ILLINOIS DEPARTMENT OF PUBLIC HEALTH

STATE BOARD OF HEALTH MEETING

Thursday, December 11, 2008

11:00 a.m.

Jams R. Thompson Center

100 West Randolph Street

9th Floor

Chicago, Illinois

Reported by: Donna T. Wadlington, C.S.R.

BOARD MEMBERS:

DR. JAVETTE C. ORGAIN, Chairman
MR. DAVID McCURDY
MR. KEVIN HUTCHISON
DR. JANE JACKMAN (via phone)
DR. JERRY KRUSE
MS. KAREN PHELAN
DR. PETER ORRIS
DR. TIM VEGA (via phone)
DR. HERBERT WHITELEY
DR. CASWELL EVANS
DR. JORGE A. GIROTTI (via phone)
MS. ANN O'SULLIVAN

ALSO PRESENT:

MR. DAVID CARVALHO
DR. WALTER BRADLEY (via phone)
MS. CLEATIA BOWEN (via phone)
DR. CRAIG CONOVER (via phone)
MS. DENISE GAINES (via phone)
MR. MARK GIBBS (via phone)
MS. SUSAN MEISTER (via phone)

P R O C E E D I N G S

CHAIRMAN ORGAIN: We need to start.

In terms of the approval of the -- let's go with the September meeting summary. Are there any additions or corrections to the September meeting summary?

Anyone?

Okay. Then I would by consensus approve the meeting summary for September the 11th. Okay.

Now I would like to go back to, hoping Cleatia would be on the line, but I would like to go back to the meeting summary for June the 12th.

And, again, the language was not incorporated as we would have liked it to be on page 2. Under D, child health examination code, eye exams, I'm going to enter the language so that it's on the record for the correction.

It should say the "State Board of Health members who are physicians expressed concern that the code was not based on

evidence-based practice as per USPSTF," which is the United States Preventive Services Task Force. That was our primary discussion and that would be the correction for that June 12.

Based on that I would move that we approve with that language change, and if there is no objection, by consensus.

MS. MEISTER: Dr. Orgain, this is Susan Meister.

CHAIRMAN ORGAIN: Hi Susan.

MS. MEISTER: And I'm taking notes for Cleatia while she notifies people about this phone line. Could you please repeat that language for me?

CHAIRMAN ORGAIN: Yes. State Board of Health members who are physicians expressed concern about the child health examination code in that it was not based on evidence-based practice as per USPSTF, United States Preventive Services Task Force.

MS. MEISTER: Thank you.

CHAIRMAN ORGAIN: Thank you.

MR. CARVALHO: And there is a transcript of this meeting, so that could be referred to for preparation of the minutes as well.

CHAIRMAN ORGAIN: Essentially, we had a lot of discussion and that was the main discussion in regards to what we should have pulled off.

Okay. With that we can move on to Item No. 3 on the agenda. David.

MR. CARVALHO: Certainly.

As I mentioned to one or more of you, Dr. Arnold is in Taipei, and while we briefly toyed with the idea of taking advantage of time zone differences decided that might not be practical. So his trip to Taipei comes off of his earlier trip to Poland last year. So he has definitely gotten about as far away from here as you can in both directions in the last month. His trip is involving matters relating to preparedness in both bio and terrorism preparedness from a health perspective.

And he is in Taipei at the request and invitation of ASTO, the American State -- Association of State Territorial Health Officers -- sorry, the Association of State and Territorial Health Officers and also the military in which he still ranks as a colonel.

ANNOUNCEMENT: Jorge Girotti has joined the conference.

CHAIRMAN ORGAIN: Thank you, Jorge.

DR. JIROTTI: Good morning. Sorry.

CHAIRMAN ORGAIN: Not a problem.

MR. CARVALHO: I asked him if there is anything in particular newsworthy that he wanted me to share with you today. A lot of what is newsworthy you are reading in the papers.

But what is newsworthy -- one of the things that Dr. Arnold is putting together and looks forward to presenting to you in person is plans he is developing for something that he's calling a fusion center and a fusion center -- I don't want to steal any of his thunder.

But in a general sense, a fusion center is a place where relevant information is brought together in realtime to assist in making decisions relating to health and incidences that may arise. Sort of a domestic and health version of something that might more typically be seen in a military or law enforcement environment.

And he published a brief article outlining this concept in one of the Homeland Security Journals last month and has been working with the CDC on developing the concept. And, apparently, we would be among the first or would be the first in the nation to do this and the CDC is very excited about the idea and, in fact, would like to do something similar on the federal level.

And so that's just a hint of the presentation. I will leave it to Dr. Arnold at your next meeting to lay this out in greater detail.

In that position we've been

finding ourselves a lot lately where theoretically we are preparing next year's budget but in reality we are still dealing with the fallout from last year's budget and as with, I guess, the economy in general, the economy of state government is not good.

Our budget, as with all budgets, was adopted with the three percent holdback which probably the idea of a holdback may sound a little bit weird. So let me -- as you know government budgets are adopted as line item budgets. They line item every little detail of what may be spent and that's an authorization. Legislature calls it an appropriation that authorizes expenditure up to that line.

And the way a holdback typically works is rather than either the agencies or the Governor's office or the legislature trying to figure out how to nick the several, many line items that aggregate into the whole budget they do a holdback and figure,

okay, we've authorized everything or almost everything. But we only give you 97 percent of the money that would be necessary to do everything and so you, as you manage your budget, need to figure out how to stay within that appropriation authority minus, in effect, three percent.

And so, for example, with a few exceptions it leads to most of our grant-making being at 90 percent of the appropriated level. Most of our hiring authority it may be on paper but we can only spend 97 percent of our personnel lines and all across the board.

Those of you who work in government probably have seen some work concepted in your government. It's become very common in the last decade or so.

There is discussion of increasing that holdback even more which could be dramatic. Because especially if you increase it during a fiscal year, the impact is basically

twice. So, for example, if January 1 the holdback was increased two percent, you would actually have to reduce four percent because you only have half the year to make up for the fact that you were spending at a different level. So all of that is up in the air. Maybe even more up in the air than it was first mentioned last week.

And so we will, along with all state agencies, we'll be quite challenged to deal with that and then everybody who receives money downstream from state government will be quite challenged with that.

One ray of good news, which doesn't directly affect the Department of Public Health but certainly affects health care in the state, is that the Federal Government has given approval to the state plan amendment that the Department of Health Care and Family Services submitted regarding the so-called hospital assessment or some people call it the provider tax. But nobody likes to use the word "tax" so

it's called the hospital assessment and that assessment could lead to $700 million or so in increased reimbursement to providers in the state and a subset of that whole transaction could lead to 20 to 80 and I realize that's quite a range but 20 to 80 dollars --

ANNOUNCEMENT: Jane Jackman has joined the conference.

CHAIRMAN ORGAIN: Thank you.

MR. CARVALHO: Hi Jane.

MS. JACKMAN: Hi.

MR. CARVALHO: Twenty to $80 million increased reimbursement for the Cook County Health and Hospital System, which is also under some budget challenges. So that was approved by the outgoing Bush administration last week and that's generally good news for health care.

Why don't I stop there and certainly take any questions that the Chair wishes to entertain.

CHAIRMAN ORGAIN: Herb.

DR. WHITELEY: Has Dr. Arnold visited

with the Board at all?

MR. CARVALHO: Which Board?

DR. WHITELEY: I don't recall seeing him in person or on the phone and we have had not a chance to meet him yet.

MR. CARVALHO: Not yet. Look forward to doing the next meeting in person.

DR. WHITELEY: That would be great.

MR. CARVALHO: Okay.

MR. McCURDY: He was on with us briefly in the Rules Committee on the phone one time.

MR. CARVALHO: Yes. He -- as you recall with Dr. Whitaker as well, the Governor's office tends to send him a lot of places and so we schedule these meetings onto his schedule and then he often gets sent places.

I think this is as far as he's been sent. Oftentimes, it's just somewhere -- elsewhere in the State but the next meeting ought to be easier. Usually he's been sent in connection with the expansion of some program,

either the Breast and Cervical Cancer Program or the Kid Care Program or the Family Care Program and I will hazer to guess that there is probably not going to be some expansion program three months from now.

DR. WHITELEY: Thank you.

MR. CARVALHO: And I think we will be going around the state talking about contractual programs.

CHAIRMAN ORGAIN: Thank you for the question.

I believe that I would like to go back to an item that wasn't on the agenda and that's approval of the agenda and if there are any additions to that in regards to the agenda.

David, I wanted to add those things. From informational perspective I distributed some information and I would like to just add that.

MR. CARVALHO: Sure.

MR. McCURDY: The report card from the College of Emergency Physicians for the State of

Illinois was in the news yesterday. If we could have some brief conversation about that, perhaps, during the discussion time.

CHAIRMAN ORGAIN: Additionally, what you've received and what we will include in the minutes is a request from the Illinois Academy of Family Physicians in regards to MRSA as well as information in regards to the sunsetting of the Illinois Medical Practice Act.

MR. CARVALHO: Denise or Cleatia, are one of you on the line?

MS. GAINES: Yes. Denise is here.

MS. BOWEN: Cleatia is here.

MR. CARVALHO: Great.

Obviously, you wouldn't be prepared to speak right this moment, but perhaps while we are meeting if one or the other of you could see if Dr. Conover could join us on the call because there is a question about MRSA.

You could check with Melanie. I'm not exactly sure who within the agency was the one who analyzed and developed the response

regarding the American College -- or the emergency physicians report that came out a couple days ago.

MS. BOWEN: Okay. I'll check.

MR. CARVALHO: Well, Melanie's our spokesman, but I assume it's probably Dr. Bradley. But if not, Melanie might be an easier way to figure out who it was she dealt with and if that person could also join us later and I suspect that the Chair would be amenable to hearing from those persons when you can get ahold of them.

MS. BOWEN: Okay. I'll get back to you.

MS. GAINES: Excuse me, David. We're in the process of getting Dr. Conover. He's right upstairs, so the secretary is in the process of getting him to phone in.

MR. CARVALHO: Okay. Great.

CHAIRMAN ORGAIN: David, is there anyone who could speak on the Medical Practice Act from an IDPH perspective?

MR. CARVALHO: Well, as you may know, the Department of Public Health actually used to be the person who dealt with the Medical Practice Act back -- I don't know -- probably when somebody here was still a child. And Professional Reg was created to take it over. So it's really the Department of Professional Reg. I mean, obviously, we're anxious about this along with you but the Department of Professional Reg is taking the lead on this.

Denise, you are familiar with this issue, by the way?

The Illinois Medical Practice -- we went through this last year with the environmental --

DR. ORRIS: Actually, this year.

MR. CARVALHO: Dr. Orris, does.

Last year and this year with the Environmental Health Practitioner Act sunsetting and nobody in the legislature apparently caring and taking the --

MS. GAINES: They would hopefully come

back for a special session for it. Now speaking to people yesterday their hope was that during the two days when they are back this Monday and Tuesday coming up that they will hopefully maybe take it up, but I don't have faith in that. But that is the goal I know.

I just spoke to Bruce Kinnett yesterday and that will be their goal that while they are here next week they bring that up. But the problem is you have to pass it from both chambers and you also have to have the Governor to sign it real quick.

MS. JACKMAN: This is Jane Jackman. I'm actually on the Medical Licensing Board also. We met yesterday and this was discussed.

Apparently, the legislation has always been approved, but it was never voted on by the Senate. So the Senate just needs to vote on old business and, again, this has to be signed by the Governor and who knows if that's going to happen so...

And it's a problem because,

you know, after January 1 if there is no Medical Practice Act all physicians' and chiropractors' licenses is valid. Nobody knows I don't think.

MR. CARVALHO: Well, yes. We went through this, as I said earlier, with the Environmental Health Practitioner Act and analyzing what does it mean for it to be inspired and what does it mean for it to be reinstated and I believe -- and one of the problems, as you kind of noted, is if the Senate accepts the House amendment this year and the Governor signs it this year, then all is well.

MS. JACKMAN: Right.

MR. CARVALHO: If it's allowed to lapse, then the problem is -- and we went through this, as I say, with the Environmental Practitioner Act.

You want language put in there as just sort of a savings language that says, in effect, notwithstanding that we did this late, everything is okay retroactive back to January 1. And I suspected that bill, Senate Bill 2179,

doesn't prove we have that language in there because when they adopted it nobody anticipated they would be in this position.

So they would have to almost start over again with legislation or, theoretically, rather than the House accepting -- the Senate accepting the House Amendment. The Senate could refuse to accept. They could send it to a conference committee. The conference committee could put that savings language in it and go back to the Senate and the House. They could adopt it and then it goes to the Governor.

But, in any event, this General Assembly dies January -- was it 6th or 13th?

MS. BOWEN: Thirteenth.

MR. CARVALHO: Thirteenth.

So if all of that isn't transacted before January 13th -- clearly, the ideal thing would be for all of it to be transacted before December 31 and be signed.

The fall back is what I just described. That would have to happen by January 13th and be signed. If neither of those happened, then you would be in the same boat that the environmental practitioner was with -- which was like this many month gap that ultimately got fixed by legislation that went retroactive. But, you know, if it was confusing to have environmental health practitioner's regulatory status be unclear, you'll multiply that by 35 or 40 or a hundred with respect to all the physicians and chiropractors in the state.

So, not much we can do other than hold our breath. But, Denise, you're saying that there is talk about the Bill coming up in the special session next week?

MS. GAINES: That's the course. That's what they are going to try to run Monday and Tuesday and a lot of people are lobbying that effort for Monday and Tuesday. Because clearly it's not scheduled to come back up again January 12, which is not optimal whatsoever, but

if you look at the current schedule, it says that it's supposed to come up on January 12, and that's way too late.

MR. CARVALHO: Well, at that point the language wouldn't have any savings language to retro it to January 1.

MS. GAINES: Exactly.

MR. CARVALHO: And I guess this is probably not a great forum to speculate about how this got to this situation. I know when we went to the environmental health practitioners Dr. Arnold was fairly new and he kept asking Denise and me how does something like this slip between the cracks and, you know, our response was slipping between the cracks is kind of a benign characterization of the situation. There are other less benign characterizations, but this one couldn't have slipped through the cracks, but we shouldn't speculate.

CHAIRMAN ORGAIN: Okay. Thank you.

So those items will be added to the agenda under discussion, and since we

have talked about the Medical Practice Act, we will have MRSA and the report card and as persons come in to report on it we will hear from them.

David, were you then through because there were no other questions for you?

MR. CARVALHO: Yes.

CHAIRMAN ORGAIN: Thank you.

David McCurdy, Item No. 4 on the agenda.

MR. McCURDY: Item No. 4, the rules committee report.

I believe you all should have received the notes on the meeting of the rules committee November 20 which summarizes our discussion of the one rule before us. The rule before us, community health center expansion, and is there somebody in Springfield who would want to provide the Board with a little background?

MR. GIBBS: Yes. Good morning. This is Mark Gibbs.

MR. McCURDY: Hi, Mark.

MR. GIBBS: This rule-making, as was discussed in the committee meeting, is a brand new ruling in its entirety. The Community Health Center Expansion Act has been in place for a number of years but for whatever reason there were never rules written to implement the act. The act was without rules. So we have developed the rules before you to administer that act.

MR. CARVALHO: We have been implementing the act. We have been issuing grants and doing that for quite some time, but when Mark was made acting division chief of that center he identified the fact that there were no rules covering that and that there perhaps ought to be. So the center put those together.

DR. ORRIS: I think he reported to us in the rules committee that you had consulted the stakeholders involved in this and this is the consensus development.

MR. GIBBS: Yes. The association --

the Illinois Primary Health Care Association has reviewed and signed off on it.

MR. McCURDY: So the -- as you can see from the meeting notes, we had some discussion, of course, about this within the rules committee having to do with a number of items and, in particular, you will note that on what is still pages 12 and 13 of the revised rules there were two -- there were some concerns and some changes.

Mark, are you still there?

MR. GIBBS: Yes.

MR. McCURDY: I just wanted to ask one question which occurred to me after the meeting and I thought I, at least, should ask it.

Since there is mention not only of the migratory -- the immigrant health centers but also statutory language about occupation-related health services for migratory and seasonal workers, then in practice does this -- this then does encompass presumably possibly services to undocumented immigrants or

is it -- is that not part of the picture here?

MR. GIBBS: Well, it could be. I really couldn't speak to that.

MR. McCURDY: Okay.

MR. GIBBS: The answer may to be federally qualified health centers or the type of community health center designated as a look-alike. We don't go on into -- through their purview or their nationality or what have you.

ANNOUNCEMENT: Tim Vega has joined the conference.

MR. CARVALHO: Hi, Dr. Vega.

Because we are often giving grants for brick and mortar or expansion of services, whoever the FQHC or other grantee sees through that process is not restricted.

MR. McCURDY: Right.

MR. CARVALHO: If they are otherwise able to see persons who are undocumented, our grant doesn't play into that one way or the other.

MR. McCURDY: Sure. Thank you.

I'll just make a couple of comments about some changes that were made and other members of the rules committee may have comments.

But I will say on page 9 of this draft under letter D toward the bottom of the page where it says "application," we had some concerns about the way that -- either establishing a new site or for that matter expanding the services of an existing site and that language has been changed and I think clarified well and so that is an improvement.

ANNOUNCEMENT: Dr. Conover has joined the conference.

MR. McCURDY: And then, secondly, on page 10 under the notification process a couple of other professional organizations were added, professional and trade organizations, the Dental Society and the Illinois Public Health Association were added to that list.

And then on -- I'm going to

move to page 12 where we did have some concerns. I think that one question -- well, it's strictly -- it's really editorial. I'm not going to raise that one.

But we had some questions on pages 12 and 13 and by and large the concerns I think have been addressed. So none of them is, I would say, major but some things that had to do with clarification.

So do other members of the rules committee have any other comments?

Are there questions from the Board as a whole? Jerry.

DR. KRUSE: Groups that are not currently FQHC's or FQHC look-alikes can apply for money if they plan to seek that designation. Is that correct in my reading of this?

MR. CARVALHO: Did you hear that, Mark?

MR. GIBBS: No, I couldn't hear that.

MR. CARVALHO: Can you apply for a grant although you're not currently an FQHC or a

look-alike and you are in application to be one?

MR. GIBBS: Yes. But you have to be formally along in the process, not just participatory.

MR. CARVALHO: So you have to be at what stage in the process?

MR. GIBBS: Well, you would have had to have formally filed to become an FQHC.

MR. CARVALHO: Okay. Not just planning on it but actually filed.

MR. GIBBS: Yes.

MR. CARVALHO: But you don't have to have been designated?

MR. GIBBS: No.

MR. CARVALHO: Okay. Do you have to be designated before you can receive a grant?

In other words, you can apply while you have got your application pending but do you have to have received that designation before you receive a grant?

MR. GIBBS: That's a good question. I would have to research that a little.

MR. CARVALHO: Okay.

MR. GIBBS: I'm not sure we've ran across that.

MR. CARVALHO: But it is a restriction of the act that the people -- in other words, by way of contrast when the Illinois Covered Program was proposed a couple of years ago there was a broader -- there was a grant -- there was a proposal to broaden grants to beyond just FQHC's and FQHC look-alikes and because the Illinois Covered proposal didn't go forward that particular piece of it also didn't go forward.

MR. McCURDY: Other questions? Comments?

Then I would move that we -- that the Board forward this to JCAR for its recommendation for approval.

MS. PHELAN: Second.

CHAIRMAN ORGAIN: Any objection?

That being the case, consensus.

MR. McCURDY: Okay.

CHAIRMAN ORGAIN: I do have a couple questions in regards to the minutes from the meeting and the committee discussed several items but maybe a brief summary on a few of them in regards to what was the gist of the conversation particularly in regards to the tobacco settlement funds in the amount of $10 million?

MR. McCURDY: I, frankly, do not recall that.

CHAIRMAN ORGAIN: All right.

MR. McCURDY: So if somebody remembers it, by all means or if Mark Gibbs has something to say about it, please do.

MR. CARVALHO: Did you hear the question, Mark?

MR. GIBBS: No, I couldn't make it out. Could you repeat?

MR. CARVALHO: The question was what is the status of the tobacco settlement money and how it interplays into this program.

MR. GIBBS: To my knowledge, we are

making new grants and old grants were paid last year. So the FY -- fiscal year '09 grant process is still at the review and near the determination of an awardee stage. So there is no money outgoing yet.

MR. CARVALHO: Does it continue to come out of the tobacco settlement funds or is this GRF?

MR. GIBBS: It's a mixed -- a blended funding of this program. There are, I think, about ten million in tobacco funds but there are also about four million, I believe, of GRF funds that go into this.

MR. CARVALHO: And just --

MR. GIBBS: Actually, two appropriations.

MR. CARVALHO: All right. And to refresh your recollection, this program started out as a grant program where grants up to around $250,000 per year for three years were made available to folks or sometimes 300,000 and then it was modified midstream to provide for

continuation grants to folks who received initial grants at an amount up to 50 percent of whatever they received in the first instance. And it was sort of a mid-course correction.

The original idea when the program was originally started, which was before I got here, so it must have been more than five years ago, was that there was going to be a lot of new money flowing from the Feds and we were kind of going to jump start FQHC's to help them build capacity; that they could then sustain activity with additional federal dollars. And when the additional federal dollars didn't come about quite as anticipated, there was a need for additional funding to sustain the programs, and so the law was changed to allow those additional grants up to 50 percent of the prior grants to the recipients.

With a fixed pot of money, of course, that cannibalizes your ability to do new grants if part of your money is now going to do sustaining grants. That was all a blessedly,

from our perspective, behind the scenes negotiation that the IPHC, among its members, and they reached consensus and presented it to the legislature and so that's the program that we have now.

So our appropriation may sound quite high for a modest number of grants each year but you need to keep in mind that every year we are also funding the second or third year of a prior grant as well as the first second or third year of the continuation grant.

And so the funds that remain after all of that to do new grants is more limited.

MR. GIBBS: If the question extended to the bill awarding those funds, those continuing payments were all made in July. As far as I know, I believe they have all been paid in full.

MR. CARVALHO: Thank you.

CHAIRMAN ORGAIN: Thank you. Thank you for the report.

Let's move on then to Item 5 on the agenda. Ann.

MS. O'SULLIVAN: The policy committee report is not in your packets, I don't believe. Both Jerry and I wrote to Cleatia, Jerry last week and myself last night, about why wasn't it there. So I don't know where it is, but she sent it to me and I think maybe the policy committee members, I'm not sure, several weeks ago.

MR. CARVALHO: I think -- of course, it's of no use to you because you were all in transit. I know I received it by e-mail this morning in an e-mail that came to, I think, all of the members. But unless you happen to have been at a computer this morning, that didn't do you any good.

DR. VEGA: This is Tim Vega. I got it this morning also.

MS. O'SULLIVAN: I asked her to bring copies and then e-mail it so that everybody would have it.

But anyway, we will summarize it and you will have it in your -- you can look forward to it when you get to your e-mail again.

UNIDENTIFIED SPEAKER: Dave, may I interrupt?

MR. CARVALHO: Yes.

UNIDENTIFIED SPEAKER: Okay. I believe Dr. Conover has joined the call.

MR. CARVALHO: Okay, great. Thank you. We'll go to that when we're done.

MS. O'SULLIVAN: Well, Dr. Conover can go. Whatever you want.

MR. CARVALHO: That's up to the Chair. How would you like to go?

CHAIRMAN ORGAIN: I'm flexible. So Dr. Conover will be reporting on --

MR. CARVALHO: You had asked about --

CHAIRMAN ORGAIN: Right, but which one of the two?

MR. CARVALHO: On MRSA.

CHAIRMAN ORGAIN: Thank you.

MR. CARVALHO: Dr. Conover --

DR. CONOVER: Yes.

MR. CARVALHO: -- Dr. Orgain sent a letter to Dr. Arnold yesterday that you probably haven't received yet from the Illinois Academy of Family Physicians of which she is the president with a question about MRSA, and since Dr. Orgain is here in person, I will let her bring the question for you.

CHAIRMAN ORGAIN: Essentially, what happens is the problem is that we don't have any rules or regulations to return persons who have been -- who may be blatantly infected with MRSA and how we return them to their environments and workplaces and how we essentially would do that particularly because the schools and workplaces are afraid of returning those persons back into those environments.

And so what we need is something from IDPH that talks about carriers of MRSA and how to handle that.

DR. CONOVER: Okay. Well, we have put up guidance for schools to the Board of

Education and there is an update from this year which is the query from IDPH now waiting for the director's signature and for the workplace OSHA has guidance and that is on our website.

For carriers there are essentially no recommendations for extraordinary measures.

MR. CARVALHO: I think what the -- and you will see the letter when you get it, but I thought it would be helpful for you to join here.

I think the idea is it would -- the suggestion is it would be useful for us to develop some sort of guidance which could well be, you know, reference to the guidance we already have if it already covers the subject of basically what are you supposed to do with somebody who has been tested positive and now needs to get on with their life. Both they need some guidance as to how they re-enter wherever they are, work, school, etc. And work, school, etc. needs some guidance on how to deal

with their re-entry.

DR. CONOVER: That does come up fairly frequently, these questions. Perhaps the best solution is to extract the guidance for various settings into one document related to kind of carrier status and management in all those different environments.

MR. CARVALHO: And it sounds like you've got many of the pieces of that already out there. They just may be in multiple documents and I think that's what the Family Physicians Academy is looking for.

And I will just get the other questions on the table and then further ask if it would be helpful for us to provide an ongoing assessment of MRSA ambulatory rates. I know we published something earlier this year on MRSA rates in hospitals.

Do we have any current capacity to provide an ongoing assessment of MRSA ambulatory rates? And if not, is there a way we could acquire that capacity?

DR. CONOVER: I mean outpatient MRSA is not a reportable disease. So there is -- you know, it's extremely common. So I don't think that is the basic assessment and some sort of disease that is common, you know, reports of each individual case would be nonproductive for all of us in terms of it'll probably get a lot of incomplete reports.

But there is a number of national surveys of ambulatory settings for which Illinois data -- but what is happening in Illinois is probably basically very similar to what's happening at a national level.

I think that we put out guidance for ambulatory settings which really should guide practice more than any kind of local assessment of what the rate is at that given time. So these guidelines have been developed by experts within Illinois and disseminated to physicians, which probably hasn't been marketed as aggressively as we would hope. But we really want physicians to follow

the guidelines in terms of management rather than trying to track, you know, what's the biograms, etc. at the local level.

CHAIRMAN ORGAIN: Peter.

DR. ORRIS: Peter Orris.

Could you just give us succinctly the rationale for no -- for the recommendation that no extraordinary measures need to be taken here?

DR. CONOVER: For carriers?

DR. ORRIS: Yes.

DR. CONOVER: Well, I mean carrier status is quite common. The prevalence in the population is at least one percent. So there is lots of people walking around that have MRSA that don't know it, where carriers may be transient.

So the basic strategy should be to have good chance hygiene and so on in these settings. So that, you know, regardless of whether or not one's, you know, MRSA status, flu carrier status, group A strep status and

serous meningitus status, any number of bugs, you know, that basically would undertake good hygiene, respiratory hygiene and so on.

DR. ORRIS: And these should be adequate to handle all these different particular risks?

DR. CONOVER: I think it's the best available strategy.

DR. ORRIS: Right.

MR. CARVALHO: Is this sort of something that has been worked out with APEC and the other -- I mean, this isn't just you working in your office, right?

DR. CONOVER: Yes. These basically reflects guidelines whether they are from OSHA.

DR. ORRIS: Though he has a lot of respect for what you do in your office we want to add, too.

MR. CARVALHO: I do. I do. We work together well but I just wanted -- you had mentioned that and I just wanted to make sure Peter knew that.

DR. CONOVER: You're probably aware that in hospital settings the Illinois legislature decided to mandate screening of both ICU and high risk patients and that goes above and beyond the recommendations of CDC, American Hospital Association, JCAR or the Society for Hospital Epidemiology all updated their recommendations this year.

CHAIRMAN ORGAIN: Kevin.

MR. HUTCHISON: I believe, Dr. Conover, and correct me if I'm wrong, this is Kevin Hutchison, that community-based or community-acquired MRSA that's in clusters is reportable as well.

DR. CONOVER: Clusters are reportable. That is two or more cases that are, you know, deemed to have a linkage in space or time not bound by the provider.

MR. HUTCHISON: So while not every ambulatory case would be, if a physician or a school or reporting entity identifies two or more cases that seemed to be epidemiologically

linked, that would be reported to the local health authority and it would then trigger an investigation and follow up.

DR. CONOVER: Right. And I probably should have stated that. So we do, you know, with some frequency investigations, interventions in school settings, prison settings, group homes, and our basic approach is that when there is a cluster we can probably intervene from a public health standpoint in terms of reducing transmissions.

Whereas, for each individual case for which there is probably tens of thousands in Illinois, we really don't have a capacity from a public health standpoint just to make recommendations. So that's really kind of individual management for those cases.

DR. VEGA: This is Tim Vega. I had a question in this regard.

Is there -- I'm not sure if they were asking that an increased reporting protocol be established, but I was -- I was

wondering if we could report what other states have had. And in our discussion with MRSA and the focus on the hospital, I think there is some -- it's such a small portion of care in America. It's only about three or four percent of care on that giving a perspective as to where -- what the ambulatory numbers could be. Is it -- it enables you to kind of deal with it on a broad level.

So I think while it's not being asked to increase mandatory reporting it was more if we could -- if any other states are reporting such data that we have that available. I think that's all it was.

DR. CONOVER: Right. And there's a few states that are funded to do individual kind of base investigation and those states probably have the best data called ABC, acute bacterial disease, surveillance, and CDC. So we know from those states as well as our own kind of convenient surveys that, you know, over 50 percent of skin and soft tissue infections in

ERs are MRSA.

DR. VEGA: That's right. Is that something we can -- I'm not sure that is -- do we put it on the website of what we collect? If that was something that could be as you go along this is just another piece of information that the general clinician views or even health planners to make that available.

DR. CONOVER: Yes. I mean, this information is -- we tried to disseminate that along with our guidelines for management of skin and soft tissue infections, which are on our website.

Again, when I speak at hospitals about MRSA periodically and survey the physician auditors how many of you are aware of our guidelines. You know, the majority are not, unfortunately.

DR. VEGA: Right. Right. But I think that's where the -- in response to this the academy, you know, will probably send out if not articles probably our portion of our e-mail and

that type of thing within the next newsletter, that type. So it's helping disseminate the information is what the academy is there for. They're specialists at that. So probably in response to this letter that would go on in their website newsletter.

MR. McCURDY: Dr. Orgain --

DR. CONOVER: Yes, I can't recall specifically if family practice has done that for us before but we would very much appreciate that going forward.

MR. McCURDY: Dr. Conover, this is Dave McCurdy.

One question that jumps out at me at least when I read the Academy's letter -- let me read you the sentence. "Employer, sports teams and others ask family physicians to certify that someone who has been identified as MRSA positive is now clear."

What I guess I don't know is what is the latitude that these entities have to, for example, perhaps, exclude people from

work or from participation if they have the information that somebody has been MRSA positive? How does that play into this?

ANNOUNCEMENT: Dr. Girotti has joined the conference.

DR. CONOVER: Yes. I don't think that's appropriate to request certification. I don't think they have the latitude to request certification and it's not considered standard of medical care to kind of, you know, perform screening of people that have had -- given soft tissue infections to designate that they, you know, no longer have MRSA in their nostrils, which is where it's typically carried.

Now, our guidelines basically focus on and the national guidelines focus on, you know, draining wounds and excluding people who have draining wounds. That's appropriate.

And if there is an outbreak, you know, at times there may be a place for screening and decolonization but at this point in the United States that's not considered part

of routine or evidence-based health care.

MR. CARVALHO: So as part of the request here, perhaps, because regardless of that being our opinion, the physicians are finding that people are asking them to do that. Is part of the request here, perhaps, that our guidance should be explicit that that's not appropriate. So that then the physician can turn around and say to the employer, well, you know, the guidelines suggest that this is an inappropriate thing and that's the reason why I'm not doing it and not because I'm just obstreperous.

DR. CONOVER: I can stick to the medical issues. I know in some settings there is legal issues related to, you know, this kind of system of, you know, documentation of status with regard to antibiotic resistant pathogens which have nursing homes, for example, you know trying to refuse to accept patients with recent infections due to antibiotic resistant organisms and that's considered, as I understand it, kind

of a violation of their rights in terms of the patients, to exclude a patient on that basis.

CHAIRMAN ORGAIN: We'll forward this on to you, this letter to ensure that you get it, highlighting those areas that we would like assistance as particularly the likes of this last one and certainly are willing to assist with disseminating the information, as Dr. Vega indicated, to, in particular, our organization and other physicians groups. And thank you.

DR. CONOVER: Yes. We would love to help with all those issues.

MR. McCURDY: One comment about this simply is to -- I mean, when I hear this it strikes me as a matter of public health ethics as well in the sense that we or those of us who are associated with the public health community did our part and importantly to raise consciousness about this. And so now consciousness is raised and people are actually acting on what we have told them in a way. And so it seems to me there is a responsibility in

this community then to maybe be proactive in addressing it, as Dr. Orgain is suggesting.

CHAIRMAN ORGAIN: Thank you very much.

DR. CONOVER: Thank you.

DR. BRADLEY: Dr. Bradley is on everyone.

MR. CARVALHO: Thank you, Dr. Bradley.

DR. BRADLEY: Good afternoon, everybody.

MR. CARVALHO: Did you want him to answer?

DR. CONOVER: I'll sign off then, Dave. Okay.

MR. CARVALHO: Thank you, Dr. Conover.

DR. CONOVER: Okay.

MR. CARVALHO: The question for Dr. Bradley -- Dr. Bradley, there was the report card a couple days ago from the emergency physicians organization that basically was this year's version of last year's report.

It gave each of the states a grade based on a number of criteria and the

State Board of Health was interested in better understanding the report with respect to Illinois and if you could maybe describe that a little bit as well as where there are opportunities for improvement that we might have some control over and where there is opportunities for improvement that we don't.

DR. BRADLEY: Sure. I'd be happy to, David. Good morning, everyone.

The American College of Emergency Physicians put out its second report in terms of ranking the states with respect to emergency care. The first one was done about three years, roughly around three years, 2005, 2006 is the first time they did that. At that time the state of Illinois ranked a C and we ranked about 22 out of the 51 states in terms of providing fair access to care. The areas that they did that they looked at that time three years ago was access to emergency care, patient safety, the public health and the last one was medical liability.

This year they added a fifth category and that fifth category was emergency preparedness. So those are the five categories that they looked at.

Now, we -- this result came out. Illinois got a C. In terms of the overall 51 states there was one state, one state that got a B. No states got an A. One state got a B and everyone else was a C, D or an F.

Where we shined this year, and I will talk about that first, is in two areas. We shined in public health quality, and in patient safety we got an A minus, and one that we really excelled in was preparedness. We received an A minus in that area, too.

They thought that with respect to public -- quality of public safety within a number of the programs that we had everything from our HIV program to our women's breast program some talk about looking at prostrate problems in men. They thought that we were truly on state of the art in terms of

development of those programs and really outranked.

Now although we ranked overall 27 this year out of 51, those programs put us in the top ten under patient quality areas. We ranked about ninth for patient safety and public health.

With respect to preparedness, we really went high there. We ranked actually eighth out of all 51 states. The things that they were excited about and thought that we had done an outstanding job in terms of preparedness was our IMERT, IENRT and renal programs. We got very high remarks for our ESRT (phonetic) written programs. As a matter of fact, we had one of the highest percentages of physicians, volunteer physicians. We ranked 43.2 per every one million population, and we were ranked eighth in all the states. So they were very, very impressed with that.

MR. CARVALHO: Dr. Bradley.

DR. BRADLEY: Yes.

MR. CARVALHO: Could you just briefly, the three acronyms that you used that nobody else knows.

DR. BRADLEY: Oh, I apologize for that.

With preparedness -- and this was developed out of the Governor's and Director's office. IMERT stands for Illinois Management Emergency Response Team, and that is a collection of volunteer paramedics, physicians and nurses who are deployed under the direction of the Director of IDPH, Dr. Arnold, to respond to disasters literally throughout the nation. This group has approximately a four to six hour deployment time.

That means once Dr. Arnold deploys them they are then sent to whatever area they are going to be needed either within the state or out of state and they will be there within four to six hours. They also have the capability of not only staying there those four to six hours but up to three weeks. Actually,

they can stay longer but three weeks we tend to rotate the teams out.

They have the ability to set up alternate health care sites, a surg center, and when they were deployed to Katrina in New Orleans, they were down there for -- two teams went down for a total of six weeks. They set up -- they were actually the only ones there. They got there and were able to set up a hospital and begin to treat patients for that period of time.

So they have equipment and trailers and vehicles that they take with them. Dr. Moses Reed is the medical director over that, but they have a number of physicians that provide medical direction in the different areas.

So IENRT is Illinois Emergency Nurses again association. Both of these respond to the doctors. IENRT, typically, it responds under the direction of IMERT. Most of these organizations are strictly volunteer. In other

words, they will leave their job and go doing whatever they are. But they are protected from leaving their jobs and also the state of Illinois helps in providing some minimal reimbursement for work time loss and, of course, the hotels and food and things like that.

Under preparedness where we got our next A, ladies and gentlemen, was because no other state has anything like the IMERT or IENRT program, the closest state that has something like that was South Carolina. Otherwise, all other states have absolutely nothing. They have different response mechanism teams and things like that but nothing to the level of IMERT that Illinois has.

They thought our response to all our disasters -- this year, you may or may not be aware, we responded to 72 different events this year, and the year is not even over yet. But during this time frame, this year we have already responded to 72 events.

At the time they got a

majority of those events, of course, they didn't get all 72 but clearly enough to see that Illinois was really prepared for doing that. So those are the things that gave us really truly high marks.

We got moderate marks in terms of B in terms of access to patient care. They liked some of our pediatric programs. We still have the same problems that all the other states have with overcrowding in terms of the emergency rooms so that's still an issue.

Where we have challenges, ladies and gentlemen, or where we have opportunity for improvement on things such as our public health and injury prevention. Those are where we tend to lose marks on and a couple reasons. First of all, when you talk about injury prevention, Illinois is a state that has a zero helmet law. So that obviously counted against us. We've never had a helmet law here. We've tried to push that.

CHAIRMAN ORGAIN: Dr. Bradley.

MR. CARVALHO: Dr. Bradley, hang on a second.

Okay. Some of what you're saying is hard to pick up on the speaker.

DR. BRADLEY: Okay. Sorry about that.

MR. CARVALHO: You were talking about injury prevention laws and in particular we have a no helmet law for motorcyclists.

DR. BRADLEY: Correct.

MR. CARVALHO: That's what he was saying.

DR. BRADLEY: And the one thing that they didn't pick up on this year and next year will help raise that score a little bit is that we now have a no smoking -- a ban of smoking within the state of Illinois. That is not included in this report. However, when they do this report again, that will be included and so that will also raise our score and so we should do much better.

MR. CARVALHO: And if I could break out for one second. We have a no motorcycle

helmet law and we probably never will have a motorcycle helmet law. You probably all know the dynamics of that down in the General Assembly.

MR. McCURDY: Dr. Bradley.

DR. BRADLEY: The helmet lobbyist group is very strong. They are pretty much even stronger than the NRA.

DR. ORRIS: Single minded.

MR. McCURDY: Dr. Bradley, we actually got a D minus on access to emergency care. We rated 39th among the states. Can you say anything more about that?

DR. BRADLEY: Part of that has actually been broken up and hang on a second, guys, I will grab that. The access to emergency care was a D and part of the problem is related to insurance, insurance reimbursement. I will give it to you the way they've sort of ranked. Number of registered persons per 1,000 people, number of physicians per 1,000 people, those are the things that have been

bringing us down and continues to have brought us down this year.

Many of you have probably seen the signs on the board. Keep physicians in Illinois. The signs that they are leaving. Part of that is the other reason that we went -- had a low score which kind of ties into the medical liability. Right now our recommendation is that we've got to keep working toward tort reform.

If you guys have the paper in front of you, you will see the average malpractice settlement for Illinois was way above the average. We were at about $543,000 in terms of the actual malpractice award. We also have twice the number of malpractice suits when compared to the 50 other states, the 50 other states. So those are the things that are bringing us down with respect to our access to emergency care.

DR. KRUSE: This is Jerry Kruse. I have a comment regarding the access as well.

When you look at the national report card that's on the ACEP website here, they have another comment related to access. It says halfway down the first page Illinois is facing a shortage of primary care and mental health professionals. An additional 448 full-time primary care providers and 75 full-time mental health professionals are needed to serve the population.

Obviously, I think those estimates are quite low on the shortage really and the issue with access to emergency care means that when there are not enough primary care providers, mental health professionals that there will be overcrowding in emergency rooms and unnecessary emergency room use.

And I just wanted to point out one more time that the states that have specific plans that form coalitions and partnerships between public health departments and public health initiatives, patient center medical homes, primary care providers, they've shown

dramatic declines in emergency room utilization.

Again, the most -- the best example of that is the CCNC, the Community Care of North Carolina, which has a vast website of its own but really gets in there and I think that's one of the real major factors is the access to emergency care relates to access to care overall.

And just one corollary comment to that, to what we have already spoken about already today that relate to the funding efforts for FQHC's and FQHC look-alikes. I think we need to continue to keep in mind that the funding to train physicians and mental health professionals to supply primary care practices, in particular FQHC's, is almost gone. There will be no new grants under the Title 7 Section 747 grant this year, which has been so wildly successful in supplying those physicians and mental health professionals.

And so even though we may have programs to open up new CHC's, it's going to be hard to fill them

and this problem, this problem with access is probably going to be a very acute one for a long period of time. And, quite frankly, I think that the State Board of Health needs to take a big picture view of this to see what we can do to impact solutions to that.

CHAIRMAN ORGAIN: Dr. Bradley, thank you. We are going to move the agenda. I appreciate your time.

DR. BRADLEY: Not a problem. Just so you guys know, very quickly, I will be putting together the entire report that talks about not just Illinois and the other states. I will be submitting it to the director's office next week. So there would be two, one for Dr. Arnold and a second will be for reference copy that will be specifically signed out, reviewed, made comments on. And I'll be more than happy to assist anybody with comments in terms of our next report.

CHAIRMAN ORGAIN: Thank you very much. Ann.

MS. O'SULLIVAN: Okay. Back to the policy committee report. We met on October 30 and I appreciate Jerry Kruse's chairing of the meeting since I had a conflict there.

A couple things came up that I think need to be reported out in particular. Kevin asked about the diversity issues and diversity funding, and we were requested to get a copy of the IDPH's diversity plan so that we can look at what our role might be. So I haven't seen that yet.

MR. CARVALHO: Cleatia. Cleatia.

MS. BOWEN: Yes, I'm here.

MR. CARVALHO: In response to that request, did you find out where our -- are you talking about our own employee or affirmative action plan?

MS. O'SULLIVAN: No.

MR. HUTCHISON: I think we were looking at the issues of health care disparity.

MR. CARVALHO: Okay.

MR. HUTCHISON: Programs and emphasis

within the state health department because I know there are some for HIV minority populations.

MS. BOWEN: We will get that report. We were looking for the wrong type of report.

MR. HUTCHISON: Because I think that will definitely bear into future discussions about SHIP.

CHAIRMAN ORGAIN: Excuse me. So it's not just HIV. It's any initiatives like that that may have a diversity component.

MR. HUTCHISON: And further from my viewpoint, I think we talked about this on the committee, to the extent possible this would reach beyond IDPH to DHS, health care financing and other state organizations that are in the setting policy and/or providing funding for disparity issues.

MS. O'SULLIVAN: Thank you.

Jerry discussed the patient center medical home document that we worked through continuing on with our 2008 agenda on

that. Jerry, did you have any other comments or issues that you wanted to bring forward?

DR. KRUSE: The only thing we discussed in that committee was that when we approved that plan two meetings ago or that organizing philosophy, community care organizations as a term was used in a very broad stroke, and as we've just noted from the emergency physicians document, there are other things that are going on that are focusing on specifically breaking out mental health services as part of those things.

And I think for that document really to focus us on what we want to do it ought to contain the words patient center medical homes, community care organizations, mental health organizations. And, actually, in one of the previous drafts that our policy committee had prepared to that before it came to the State Board of Health two times ago, those words were in there, and they were collapsed so that it would actually be a more concise

document. I think it's better that they are still there and that we amend it to put those in the appropriate places.

Actually, I do have a copy of that with that in the appropriate places if we'd like to pass it around. So it just -- it's exactly the same document except that the word mental health organization is found in three or four different places.

DR. ORRIS: Are we taking this to the consultant stakeholders, the medical societies and the family practice?

Well, in concept it's coming from there but I mean when we create this document are we also --

DR. KRUSE: Well, I think it would be good to take it to those organizations as well. I think our real task is to use it for ourselves and to make recommendations, obviously, to the Governor and the legislature with respect to it, but I think it would have more impact if we went that direction as well. I think that's a very

good idea.

MS. O'SULLIVAN: So this has been approved by the Board a couple of meetings ago.

DR. KRUSE: Two meetings ago.

MS. O'SULLIVAN: It's really editorial. I think revisions, would you say, Jerry, or do you want to go for it to be adopted again or moved?

DR. KRUSE: Yes. Well, I would think that we should adopt it one more time just to put the special emphasis on community mental health services that are so vastly needed and so very important.

MS. O'SULLIVAN: So we would move that.

CHAIRMAN ORGAIN: Any objection? Fine.

DR. ORRIS: I would add that we distribute it as part of adopting it to the appropriate professional societies for their comment, input, support.

DR. KRUSE: That would be good.

CHAIRMAN ORGAIN: And I've added it as an official document for the minutes.

UNIDENTIFIED SPEAKER: Second.

MS. O'SULLIVAN: Okay. So we are continuing down those paths in terms of looking at the agenda and working on that.

The SHIP summit and upcoming SHIP plans, Jim is going to tell us about.

MR. HARVEY: Thanks, Ann and thanks for the opportunity to report to you one more time.

Where we are right now is we are still awaiting the appointment of a SHIP team. However, we are not standing in place while that happens. We are moving ahead with other elements of our agreement so that we can get some things done.

In essence, what we are doing is we are moving ahead with assessment of dates, public health assessment of dates on health status across the state and we have had several meetings already around what the strategic

priority will be that will emphasize the health status and updating some of those assessments.

We are looking at a date in mid to late March at this point to move ahead with the national public health performance standards update meeting as well. And we are hoping that by that time one of two things happens. One is that the SHIP team will have been named and placed so that they can become full participants in the performance standards meeting. Or one of the recommendations that I would like to bring to the State Board of Health today is that in lieu of the SHIP team not being in place at this point we would ask that you will assume an oversight role in the work that is still before us so that we can, in fact, move forward with doing a lot more. I think this would be appropriate, and if we can get you all to review that, we would certainly welcome it, and we could then do so much more under that particular contract.

The only other thing -- and I

mentioned this in the policy committee meeting last -- in October, I'm sorry, is that we've got a legislative subcommittee. It started out as two committees, but it's been combined into one legislative subcommittee. That is an extension of the work that was done in SHIP '07 where we are looking at two key issues, one which was just mentioned a few minutes ago and that has to do with diversity or health disparities, rather.

And the committee is working on some proposed language that would hopefully be presented at the state level to establish a committee, a council or a commission to not just look at it but to track and, in fact, make and put forth some solid recommendations addressing the issue of what we are calling now racial, ethnic and economic health disparities throughout the state.

The other which is the action that is probably going to be a longer slough we know has to do with addressing the challenge of obesity and what we are proposing is what we are

commonly calling a sin tax. And that would be proposing somewhere around one to two cents tax assessment on soda pop, at least at this point, which could produce if handled right up to $126 million a year.

One of the suggestions is that we build into that legislative language once we prepare and recommend it a sunset clause. Of course, that might make it a bit more palatable to those who are going to line up to oppose it. But we are working on this and we will be putting those issues forward as time goes on.

So those are the elements of the SHIP report where we are right now and, of course, like I said, we would like to move ahead with as much as we can. And so if the State Board of Health agrees to assume an oversight role while we are waiting the appointment of the SHIP team, we'd appreciate it because we could, in fact, do so much more than we could.

CHAIRMAN ORGAIN: Would somebody like to move that?

MR. McCURDY: I will move it.
MS. O'SULLIVAN: Second it.
CHAIRMAN ORGAIN: Discussion?
MR. CARVALHO: Could I make a discussion?
Jim and I had talked by e-mail about this before and it's not quite tracking what we talked about. My suggestion was there be a subcommittee. If you do it as a full Board, the Open Meetings Act issues are insoluble -- well, not insoluble but they are pretty darn hard to be --
MS. O'SULLIVAN: How about the policy committee because we have been involved in it and doesn't the State Board of Health have sort of an oversight. I mean legally, legislation.
MR. CARVALHO: Ultimately, you are the oversight body for the development of the SHIP and pending the SHIP team it seemed like a good place to do that would be the policy committee until the SHIP team is appointed.
MS. O'SULLIVAN: Well, I would move

that for the policy committee and if others want to join in that and we can make that happen.

CHAIRMAN ORGAIN: Okay. Peter.

DR. ORRIS: I had a comment on the last, the obesity, so I will wait.

CHAIRMAN ORGAIN: All right. Any unreadiness in regards to that?

Okay. So by consensus then it is done. That is our role.

MR. HARVEY: We love our policy committee meetings.

MS. O'SULLIVAN: And I see from our meetings you had talked about a SHIP action steering committee. What is that?

MR. HARVEY: The SHIP action steering committee was a group that elected to stay in place with SHIP '07 to help move things along. What that's morphed into at this point is more pointedly the legislative actions that we have.

MS. O'SULLIVAN: All right. And then the part to me that is so frustrating about the appointment process and the planning team is all

the energy that was generated at the summit. So you're working on several of the access and health care issues. Where are we with the work force issues?

MR. HARVEY: And that's one of the things that was reported out in that steering committee meeting that extended from the SHIP summit was that we had that on the agenda and we determined at that point from the report from Russell Robertson up at Northwestern that they are putting a tremendous amount of energy into the whole issue of access and so many of the members of that action committee have elected to join in with the work and so we are waiting for a report back to see just where they are going.

They are talking about establishing a center, you know, to address the issue of access. So we are really excited about that and we will be tracking that and I hope that by the time we meet again we will have something to report.

CHAIRMAN ORGAIN: I would like to

respond that the establishment of the center was put on hold because of funding issues, to my knowledge and so...

MR. HARVEY: That takes us back to the drawing board again.

CHAIRMAN ORGAIN: It may. It may.

MR. HARVEY: Well, that's important news. I appreciate that.

CHAIRMAN ORGAIN: All right.

DR. ORRIS: On the obesity question, I think when you move toward the sin tax kind of approach one needs to have both a positive and negative aspect to it and, therefore, targeting children and marketing of sugar-based drinks to the kids is, I think, what you want to be talking about strategically and also so you get a change in behavior as well as making your money for the projects, etc.

And then the second part, the AMA right now and a number of different groups are taking a rather large -- well, anyway hope they are taking a large, broad view of the

question of obesity and food and nutrition from an entire industry production process, and I would hope that's the kind of thinking that we could do. We are waiting for a report from the Science Council of the AMA on that in the next few months.

MR. HARVEY: I have had a couple of phone discussions with people at AMA around that very issue and that's helping us in terms of fashioning this. And yes, childhood obesity is going to be our principal focus.

DR. EVANS: And I would like to add that the obesity issue is certainly there and that's undeniable. But soft drinks and that sugar composition is one of the primary factors in dental caries for children and that massive problem. So, hopefully, in your plan there really ought to be an oral health element to it.

Secondly, I want to echo Peter's comment. I think regardless of our interest and our goodwill regarding the effects of obesity progress has to be made within the

food industry. The way food is now packaged and prepared no matter what we do unless you are going to just eat carrots and celery it's very difficult to retain one's -- or control one's weight or control the elements of one's diet because you do not have the options of decomposing the foods that are available to you.

Evidence is that if you -- if you set about to consume no extra sodium in terms of table salt, you would still have sodium overload because of the amount of sodium that is contained in the foods that you eat and there is no way to decompose that. So without some fundamental change at the food production level we basically are kind of just flapping our gums because we are not going to make the kind of changes we want to make because we don't have the options before us.

CHAIRMAN ORGAIN: I think that's the critical question in regards to -- I'm not sure what the AMA -- how the committee at the AMA is comprised. But I know the industry is having

their own set of meetings in regards to this primarily from a profit perspective to get ahead of how we may ask them to regulate their industry and I think it's important that we make those discussions.

DR. EVANS: I've seen a report that some of these chipotle sandwiches and whatnot they have got enough sodium composition for a couple days of tolerance, not to mention the caloric intake, just on one sandwich. It's off the page.

MR. HARVEY: I know that this campaign is going to be a protracted effort and so as time comes -- as time goes by, you know, these are the kinds of important points that are going to have to be considered at some point.

CHAIRMAN ORGAIN: One more comment.

DR. KRUSE: Jim, I want to follow up on Dr. Orgain's comment about the work force. Even though we recognize there wasn't enough state money for a center, we still wanted to keep this on the front burner, and we still

wanted to gather information from the relevant sources and not necessarily do a whole work force analysis in Illinois but at least use all of the added information to make some projections and help make policy with that. Right?

MS. O'SULLIVAN: Exactly. And it seems like with the legislative committee going forth to deal with a couple of these other that were top priority issues, if there was any way that, you know, we can do the same thing with work force before we get appointments made and stuff like that. If we can get those people back on an e-mail or a call or get the information together, I mean we are -- it was just a lot of energy and information and drive to deal with those issues.

CHAIRMAN ORGAIN: Yes. There are a number of work force reports that have been done that probably need to be brought together. Okay.

MS. O'SULLIVAN: And then what do we do in Illinois?

CHAIRMAN ORGAIN: Exactly.

DR. ORRIS: Staying with the obesity or food just one more moment.

Are you thinking about utilizing the bulletin of the board of health or the policy committee or whatever of putting together some discussions in the state of stakeholders again? I mean, just with regard to them and sitting in the state they have to be involved in this discussion and I'm wondering what kind of a -- something like that that we might be able to contribute, I don't know, under this umbrella.

MR. HARVEY: Well, we are only at the strategy proposing stage at this point and so your input is extremely valuable, you know, right now and will grow in value as we go along.

And as we continue to develop the strategy and roll it out, of course, we'll come to you and we will share that with you and

we will want you to rip it apart and make any recommendations and suggestions that you can and that will really help us as we move along.

CHAIRMAN ORGAIN: Thank you very much.

MS. O'SULLIVAN: And so we will do some of that work at the next policy meeting.

DR. VEGA: Javette.

MR. HARVEY: At the next policy meeting.

CHAIRMAN ORGAIN: Yes, Tim.

DR. VEGA: I just wanted to add something on the policy committee. A lot of these different activities, whether they are obesity or exercise, vascular disease, there is a lot of activity but we in the policy committee we talked about the medical home and basically that was a strategy to actionize these activities.

And one thing that has come up that we can certainly do some action on is that the CMS in Washington is picking states as we speak to qualify for a medical home

demonstration state and the -- and a medical home basically is an integration point for public health, mental health. But that's where the ideas and the guidelines for whether they are obesity or work force -- kind of where the rubber meets the road.

And so at least one thing that we can do, and I just proposed this, is that we write a letter to CMS advocating Illinois as one of their demonstration sites where we can get some public health, and nursing, and mental health all integrating into medical home in the communities where they're needed.

We're a good selection as far as a state. We haven't had a CMS demonstration project in our state. Senator Durbin was the author of the legislation that created this, and I think it's a good opportunity.

But time is essential since they are going to pick that state -- those states. I think it's four or eight in December. So at least it is consistent with our policy to

use medical home as an implementation tool for all these various aspects of SHIP.

CHAIRMAN ORGAIN: December. Today is December the 10th.

MR. CARVALHO: The 11th.

CHAIRMAN ORGAIN: The 11th. Thank you.

Tim, did you have any additional information about dates?

DR. VEGA: I don't have any information on states. I know other states are --

CHAIRMAN ORGAIN: Dates. Dates. The dates.

DR. VEGA: Oh, the dates. No. They have not indicated that they have picked anybody. I assume that they are going to be a little bit late. In January they will make their announcement. So if we -- you know, I hope that we can get a letter off just advocating for ourselves. We would be an excellent demonstration site because we have

urban, rural. We have high specialty areas, low specialty areas, high Medicare cost areas, low Medicare cost areas and we haven't had a CMS demonstration in our state ever. So all of those things are reasons to get it.

If we do have a demonstration, they would recruit 400 physicians and have them create medical homes. A medical home by definition would be things that are geographic and so that they deal with disparity issues. They integrate mental health. They integrate public health and nursing. So that's why, you know, we have a lot of activity out there as far as ideas of what to do, but we need actionability, and I think that's what the medical home takes a step towards.

CHAIRMAN ORGAIN: Let me just comment so that we can move the agenda.

And I apologize. Tim and I had spoken about that. We do have the information and we can work with IDPHI in regards to getting that done and recruiting

collaborators to get that done in a timely manner because we have the documents about that information.

MS. O'SULLIVAN: So this would go through the department.

CHAIRMAN ORGAIN: Tim, who would be the applicant?

DR. VEGA: The applicant would be individual physicians or groups. The big thing now is --

MR. CARVALHO: No, no. Tim, who applies to CMS for Illinois to be designated as a demonstrator?

DR. VEGA: Oh, nobody applies. They just pick.

MR. CARVALHO: Does CMS pick the state?

MS. O'SULLIVAN: Who writes the letter?

DR. VEGA: There is no application for eligibility. Every state is eligible but I have called them, the people who created the proposal

request, and I asked them, well, do states -- do states lobby or advocate for this and she says, yes, they do all the time.

CHAIRMAN ORGAIN: So essentially --

DR. VEGA: And nobody from Illinois was doing that.

CHAIRMAN ORGAIN: So, essentially, then what we need is that advocacy to CMS to select us as a demonstration state.

MS. O'SULLIVAN: Where does the money go?

MR. CARVALHO: Somebody should look into --

CHAIRMAN ORGAIN: Exactly.

DR. VEGA: I've been getting the associations to call. I sent information to Senator Durbin and our local senator -- our local congressman asking them to send a letter to CMS and to think about Illinois.

But the public health department is a -- and if they see us advocating for it, that's what they want to see. They want

to see public, private integrative type of response. That's what they want to see. So us being on board and advocating for this would be very -- a good feather.

CHAIRMAN ORGAIN: Let me recommend that if there is -- if the policy committee could just huddle, set up a time to meet quickly after our meeting to further discuss this and develop some strategy around how to do it if that's acceptable and we can move the agenda forward. We can get some additional information as to what the process might be and how to do that advocacy around that issue.

DR. ORRIS: Do we need to pass something to authorize it?

CHAIRMAN ORGAIN: No, the policy committee can meet and then if necessary -- we don't know what the details of the process is in order to pass anything at this point.

Thank you, Tim, for bringing that issue up.

Jim, did you have anything to

-- well, go ahead.

MS. O'SULLIVAN: Well, I guess there were a couple of other action items, Dr. Orgain, that I don't know if you wanted to bring up related to the enforcement of the Smoke Free Illinois, the economic crises, their waste, State Board of Health can assist that and how about funding for programs that no longer receive funding were just some of the other issues that I saw in the notes from there.

And the last thing is and I see on the agenda so I am happy to -- that we will be dealing with that. It's been very confusing this year in terms of who's members of the -- who are the members of the policy committee and who are not and some people get notices and some people do not. So I'm glad that we are going to be clarifying that. That's been just an ongoing issue all year. So we will get that straightened out.

CHAIRMAN ORGAIN: All right. Thank you.

DR. WHITELEY: So where are the policies on the Smoke Free Illinois? What's the latest on that?

MS. O'SULLIVAN: Nothing I don't think. David.

MR. CARVALHO: Well, the statute is in place. The rule-making was killed by the Joint Committee on Administrative Regulation and so the question that has not yet been addressed is are there statutory changes that are going to be required to develop rules that will meet the requirements of JCAR. The issue on its surface, at least, that JCAR was concerned about was due process for people who have been cited for violation and what should the process be and --

CHAIRMAN ORGAIN: David, I think you reported on it at the last meeting. Have there been any changes since then?

MR. CARVALHO: No. There is no change since the last time.

CHAIRMAN ORGAIN: All right. Thank you. So, unfortunately, there has been no

change. Is there anything that we can do?

MR. CARVALHO: Well, not at this time. In the absence of statutory change that would support the regulations to provide the due process, if we were to propose regulations that had due process provisions, JCAR would tell us that we don't have the statutory authority to do that, but they also don't like the rules without that. So there is -- we're kind of stymied; other than to say to everybody that the law is in place and it's still a violation of the law to be smoking in a place that you are not supposed to be smoking.

DR. ORRIS: I take credit for streamlining government, too.

MR. CARVALHO: Yes. So the General Assembly starts fresh January 13th, and we will be looking for legislative resolution to support a regulatory resolution.

DR. WHITELEY: Thank you.

DR. ORRIS: Can I ask one other question from the policy committee on this -- on

the economic situation?

Dr. Goldberg had that suggestion about people losing their insurance. Do we send that to you, David, for advice about what to do? Should we bring that here or what do we need to do?

MR. CARVALHO: Well, let me summarize it and then tell you what -- I hooked Dr. Arnold into that and he e-mailed me at 4:00 a.m. of whatever place he was. He thought it was an interesting idea and that we should discuss it with the insurance director when he gets back, when Dr. Arnold gets back. He should be back Saturday.

But the issue was is there an opportunity to facilitate future health care for persons who lose their health insurance coverage because of the economic downturn; if insurance companies are mandated to make available to people who are being dropped off insurance information about the care that they've received to date.

So that while obviously that's not exactly a proxy for a medical record, it nonetheless provides the covered individual with information that might be useful if they get their care at a free clinic or at a public facility, if there is some interruption in care because they have to change from their ordinary provider because they have lost insurance.

DR. ORRIS: In essence, an exit letter from the insurance company if you're being dropped that lists what they've supported, what the diagnoses are and the medication, which hopefully is just pushing a button there.

MR. CARVALHO: So we will discuss that with the insurance commissioner who's now actually the head of the whole department. The Insurance Commissioner, Michael McRaith, was recently promoted to being head of the Department of Financial and Professional Regulation.

CHAIRMAN ORGAIN: Does that then take care of everything in the policy committee

report?

MS. O'SULLIVAN: Yes.

CHAIRMAN ORGAIN: Thank you.

I would like to move then to election of officers and come back to legislative update, if there is one.

MR. CARVALHO: Sure.

CHAIRMAN ORGAIN: First let me then ask for nominations for the vice chair for the committee. Our current vice chair is David McCurdy.

MS. PHELAN: I nominate David McCurdy.

DR. WHITELEY: I second.

DR. ORRIS: Can he be renominated?

CHAIRMAN ORGAIN: Yes, he can.

Hopefully, it will be moved and seconded to nominate David McCurdy. Do you accept?

MR. McCURDY: I would.

CHAIRMAN ORGAIN: Okay. Very good. Then all in favor?

RESPONSE: Aye.

CHAIRMAN ORGAIN: Unanimous.

All right. Then I have to remove myself in terms of the next part and you can take over that part.

MR. McCURDY: Okay. We now are entertaining nominations for chair and I suspect that everybody knows who the chair is so I won't repeat any information you have. The floor is open.

CHAIRMAN ORGAIN: Absolutely.

MS. O'SULLIVAN: Okay. I nominate Dr. Orgain.

DR. EVANS: Second.

MR. McCURDY: Would you accept?

CHAIRMAN ORGAIN: Any other nominations? Anybody interested?

MR. McCURDY: Well, we have to ask would you accept.

CHAIRMAN ORGAIN: Yes.

MR. McCURDY: Okay. She would accept. Are there other nominations?

DR. EVANS: Call the question.

MR. McCURDY: We will call the question. All in favor say aye.

RESPONSE: Aye.

MR. McCURDY: Opposed?

(No response.)

CHAIRMAN ORGAIN: Thank you.

MR. McCURDY: Mission accomplished. Back to you.

CHAIRMAN ORGAIN: Thank you very much.

Let me, if I may, do committee assignments and let's start off with the rules committee. Who is interested in as we move into 2009 participating on the rules committee?

Peter Orris, Karen Phelan, Caswell Evans, David McCurdy.

Anyone else interested?

Okay. So that duly constitutes the rules committee.

So let's now go to the policy.

MR. CARVALHO: Can I make one suggestion?

CHAIRMAN ORGAIN: Yes.

MR. CARVALHO: When you have an even number of committee, while there are very few split votes, that's not a problem, it does affect your quorum requirement. A four-member committee would still require three people for a quorum. A five-member committee would require three people for a quorum. So you have a better shot at getting quorums if you have a five-member committee rather than a four.

MR. McCURDY: I thought we had five.

MR. CARVALHO: I think you just mentioned four names.

MR. McCURDY: Dr. Orgain had served on it in the past, as I recall.

CHAIRMAN ORGAIN: And I usually --

MR. CARVALHO: Well, ex officio you wouldn't count towards a quorum.

CHAIRMAN ORGAIN: That's correct.

MR. CARVALHO: I don't think our bylaws prohibit you from serving as a full pledged member so you should appoint yourself.

CHAIRMAN ORGAIN: All right. Then I

will. I had been -- I come in and out of all the committees but that's fine.

MR. McCURDY: Do what seems good to you.

CHAIRMAN ORGAIN: That's fine. All right. For policy committee.

Okay. So that's Karen Phelan, Jerry Kruse, Ann O'Sullivan, Kevin Hutchison and Javette Orgain.

DR. VEGA: I've been on the policy committee.

CHAIRMAN ORGAIN: Oh, Tim Vega. Good. Thank you, Tim.

All right. I'll take myself off.

MR. CARVALHO: Yes. You can continue to drop in but you wouldn't count for a quorum nor detract by your absence.

CHAIRMAN ORGAIN: Okay. Very good.

So I think that that then clarifies our two standing committees and the question becomes do we feel that there is any

need for any other committees for the board.

MR. McCURDY: One request with regard to the standing committees the policy committee I know the question had arisen who is on it and who gets notified. I would hope that we would all be notified of meetings even if we are not members.

CHAIRMAN ORGAIN: Okay.

MR. McCURDY: Would that be possible?

CHAIRMAN ORGAIN: Absolutely.

MR. CARVALHO: Cleatia, you heard that, correct?

MS. BOWEN: I will notify everybody of the rules committee meetings and the policy committee meetings.

MR. CARVALHO: Great. Thank you.

MS. O'SULLIVAN: And I noticed that question before and I know that we shouldn't have to do this but sometimes we forget what committee we are on. So like when you send out a rules committee reminder maybe you just note who the rules committee members are. I mean,

that has come up a couple times. You know, we're all on fifty million committees so you can't remember which one you're on for what thing. So if you can just note who the members are who are supposed to be there and the same thing for policy.

CHAIRMAN ORGAIN: All right. Peter.

DR. ORRIS: Do we want --

MS. BOWEN: If I could reiterate here, back in March of this year on the policy committee you had the following persons which was Ann O'Sullivan as chair, Kevin Hutchison, Dr. Jerry Kruse, Dr. Tim Vega, Dr. Girotti, Karen Phelan, Dr. Peter Orris and Dr. Caswell Evans.

Is that the committee for this year?

MR. CARVALHO: No, no. Cleatia, that's what they just went through. Dr. Orgain just identified who was on the committee. There's five members on one committee, five members on the other committee, but all of them

want to get notice.

MS. BOWEN: Okay.

MR. CARVALHO: You can refer to the transcript if you didn't catch it in the motion.

MS. BOWEN: All right. Well, it was kind of fuzzy here.

MR. CARVALHO: Okay. Thank you.

DR. ORRIS: Listening to the press conference from the White House elect from 51st Street this morning the context of the press conference was about the initiative and the pressure for reorganizing a health care system and I'm wondering if the policy committee makes that a major emphasis. Do we want to have a separate committee this year that might want to get together with other like-minded Illinoisans, etc.?

CHAIRMAN ORGAIN: What was your question again, Peter, please?

DR. ORRIS: I just think that it would appear, the economic situation notwithstanding, that it's going to be major pressure to do

restructuring and major pressure from Washington to involve people at the grassroots and in states, etc.

And so my question is do we want to have a committee for this year working on that, that we might include other people from outside of our members here or does the policy committee want to do it?

MS. O'SULLIVAN: I think what we are doing sort of fits part of that. But it all depends upon the workload and what -- you know, what the rest of the group would think.

MR. HUTCHISON: I think the question is great and it occurs to me that we are kind of in this hiatus with the State Health Improvement Plan Task Force because I know access to care, quality of care and many of the disparities and many of the things that we are concerned about as a board are being addressed through the State Health Improvement Plan which should resonate with national policy, but there is no committee in place. So it gets back to who needs to keep

the momentum going because life is moving on in the country in terms of health care reform and Illinois should really have a voice in that process.

So right now it's kind of a policy committee but I think -- I don't have the answer. I'm just confirming what Dr. Orris said in terms of us having this important opportunity, if not obligation, to be speaking for this on behalf of public health issues in the broad sense for national health reform.

CHAIRMAN ORGAIN: Jerry, did you have a comment?

DR. KRUSE: Oh, no, I didn't.

CHAIRMAN ORGAIN: Did you have any comments?

MR. McCURDY: Well, my only comment there is that in terms of the State Health Improvement Plan, certainly as well as health reform, just the fact of the continuing recession and the economic crisis and its likely impact on public health, not just how are people

going to pay for things, but, you know, there is all of that seems like it needs to be part of our agenda in both fronts.

MR. HUTCHISON: Maybe I could have the question. Since we are advisory to the director of public health department, as the public director, IDPH have made overtures or given information or is informally pushing a platform for national health reforms and our Board can endorse the work that Dr. Arnold is doing for our work in concert with some efforts. Again, it's kind of a procedural thing, but that would be one avenue.

Because we get our vested vetting here as serving as a State Board of Health as advisory to the state health department, and our current State Health Improvement Plan has a lot of these important issues in place. In the absence of the task force, we could just push a letter to the President Elect, to the new health secretary and other folks, but I wouldn't want to, you know,

go -- as a State Board of Health, we wouldn't want to go around the Director, I don't think, but, hopefully, that would be enforcing what the Director is already doing.

MR. CARVALHO: Yes. Well, let me figure out a way for you to work in concert with what the Director -- keeping in mind that just as with the effort here in Illinois when we were working on the universal health plan, although the staffing of it was staffed by the Department of Public Health, it brought in HFS and DHS and this will, too. So we will all be working. You know, Dr. Arnold won't be doing this alone even within the state. It will be with Barry Merrill (phonetic) and Carol Adams and the Governor's office.

MR. HUTCHISON: To move this forward I would suggest that our board chair and our policy chair maybe collaborate if there is letters or correspondence or something needs to be pushed out ASAP while this is in and we have an opportunity to have input to it in the

interest of time frame.

MR. CARVALHO: And public health in particular I think ASCHO and some of the other national organizations of relating to public health will also -- will be working vertically and horizontally. Horizontally here within the state and vertically within our areas.

And just as with again the universal coverage proposal that was developed in Illinois there were pieces of it that related to public health independent of the way that public health is benefited by everybody being insured.

Similarly, we would be pushing in the vertical way through national organizations for that same kind of technology that the public health issues independent of the general benefit of everybody being insured that need to be part of the development of a proposal. And then we have, you know, certain bat channel avenues as well.

CHAIRMAN ORGAIN: Okay. Let's move on.

Let me just announce the meetings schedule for 2009 that you do have that in your packets so please take notes.

MS. O'SULLIVAN: I would like to add the policy committee onto this as a routine basis. We did that last time and it worked. I looked at my calendar to sort of mesh with what we had done before. Thursdays seem to work out well. I was looking at February 5th, May 14th, August 6th and November 5th.

CHAIRMAN ORGAIN: Thursdays at what time?

MS. O'SULLIVAN: 1:00 to 3:00.

CHAIRMAN ORGAIN: 1:00 to 3:00 p.m.

MS. O'SULLIVAN: So with that I don't know how we go about setting these, but it seems like it worked better to just set them at the beginning of the year. So when we do this for next year if we can like communicate on that, Cleatia, and then we will have it right along

with this.

CHAIRMAN ORGAIN: So let me repeat. Thursdays from 1:00 to 3:00 p.m., February 5th, May 14th, August 6th, and November the 5th. Is that correct?

MS. O'SULLIVAN: Yes.

CHAIRMAN ORGAIN: Thank you. Good.

MS. O'SULLIVAN: November 5th.

CHAIRMAN ORGAIN: November.

MS. O'SULLIVAN: And, David, then if we can make sure that you are there to work with us.

MR. CARVALHO: Thursdays usually work well.

MS. O'SULLIVAN: That's kind of why we were --

MR. CARVALHO: And Mary Driscoll in my stead will probably be the appropriate person.

MS. O'SULLIVAN: Okay, great.

CHAIRMAN ORGAIN: Okay. Peter.

DR. ORRIS: Are we still all on or are we being reappointed or what?

MR. CARVALHO: You are one of the boards that you -- not all boards are this way. But you are one of the boards whose members remain in place until you are terminated.

CHAIRMAN ORGAIN: Herb, you had a question?

DR. WHITELEY: No.

CHAIRMAN ORGAIN: All right, Dave.

DR. EVANS: Just for clarification, was the March meeting and the September meeting in Springfield for the Board?

MS. O'SULLIVAN: Yes. I was wondering about that.

CHAIRMAN ORGAIN: This is December. So March is Springfield and September would be Springfield as well.

DR. ORRIS: And could we try to do television again? I asked the communication from here to there I noticed in the back --

CHAIRMAN ORGAIN: I saw them video conferencing.

MR. CARVALHO: We just need to secure

the facilities. It's not hard to -- well, it's not hard to do if you have got the room.

DR. ORRIS: And you need the technician the first couple times to help.

DR. KRUSE: I might also ask if you have trouble finding rooms ask SIU. We have lots of rooms.

MR. CARVALHO: We have actually learned that in connection with this certificate of need task force which has been using SIU for their meetings in the Springfield location which is a perfect dovetail into the only thing I have on the legislative update.

CHAIRMAN ORGAIN: Okay.

MR. CARVALHO: Which is, your name has come up. Okay. What do I mean by that? As you may or may not know this --

CHAIRMAN ORGAIN: SIU.

MR. CARVALHO: The State Board of Health.

The certificate -- there is something called the task force on health

planning reform, otherwise known as the CON Task Force, that has been looking at whether or not and under what circumstances to continue the certificate of need process in Illinois. It has been a long interesting process. And I serve ex officio on that.

It's a task force of eight legislators, five or six people from the Attorney General's office and five or six people in certain categories like hospital, etc., designated by the Governor. Twelve members have to agree on a proposal.

They are in the final strokes of finishing their recommendations. Their final meeting was last Monday, but it didn't get everything done so their next final meeting is set for Friday. Future final meetings to be determined.

MR. HUTCHISON: And that's final.

MR. CARVALHO: And that's final.

And it took an interesting twist that is relevant to you so I thought I'd

bring it to your attention. Keep in mind that this is a task force report which will then go to the legislature and the legislature will consider what to do with the report.

But in particular, historically, the certificate of need process has not been pursuant to a comprehensive health plan with respect to the State of Illinois but rather sort of a negative plan which is to say an inventory of what facilities exist, what need is therefore necessary. Applicants come in. If they exceed that need, they are turned down, and if they are within that need, then they are approved.

And so one of the things that the task force has identified is a need for a comprehensive health plan to distinguish from the State Health Improvement Plan which led to a question in the minds of some legislators who should -- A, who should serve on the CON board, how should that be determined, and, B, who should vet the comprehensive health plan.

So the proposal on the table was to create a -- and hang with me on this one -- to create a nominating committee consisting of the ethics officers for the Secretary of State, the Treasurer, Comptroller, Attorney General and Governor. Those five people's ethics officers would themselves nominate a panel of people. That panel of people would then nominate people to serve on the CON task force and nominate somebody to be the comprehensive health planner, which is otherwise a division chief in my office actually, and would also nominate people to serve on a comprehensive health planning board whose sole purpose would be to annually approve the comprehensive health plan.

The people who would be nominated through this process, there would have to be three nominees submitted to the Governor for every vacancy. So a nine-person board would have 27 nominees. All of them would have to go through FBI background checks and then be

gratified by both the House and by the Senate.

MS. O'SULLIVAN: Now, this occurred on Monday before Tuesday?

MR. CARVALHO: Oh, yes. Yes.

MS. O'SULLIVAN: I was just wondering.

MR. CARVALHO: This has been on the table for months.

MS. O'SULLIVAN: All right.

MR. CARVALHO: During the course of those conversations, I suggested to them that rather than setting up a nine-person board selected through that process for the sole purposes of adopting the comprehensive health plan parallel to the nine-person board that would be a CON board; that since we already had in place a State Board of Health that each year over every five years would vet the State Health Improvement Plan; that perhaps the State Board of Health could also vet the comprehensive health plan as it's developed from time to time.

In the category of be careful of what you ask for, it briefly then turned into

a proposal that the State Board of Health be appointed through that same process that I described where the 17 of you would come from the list of 51 nominees that would be vetted through the process I described and I think they have tentatively settled on not doing that, relying on the State Board of Health as it is currently comprised and currently appointed.

But the comprehensive health plan would be developed by the new Center for Comprehensive Health Planning, which would be a center in my office, just like the Center for Rural Health and the Center for Health Policy, but that the person who runs that center, unlike my other division chiefs, would be appointed through that process involving the nominating committee and the ethics officers and the -- both houses of the General Assembly and then that person would develop the plan and bring it to you on an annual basis.

So I don't know whether that will happen, but since I sucked you into it, I

thought I'd let you know.

MS. O'SULLIVAN: How do you keep all that straight in your mind?

DR. ORRIS: That doesn't mean that we have two facilities, right?

MR. CARVALHO: No, no. You would -- you would -- and this is where the concern was that a health plan would have a great impact on what kind of facilities would be approved and so then who would -- you know, frankly, the issue was who is going to keep you guys on. Well, I volunteered but --

DR. ORRIS: What happened to our just advisory status? I mean, don't get us that close to doing that. That is a lot of money people will have at risk.

MR. CARVALHO: That's true. So in any event, that issue is out there. And as I say, we'll keep you apprised of where it goes, but that's the end of my report.

CHAIRMAN ORGAIN: Okay. That completes everything on the agenda. Thank you

for the re-election.

Everybody have a good holiday. And if there is no objection, we're officially adjourned.

Yes, the policy committee will stay for a minute. So we're officially adjourned.

(WHICH WERE ALL THE PROCEEDINGS HAD IN THE ABOVE-ENTITLED MATTER.)

STATE OF ILLINOIS)
)
COUNTY OF C O O K)

I, DONNA T. WADLINGTON, a Certified Shorthand Reporter, doing business in the County of Cook and State of Illinois, do hereby certify that I reported in machine shorthand the proceedings in the above entitled cause.

I further certify that the foregoing is a true and correct transcript of said proceedings as appears from the stenographic notes so taken and transcribed by me this 12th day of January, 2009.

_____

DONNA T. WADLINGTON
CSR #084-002443