "rendering assistance" must also include accepting a transfer of a COVID-19 patient from another Hospital, including Hospital inpatients, and from State-operated entities (collectively, "transferring entities") that do not have the capacity and capability necessary to provide treatment for a COVID-19 patient. The receiving Hospital shall accept such transfer of a COVID-19 patient if it has sufficient capacity and capability necessary to provide treatment for the COVID-19 patient. In determining whether a Hospital has sufficient capacity and capability necessary to provide treatment for a COVID-19 patient, the Hospital shall consider, at a minimum, its ability to provide safe and effective treatment consistent with any current guidance from IDPH and available supplies, staffing, and ICU and medical/surgical bed capacity.

iv. For Health Care Facilities, "rendering assistance" must also include, consistent with current guidance and recommendations from IDPH (1) conducting widespread testing of residents and widespread and regular testing of staff for COVID-19, and (2) accepting COVID-19 patients upon transfer or discharge from a Hospital or Health Care Facility.

(b) For Health Care Professionals, "rendering assistance" in support of the State's response means providing health care services at a Hospital or Health Care Facility in response to the COVID-19 outbreak, or working under the direction of IEMA or IDPH in response to the Gubernatorial Disaster Proclamations.

(c) For Health Care Volunteers, "rendering assistance" in support of the State's response means providing services, assistance, or support at a Hospital or Health Care Facility in response to the COVID-19 outbreak, or working under the direction of IEMA or IDPH in response to the Gubernatorial Disaster Proclamations.

Section 3. Pursuant to Sections 15 and 21(b)-(c) of the IEMA Act, 20 ILCS 3305/15 and 21(b)-(c), I direct that during the pendency of the Gubernatorial Disaster Proclamations, Hospitals that continue to cancel or postpone all elective surgeries or procedures in order to respond to the COVID-19 outbreak, or Health Care Professionals providing service in such a Hospital, shall be immune from civil liability for any injury or death alleged to have been caused by any act or omission by the Hospital or Health Care Professional, which injury or death occurred at a time when a Hospital or Health Care Professional was rendering assistance to the State in response to the COVID-19 outbreak by providing health care services consistent with current guidance issued by IDPH. This section is inapplicable if it is established that such injury or death was caused by gross negligence or willful misconduct of such Hospital or Health Care Professional, if 20 ILCS 3305/15 is applicable, or by willful misconduct, if 20 ILCS 3305/21 is applicable.

Section 4. Pursuant to Sections 15 and 21(b)-(c) of the IEMA Act, 20 ILCS 3305/15 and 21(b)-(c), I direct that during the pendency of the Gubernatorial Disaster Proclamations, Hospitals that conduct elective surgeries or procedures beginning on or after May 11, 2020, or Health Care

Professionals providing services in such a Hospital, shall be immune from civil liability for any injury or death relating to the diagnosis, transmission, or treatment of COVID-19 alleged to have been caused by any act or omission by the Hospital or the Health Care Professional, which injury or death occurred at a time when a Hospital or Health Care Professional was rendering assistance to the State in response to the COVID-19 outbreak by providing health care services consistent with current guidance issued by IDPH. This section is inapplicable if it is established that such injury or death was caused by gross negligence or willful misconduct of such Hospital or Health Care Professional, if 20 ILCS 3305/15 is applicable, or by willful misconduct, if 20 ILCS 3305/21 is applicable.

Section 5. Pursuant to Sections 15 and 21(b)-(c) of the IEMA Act, 20 ILCS 3305/15 and 21(b)-(c), I direct that during the pendency of the Gubernatorial Disaster Proclamations, Health Care Facilities or Health Care Professionals providing services in a Health Care Facility, shall be immune from civil liability for any injury or death relating to the diagnosis, transmission, or treatment of COVID-19 alleged to have been caused by any act or omission by the Health Care Facility or the Health Care Professional, which injury or death occurred at a time when a Health Care Facility or Health Care Professional was rendering assistance to the State in response to the COVID-19 outbreak by providing health care services consistent with current guidance issued by IDPH. This section is inapplicable if it is established that such injury or death was caused by gross negligence or willful misconduct of such Health Care Facility or Health Care Professional, if 20 ILCS 3305/15 is applicable, or by willful misconduct, if 20 ILCS 3305/21 is applicable.

Section 6. Pursuant to Section 21(c) of the IEMA Act, 20 ILCS 3305/21(c), and the Good Samaritan Act, 745 ILCS 49, I direct that during the pendency of the Gubernatorial Disaster Proclamations, any Health Care Volunteer, as defined in Section 1 of this Executive Order, shall be immune from civil liability for any injury or death alleged to have been caused by any act or omission by such Health Care Volunteer, which injury or death occurred at a time when the Health Care Volunteer was rendering assistance to the State in response to the COVID-19 outbreak by providing services, assistance, or support consistent with current guidance issued by IDPH. This section is inapplicable if it is established that such injury or death was caused by willful misconduct of such Health Care Volunteer.

Section 7. Nothing in this Executive Order shall be construed to preempt or limit any applicable immunity from civil liability available to any Hospital, Health Care Facility, Health Care Professional, or Health Care Volunteer.

Section 8. If any provision of this Executive Order or its application to any person or circumstance is held invalid by any court of competent jurisdiction, this invalidity does not affect any other provision or application of this Executive Order, which can be given effect without the invalid provision or application. To achieve this purpose, the provisions of this Executive Order are declared to be severable.

JB Pritzker, Governor

Issued by the Governor May 13, 2020
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ILLINOIS SHOULD SUSPEND, REPEAL HOSPITAL BED LIMIT LAW TO ADDRESS COVID-19 CRISIS

by **Bill Reveille** MARCH 30, 2020

Health care institutions need flexibility to prepare for infection rates that could overwhelm current hospital bed capacity.

Hospitals and other health care providers need flexibility to respond rapidly to a looming health crisis. The spread of the COVID-19 virus could cause a shortage of beds in Illinois hospitals if projections of the infection rate come true.

But antiquated state regulations could get in the way.

Before expanding bed capacity, Illinois hospitals normally require approval from the state by obtaining a "certificate of need," or CON, after completing a lengthy process to demonstrate that new beds are necessary.

Fortunately, the Illinois Emergency Management Agency Act grants Gov. J.B. Pritzker emergency powers to suspend any provisions of a regulatory statute that would prevent, hinder, or delay necessary action by the state or state agencies. Pritzker has the power under the act to suspend the CON law in the event of a public health emergency. The governor already announced plans to convert Chicago's McCormick Place convention center into a 3,000-bed field hospital for COVID-19 patients by April 24. But suspending CON laws formally would give hospitals around the state the flexibility to expand capacity without waiting for government approval.

By suspending the CON law to give hospitals throughout the state the ability to immediately add bed capacity and other necessary infrastructure, Pritzker would be following the lead of North Carolina, which temporarily lifted one of the more restrictive CON laws to meet the pandemic.

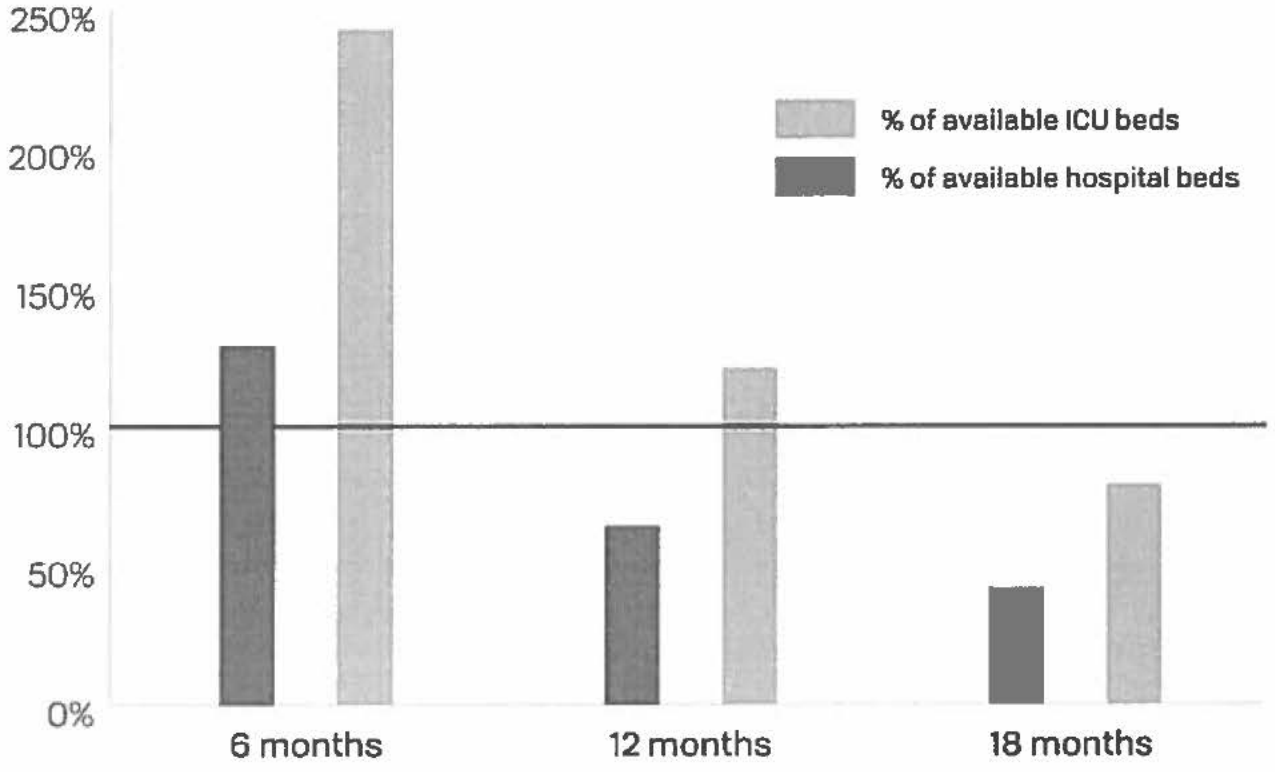
Illinois should suspend its law, then make a full repeal.

CON laws could stand in the way of smart responses to future health crises. And they fail to achieve their basic objectives – lowering health care costs while simultaneously improving the quality of health care. In fact, researchers in 2011 found Illinois would have had 87 additional hospitals and 20 additional ambulatory care centers if not for this antiquated system.

COVID-19 patients are projected to overwhelm Illinois hospitals

According to the Harvard Global Health Institute, or HGHI, a best-case scenario based on mathematical models would see 20% of Illinois' adult population, or almost 2 million people, becoming infected with the novel coronavirus, which would overwhelm the state's hospitals.

Illinois currently has too few hospital beds to treat COVID-19 patients
Illinois' estimated capacity of hospital beds, intensive care unit beds based on duration of coronavirus pandemic



Source: Harvard Global Health Institute

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According to HGHI, if close to 2 million people become infected, 400,000, or 20%, could require hospitalization and over 88,000, or 4%, could require treatment in an intensive care unit, or ICU. As of March 24, 16% of infected patients had required hospitalization and 4% required ICU care, according to the Chicago Tribune. The HGHI study does not include the newly announced 3,000 new beds planned for the McCormick Place field hospital, but it demonstrates how severely a rush of coronavirus cases would stress Illinois' hospital capacity if this number of infections occurred within six months or were spread out over 12 months or 18 months.

Illinois has 30,006 total hospital beds, according to HGHI, exclusive of the 3,000 new beds planned for the McCormick Place field hospital. If all COVID-19 infections occurred within six months, the state would need 27,409 beds to adequately treat all patients. Comparing HGHI projections to Illinois Department of Public Health, or IDPH, statistics as of March 23, the state would have the following needs.

Non-ICU bed needs:

- Illinois has 12,588 non-ICU beds available as of March 23, according to IDPH.
- HGHI estimates that Illinois could potentially have 21,293 beds available, but only if the occupancy rate for non-COVID-19 patients was reduced by 50%.
- If all COVID-19 infections occur within six months, the number of non-ICU beds needed, according to HGHI, is 129% of beds potentially available.
- If COVID-19 hospitalizations are spread over 18 months they would require 42% of Illinois' potential bed capacity.

ICU bed needs:

- Illinois has 1,106 ICU beds available as of March 23, according to IDPH.
- HGHI estimates that Illinois could only have 2,418 ICU beds potentially available but would need 5,875, or 243% of potential ICU bed capacity, if all COVID-19 infections occur within six months.
- If infections occur over 18 months, they would still require 79% of potential ICU capacity.

Illinois' CON law deprives hospitals of needed flexibility

If an Illinois hospital wants to increase its bed capacity by 20 beds or 10%, whichever is less, over a two-year period, Illinois' CON law requires approval from the Health Facilities and Services Review Board. This law is scheduled for repeal on Dec. 31, 2029.

Based on the potential number of COVID-19 patients, any sufficient increase in bed capacity would require board approval. The restrictions on bed capacity also apply to recategorizing beds for a different purpose and relocating of beds from one location to another, even if there

is no net increase in total bed capacity. That deprives hospitals of much-needed flexibility to respond to rapidly changing needs of patients and the community at large.

The CON law also requires approval from the board before the construction or modification of any health care facility, including hospitals. This applies to capital expenditures, including diagnostic and therapeutic equipment, that meet the following cost thresholds:

- $13,743,450 for hospitals
- $7,768,030 for long-term care facilities
- $3,585,250 for all other facilities

The CON process can also be long and costly, requiring complex calculations and forecasts. Illinois' application template is 78 pages long. Not only that, but the board has up to 120 days to act on an application. Recent applications have been approved within 90 days, but that is an eternity in the context of the current crisis.

History of Certificate of Need

CON laws became popular in the 1970s as a way to simultaneously improve quality of care, by limiting the number of providers available to perform certain procedures and allowing providers to specialize and improve service quality, and limit the growth in health care spending.

Illinois' CON law was enacted in 1974 after the federal government passed the National Health Planning and Resources Act that encouraged the adoption of CON laws nationwide, according to the Mercatus Center at George Mason University. The federal government withheld funding from states that failed to adopt CON laws.

According to Mercatus, the goals of the federal legislation were to ensure or encourage an adequate supply of health care services at lower cost and higher quality, to increase access in rural areas, provide more charity care, and encourage use of low-cost alternatives such as ambulatory care.

However, research showed CON laws were failing to achieve these goals, and Congress repealed the federal law in the mid-1980s. Subsequently, 15 states representing 40% of the U.S.

population repealed their own CON laws, but not Illinois.

CON laws have failed to achieve their objectives and may have done more harm than good

CON laws like those in Illinois have failed to serve their purpose. They were supposed to increase the quality of health care by limiting the number of providers of certain procedures, according to a 2017 Mercatus Center paper, thereby allowing practitioners to specialize and improve service quality. Mercatus found instead that:

- CON programs restrict the supply of health care services they regulate, which can lead to an increase in per unit costs and a reduction in quality, according to economic theory.
- The weight of evidence suggests that CON laws are associated with higher levels of spending.

Two studies published by the Mercatus Center found Illinois' CON law may have had an adverse effect on hospital quality as measured by factors such as re-admission rates, mortality rates, and patient experience surveys.

Illinois' hospital bed limit law puts patients at risk
Estimated percentage difference in hospital quality indicators were Illinois to eliminate certificates of need

Hospital quality indicator	Estimated % difference
Post-surgical complication deaths	-5.7%
Pneumonia deaths	-5.3%
Heart failure deaths	-2.9%
Heart attack deaths	-2.5%

Source: The Mercatus Center at George Mason University

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The Mercatus Center concluded that:

- There is no evidence that quality of care at hospitals in CON states is better than in non-CON states.
- Hospitals in CON states performed worse than those in non-CON states on eight of nine indicators in the study.
- The average 30-day mortality rate for patients discharged with pneumonia, heart failure and heart attack in CON states was 2.5 to 5% higher than hospitals in non-CON states.

CON laws have also failed to improve access to care. According to Mercatus, patients in CON states have access to fewer hospitals and fewer hospital beds per capita than non-CON states and fewer dialysis clinics, ambulatory surgery centers, medical imaging services and hospice care facilities. The study concluded that, in 2011, Illinois could have had 295 hospitals instead of the 208 it actually had, and 140 ambulatory surgery centers instead of 120.

In September 2008, representatives of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice delivered a joint statement to the Illinois Task Force on Health Planning Reform. The statement summarized the agencies' experience investigating and litigating antitrust cases in health care markets across the country, plus the results of numerous hearings on competition and policy concerns in the health care industry. Among their key findings:

- Certificate of need laws impede efficient performance of health care markets.
- The methodologies used to pay health care providers in the 1970s that may have justified CON laws have significantly changed.
- On balance, CON requirements have no effect or can actually increase per capita spending, including hospital spending.

When federal CON legislation was passed in 1974, the federal government and private insurers paid health care providers on a "cost-plus" basis that provided incentives for over-investment, according to the joint statement. This could have caused a medical arms race that resulted in unnecessary expansion of services so providers could offer the perceived highest quality of services. However, payment methodologies have significantly changed since the 1970s, eliminating the original justification for CON programs. Insurers now negotiate prices for medical care.

The CON process is also susceptible to corruption. In 2004, a member of the Illinois Health Facilities Planning Board was convicted for accepting a kickback from a construction company in exchange for approving a CON application.

Nonetheless, Illinois failed to repeal its CON law.

Illinois should repeal its CON law

CON laws were supposed to improve the quality of health care while controlling the growth of health care costs. Studies have shown that they accomplished neither and have had the opposite effect.

The COVID-19 crisis threatens to overwhelm Illinois hospitals that have an insufficient number of regular and ICU beds available to treat patients. The inability of hospitals to respond rapidly could put patients at risk.

Illinois' CON law has not worked as planned. The COVID-19 crisis mandates suspending it, and the need for a more flexible, better-functioning health care system demands a permanent repeal.

Hospitals do best to prep for worst: If infection rates are not slowed, system could be overwhelmed

Schencker, Lisa; Heinzmann, David

FULL TEXT

Even as Chicago-area hospitals make preparations to treat a growing number of patients with COVID-19, some experts are warning of scenarios where the system could be overwhelmed.

Hospital leaders are hoping that the cancellation of schools, emptying of restaurants and prohibitions against large gatherings in Illinois will keep their facilities from overflowing with COVID-19 patients in coming weeks and months. But they have already started making changes in case those measures aren't enough.

Many have started reassigning medical staff, canceling elective surgeries to save resources, moving testing for COVID-19 outside typical patient areas and drawing up plans for how to house large numbers of patients.
But some experts say it is unlikely that Illinois' hospital systems could expand facilities anywhere near enough to avoid being overwhelmed if more than a certain number of people become infected in Illinois in too short a time span.

"Everything depends on the effect of the social distancing. The efforts to test and isolate sick people who test positive and quarantining their close contacts is also critical," said Mark Dworkin, a professor of epidemiology at the University of Illinois at Chicago School of Public Health.

"Once they exceed capacity, and if additional supplies and equipment are not available, they will be making difficult decisions resembling a MASH unit receiving injured from a battlefield," Dworkin said.

Most people who get COVID-19 don't get severely ill, and social distancing might help Chicago hospitals keep their heads above water in coming months. But in the short term, experts expect the situation to get worse before it gets better.

Illinois saw a flash of how quickly things can change Tuesday when Gov. J.B. Pritzker announced in a news conference that a single COVID-19 case discovered over the weekend at a senior living facility in Willowbrook had mushroomed into 22 cases -- 18 residents and four staff members -- after more testing.

On Wednesday, the Illinois Department of Public Health announced 128 new cases of coronavirus in the state, bringing the total to 288. The state also said 20 more people at the Willowbrook facility had tested positive for COVID-19.

"Based on data we're seeing across the country and Illinois, we should be expecting an influx of patients across the Chicago area into hospitals and the health care system over the next several weeks," said Dr. Brian Stein, the acting chief quality officer at Rush University Medical Center.

The Illinois Department of Public Health was not able to immediately provide estimates or projections of how many COVID-19 patients might need to be hospitalized in coming weeks or months.

But data analysts from Rush said cases in the U.S. are now growing at a similar rate to those in Italy, France, Germany and the U.K. If the cases continue to increase at the current rate, the analysts said, the U.S. may have nearly half a million cases by the end of the month, though it's possible that new measures meant to keep more people at home could result in lower numbers.

The Rush analysts are still working on a model to estimate how many cases might be expected in Illinois. But experts who have already produced such models have some potentially dire predictions, while also noting it's possible those predictions won't come to pass.

Researchers at the Harvard Global Health Institute teamed up with the nonprofit news organization ProPublica to model what could happen in cities across the country, including Chicago. According to their model, if 20% of people in the Chicago hospital market develop COVID-19 over the course of six months, area hospitals would need about 176% of their available beds. If the transmission of the illness is slowed, such as through social distancing, and 20% get the disease over 12 months, only 88% of Chicago hospitals' available beds would be needed.

However, if 40% get the illness -- regardless of whether it's over six, 12 or 18 months -- Chicago hospitals would need to expand their bed capacity, according to the analysis.

The Illinois Health and Hospital Association has been coordinating planning conversations between hospital administrators and government officials, said Danny Chun, spokesman for the organization.

"Only one scenario works," Chun said. "Any other scenario and hospitals get overwhelmed. That's just a mathematical fact."

As of Wednesday, 1,764 adult intensive care beds in Illinois were occupied, and 825 were empty, according to the Illinois Department of Public Health. Illinois had 1,450 ventilators available and 714 in use.

Chun noted that the Pentagon announced it was putting 2,000 ventilators into the nation's medical system. However, that is a small fraction of what may be needed.

"Clearly there are not going to be enough ventilators if a peak demand hits all at once," he said. He also pointed out that 80% of the people who get sick won't need to be hospitalized and people should consult their doctors over the phone before deciding to seek help in person to minimize unnecessary use of hospital facilities.

"If you can stay at home, stay at home," he said. "We've got to reserve space for the 20% who have to be hospitalized."

At Edward-Elmhurst Hospitals, administrators said they are reorganizing some operations at their two hospitals -Edward Hospital in Naperville and Elmhurst Hospital -- to brace for what's coming.

"We have a space issue and a people issue," said Dr. Sanjeeb Khatua, the chief physician executive for Edward-Elmhurst. Caring for people infected with COVID-19 creates an outsize drain on the hospitals' resources, especially staff.

Elmhurst Hospital has one COVID patient currently admitted, Khatua said. Exposure to that patient has necessitated some of the staff be monitored and kept at home. While declining to specify how many people they have sent home because of the single case, he said: "It's not one or two of us. I'll tell you that."

To try to minimize the impact, Edward-Elmhurst erected tents in the parking lot outside the Edward emergency room and in the ambulance bay at Elmhurst Hospital to keep evaluations of people presenting COVID symptoms or concerns away from the interior of the hospitals.

Also, they have shut down their walk-in clinics that operate at Jewel-Osco stores so those workers can be redeployed. As far as equipment and protective gear, Khatua said the hospitals have a three-month supply of personal protective equipment if use continues at the current rate.

But "our burn rate is going faster every day," he said. "As of right now, we're OK, but I can't predict what the next weeks will bring."

Many hospitals have also canceled elective surgeries, a move that should free up a number of intensive care beds, which are often used to monitor patients post-surgery, said Stein, of Rush. It's also possible hospitals may need to put patients needing intensive care in other areas of their facilities.

A handful of Rush workers have been sent home because of exposure to COVID-19 patients, Stein said. As the number of COVID-19 patients increases, Rush will likely reassign certain employees to different functions in the hospital, such as doctors and nurses who are no longer performing elective surgeries.

At hospitals across the country, staffing will likely be a major challenge as the number of COVID-19 cases grows. Hospitals are typically staffed to about 60% capacity, said Chris Plance, a managing consultant with PA Consulting, who works with hospitals. Even if hospitals can find enough doctors, it could be difficult to hire enough nurses, he said. During bad flu seasons hospitals typically must compete with one another to hire temporary nurses from agencies. And the coronavirus outbreak could be much worse than a nasty flu season.

"These are skilled workers, and they're not just sitting around waiting to be employed," Plance said. The Illinois Nurses Association is calling on public officials to provide child care for nurses, to free more of them up to work as the illness spreads.

Dr. Robert Citronberg, director of infectious diseases at Advocate Lutheran General Hospital in Park Ridge, acknowledged that a shortage of frontline medical providers is possible. It's also possible that the hospital could reach capacity, he said, though officials are taking many actions to try to avoid that, such as postponing elective surgeries.

Sinai Health System, which runs Mount Sinai and Holy Cross hospitals, is working to keep its staffing levels high, such as by offering bonuses to health care workers to pick up shifts and streamlining and consolidating certain units. And it's considering setting up tents, as Rush has done, or setting up a drive-thru to test potential COVID-19 patients.

Sinai expects the majority of people it sees with COVID-19 won't need to be hospitalized.

Sinai has modeled out four different scenarios for its hospitals. In the worst case scenarios, the hospitals would likely move all COVID-19 patients to one area of each hospital, said Airica Steed, Sinai executive vice president and chief operating officer.

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CAPTION: Photo: Emergency room nurse Korrine Potter enters a tent that Edward Hospital in Naperville set up to

test possible coronavirus patients. STACEY WESCOTT/CHICAGO TRIBUNE; Emergency room nurse Korrine

Potter moves medical equipment inside the tent at Edward Hospital. STACEY WESCOTT/TRIBUN (News section,

Page 1)
CREDIT: By Lisa Schencker and David Heinzmann

DETAILS

Subject:	Patients; Emergency medical care; Ventilators; Surgery; Physicians; Hospitals; Public health; Workforce planning; Illnesses; Coronaviruses; Intensive care; Nurses; Public officials; Hospitalization; Disease transmission; COVID-19
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How hospitals answer life, death questions in crisis

Kogan, Rick

FULL TEXT

As every hospital on this planet is or soon will be in the troubling and agonizing process of being stretched to its physical limits under the shadow of the coronavirus pandemic, questions abound: Have we enough beds? How many ventilators do we have and how many will we need? How many will die?

Important questions to be sure, essential questions even if precise answers at this point are elusive. But there is also an emotional and ethical component to this ongoing crisis, and it goes to the core of who we are as human beings. The pandemic has yet to exercise its full force on the United States, yet to hit Chicago hard. But just as we study the charts and numbers embellishing stories about this illness, we should heed a couple of disconcerting facts (consider them harbingers if you must) from across the globe:

In the Chinese city of Wuhan, the need last month was for more than 1,000 ventilators and respirators to help people breathe. Only about half that number were available. How many died as a result?

In Italy, ventilators were being rationed, with the young and others deemed to have a good chance of survival moving to the top of the list. Dr. Daniele Macchini posted on Facebook a lengthy and unsettling description of what he is observing, writing, "Every ventilator becomes like gold." An ICU doctor at a hospital in Bergamo, near Milan, he further wrote, "The staff is exhausted. ... Doctors move beds and transfer patients, administer therapies instead of nurses. Nurses and doctors with tears in their eyes because we can't save everyone, and the vital parameters of several patients at the same time reveal an already marked destiny."

Father John Cusick, longtime priest at Old St. Pat's Church on the Near West Side, hesitated not a second when asked, "How should hospitals prioritize the sick?"

He said, "It's simple. The sickest person goes on top of the pile."

He elaborated: "Every individual hospital has its own pecking order. I see it all the time in emergency rooms. Someone who comes in with strep throat is going to wait behind a gunshot victim. This will be something we have never seen before."

Cusick, who is 74, knows death. He has officiated at hundreds, perhaps thousands, of funerals for people of all ages. "I feel for any of those who will have to be making these decisions. If the decision comes down to getting a ventilator to a 20-year-old with the virus or an 80-year-old who also has it, as well as some underlying illness, I would personally if reluctantly choose the 20-year-old, because one hopes he will have a full life and make important contributions in all the years he likely has left to live. But I hope we never get in that situation. It is at once simple and complex and terrifying."

There is, at this stage, no way to know where we are heading.

"There are going to be some very hard choices made, from doctors and patients," he says. "The doctors are like God, holding lives in their hands. I know that many of them must confront this every day but this is going to be much different."

Dr. Cory Franklin worked for nearly four decades at Cook County (now John Stroger) Hospital. He often contributes stories to the Tribune and is the author of a fine and surprisingly lively 2015 book "Cook County ICU: 30 Years of Unforgettable Patients and Odd Cases" (Chicago Review Press).

He was at the hospital when the heat wave of 1995 packed it with bodies. And he was there for what he calls "the last major epidemic, the AIDS epidemic of the 1980s. We took in a lot more patients than some other hospitals when things were looking rather hopeless. But we demonstrated that the intensive care unit could save lives and by 1991 came the arrival of effective AIDs drugs."

He is an optimistic man at 65 years and though he knows hospitals will be severely tested in the coming days, weeks and months, he says, "One has to always keep one eye hopefully on the future. I want us to avoid at all costs a rationing situation and I think that can be done with Chicago's hospitals approaching this in a cooperative manner, if one of them starts to feel strain. We must do everything we can to avoid making a choice between patients." He and so many others cling to that hope. But this is a crisis that moves with lightning speed. Italy recently announced, via the civil protection department of the Piedmont region and a crisis management unit in Turin (as well as in subsequent stories coming out of Europe as Chicago greeted Tuesday morning), that with intensive care unit beds in danger of soon being fully filled, that patients over 80 or in poor health could be denied ICU treatment. It hasn't happened yet but many doctors fear that some patients will, in essence, be left to die. As one Italian doctor chillingly put it, who lives and who dies "is decided by age and by the (patient's) health conditions. This is how it is in a war."

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CREDIT: By Rick Kogan

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Gut-wrenching decisions await when hospitals fill up

Wenger, Neil S; Shapiro, Martin F

FULL TEXT

The COVID-19 catastrophe is about to require Americans to make tough decisions for how to allocate scarce resources that can determine life and death.

This is especially true with ventilators and beds in intensive care units. Many hospitalized patients in ICUs are dying of cancer or advanced irreversible dementia, or are on ventilators because of irreversible heart, lung or liver failure. In a large proportion of these kinds of cases, the physicians caring for the patient recognize that death is imminent, but treatment continues, often because families are unwilling to recognize the inevitable.

Americans value their autonomy in such situations, so persuading families to forgo further medical treatment is challenging and often elicits considerable anger. Doctors understandably tend to avoid these difficult conversations if they encounter resistance.

With the rapidly expanding COVID-19 pandemic, there is a very strong likelihood that despite heroic efforts by hospitals, we will run out of ICU beds and ventilators. If we continue to prioritize patients for whom meaningful recovery is virtually impossible, we may be doing this at the expense of patients with greater prospects of recovery with appropriate treatment.

Inappropriate use of critical care resources is not new. Intensive care that prolongs life without achieving an effect that the patient can appreciate as a benefit is all too common in the U.S. health care system. But the consequences of doing this have not been easy for the public to discern -- like wasted resources, patients waiting longer in emergency rooms for critical care beds or those needing organ transplants dying in small hospitals while waiting for a bed at the transplant center.

As is beginning to happen in New York City, and has already happened widely in Italy, the demand for ICU beds for COVID-19 patients will overwhelm the supply and lives will be lost as a result.

What are we to do? Some may say it's impossible to put anyone in the position of making a "Sophie's Choice"-type decision about who will live and who will die. But it is not just ethically acceptable to prioritize treatment for a patient more likely to benefit compared with another, it is an ethical imperative.

Medical care is a shared societal resource to be applied where it is most effective. Under conditions of critical care overload, we must ensure that patients who are most likely to benefit receive treatment. Triage choices must be based on the best possible objective models predicting clinical outcomes and never on irrelevant criteria such as ethnicity or gender, ability to pay or family insistence that their loved ones get the ICU beds.

Likewise, triage based on arrival time at the hospital is too blunt a way to allocate a valuable resource. All intensive care is a time-limited trial intended to save lives. Patients who get worse rather than better with optimal treatment, who are less likely to benefit compared with others in need who are waiting, or who may not benefit at all, must lose their spots.

In the COVID-19 crisis, this means that ventilators and ICU beds should be denied to or withdrawn from patients for whom the benefits are minimal at best, and those resources given to patients who are more likely to survive. These gut-wrenching actions must be carried out with compassion, support and palliation.

When objective measures are not used to allocate a scarce resource, those with influence and wealth win out. We have already witnessed this with coronavirus testing, with athletes and celebrities with no symptoms being tested, contrary to testing guidelines, while others exhibiting symptoms have not received the test. Fair distribution of
scarce resources requires knowledge, unbiased implementation, ethical firmness and transparency.

The American public needs to be educated on the rules for medical decision-making so that it's clear why some patients receive treatment while others do not. By standing together, we can achieve the best outcomes for the most people.

Tribune Content Agency

Neil S. Wenger is a professor of medicine at the David Geffen School of Medicine at UCLA. Martin F. Shapiro is a
professor of medicine at Weill Cornell Medical College.

CAPTION: Photo: Specialized nurses work on a COVID-19 patient in an intensive care unit in Ponte San Pietro,
Italy, on March 23. FABIO BUCCIARELLI/THE NEW YORK TIMES

CREDIT: By Neil S. Wenger and Martin F. Shapiro

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'Outgunned, outmanned and underfunded': Inside Roseland hospital's battle against the coronavirus

Stacy St Clair; 's Joe Mahr; Pratt, Gregory

Inside the Roseland Community Hospital intensive care unit, nurse Subu Kirugulige suctions secretions from the mouth of a COVID-19 patient, an unconscious middle-aged man who has been on a ventilator for several days. A television plays quietly in the background as Kirugulige goes about his work in the cramped room, a three-walled stall with a privacy curtain. The nurse never once glances at the screen, not even when a city public health official declares Chicago has begun to flatten the coronavirus curve.

But Kirugulige's brow -- one of the few parts of his head not covered by a mask or hair net -- furrows behind his large face shield.

His 10-bed ICU has been at capacity for weeks. At the moment, there are nine confirmed or suspected COVID-19 cases. Eight patients are on ventilators. Many of them have organs threatening to fail.

"And I've got three more in the emergency room who are waiting for a bed up here," Kirugulige says after leaving the patient's room. "I know the city has all the data, but it doesn't feel like anything is flattening for us."

Indeed, Roseland has been riding the coronavirus's deadly climb from the beginning, trying to bend an invisible enemy that has struck lower-income predominantly African American neighborhoods on the Far South Side harder than wealthier and whiter communities elsewhere in the city. It does so with the if-not-us-then-who mentality of safety-net hospitals across the country, as a place where anyone can receive medical care and not be turned away for lack of money or insurance.

It's a difficult, almost herculean, quest for the 134-bed hospital, which has long suffered from a lack of resources and a two-star reputation. It's a challenge that has taken a significant toll on the hospital's budget and an even greater one on its staff.

In the ICU, for example, not a single patient was conscious Wednesday, meaning the nurses were responsible for their patients' total care. Everything from maintaining airways and managing nutrition to preventing urinary retention and avoiding bedsores fell on their shoulders.

The hospital says it has had 10 confirmed deaths attributed to COVID-19 since March, though some cases remain under investigation. It's a number that's difficult to put in perspective because other area medical centers have closely guarded such information.

Roseland, meanwhile, wants the tragedy to be more clearly understood.

"We are literally on the front lines and we are being bombarded from every angle," said Tim Egan, Roseland's president and CEO. "We are outgunned, outmanned, underfunded, and no one is coming to help us. But we are going to win this war."

If nothing else, the past month has been an exercise in self-reliance and creative problem-solving. For example, when the outbreak began, Roseland did not have enough temporal thermometers to handle the crush of patients. Nurses brought their own and let the hospital keep them until new ones could be purchased.

After a kitchen employee exhibited COVID-19 symptoms last month, the hospital shut down its food service operation and scrambled to find meals for both patients and staff members. Local churches sent dinner after homemade dinner, while employees asked their social circles for help.

Egan is the 2nd Ward Democratic committeeman, and friends sent dozens of pizzas and thank-you notes. Administrator Elio Montenegro raised more than $2,000 on his Facebook page to buy Subway sandwiches. Another employee's family sent over full chicken dinners on Wednesday.

"People have been very generous and it really has meant a lot to us," nurse Lynette Houston said. "We see that people appreciate what we're doing, and it makes the bad days a little easier."

Built in an area settled by Dutch immigrants, Roseland's hospital opened in 1924, a time when real estate agents urged racially restrictive covenants that barred residents and developers from selling to African Americans. During the tail end of the Great Migration of Southern blacks to Chicago in the 1960s, real estate profiteers played on white fears and racist views of African Americans moving in, as neighborhoods changed almost overnight. Extreme disinvestment, depressed property values and the decline of industry followed, leading to high unemployment and crime.

Nestled between Interstate 57 and the Bishop Ford Freeway, the neighborhood had a paralyzing 20% unemployment rate even before the pandemic. About 1 in 5 residents lives below the poverty line, according to city data.

The hospital has been a mainstay, providing jobs and health care to residents in dire need of both. Roughly 95% of patients are on Medicaid, the government-subsidized insurance program for low-income people, including children, pregnant women and people with disabilities.

"Roseland Hospital is an anchor on the South Side of Chicago," said 9th Ward Ald. Anthony Beale, who represents the neighborhood. "It's one of the last few necessities we have."

Roseland finds itself at the heart of the city's coronavirus outbreak, in large part because of the health care inequities laid bare by the pandemic. Public records show black Chicagoans are dying from COVID-19 at a rate more than four times higher than white residents.

Three of the five ZIP codes with Chicago's highest death rates fall at least partially within Roseland's boundaries. The neighborhood's ZIP codes represent just 7% of the city's population, but 16% of total deaths.

"We knew this would occur," said Dr. Terrill Applewhite, chairman of the hospital's COVID-19 task force. "Roseland hospital is in a health care desert. We don't see grocery stores, we don't see clinics, and as a result, we're covering a large swath of territory where you don't have any health care being delivered."

Like almost all of the hospital's 450 employees, Applewhite is doing multiple jobs. One minute he's securing protective personal equipment for employees, and the next he's running to the emergency room to insert a catheter for a patient, before heading up to the intensive care unit to check on another.

It's the sort of multitasking many at Roseland accept as a matter of course. The marketing department is calling patients who have negative COVID-19 test results, while doctors take turns calling the positive cases to provide medical instructions.

A hospital administrator who typically handles long-term strategy spent part of Wednesday afternoon trying to fix the broken automated door leading into the ICU. Even the chief financial officer runs supplies around the building as needed.

And then there's nurse Lynette Houston.

As the hospital's emergency room manager, she oversees staffing for an overwhelmed department, cares for patients, reports daily COVID-19 data to the Illinois Department of Public Health and supervises the testing tent for first responders. She also maintains strict control of the hospital's PPE supply, which has been bolstered by government allotments, donations and her trips to Home Depot.

The hospital's staff believes it has enough equipment to weather the pandemic's storm, in part because of Houston's waste-not-want-not distribution policy. She gives everyone the gear they need, but she doesn't hand out extras. A 13-year veteran at Roseland, Houston can't remember the last time she took a day off. Hospital administrators believe it was about three weeks ago.

"I'm asking my staff to work more, to do more. I can't ask them to do anything I won't do myself," she said. "There will be a time to rest, but now is not that time. Not while this community still needs us like it does."
Houston's emergency room on a recent Wednesday afternoon illustrated her point. Every bay in her 19-bed department was filled. Three more patients were lying on beds around the nurses' station.

And that was a good day, she said. Last weekend, there were nine beds around the nurse's station. On Wednesday afternoon, seven of the beds contained patients with confirmed or suspected COVID-19 cases, though the hospital treats everyone as if they have the virus until tests prove otherwise. About 30% to 40% will be admitted, hospital officials said.

Houston walks around the department wearing a rhinestone diadem on the front of her surgical cap. A staff member gave the costume headbands to nurses a few days ago, offering a touch of whimsy in an otherwise sober atmosphere.

Dressed as if she is responding to a hazmat spill with a little sparkle, Houston speaks to patients like the grandmother she is. Her voice is simultaneously kind and authoritative. She talks them through the various tests, her eyes crinkling in a way that suggests a smile behind her surgical mask.

"Don't worry about it hurting," Houston told one patient as she prepared to poke her with a needle. "I do it all the time."

In between patients, she stops by the nursing station and checks on everyone there. She makes jokes and gently teases.

"They're exhausted. They worry every single day about bringing this virus home to their families," she said. "I will do anything I can to make them smile or laugh a little bit."

The hospital has dedicated a 20-bed medical wing to caring for patients with the coronavirus, though the more serious cases must go to the ICU. On Wednesday afternoon, the emergency room had three patients on ventilators waiting for spots in intensive care, which has been full for weeks.

"If they can't go up to the ICU, it's best to keep them there (in the emergency room), where we have the staff and have the monitors," Dr. Applewhite said. "It's a safer environment for the patients."

The emergency room patient load has decreased the past two weeks, a decline attributed to the walk-up testing the hospital began offering. Roseland also has been providing tests to first responders, including

staff members at the Cook County Jail, where more than 500 detainees and guards have tested positive for the virus.

The hospital says it has conducted more than 5,000 tests since mid-March, though it has drawn some criticism for results that have taken as long as two weeks. Hospital officials recently hired a different lab to conduct the tests on site, and they say the response time should improve dramatically.

Roseland is one of the few mass testing sites that allows patients to be tested without being in a car. In a neighborhood where many residents don't have their own transportation, that's crucial. The hospital also relaxed its rules on who could receive a test, giving it to anyone regardless of whether they have a doctor's order, COVID-19 symptoms or an underlying condition that would make the patient vulnerable to the virus' deadly grasp. By the time Gov. J.B. Pritzker declared testing available to anyone who is symptomatic on Thursday, Roseland already had been doing it for two weeks – without knowing how much it will be reimbursed for it.

"Look, people are scared," said Egan, the CEO. "If giving them a test offers them some hope or gives them a sense of control in light of the (racial) disparity rates, then we're going to do it."

As his hospital punches above its weight, Egan keeps a worried eye on the pandemic's rising financial cost, which he describes as "clicking like a broken taxi meter."

The hospital, which he said has a $50 million annual budget, spent an unanticipated $1 million on pandemic preparedness. That includes medical equipment, protective clothing and transforming the lobby into an overflow emergency room for low-risk patients. Revenue also is expected to take a significant hit because like most hospitals, it has stopped performing elective procedure in light of the outbreak.

"That's one thing for a Northwestern," said Stephanie Altman, director of health care justice at the Shriver Poverty Law Center. "It's another thing for a Roseland or the other safety net hospitals that operate on such slim margins. ... When you take a lot of Medicaid, you are existing on a razor's edge."

Roseland has applied for a federal loan included in the $2 trillion stimulus package, money Egan says would be used to give his staff hazard pay. The program, which is intended to keep small businesses from closing or furloughing employees, ran out of money Thursday, and it's unclear if Roseland will receive any assistance. The hospital also has seen its nursing costs soar as the staffing agencies it regularly depends upon to fill shortages have nearly doubled their hourly fees. Like other Chicago safety-net hospital administrators, Egan said it has become difficult to find agency nurses because many have taken better-paying jobs at the McCormick Place alternate care facility, which is being jointly operated by the city and state.

Mayor Lori Lightfoot said the new facility has not cherry-picked any employees from Roseland. City rules are less stringent, however, when it comes to hiring nurses who worked for staffing agencies prior to the pandemic.

"The McCormick Place Alternative Care Facility is to be a help to the hospital system, a safety valve if you will, to make sure we're not overwhelming the current hospital system," Lightfoot said Thursday. "We don't do that if we take away their staff, and that's why we worked hard to make sure that that wouldn't happen."

A Pritzker aide said the administration has put safeguards in place to avoid nurse poaching, and if Roseland has a

shortage, it should ask the state for help through its local emergency management system.

Said Egan: "We're not waiting for anyone to come rescue us. We'll do it like we always do it -- alone."

As the temperatures dropped Wednesday afternoon, Houston headed outside to the testing tents to retrieve two

thermometers. By that point, she had been at work for nearly 12 hours. She hadn't sat down for five.

Houston said her cousin recently died from the virus, and the inability to grieve with her extended family only

amplifies the sorrow. She has seen her grandchildren just once in a month, when she waved to them through a car

window.

She doesn't think about taking a long vacation when this all ends. Instead, she daydreams about having margaritas

with co-workers and hugging her mother.

Mostly, she tries not to dwell on what she deals with every day and when it might be over.

"If you think about it," she said, "you would stay up crying instead of sleeping."

Tears pool in her eyes as she admits she wept on the way to work that morning -- a deep cry prompted by a string of

messages from relatives telling her to be safe.

She collected herself by the time she entered the building.

"What I'm dealing with is nothing compared to what some of these patients are going through," she said. "They need

me to be strong."

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CAPTION: Photo: Roseland Community Hospital intensive care unit nurse Subu Kirugulige finishes tending to a COVID-19 patient.; Photo: Houston adds a decorative headband to the surgical cap of a nurse in the hospital's emergency room as part of her effort to provide levity.; Photo: Houston shifts patients around in the bays of the hospital's crowded emergency. ; Photo: Housekeeper Tonia Harvey cleans a bed in the Roseland Community Hospital intensive care unit after a COVID-19 patient died on Friday. ; Photo: Nurse Lynette Houston gathers temporal thermometers from the outdoor testing tents at the hospital on Wednesday. The hospital has just a few of the thermometers available. ; Photo: Dr. Terrill Applewhite, chairman of the Roseland Community Hospital's COVID-19 task force, prepares to perform a procedure in the emergency room. ; Photo: Patients line up Wednesday for COVID-19 testing in the lobby area of Roseland Community Hospital that has also been converted into an overflow emergency room for low-risk patients.; E. JASON WAMBSGANS/CHICAGO TRIBUNE PHOTOS

CREDIT: By Stacy St. Clair; The Tribune's Joe Mahr and Gregory Pratt contributed.

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Hospital woes are also heating up in coronavirus cold zones

Zorn, Eric

FULL TEXT

Vermillion County, halfway down the state from Chicago along the Illinois-Indiana border, saw its first case of COVID-19 on March 31.

That was more than three weeks after Gov. J.B. Pritzker issued a disaster proclamation due to the threat of the novel coronavirus and 10 days after Pritzker's statewide stay-at-home order went into effect.

Since then, county health officials have reported 11 cases of the disease, just two hospitalizations and no deaths. But the quiet weeks have nevertheless been bad weeks at the OSF HealthCare Sacred Heart Medical Center in the county seat of Danville. Sacred Heart, with about 100 beds, is the area's main hospital and one of scores of similar facilities throughout the state that are off the front lines of the battle against the pandemic but still suffering plenty of shell shock.

When you hear that hospitals have stopped performing elective medical procedures, you may think of tummy tucks,nose jobs and Lasik. But the term also covers joint replacements, weight-loss surgeries, sleep studies and such screening and surveillance tests on otherwise stable patients as colonoscopies, mammograms, blood measurements and imaging scans.

The result has been a drop of roughly 33% in the inpatient population, according to Dr. Jared Rogers, president of Sacred Heart and a sister hospital in Urbana, 30 miles to the west.

This April, Sacred Heart also has seen a 39% decrease in average daily traffic to its emergency room compared with last April.

Rogers listed three reasons for this:

* A decrease in serious injuries because people are staying home and not driving or otherwise putting themselves in harm's way. The Illinois State Police reports a 53% drop in reported traffic crashes in the first 22 days of April compared with the first 22 days of April 2019.

* A decrease in the number of such infectious diseases as the seasonal flu, again the result of so many people staying home and not gathering in large groups or touching contaminated public surfaces.

* An increase in the number of people who feel reluctant to go into any sort of hospital setting for fear of being exposed to the virus. Chicago doctors have also reportedly noted an otherwise inexplicable drop in the number of patients presenting in the ER with heart attack or stroke symptoms.

"Emergency rooms are very safe places," Rogers said. "We take great care to quickly isolate those who may be suffering COVID-19 and keep them away from those who are injured, suffering chest pains and so on."
Spokesman Danny Chun of the Illinois Health and Hospital Association said that effects like that are causing hospitals statewide to lose about $1.4 billion a month during the crisis. "Inpatient revenues are down 30% to 50% and outpatient revenues are down 50% to 70%," said Chun. "That's not even counting the costs of caring for COVID-19 patients."

Chun said that Pritzker's announcement Thursday afternoon that he will soon loosen the restrictions on elective medical procedures in some cases is "a good sign," for hospitals, "but we have no idea what the impact is going to be until we see the specifics of the changes."

Rogers declined to say how much Sacred Heart has been suffering financially during the crisis, but allowed, "We've had to make some hard decisions. We've had to require some staff members to take unpaid time off. All our executives have taken a reduction in pay."

Sacred Heart's parent company, OSF HealthCare, announced in a news release earlier this month that "as volumes have continued to decline" administrators have been "retraining and moving" staff along with imposing furloughs and hiring freezes in its 14 hospitals in Illinois and Michigan.

The Danville facility traces its roots in town back to 1882, when a group of Franciscan nuns took over a 14-room hotel and re-christened it as St. Elizabeth Hospital.

Its survival may depend on getting a sustaining share of the anticipated $175 billion in new federal relief funds earmarked for hospitals and other health care providers. Chun said lawmakers have still not clarified how that money will be allocated.

And even though COVID-19 has barely shown itself in Vermillion County so far, Rogers, a former U.S. Army doctor who served in Germany in the 1980s, said he and his staff remain highly aware of the need to be ready should an outbreak strike.

"It's like we used to say in the Cold War," he said. "You've got to stay vigilant. Because if something happens, it could be devastating."

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CAPTION: Photo: OSF HealthCare Sacred Heart Medical Center in Danville. The hospital has seen a 39% drop in average daily traffic to its emergency room compared with last April. OSF HEALTHCARE
CREDIT: Eric Zorn

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What it's like to treat a COVID-19 patient: Springfield nurse explains the process

Bowen, Alison

FULL TEXT

Tom McClure is a nurse in the intensive care unit at Memorial Medical Center in Springfield who has treated multiple patients with the novel coronavirus. In his unit, which has 15 beds, four patients are diagnosed with COVID-19 and four are awaiting test results.

He answered questions about what is involved in caring for a coronavirus patient at his hospital. This interview has been edited and condensed.

Q: What happens when a patient comes in who might have the coronavirus?
A: The ER has been quarantining them in their own special corona area, and then we have a dedicated general floor that's just for people that are suspected of COVID or that have COVID that are not that sick yet. Most of the people that we've got in the ICU are coming directly from the general floor.

Q: What are health issues that patients are experiencing in the ICU?
A: For the really sick ones that we have had, they're going into ARDS (acute respiratory distress syndrome). All we can do to fix it is supportive care. We can put you on the ventilator; we can do this thing called proning, where we put you belly-down on the bed. But doing it in an airborne infection isolation room, usually it's a six-person job. The last time I had to do it, because of our isolation policies, we did it with three. It's much more difficult; it's much riskier.

Q: The availability of ventilators has been a concern across the country. How is the situation there?
A: Ventilator supply so far has been OK. That said, everything's subject to change. The only supplies that we've been getting low on, we were low on bleach for about two weeks, and there have been some community donations of Lysol wipes.

Q: What is involved in caring for a patient with coronavirus?
A: ICU nurses are creatures of habit. Every day we start off with a safety huddle, where we talk about updates on the corona pandemic. We go room by room and say what each person has. That way if you hear the alarm going off, you know that you need to respond to it.

Every two hours we try to turn our patients. Every day we do mouth care. That includes cleaning out their mouths. Our staffing ratios have stayed the same. We can go up to three patients. Prepandemic, three ICU patients, it's tough. Now, it's impossible. You do not feel like the best nurse. There are things that get missed -- mouth care, turns. You just have to focus on triage, on the absolutely life-sustaining stuff, which is unfortunate. It hasn't happened a lot, but it definitely has happened.

Q: How many people can be in a room?
A: They don't want us to be in the rooms for too long, but with ICU rooms, it's not possible. We can't not be in the room. If we're not in the room, then they're going to die, unfortunately.
You have the nurse that's taking care of the patient; you have the attending physician. No residents are allowed. We're trying to limit it.

Q: Have any of your co-workers been diagnosed with the coronavirus themselves?
A: I only know of one person that's quarantined with symptoms. But it could have been community acquired. So far, knock on wood, we've been fairly safe on our unit. They have us checking our temperature every day. But latest reports I've read, 25% of people could be afebrile (without fever). There's not a good way to tell who's got this and who doesn't.

Q: How are rooms cleaned?
A: We clean the rooms. Housekeeping will come and clean the rooms afterward. We let them sit for hours to blow out any of the particles. After that they will Tru-D the room -- it's a machine that throws UV light all over the room. It looks like a big chunk of a tanning bed. It's pretty wild-looking.

Q: What is the process to go into a room?
A: I'm using a special mask, the PAPR (powered air-purifying respirator). You wear the actual respirator unit around your waist on a belt, and then it has a hose that comes up your back, and it goes into a hood that comes over your face, and then it forces the air out of the mask. It's very loud.

I grab my PAPR unit, turn it on, and then we have a pressurized tester that you put on the end of the tube. It's like a small pingpong ball on the inside. If that pingpong ball floats to the top, you know your unit's working. You always check the battery. Then you put that on around your waist. You have to get the gown on over the unit, which is a pain. You put on your hood, and you put on your gloves. I usually do a little turn for the safety officer (who checks that everything is correct).

Once my nursing stuff's done, I knock on the door (to the anteroom, a room that is between the patient's room and the hallway). You do hand hygiene with sanitizer over your gloves, pull off the gown, gown goes in the garbage. Hand sanitizer again, because your gloves come off with the gown. Then you enter the anteroom; you make sure your door closes on the patient side. You knock on the hallway door. Dissemble PAPR, clean it. You do hand hygiene again. You're doing hand hygiene a total of five or six times.

Q: For family members who might have a patient, especially with visitors limited, any advice for checking on their relative?
A: We'll take the patient one of our iPad tablets, so they can see their family, that we can bring to the bedside. We're able to bleach those.

The biggest thing that I would tell families upfront is nominate a spokesperson for your family, because any time a nurse is on the phone with you, they're not taking care of your family member. We don't mind giving updates, but we like to talk to one family member. That frees up our time, so we can do our job for them.

I would just ask the nurse their general impression -- how do you think they're doing right now? If somebody's not doing well, my key phrase is I say, "They're critically stable at the moment." That's my code that they're not doing so hot.

Q: What do you wish people knew? What would help?
A: I would like if people could write their representative in government and tell them we do need to make sure that manufacturers are making the things that we need. The ventilators, the masks, the bleach wipes, the stuff that we know protects us and protects the people we're taking care of. I think it's going to last longer than a lot of people think.

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CAPTION: Photo: Tom McClure works in the intensive care unit at Memorial Medical Center in Springfield. JESSICA ADAMS
CREDIT: By Alison Bowen

DETAILS

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12 nurses at University of Illinois Hospital in Chicago test positive

Heinzmann, David

FULL TEXT

A dozen registered nurses at the University of Illinois Hospital in Chicago have tested positive for COVID-19, according to the union that represents nurses at the hospital.

The report highlights the vulnerability of health care workers caring for patients infected with the disease. Officials with the Illinois Nurses Association said they believe a shortage of masks and other personal protective equipment contributed to the infections.

"They do not know day to day if they will have masks, gowns, gloves or goggles for that shift," said Alice Johnson, executive director for the union. "One nurse said their unit manager scolded them for wearing a mask in a room where a COVID-19 positive patient was being intubated."

A total of 40 hospital staff members have tested positive for COVID-19, a hospital spokeswoman said Friday. Hospital CEO Michael Zenn confirmed the number of infected nurses and lauded the "heroic efforts" of the hospital's staff but challenged the notion that administrators had discouraged the use of appropriate PPE.

"Our policy for COVID-19 is that all providers who care for patients confirmed to have COVID-19 or suspected of having COVID-19 should wear PPE," Zenn said. "There are no circumstances in which we would ask our care providers to forgo PPE when caring for COVID-19 patients."

According to internal U. of I. Hospital reports obtained by the Tribune, the number of staff members who are infected has grown rapidly. While the hospital confirmed it was 40 on Friday, the reports showed 19 infected as of Thursday. That number had grown from 11 on the previous day, according to the Medical Staff Daily Status Report.

Medical professionals have been expressing growing concern about the dwindling supplies of N95 masks and other PPE to shield them from sick people transferring the disease. The U. of I. daily status report listed supply levels for some items; N95 masks were said to be at a "critical-stable" level, with a "2 week supply as of 3/18/2020."

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CREDIT: By David Heinzmann

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Hospital workers at risk: Like doctors and nurses, other employees face elevated exposure to coronavirus

Bowen, Alison

FULL TEXT

When she uses her equipment to assess the kidneys of COVID-19 patients, Angela Huang scoots her machine so close that she and the patient are often hip to hip.

As a diagnostic medical sonographer at a Chicago hospital, Huang is sometimes in the rooms of patients with the coronavirus for an hour. She holds the hands of people nervous about procedures; she scans their organs. "You are with your machine within 2 feet of the patient," she said. "You are intimately connected with them." It's a fascinating job she loves. But it's a role now putting her at more risk than she ever imagined.

Huang is one of thousands of people who work in hospitals who are not doctors or nurses, but who share the same elevated exposure to the coronavirus. They walk through the same doors, use the same elevator buttons and take the same precautions when they return home to their families. They are food service workers who bring in trays and cut up food for patients, electricians who travel throughout a hospital to change lightbulbs and receptionists who welcome patients. And many say they feel forgotten.

"People feel overlooked," Huang said, "and they're definitely a part of that front line."

According to the Illinois Department of Public Health, at least 5,913 Illinoisans who work in health care have tested positive for COVID-19, and 34 have died. And the numbers are likely larger because of inconsistencies and omissions in data collected.

Nationally, the Centers for Disease Control and Prevention reported about 9,000 cases of COVID-19 among health care personnel, a wide designation that includes pharmacists, laboratory workers, security guards and clerical staff. Within this group, 90% were not hospitalized, and 27 people died. A CDC spokeswoman noted this data is likely an underestimate.

Greg Kelley, president of SEIU Healthcare Illinois, said the union has been trying to find out from hospitals how many members have been sick. Employees the union represents include clerical workers, lab assistants, dietitians, physical therapists and cooks. These are hospital workers like Juan Martinez, a surgical technologist who died in April, just days before his planned retirement date, after testing positive for the virus.

"The virus doesn't discriminate," Kelley said. "We have too often focused on doctors and nurses, and while obviously they are critically important to the team, there are thousands of workers who aren't doctors, who aren't registered nurses, who are also working on the front line, who are too often forgotten, who aren't protected."

In April, Jefferey Haggins, a mental health aide at Loretto Hospital, got a fever and began experiencing shortness of breath, then fatigue. He tested positive for COVID-19. Haggins spoke to reporters from a hospital bed in intensive care, where he lay prone with oxygen support. He has since been discharged.

His unit saw COVID-19 patients daily, he said. He had access to masks, but brought his own hand sanitizer. "We don't feel protected," he said. "We have to fight and scratch and claw to get the basic, the below basic, of necessities."

The risks that all workers are taking should be offset by hazard pay for everyone, as well as protective gear that is easily accessible, Kelley said, adding that all hospitals should have widespread testing available to workers. Aan emergency room technician at Loretto Hospital, Wellington Thomas has duties including lifesaving measures such as assisting with ventilation and wound care. He said he is concerned about whether enough protective gear will be consistently available and where it will be distributed. "We do take care of patients," he said. "The problem in this situation we're facing right now is, are we being taken care of?"

Michael Hickey, an electrician at Provident Hospital, works around the hospital, making sure no light is out. He wants patients arriving at the hospital to feel the place is cared for and, therefore, they will be too. Nonetheless, he worries about his safety.

"I've got two kids at home. I've got a wife at home, my parents are in their 70s, her parents are in their 70s, and I'm a diabetic," he said. "When you click off a couple of different checkmarks on that list, I was super nervous. I'm still super nervous about it."

As a housekeeping specialist at Northwestern Memorial Hospital, Candice Martinez does not know a patient's illness when she enters a room to clean. Early on, some patient rooms were marked with a COVID-19 designation. However, some were not. Martinez tested positive in March for the coronavirus.

"I started feeling achy, then my throat started hurting," said Martinez, who returned to work this month. "It's scary because I'm not sure how this is supposed to play out."

She said as the pandemic began to spread and more patients were admitted, she was provided with protective gear, but not every workday. She was given only surgical masks, not N95 respirators.

During each shift at her hospital, Huang visits patients in the COVID-19 unit. The first time she walked in, she said she was spooked by the plastic sheets separating the unit from the rest of the hospital.

Her first COVID-19 patient had a seizure during her scan. When she arrived with her equipment to scan her second patient, a doctor outside told her the patient had just passed away.

These days, the long process to put on protective gear has become a new normal for Huang. But as a single mom, she worries about bringing the virus home to her son.

Recently, Huang was in a room with a 95-year-old patient with the coronavirus. The patient was nervous about having a catheter put in, so Huang went to find someone to help calm her.

"It's really an honor to be able to scan COVID patients right now," she said. "They're not allowed visitors, and often times we are one of the only people that they see."

Huang walked outside the room to see if someone could assist. The first person she saw was not a medical worker, but a housekeeping specialist passing by. Huang asked if she would be willing to come in and hold the woman's hand.

"She did not hesitate," Huang said. "She jumped in and grabbed a gown."

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CAPTION: Photo: Angela Huang is a diagnostic medical sonographer at a Chicago hospital. "You are with your machine within 2 feet of the patient. You are intimately connected with them." ARMANDO L. SANCHEZ/CHICAGO TRIBUNE; Photo: Angela Huang is a diagnostic medical sonographer at a Chicago hospital. ANGELA HUANG

CREDIT: By Alison Bowen

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Chicago hospital prepares for surge of COVID-19 patients

By Tia Ewing
Published March 26, 2020
Coronavirus
FOX 32 Chicago

CHICAGO - Mayor Lori Lightfoot issued a dire warning Thursday as coronavirus cases surge in the Chicago area, and hospitals are getting ready for the worst.

The lobby entrance at Rush University Medical Center in Chicago is called the Brennan Pavilion. Starting Friday, it will open for patients that have illnesses not related to coronavirus. The hospital is prepping in case there's a surge.

The state of Illinois has seen its biggest jump in COVID-19 cases since the pandemic began. Illinois now has more than 2,500 people infected and 26 people have died.

Mayor Lightfoot says hospitals in Chicago could soon be overwhelmed.

"We could be expecting upwards of 40,000 hospitalizations in the coming weeks," the mayor said. "That number will break our healthcare system."

That number is alarming, but Rush is prepping for just that.

Rush has always been prepared for handling cases of highly infectious diseases. The hospital is one of 35 federally designated hospitals to deal with infectious diseases.

Rush has created a "Coronavirus Triage" for anyone driving themselves – or being brought in an ambulance – to the hospital that has the virus.

The hospital also has a drive-thru for COVID-19 testing.

Now, Rush has unveiled its main lobby has been converted into a clinic to handle patients that have minor ailments.

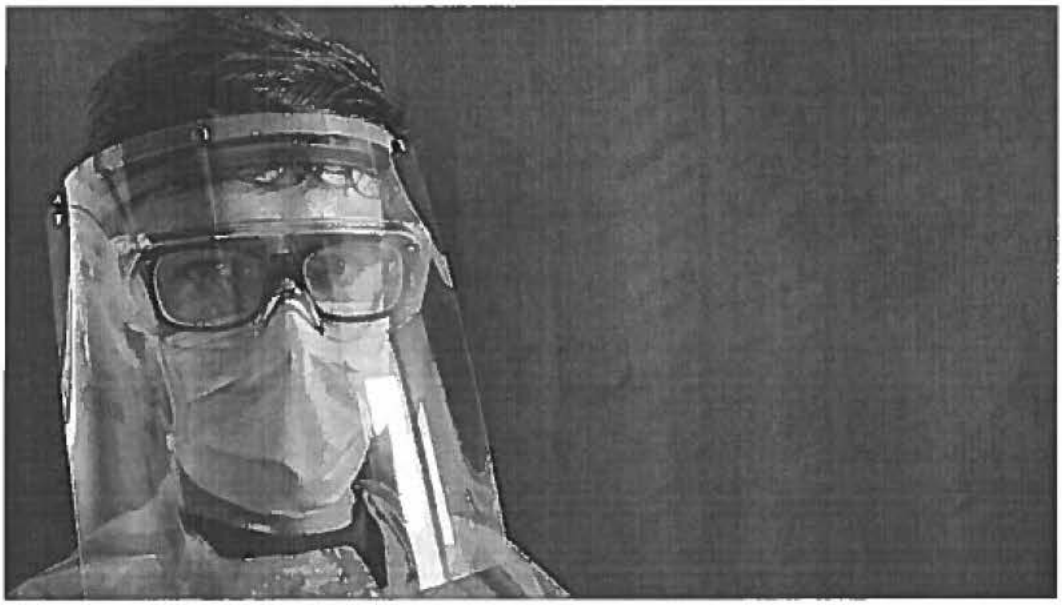
"We anticipate a large amount of patients coming to the emergency department. In that case...we don't want them exposed [to COVID-19, so] we bring them to this area," said Dr. Dino Rumoro, dean of Rush Medical College.

Rush also says they have recently seen a number of patients with upper respiratory symptoms. Those patients think they have coronavirus, but many of them do not.

'It's really a hard time right now,' says Chicago nurse looking after COVID-19 patients

By Yella Hewings-Martin, Ph.D. on April 28, 2020

Medical News Today spoke to a registered nurse whose regular day job is looking after patients on psychiatric units. Now, he finds himself caring for people with COVID-19, as well as patients on other wards.



Joe is a registered nurse in Chicago.
Image credit: Joe, 2020.

Joe, who asked us not to include his surname, is a registered nurse working in a hospital in the Chicago suburbs. He usually works on an inpatient psychiatric unit.

with the disease.

In this interview, Joe tells us about his work, gives his view on how the pandemic is already taking a toll on mental health and how it will likely continue to do so, and describes how he tries to unwind after his shifts.

Joe also shares two things he wants everyone to know about COVID-19.

Saying goodbye over video conference

MNT: How has your job changed in the past few weeks?

Joe: The hospitals are trying to accommodate the COVID-19 cases by pulling nurses from a variety of departments and ensure they provide adequate training to care for people with COVID-19. We are planning for a surge and want to be ready.

I usually work in adult inpatient psychiatry, but due to the staffing demands caused by the increasing numbers of COVID-19 patients, the hospital asked me, and many others, to rotate and train in different departments.

Was this helpful?

MNT: What was your last shift at work like?

Joe: It's hard to describe and give an accurate description of what goes on in one shift. But I will try.

The last time I worked on a COVID-19 unit, it was a med-surgical floor, which is now dedicated to treating only COVID-19 patients. On that day, we discharged someone who was getting better to go home to self-quarantine. However, we also witnessed a patient's family saying goodbye over a video conference because they couldn't visit.

The person later passed away. So, it's a really hard time right now. It's hard to anticipate. What has been consistent, though, is that everyone is doing their best.

MNT: That sounds really hard and very different from your regular day job. Is your hospital doing anything to help prepare you for this very different way of working?

Joe: If you're feeling unsafe or feeling like it's too much, the hospital has been doing a good job of providing additional training and giving all the support needed. It's not easy, but it's what has to be right now.

MNT: Do you feel safe when you are at work?

Joe: Yes, I do.

'Everyone has been thrown out of their comfort zone'

MNT: How quickly has the situation changed in your hospital?

Joe: It was probably 3–4 weeks ago, right around when the stay-at-home

MNT: Do you have enough capacity to take in increasing numbers of patients?

Joe: Thankfully, so far, we do. We can accommodate all these patients by expanding into different departments, but there is going to be a point when there is not enough room. We haven't hit that point yet.

MNT: Because your job has changed so much, are you ever reluctant to go to work?

Joe: All of this has happened so fast. I am not reluctant to go to work; I want to do my part to help be part of the solution to this pandemic.

It is, however, stressful. I find myself out of my comfort zone, working on a different unit than I usually do. But I have been working with some amazing nurses. Everyone is doing their part to help.

MNT: What do you do when you get home? How do you switch off?

Joe: I like outdoor activities, just being able to be outside. I have been avoiding large groups and public places, but being alone outdoors helps me relax.

At the moment, we are still able to be outside where I live, as long as it's not in large groups. But this could change at any time. Hopefully, it doesn't get to that point.

MNT: As someone who usually works in psychiatric units, how do you see this pandemic affecting the mental health of your patients, your colleagues, and also the wider community?

Joe: Well, unfortunately, there's a lot of anxiety. This is a traumatic experience for every person in the world, in a sense. So I foresee an increase in cases of psychiatric admissions following this.

We are already seeing people coming into the inpatient psychiatric units with paranoia, anxiety, and depression-related issues due to the pandemic and isolation at home. So it's already starting.

I see it getting more progressive, and, unfortunately, there is already a shortage of mental health services. There's always a demand for it, and I predict that following this pandemic, there is going to be even more demand.

MNT: Are there practical things that people can focus on to help them deal with their anxiety and worries around COVID-19?

Joe: If it's fear of contracting COVID-19, follow the published recommendations. If someone needs to go out in public, wear a mask, wear gloves, learn about cross-contamination, wash the hands, stay away from other people.

Otherwise, STAY HOME. Stay up to date on the current recommendations.

At home, isolation can be hard for a lot of people. There are lots of resources online — lots of tools and techniques that people can look up and use to help them cope with anxiety during this time. For example, mindfulness techniques, and taking each day as it comes — one day at a time.

Unfortunately, right now, a lot of outpatient therapy and mental health services are closed down to minimize the transmission of the virus. So take advantage of the resources available online for now.

MNT: Everyone is relying on you and your colleagues to look after them, treat them, and in some cases, accompany them during their last moments. How do you think healthcare professionals might deal with these experiences in the long term?

Joe: I think everyone deals with anxiety and stressful situations in very different ways. It helps to know that the support is out there if we need it, knowing we are a team in this pandemic, and knowing that every fear someone holds is valid and that we need to take it seriously.

> We are dealing with something very stressful, difficult, and with little room for repose. If things become too overwhelming, don't hold it in. Talk to someone who can help.

'Every healthcare worker should get the support and recognition that nurses and doctors have'

MNT: Is there something that you wish people to know about the new coronavirus?

Joe: There are two things. Firstly, while there has been a lot of coverage of the COVID-19 pandemic, one thing I would say is to take it seriously. Take the recommendations seriously. If there are stay-at-home orders, follow them.

The people who work on the front lines and see these cases up close can vouch for how serious it is.

The second thing concerns the amount of publicity and focus on the nurses and doctors battling this on the front line. But there is a whole other group of people at the hospital who play vital roles.

security services, transporters, the front line in the hospital goes beyond the nurses and doctors.

There are many more to add to that list as well, and I think that every healthcare worker should get the support and backing that nurses and doctors have. Without everyone working together, we would not be able to battle this pandemic.

MNT: When you think about the day that lies ahead of you, do you have any worries?

Joe: I try not to worry about it beforehand. I try to go into work as relaxed as possible and address things as the day unfolds. The way that I get through my shifts and the way that I do my best at work is to go in with an open mind.

MNT: Do you know which department you will be working in today?

Joe: Yes, it will be a COVID-19 unit.

Here is a list of resources that Joe put together following our conversation with him:

- **Telephone Support:**
  - The National Suicide Lifeline: Call 800-273-8255 or chat online here.
  - The Trans LifeLine for peer support for trans people: 24-hour hotline 877-330-6366. *This hotline is staffed exclusively by trans operators. It is the only crisis line with a policy against non-consensual active rescue.*
  - The National Parent Helpline: Emotional support and advocacy for parents. Call 855-427-2736
  - The Disaster Distress Hotline: A free, national hotline providing 24/7, 365- day-a-year crisis counseling and support to people experiencing emotional distress related to disasters (including infectious disease outbreak). Trained counselors offer crisis

800-985-5990 or text TalkWithUs to 66746. For **Spanish speakers,** call 1-800-985-5990 and press "2."

- **Virtual Meetings:**
  - Depression and Bipolar Support Alliance: Find online support groups here.
  - Refuge Recovery: Join online meetings here.
  - Alcoholics Anonymous (AA): Find online meetings here.
- **COVID-19 Information:**
  - Medicare and Coronavirus: Find answers about COVID-19 and Medicare here.
  - CDC:Find out more about mental health & coping during COVID-19 here.
  - SAMHSA:Find out how to cope with stress during infectious disease outbreaks here.
  - Mental Health America: Find help here.
  - Mental Health First Aid: Courses in response to COVID-19 here.
- **Resources for families with children:**
  - The National Child Traumatic Stress Network (NCTSN): Find a guide to help families navigate COVID-19 here.
  - Child Mind Institute: Supporting families during COVID-19. Phone consultations are available here.
  - The National Association of School Psychologists offer a guide on talking to children about COVID-19. More details here.

For live updates on the latest developments regarding the novel coronavirus and COVID-19, click here.

Public Health Emergency Medicine Infectious Diseases / Bacteria / Viruses
COVID-19

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Hospitals far busier, taking hit financially: Losing $1.4B monthly with surgeries canceled

Schencker, Lisa; Heinzmann, David

FULL TEXT

Though Illinois hospitals are, in many ways, busier than ever as they care for patients with the new coronavirus, they're also taking a financial beating that's affecting their workers and raising questions about how the institutions will recover once the worst of the pandemic has passed.

The Illinois Health and Hospital Association estimates that hospitals statewide could now be losing about $1.4 billion a month. That's the money hospitals are missing out on because of canceled elective surgeries and fewer visits by other patients, many of whom may be avoiding medical care for fear of catching the virus.

"It's very serious and perhaps unprecedented," said Ken Kaufman, managing director of the Chicago-based advisory and consulting firm Kaufman, Hall and Associates. "Everyone has been really scrambling to figure out the pieces of the puzzle and how we're going to put things back together again."

Hospitals across the country are receiving federal dollars to help them handle their cash-flow issues, but experts say it's not nearly enough to plug the financial holes many are now facing.

In Illinois, hospitals are trying a number of tactics to stanch the bleeding, including reaching into their reserves, halting improvement projects and sending workers home -- sometimes with pay and sometimes without. Hospitals are sidelining workers because, without elective surgeries and with declines in outpatient care, there may not be enough work for them, at the moment. They also want as few extra people in hospitals as possible, to help slow the spread of the coronavirus.

Peoria-based OSF HealthCare, which operates numerous downstate hospitals, as well as Little Company of Mary Medical Center in Evergreen Park, announced cost-cutting measures on April 7, starting with reduced pay for executives. But the planned cuts also include unpaid leaves of absence, reduced retirement plan contributions, mandatory paid time off and a hiring freeze on certain positions, OSF spokeswoman Shelli Dankoff wrote in an email.

Sinai Health System, which runs Mount Sinai and Holy Cross hospitals in Chicago, has shifted about 300 caregivers who are no longer needed for their regular duties into a labor pool, through which many have already been reassigned to other jobs. About half of those people, however, are at home at any given time, using their paid time-off days to continue earning money, said Jason Spigner, Sinai's chief human resources officer.

Chicago's Lurie Children's Hospital has sent home about 20% of its staff through the end of April, with pay, said spokeswoman Julie Pesch. It's also placed many of its other workers in new, more in-demand roles for the time being, such as screening other employees each day for COVID-19 symptoms before they're allowed to enter the building.

Urbana-based Carle Health System has also redeployed many of its workers into other roles. Some who haven't been reassigned are at home, being paid through a program typically reserved for the system's sick workers.

Pipeline Health facilities Weiss Memorial Hospital in Chicago and West Suburban Medical Center in Oak Park have "furloughed a small number of staff primarily in administrative and support roles so that more resources could be dedicated to direct patient care," a spokeswoman said in a statement. Those furloughed employees are continuing to receive health insurance and other benefits.

Loyola Medicine said in a statement that "this unprecedented global crisis has forced us to make incredibly difficult decisions," including furloughing primarily nonessential, nonclinical staff, reducing hours for other staff and reducing executive pay.

Loyola said furloughed workers will continue receiving health, dental and life insurance benefits. "We hope to bring back as many furloughed employees as we can, when possible," the statement said. Loyola has also frozen all nonemergency capital spending. Loyola Medicine includes Loyola University Medical Center in Maywood, Gottlieb Memorial Hospital in Melrose Park and MacNeal Hospital in Berwyn.

Advocate Aurora Health, which has 12 hospitals in Illinois, said in a statement: "All team members will continue to receive compensation and benefits through April 30 and we are reassigning team members to help in other areas based on need. We will evaluate our pay practices month to month." Some Advocate employees are now home, not working, though they're still being paid.

Some hospitals are continuing to pay workers they've sent home, in part because they want to ensure those employees will still be available if hospitals should see surges in COVID-19 patients in coming weeks, as well as when hospitals eventually return to their normal loads of elective surgeries and other patient visits.

"The kind of care we provide requires a very unique workforce, and we are doing everything we can to maintain that workforce," said Lurie CEO Dr. Tom Shanley.

In fact, some area hospital systems, including Advocate Aurora and University of Illinois Hospital, have even enhanced pay for some employees working with COVID-19 patients.

That doesn't mean, however, that hospitals will be able to pay workers who aren't needed at work, indefinitely. Shanley said layoffs at Lurie would be "a very last resort."

Lurie's finances have been particularly challenged because the hospital is not seeing many COVID-19 patients -- children who get the disease tend not to fall severely ill. But Lurie has still postponed elective surgeries and is seeing far fewer patients. It's had about 70% fewer outpatient visits and about 30% to 40% fewer inpatients in recent weeks, Shanley said. And that's after raising the maximum age for patients from 21 to 25, partly to help take pressure off other area hospitals.

The children's hospital is losing about $10 million a week because of the drop in elective surgeries, outpatient visits and inpatients, said Susan Gordon, Lurie senior vice president and chief external affairs officer. "That is a gigantic fiscal hit to us," she said.

Carle, in Urbana, is using its reserves to help it get through COVID-19, said Dr. James Leonard, president and CEO. "We made a decision to reach into those reserves and to use those to not furlough people for as long as possible," Leonard said, though he acknowledged that "it's not bottomless." Carle estimates that its revenue dropped 10% to 15% in March, and it expects April will be worse.

Other hospital systems, such as Sinai, are actively looking to donors to help them bridge shortfalls. Sinai is treating many COVID-19 patients -- it's already surpassed its pre-coronavirus capacity for ICU patients. But the three-hospital system is now facing a $10 million monthly shortfall because of fewer outpatient visits and canceled non-urgent and elective surgeries, amid the state's stay-at-home order.

"We don't have the cash on hand sufficient to let us weather $10 million per month," said President and CEO Karen Teitelbaum. So far, Sinai has received about $1.6 million in donations to help it through this time, she said. Sinai has also received more than $4 million from a $100 billion federal emergency fund for hospitals and other health care providers created under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. And it's gotten another $29 million through a different and recently expanded federal program for hospitals, though that money must be repaid.

"If we didn't have all of those options coming in, it would be a totally different conversation," Teitelbaum said. Still, hospitals say the federal money isn't enough to cover all their losses.

"Our revenue has decreased; our expenses have not," said George Miller, CEO of Loretto Hospital in Austin. Loretto is also dealing with a nursing shortage, as the cost of help from staffing agencies has skyrocketed beyond what the community hospital can pay, he said. "We're doing it with duct tape and chewing gum."

Miller said Loretto has not had to lay off staff yet. Although revenue has plummeted from the stoppage of most noncritical care, the hospital is full of patients, especially those afflicted by the virus. Loretto had cut expenses because of budget issues before the pandemic hit, he said, and that has left the hospital in better position to make payroll at the moment.

"We have been able to hold our own, but I'm not sure we can do that for six to 10 months," he said. As of this week, Lurie was slated to get only $123,000 from the first distribution of money under the federal CARES Act, Gordon said. That's because that first pot of money is being distributed based on Medicare payments, and Lurie, as a children's hospital, doesn't get much Medicare funding. Lurie is hoping future distributions won't be based just on Medicare.

Illinois hospitals also continue to contend with the same financial challenges they faced before the coronavirus. Before the pandemic, about 40% of the state's hospitals were operating in the red or close to it, according to the Illinois Health and Hospital Association.

In recent years, several Chicago-area community hospitals closed, squeezed by increasing expenses, competition from larger hospitals and reimbursements from Medicare and Medicaid that didn't fully cover the costs of care. Recently shuttered hospitals include Westlake Hospital in Melrose Park and MetroSouth Medical Center in Blue Island, both of which are now among a handful of sites in Illinois being prepped to offer additional beds for COVID-19 patients.

Those pre-coronavirus financial pressures remain for many hospitals, in addition to the money they're now losing because of fewer elective procedures and outpatients.

Roseland Hospital, for example, on the city's Far South Side, is expecting to get about $3 million less this year from a state Medicaid distribution program combined with several other state pots of money. The hit comes as Roseland has rolled out COVID-19 testing to serve its communities, which are mostly African American, a group that's been disproportionately harmed by the virus.

Without that money, Roseland might have to end its obstetrics program, which is one of the few left on that side of town after Jackson Park Hospital and Medical Center closed its program last year and MetroSouth hospital closed, said President and CEO Tim Egan.

"This hospital has been underfunded for decades, and now we are showing our value to not only the Roseland community, but to the entire state of Illinois, the entire city of Chicago," Egan said.

It's too early to say exactly how the challenges hospitals are now facing will affect them, their patients and workers over the long term, experts say.

But hospitals can't necessarily expect that all the potential revenue they lost during the COVID-19 crisis will flood back once the state reopens, Kaufman said. People might still continue to put off elective procedures or find other places to get them done, he said.

"Even with the return of that work, there's going to be significant financial damage to almost every hospital in the United States," Kaufman said.

Hospitals also won't be able to perform all the procedures that were canceled, all at once, said Danny Chun, a spokesman for the Illinois Health and Hospital Association.

"Nobody knows what the level of services will be after this is all over," Chun said. "Health care will never be the same."

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CAPTION: Photo: Lurie Children's Hospital employees screen fellow employees and give out hand sanitizer and masks as workers arrive on Wednesday. ANTONIO PEREZ/CHICAGO TRIBUNE

CREDIT: By Lisa Schencker and David Heinzmann

DETAILS

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Rush hospital system latest to make cuts: Amid financial struggles executives take a pay cut, yearly raises being withheld

Schencker, Lisa

FULL TEXT

The Rush University System for Health plans to withhold raises this year and is asking executives to take pay cuts after suffering financial losses related to the COVID-19 pandemic.

Many Chicago-area hospitals have been making cuts in recent weeks after losing money because of canceled elective surgeries, fewer non-COVID-19 patients and the costs of handling the pandemic.

Rush had an operating loss of $43.1 million in March, according to a Rush memo obtained by the Tribune that was sent to employees this week. The system includes Rush University Medical Center, Rush Oak Park Hospital and Rush Copley Medical Center in Aurora.

"Like many hospital systems across the country, Rush must take critical steps to ensure its vitality," Rush said in a statement. "The initiatives described in the memo are difficult, but we are committed to doing what's right for the Rush University System for Health. That means taking a measured and balanced approach in implementing cost containment initiatives and solutions across the system."

The CEOs of the system and Rush University Medical Center are taking 25% salary cuts, and the CEOs of its other two hospitals are taking 10% salary cuts. Other senior leaders have been asked to take voluntary cuts of 5%. The system also will not pay out salary increases this fiscal year. In addition, incentive pay, awards and bonuses will be suspended for executives, faculty and providers. And Rush will defer its employer match of employees' 403(b) retirement plans.

Employees of the main medical center on the Near West Side and the Oak Park hospital who don't work with COVID-19 patients will be required to use at least one week of paid time off by June 27, as long as they have accrued at least two weeks.

Rush said in the memo that some of the changes must be approved by the board of trustees.

A number of other local hospitals and hospital systems also have responded to the financial challenges of COVID-19 in recent weeks by making cuts.

Last week, the University of Chicago Medical Center announced it would furlough and/or temporarily reduce hours for employees in nonclinical roles, through the use of vacation and personal holiday time. The hospital also said it's suspending merit pay increases this fiscal year, along with its incentive compensation programs for all executives and directors.

The University of Chicago Medical Center saw a $70 million-a-month dip in operating revenue in March and April. Other local hospital systems that have furloughed workers in recent weeks include Sinai Health System, Lurie Children's Hospital, OSF HealthCare, Loyola Medicine, Weiss Memorial Hospital in Chicago and West Suburban Medical Center in Oak Park.

The Illinois Health and Hospital Association has estimated the state's hospitals are losing $1.4 billion a month. The state issued guidance to allow hospitals to resume performing elective surgeries beginning Monday, and a number of hospitals are doing so. But in many cases, it will take time for hospitals to restart their normal surgeries as they work through backlogs and rebuild capacities, while ensuring they still have enough beds for COVID-19 patients.

Some hospital leaders are also concerned some patients will continue to put off surgeries out of fear of visiting hospitals while COVID-19 continues to spread.

CREDIT: By Lisa Schencker

DETAILS

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No. 130042

In the Supreme Court of Illinois

DONALD JAMES, as Executor of the Estate of Lucille Helen James, Deceased,	)	Appeal from the Appellate Court of Illinois, Second District, No. 2-22-0180
MARK R. DONESKE, as Executor of the Estate of Rose H. Doneske, Deceased,	)	There Heard on Appeal from the Circuit Court of the 16th Judicial Circuit, Kane County, Illinois
FRANCES G. DEFRANCESCO, as Executor of the Estate of Jack P. DeFrancesco, Deceased,	)	Case Nos.:
PATRICIA VELICH, as Executor of the Estate of Marion May Heotis, Deceased,	)	2020 L 247; 2020 L 259; 2020 L 260;
FAITH HEIMBRODT, as Independent Administrator of the Estate of Carol Orlando, Deceased	)	2020 L 264; 2020 L 273.
Plaintiffs-Appellants,	)	Hon. Susan Boles Judge Presiding.
v.	)	
GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company d/b/a BRIA HEALTH SERVICES OF GENEVA,	)	
Defendant-Appellee.	)	

NOTICE OF FILING and CERTIFICATE OF SERVICE

TO: See Attached Service List

You are hereby notified that on **March 6, 2024**, we electronically submitted to the Clerk of the Supreme Court of Illinois, through eFileIL, ***Amici Curiae Brief of The Illinois Health and Hospital Association and The Illinois State Medical Society,*** and ***Notice of Filing and Certificate of Service***, true and correct copies of which are attached and hereby served upon you.

Respectfully submitted,

THE ILLINOIS HEALTH AND HOSPITAL ASSOCIATION and
THE ILLINOIS STATE MEDICAL SOCIETY

By: */s/ Hugh C. Griffin*
Hugh C. Griffin, their attorney

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CERTIFICATE OF SERVICE

I, the undersigned, a non-attorney, certify that on this **6th** day of **March, 2024**, true and correct copies of the attached ***Amici Curiae Brief of The Illinois Health and Hospital Association and The Illinois State Medical Society,*** and ***Notice of Filing and Certificate of Service***, were electronically submitted and served via eFileIL and e-mail to the attorneys of record on the attached Service List.

Under penalties as provided by law pursuant to section 1-109 of the Illinois Code of Civil Procedure, I certify that the statements set forth in this instrument are true and correct to the best of my knowledge, information, and belief.

By: */s/ Denise L. Smith*
Denise L. Smith

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