STATE BOARD OF HEALTH
THURSDAY, SEPTEMBER 11, 2008
11:00 A.M.
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIRECTOR'S CONFERENCE ROOM - 5TH FLOOR
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SPRINGFIELD, ILLINOIS

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MEMBERS PRESENT OF THE STATE BOARD OF HEALTH

JAVETTE C. ORGAIN, M.D., M.P.H. (Chairperson)
DAVID B. MCCURDY, D. MIN. (Co-Chairperson)
CASWELL EVANS, D.D.S., M.P.H.
KEVIN D. HUTCHISON, R.N., M.S., M.P.H. (VIA TELEPHONE)
KAREN PHELAN
TIM VEGA, M.D.
JANE JACKMAN, M.D.
HERBERT E. WHITELEY, D.V.M (VIA TELEPHONE)
JORGE A. GIROTTI, Ph.D. (VIA TELEPHONE)

ALSO PRESENT:

Cleatia Bowen
David Carvalho
Mary Driscoll, IDPH (Via Telephone)
George Dirks, IDPH
Steve Derks (SBOH Member)
I N D E X

11:00 a.m. I.   Call to order and introduction of members  5

11:05 a.m. II. Approval of June 12, 2008 meeting summary  5

11:10 a.m. III. Director's Remarks  11

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A. SHIP update  62

12:05 p.m. VI. Preventive Health Services Block Grant Update  64

12:17 p.m. VII. Legislative Update  73

1:00 p.m. IX. Adjournment
CHAIRPERSON ORGAIN: Thanks, everyone. We have -- I believe we have a quorum, I think --

MS. BOWEN: Yes.

CHAIRPERSON ORGAIN: -- in order to be able to vote and proceed with any action that we need to take. The Director is unavailable. I guess we're waiting on David Carvalho.

MS. BOWEN: Yes.

CHAIRPERSON ORGAIN: But I will begin with the approval of the June 12th meeting summary, and I believe we have a number of grammatical corrections that we will forward to Cleatia to change. And what I would like is for anyone to express any substantive corrections, and we'll forward the grammatical things to her, but let's deal with any substantive changes that you might have on the meeting summary. Any comments?

MR. MCCURDY: Madam Chair, on Page 2 of the meeting summary, letter D, the discussion about the Child Health Examination Code, the first sentence says that the State Board of Health members who are physicians expressed opposition to the rule, that this law is an attempt by the Optometric Association to infringe on their practice. The transcript just does
not support that interpretation, at least as I read it. It seems to me that that could be amended to say the State Board of Health physician members expressed opposition to the rule, period, and then Dr. Javette Orgain expressed concerns, et cetera. Now, you know, there may be another way to say that, but that would be my suggestion right off.

CHAIRPERSON ORGAIN: I believe that we probably need to amend that to say that the State Board of Health member -- physician members expressed concern about the language in the rule, not the rule itself, but the language in the rule that needed to be clarified in regards -- in particular, in regards to who would be allowed to perform the eye examination.

MR. MCCURDY: And that certainly would fit the transcript.

CHAIRPERSON ORGAIN: In addition, several members, not just myself, expressed concerns about the cost of the eye examination.

MR. MCCURDY: Also, and this may be partly technical, but I think it's more than just wording. But the action whenever we voted to approve something, quote, unquote, it says something like we voted to forward it to JCAR, we voted to send the rule for
publication. So in this case, to say that we did not approve the rule doesn't quite seem to fit. It would be that we voted not to, whatever, send it for publication. I would guess that would be the language. Would that be right, David, something to that effect?

MR. CARVALHO: Well, the minutes are a reflection of what you actually did. Whether you actually did it the way you just described it, I'm not sure.

MR. MCCURDY: Okay.

CHAIRPERSON ORGAIN: Here is a technical question. As we vote on the rules, are we approving them or not approving them? What are we doing?

MR. CARVALHO: You are --

MR. MCCURDY: We don't approve.

DR. VEGA: We advise, don't we?

MR. CARVALHO: Well, let me look at the statute at an intermediate spot.

CHAIRPERSON ORGAIN: That is the real question. So the language needs to reflect our capabilities in regards to what we do with the rules. So as we're voting, and I think that's what David McCurdy is suggesting, we're voting to send it forward or voting not to based on our concerns.
MR. CARVALHO: Yeah, because voting to send the rule to JCAR isn't probably the right wording either.

CHAIRPERSON ORGAIN: Either, exactly.

MR. CARVALHO: Because you don't do that, you give us your view and then we incorporate it, and then we sent to it to JCAR.

CHAIRPERSON ORGAIN: Exactly.

MR. CARVALHO: And then in this particular instance, as we reflected in a letter to you, we felt a need to go forward, because there is a state statute, and the basic disagreement was with the statute, not with the rule, and we --

CHAIRPERSON ORGAIN: And we'll need to discuss that after we do the meeting summary, because that's not actually what occurred.

MR. CARVALHO: Okay.

CHAIRPERSON ORGAIN: So that's an interpretation that we need to discuss, but that doesn't have any reflection right now in regards to the rules.

MR. CARVALHO: I understand.

CHAIRPERSON ORGAIN: Okay. All right. So what we will do, we'll amend that as soon as we -- as soon as David assists us with the appropriate language based on the statute.
MR. CARVALHO: Okay.

CHAIRPERSON ORGAIN: Okay. All right. Were there any additional changes?

MR. MCCURDY: Under the Language Services Code, which we also considered the sentence that begins, Citing David Carvalho, it doesn't quite make sense the way it's worded. I'm guessing that what it would be is something like that David had explained that an amendment to the legislation to remove the language did not pass, and then the legislation itself was amendatorily vetoed by the Governor. But I may not be not quite accurate on the process. But as it stands, it doesn't make sense. You wouldn't amendatorily veto legislation that did not pass.

CHAIRPERSON ORGAIN: So David, fix this for us, please.

MR. CARVALHO: Yes. Let me read this right now.

CHAIRPERSON ORGAIN: And while he's working on that, are there any other ideas or changes in regards to the minutes?

MR. MCCURDY: Nothing substantive from here.

MR. CARVALHO: The way it should be worded is that an amendment removing this language was -- was introduced, did not pass, was amendatorily vetoed into
the bill by the Governor, and the veto was overridden.

CHAIRPERSON ORGAIN: Okay.

MR. CARVALHO: So the original bill allowed for
family members. There was an amendment to remove
that. It was not removed. The Governor in his
amendatory veto removed it, and then the legislature
overrode his -- leaving the language in as it stood.

CHAIRPERSON ORGAIN: As it stood, okay.

MR. CARVALHO: The status quo will protect
itself.

CHAIRPERSON ORGAIN: Okay. And -- and I didn't
check, but is this accurate that I abstained?

MS. BOWEN: I went through the list. I went
through the --

CHAIRPERSON ORGAIN: The transcript, and I didn't
get an opportunity to check.

MS. BOWEN: And I --

CHAIRPERSON ORGAIN: I probably abstained because
of lack of clarity.

MS. BOWEN: Okay.

CHAIRPERSON ORGAIN: Thank you. With those
things in mind, including the grammatical things that
will be forwarded to you, I just move that we receive
it to get the final version at our next meeting, if
that's acceptable.

MS. BOWEN: Okay.

CHAIRPERSON ORGAIN: Okay. With no objections, we can move on to the next item on the agenda, and that's you.

MR. CARVALHO: Actually, let me just -- one last check to see if he was able to --

CHAIRPERSON ORGAIN: Call in?

MR. CARVALHO: Is someone on the phone?

CHAIRPERSON ORGAIN: Yeah. There are several persons on the phone.

MR. CARVALHO: We should introduce ourselves by our names when we talk, and this is Dave Carvalho.

Dr. Arnold is in Sacramento at the ASTHO, Association of State and Territorial Health Officers, annual meeting, sometimes referred to as ASTHO. And they're in a different time zone, and we were hoping he might be able to call in, but it has not happened. But I did speak with -- excuse me. He is out there with Marilyn Thomas, and I spoke with them this morning, and there were several items that he wanted me to bring to your attention in the director's report.

I'll start with good news for a change. In the Illinois breast and cervical cancer program, we
had set as a goal last year to increase the number of
women seen by 5,000 over the prior year, which was
21,000. Instead, we saw 7,000 new women, so for a
total of 28,000, and we are anticipating seeing 36,000
in the next year. So over these two years, that will
be basically a 70 percent increase in that program.
And there's been a lot of outreach efforts on this all
across the state, including extraordinary amount of
Dr. Arnold's time personally in outreach all across
the state, and so we're gratified to see the increase
in the number of women screened. We can prepare and
share a report on the statistics, you know, the number
of cancers detected and things like that. Don't have
that at this moment, but we'll be preparing a report
on the successes of this program.

I hate to say good news or success in
connection with a flood response, but I think we
actually had a very good response to a very
unfortunate situation. As you may know, in June
through early July, we and many others were responding
to flooding in the state of Illinois that impacted
about 20 counties, three regions, Marion, Peoria,
Edwardsville. And as with anything like this, the
responses across many quarters and many sectors and
many across the state factors, we traditionally work
with the local health departments in situations like
this, and did so in providing bottled water and
larvicide, tetanus vaccinations, and as importantly,
medical advice. There's sometimes a tendency in
situations like this for medical advice to be coming
from 17 different quarters, and we try to arbitrate
and mediate some of that. The one I know of is
everybody assumes everybody needs to get a tetanus
shot. And, of course, that's not the case, and
everybody wants a supply of tetanus to cover everybody
in the county, and, of course, that's also not the
case. So we also act as an intermediary of medical
advice.

But the retrospective -- I forget, there's
an acronym for that, for the after the fact look at
the response to a disaster is in the process of being
prepared, and it was a good response, and seems to be
the perception out there among local health
departments as well.

On the bad news side of things, we had a
$5 million cut in federal preparedness funds that
we're still trying to sort out exactly what the
implications will be for the Department, but we're
most concerned about impact on our lab and impact on 
our infectious disease programs. Dr. Arnold and 
Marilyn have made trips to Washington, and we can only 
hope that the -- as the election approaches or after 
the election happens, that there's a greater 
sensitivity to the needs for these funds in the 
states.

In a similar vein, we also have about 
$1.8 million of cuts in programs affecting our health 
promotions office, which that's George's office. And 
the programs impacted there were arthritis, the 
nutrition, obesity and physical activity program, and 
then the oral health program. And because I knew 
Dr. Evans would have a particular interest in that 
one, it's a $400,000 cut of the 1.8 million that I 
mentioned, and the -- and that also we're sorting out 
the impact, but it will have an impact on our ability 
to support staff and the fluoridation and dental 
sealant programs.

So both of those are presenting real 
challenges at a time when our budget itself was a 
mixed blessing. I think I told you at the last 
meeting that one of the big hits in our budget 
actually affects the local health departments, which
was their proposed $5 million increase in the grant for local health departments, did not continue this year. It was an add-on last year. We put it into the budget to continue this year. There was all sorts of behind-the-scenes negotiations to deal with the formula. That was all resolved, and then the money was cut. So that's an impact on local health departments.

Those four items were the ones that Dr. Arnold asked me to specifically bring to this report.

DR. JACKMAN: I've got a question.

MR. CARVALHO: Yes.

DR. JACKMAN: On the federal cuts in the federal preparedness programs, is that true for all states?

MR. CARVALHO: Yeah. I don't know if it's exactly proportional across the states, but there's a cut there. What we are seeing, and I suspect you are seeing too, is most of our federal funding streams are being cut or flatlined -- flat funded. And I know in my office, I'm seeing it in BRFSS money, in the cancer registry money, and it is pretty much across the board. And CDC is going through some introspection of their own as to just how to approach things, and just a lot of flux in this funding. I think George
actually may have something later in the meeting to
talk about relating to the PHHS block grant and the
annual struggles on that one too.

Any other questions?

DR. EVANS: Yeah. You mentioned the oral health
program, the loss of the CDC funds. My take on it is
sort of really guts what's going on at the state
level. I'm just really questioning how high a
priority is that, and what specifically is being done
by the Department, in that there seems to be some
outside opportunity that the CDC could be persuaded to
in fact provide those funds.

MR. CARVALHO: You mean like Outside Chance?

DR. EVANS: Yeah.

MR. CARVALHO: You don't mean outside funder, you
mean --

DR. EVANS: Yeah, in terms of some advocacy that
might be the outcome. I'm just wondering what is the
state doing to try to achieve that outcome.

MR. CARVALHO: Probably Tom Schafer would be a
better person to speak to that. If advocacy would get
the money back, I know that we're great on being
advocates. But I didn't think it was in that
situation that just advocating for it would get the
money back.

DR. EVANS: I think that's part of it, but I'll call Tom Schafer. I'm concerned where that is on the priority list.

MR. CARVALHO: We have 200 programs, all of which we're trying to preserve and protect. It's certainly -- it's not off the priority list. I guess I can't say that it's higher or lower. You know, preparedness money, we're also advocating for, all the CDC funding streams, the PHHS block grant. But I think your characterization of it gutting the program is an accurate one, so we certainly want to preserve the program. I think right now Tom is the person to talk to, but Tom's reeling -- and George may be able to address this later -- is reeling from three of his programs being very dramatically cut by cuts in federal funds, and strategies how to restore it is one of the things that the director is working on, is developing a relationship with an outside grant writing firm that will help broaden our -- broaden the net we cast for federal funds. We have historically looked at CDC and HHS for obvious reasons, that in the health area that's where the money is, but through these discussions with some consultants, we're
broadening our perspective to other agencies that have
money that could be shoehorned into some of our
programs. And the ideal one is where you can get
federal money that displaces a local effort, that can
then be redirected to the things that you've lost
somewhere else.

So there are various strategies, just
nothing specifically to report just yet in terms of
successes.

DR. VEGA: This is Tim Vega. I had a question
regarding that. When they're looking at funds,
federal opportunities, are those -- is there a pattern
as to what is being funded and what is not, like a
primary, you know, primary dental care, primary health
promotion issues losing priority, or is there a trend
there?

MR. CARVALHO: Other than the trend of most
things being reduced. You know, I think there are
some things where everybody is being cut. There are
some things where they only have the funds to support
five states or seven states or eight states, and
they -- either in a sense of moving it around, you
lose it, or in a sense that there's some other place
that they would rather put it, you lose it. And so I
think probably every cut we've experienced -- I'm sorry, all of the different categories of cuts I've described are included in the cuts we've experienced. So there are some where they move it around, there are some where they're just reducing everybody. There are some where -- you know, there's actually some that have been increased, not a huge amount, but on one of the projects that I'm working on, that the CDC funded, they had leftover money and they particularly liked the job we were doing, so they just out of the blue said here is another $25,000 towards the end of their fiscal year. So all of those different categories of things, we're just trying to develop a new strategy for.

DR. VEGA: There's no pattern?

MR. CARVALHO: Other than decline, yeah. The pattern is decline.

DR. VEGA: Like I said, you know, there's kind of -- early on the amount of money in emergency preparedness and a lot of the -- a lot of those regional areas had vehicles or things like that, then you kind of see them, you know, those are efforts that deteriorate over time. You know, vehicles will just get rusty in a parking lot, and so it's unfortunate to
see that.

MR. CARVALHO: And to be fair -- well, fair is not the right word. I mean, I didn't work for the state when 2/11 [SIC] first happened. I was elsewhere. And a month later, I was at a conference where people are talking about, okay, everybody reposition all of their asks to the federal government under the rubric of preparedness. So it may well be what we're calling cuts in preparedness are just reductions from numbers that maybe were higher than -- emotions may have swept those numbers to higher numbers that may have made sense based on the underlying situation, and then everybody who partakes of those funds --

DR. VEGA: Higher expectations.

MR. CARVALHO: -- yes, increases their expectations and their dependency. And then when the funds recede, a problem that wasn't being addressed at all is now lost without the federal funds to begin with. Some of that, you know, candidly, probably some of that is going on in the area of preparedness. And that will be in the transcript, and I'll have to explain it to somebody.

DR. EVANS: I'll be the first to support you,
being a long-term product of public health efforts, certainly at the local level and nationally. I think what you described is quite accurate, and much of what we would call core public health that moved into the direction of disaster preparedness. And not to minimize that because particularly on this day, we're reminded of disasters we've had. But public health in terms of its core need is not a disaster response phenomenon, and the core public health issues have been left to wither on the vine over the last -- I would argue eight years, going on eight years, and that's part of the trend that we're looking at.

You know, I think that that's a problem across the board, and it may affect Illinois disproportionately, I don't know, but that's part of the phenomenon that's been affecting public health for a good long while now.

DR. JACKMAN: I'm Jane Jackman. This is really distressing about the oral health program, because coming -- what I see in Springfield, that is one of the major unmet health care needs, especially among children. And it's very hard, and I imagine it probably is in most communities, too.

MR. CARVALHO: I'd say everywhere, certainly
everywhere I've gone, it's been identified as an unmet need. Downstate, middle of the state, many suburban regions of the state, many of the communities in the city of Chicago. And as you know, as a state government with a once a year budget and reacting to a federal government with a once a year budget, when things happen mid-budget year, you're left scrambling a little bit on how to deal with them in the moment, and then you develop plans on how to deal with them over the longer haul. This one is one of those where, you know, mid-stream, when the feds do something -- if they had done it in February, I don't know how successful we would have been, but certainly our advocacy in the state budget level would have been trying to meet the need.

What happens mid-budget year, and as you recall, when I was discussing the budget in June, there were several state budget hits to health promotion that came out of the blue, and then now these federal ones to boot. So we've got some challenges, and we'll be working through them.

Off the record.

[WHEREUPON THERE WAS A SHORT DISCUSSION OFF THE RECORD.]
MR. CARVALHO: Dr. Orgain, back to you.

CHAIRPERSON ORGAIN: Yes, I know. But I was looking at something to be clear.

I think that you have completed all of your comments in regards to director's remarks, and so that brings us to Agenda Item No. 4, for the rules committee report.

MR. MCCURDY: Dave McCurdy. Now, we had two items that we considered at our meeting, and you have received draft minutes of the meeting. Since they're labeled draft, I guess we'd better ask for approval of the minutes. Is it necessary?

CHAIRPERSON ORGAIN: Approval of committee minutes, yes.

MR. CARVALHO: Technically the rules committee would approve the minutes at the next meeting.

MR. MCCURDY: That's what I would have thought.

MR. CARVALHO: We provided them as drafts so everybody can see them and read them. You will approve them at the next meeting.

MR. MCCURDY: And the draft you have does incorporate some changes to an earlier draft, so pretty much reflects what we did.

CHAIRPERSON ORGAIN: David?
MR. CARVALHO: Yes.

CHAIRPERSON ORGAIN: The question would be the members of the rules committee who are here could also approve the draft?

MR. CARVALHO: Well, they could -- not to be too technical --

CHAIRPERSON ORGAIN: That's helping.

MR. CARVALHO: They could certainly assent that this is what they believe of the minutes, but the action would have to be at a duly called meeting of the rules committee with the Board present and all that stuff.

MR. MCCURDY: We'll take these as a guide and we'll leave it at that.

We considered a couple of rules, and without further ado, let me proceed to the first one that's listed, which is the adverse event reporting code. Is there someone from the Department who wants to comment, perhaps David?

MR. CARVALHO: Yes. This one is in my office, so -- actually both of these are in my office, so I'll comment upon it.

The adverse health care event reporting law was adapted as part of legislation that created the
hospital assessment program. It was a last minute
insertion into that law from behind the scenes. My
reports are it was sort of a quid pro quo. Okay, if
you all want increased Medicaid payments for -- under
hospital assessment, there's this bill over here that
didn't make it out of committee that we would like to
draft onto the law, and so it came to be.

It grows out of -- it's modeled after a
similar law in Minnesota, and both of them grow out of
recommendations of the Institute of Medicine regarding
patient safety and medical error. And in particular,
the theory of this law is very different from other
programs within the Department regulating health care.
As you know, we have a whole health care regulation
division office, and they go out and make inspections,
and in the case of nursing homes, heavy fines, in the
case of hospitals, threaten suspensions and require
plans of correction. But that is all a regulatory,
perhaps one might even say punitive approach to
improvement.

The premise of adverse health care event
reporting is to create an environment in which all
adverse health care events as defined are reported to
a central place, along with a root cause analysis and
then ultimately a plan of correction. And while each
of those incidences is dealt with individually at each
institution, it generates a database of information
and accumulated learning that is then shared back to
the health care community. And so if one notices a
never event at one hospital and another never event at
another hospital and sees a pattern that can all go
out back to hospitals. Any hospital can access the
database, and in a blind way, because you won't have
patient names and you won't have specific hospitals,
but in a blind way gather information about never
events.

And I've used that term, never events.

That -- the adverse health care event reporting law is
not simply a reporting of every bad thing that happens
in a hospital. The adverse health care events are
specifically defined in the statute, and they are what
has come to be known as the never events, called the
never events because they're events that are never
supposed to happen. What do I mean by that? If you
go into the hospital with a disease, and the disease
runs its course and you die, that's a bad thing, but
that is not unexpected. If you go into a hospital for
surgery on your left leg and they take off your right
leg, that is never supposed to happen. That isn't just the ordinary course of things.

And so there are a number of identified events like that that just simply never should happen and are always the result of some failure in the process. Those events have been identified by the National Quality Forum and are incorporated into the statute by way of footnote. Those events and the list of those events is evolving, and several changes have been made since they were first issued. Those are not reflected in these rules because they are not yet reflected in our statute.

So the rules implement the program of adverse health care event reporting. Because our law was very similar to Minnesota's law, Mary Driscoll, who is responsible for this program, and I visited Minnesota last year to get a better understanding of how it was working in practice. One of the things that Minnesota -- two of the things that Minnesota had that we did not have, was their law was put together through a cooperative partnership between the health department, the hospital association and the QIO, quality improvement organization, in Minnesota, and that process led to the law, as opposed to here, as I
mentioned to you, the law was to a certain extent pushed upon the hospital community.

So because it was put together in that way, in fact, the QIO and the hospital association thereupon volunteered to assist in the implementation of the law, and the entire web based reporting system was developed by the hospital association for free for the health department, and the initial reviews of all of the root cause analyses and corrective action plans was done for free by the QIO. Now, ultimately the Department in its subsequent budget got the resources to pay the QIO, and they've had that ongoing relationship.

So we were -- and then secondly, Minnesota law does not require rulemaking unless the statute specifically requires it, and the statute did not. So they just started.

Our law required that an advisory committee be established and the advisory committee be meaningfully involved in all the details of the development of the program, and then, of course, we began the rulemaking. As well, this program received no funding initially, and so with no funding, the Department did not move forward with implementation.
Our estimation was that it would cost about a million dollars a year to implement this program. So we do have funding, so we moved forward with this rulemaking. There was an advisory committee established. The statute spelled out its membership of nine people in various categories, and we developed what was the first draft of these rules with that committee. And they met several times and provided guidance and input, and then we brought it to the rules committee last week or the week before, and they provided further guidance and input. And that's the background and the genesis of what you have now.

MR. MCCURDY: In terms of the guidance and input, I won't try to rehearse what's in the minutes regarding this. I will say that in looking through it, it looked to me like most of the changes were incorporated. A couple of comments about that. One is the definition of adverse health care event, and Karen, you may want to comment on that.

MS. PHELAN: I just bring to your attention that we did try to change it. It notes that it's Section 235.110, and it should have been 235.130, and it's noted above as adverse health care events.

MR. CARVALHO: Okay.
MR. MCCURDY: And then I would want to note one other item, and that would be on Page 12, and that is Section 235.260, communication and annual report. We had some discussion about Item C, that the Department would publish an annual report. And the question in the minutes spelled that -- was raised was whether or not -- how that might be spelled out, who would receive the report, and there was a request that that be spelled out in some way here in the rules. So I just want to know that at least so far, I don't see that that's been addressed.

MR. CARVALHO: What would you like to see?

MR. MCCURDY: Who would get the report? Is there any way to say, here is -- not only here is a general audience, but are there particular people to whom it will be distributed.

MR. CARVALHO: Sure. I'm just trying to think of what we might put in there. Our intention was to, of course, to publish it on -- on the web, put up a PDF file of the report and then print a limited number, because sometimes you get requests from people for hard copies. I walked away from Minnesota with a hard copy that the director gave me.

MS. DRISCOLL: I think -- this is Mary Driscoll.
MR. CARVALHO: Oh, I didn't know you were on the call, Mary. I would have deferred to you.

MS. DRISCOLL: I think that what they do in Minnesota is they do publish the report on the web, and then they give hard copies to the legislators, and then there's hard copies available to people who request them.

MR. CARVALHO: Would you like us to put will publish an annual report -- what words would you like to see changed?

MR. MCCURDY: Don't have specific -- our intention, as I understood it, the meeting was for the Department to consider how that might best happen.

MR. CARVALHO: Well, our plan is to publish it on the internet and then print some copies and make them available to people who request them.

MS. DRISCOLL: I would agree with that, to make the copies available upon request.

MR. MCCURDY: Okay.

DR. EVANS: Just to follow up, kind of housekeeping, when these types of reports are done, is there not an executive summary that summarizes the report, an executive summary of the report, that the executive summary can perhaps suffice for most readers
in the large readership, and fewer people are probably interested or would need the details, which kind of takes the pressure off multiple copies of details.

MR. CARVALHO: Oftentimes there are, and in fact, one of the things now that they've been up and running for several years, one of the things they do in Minnesota is they do something -- they prepare something that meets the technical requirements of providing a report, and then they do something that is more of a consumer oriented version of it. Again, both of them are on the website and both of them they have limited copies that they make available to people. But they use it as an instrument of education, not just reporting, and that's -- I think we expect to do the same. The number of copies will probably depend on our budget for printing, but our plan is to do something similar, try to make something that's useful to consumers and then something that meets the technical requirement.

Because one of the things -- there's an embedded slight contradiction between the philosophy of the Institute of Medicine study and the statute as it was done in Minnesota and here, which is if the idea is it's supposed to be a learning collaborative,
nonpunitive, not single people out, then doing an annual report that says, and by the way, you know, Mother of Mercy Hospital had three of these and two of these and one of these, is singling people out and is doing it that way.

I think while there may be that conflict, it is unavoidable, because I think the notion both in the legislature and probably in the public that we are accumulating information about all of these events and not telling anybody anywhere that they happened would be difficult to sustain.

So we are preparing the report. We will be preparing the report that tallies the number of events at each hospital by name, by category. But the real meat and potatoes of the report should be the words and the discussion of trends. And if you look at the Minnesota report, you will see that they will have a focus in a particular annual report of one or two noteworthy trends and other sections that describe what consumers should be doing and what they should and shouldn't be worried about and how they should interpret this information. And it's a platform for discussing patient safety issues generally. You've got people's attention. Every year the newspapers are
going to write an article based on this report. It's a good time to address issues of patient safety generally and not just focus on a tally.

CHAIRPERSON ORGAIN: David, is it not the proceedings of the Department for the most part, when there's a report, it's available to the public?

MR. CARVALHO: Yes.

CHAIRPERSON ORGAIN: So the question would be the requirement for additional language, since that is the standard protocol?

MR. CARVALHO: Right.

CHAIRPERSON ORGAIN: So that's what I wanted to address.

MR. CARVALHO: Well, for example, because the Department will publish an annual report and make it available to the general public, you know, we're just not --

CHAIRPERSON ORGAIN: That's fine.

MR. CARVALHO: You know, we're not going to mail out 11.5 million copies. Just make it available to the general public.

DR. JACKMAN: Jane Jackman. In Minnesota, they've had this going for a while?

MR. CARVALHO: I believe they've had four annual
reports, yes.

DR. JACKMAN: Is there any downward trends in adverse events?

MR. CARVALHO: Well, there are -- there may just be starting to be, because one of the problems you have is initially there's quite a ramp up, because as people become more familiar with reporting. And so the first couple of years, I think most things saw increases rather than decreases, but I do think that was a reporting phenomenon. They have identified specific things that were general problems that they do see downward trends in. And then one of the things that distinguishes Illinois' law and Minnesota's law is Illinois' law omitted a couple of items that were in the National Quality Forum's never event list and are in the Minnesota law which very closely hues to the National Quality Forum's never event list.

For example, Illinois omitted pressure ulcers, and in fact, by number, it's by far the largest occurring never event, and so that was a significant omission.

And then Minnesota added a change that the NQF just recently did, and Mary, correct me if I've got this wrong, but it relates to falls -- I believe...
the original list was falls involving death, and now
NQF and Minnesota have falls involving serious injury.
And so obviously those numbers, when you bring serious
injury in addition to death, those numbers go up.

But from what we saw, we were very impressed
with what they've done and what they're doing. And
the one thing that I wonder about is the health care
experience in several states is probably not that
different. So we have this Illinois law, and so we
will implement this Illinois law, and we will enjoy
doing it. But at some point, you do wonder, is the
marginal benefit for the 47 states to do this is
probably not that high if that state got that report
from 46 other states and read them and shared that
information with their colleagues. But be that as it
may, we will do it.

MS. DRISCOLL: This is Mary. Probably the
benefit actually comes to the hospital or the
ambulatory surgery center itself by them having to
actually report the event and analyze it through a
root cause analysis and make up a corrective action
plan. That's probably where the real benefits will
end up coming from.

MR. CARVALHO: Very good point. Is there any
other discussion?

DR. VEGA: Tim Vega. Just real quick. Is this idea where -- a learning process rather than punitive, something that is applicable to other parts of regulation? I was thinking the Department of Regulation, if they -- it's more -- it's smaller. Do they think this way, or is that -- I'm not familiar how they process a complaint or --

MR. CARVALHO: I think from what I've read, people have generally advocated that both exist. In other words, not that this replaces a regulatory function, but you know, there are certainly discussions about the next step, the near miss reporting. There are certainly a number of people who think that you learn much more by looking at near misses, or I guess it's near hits, than you do from what are hopefully outlier events. Because the -- the other types of things happen much more often, and the outlier events are not necessarily the best way to analyze what's going right or wrong in an institution.

It's certainly the theory behind patient safety organizations, and as you know, there are fits and starts efforts around the country to set up patient safety organizations also, cloaked, as this
one is, with a nondisclosure provision. You will see in the statute and reflected in the rules that any event reported into this process cannot be used for any other purpose. We cannot just hand it over to health care reg and say, oh, by the way, we got a really bad one yesterday, and it cannot be subpoenaed by a lawyer in a lawsuit.

DR. VEGA: But I was thinking -- when I kind of sit on some credentialing, and often there are individual cases whether there are lawsuits or complaints to insurance that you analyze. And often it's, okay, go to a class, here is your fine, and it's very much of a punitive, nothing changes. But if you look at those carefully, they are often systemic things, whether it's in the office or whether it's the way they operate in the hospital. And I always thought that the Department of Regulation had -- there's some ideas here that can change that to a learning thing, rather than a punitive thing. So I just didn't know how far apart the Department of Regulation stood from this world, that's all.

MR. CARVALHO: You mean the Department of Professional Regulations that licenses providers?

DR. VEGA: Uh-huh.
MR. CARVALHO: Interesting. I've not had any conversations with them on that subject, but I will.

MR. MCCURDY: I wonder if we should move on, because we have another -- unless, Dr. Jackman, you have --

DR. JACKMAN: No, that's fine.

MR. MCCURDY: I would move that we -- and we'll have to figure out, again, what the right language is, but that we forward this rule perhaps to the Department for their forwarding to JCAR. And in the process, that we incorporate changes that have been discussed today, of which there are at least two that I'm aware of.

MS. PHELAN: I have two grammatical things which I'll just forward over, if that's okay. Those can be incorporated.

MR. MCCURDY: With the agreement of the committee, that would be fine. I would move that.

DR. EVANS: I second.

MR. MCCURDY: All in favor, aye.

MULTIPLE SPEAKERS: Aye.

MR. MCCURDY: Opposed? Extensions?

Then can we turn our attention to the next rule, which is Loan Repayment Assistance for
Physicians.

MR. CARVALHO: And by the way, although it doesn't entirely answer the question, what the statute says, is that one of the responsibilities of the State Board of Health is to review the final draft of all proposed rules, and it says the Board shall review the rules within 90 days, shall take into -- then the Department shall take into consideration any comments and recommendations of the Board. And then further, if the Department disagrees with the recommendation of the Board, it shall submit a written response outlining the reasons. So I think -- I don't think it's terribly critical, but I think if you had a motion to approve -- or a motion to recommend the adoption of the rule, that that would be fine.

MR. MCCURDY: Okay.

MR. CARVALHO: And similarly, a motion to recommend the non-adoption of the rule --

CHAIRPERSON ORGAIN: Non-adoption.

MR. CARVALHO: -- in the alternative.

MR. MCCURDY: Sure.

MR. CARVALHO: So this second rule -- is Mark Gibbs on the phone? I didn't have ask him to be, so I will handle this. This is also in my office.
A few years back, a bill was passed that adds to several other statutes that are already out there and several other programs that are already out there. It, however, was much more general, and it had no funding, and it was explicitly provided to be subject to appropriations. So we did not jump on this one to adopt rules right away. I think this bill passed a couple of years ago. In fact, it passed in the same session where the tort reform issue was dealt with generally, so that was several years ago. But in the process of reviewing one of our rules -- or one of our statutes, not yet rules, drafted, the Rural Health Center identified this one and drafted some rules.

So the statute as originally written provided for a program of loan repayment assistance to all physicians everywhere in the state of any category that agrees to stay in the state. And I think our original fiscal note impact estimate was several billion dollars.

So that -- that law hasn't been funded. And in anticipation of the expectation that if and when it were funded, it would probably not be funded in the amount of a billion dollars, we proposed a rule that included some prioritizing so that whatever limited
funds -- I think -- I don't have that in front of me. I think we said should there be insufficient funds, but you should know that, yes, there will always be insufficient funds that we could prioritize. And that's reflected in the rule that's in front of you.

So some of the defined terms include health professional -- I'm sorry, health professional shortage areas, and the operative terms relating to always the italicized provisions of the statute and the operative provisions of the rule are the non italicized.

CHAIRPERSON ORGAIN: So I have a question based on that.

MR. CARVALHO: Yes.

CHAIRPERSON ORGAIN: In regards to full-time practice, on Page 2, where the time spent in on-call status will not count toward the 40-hour week. So you said that's nonoperative status?

MR. CARVALHO: Yes. That comes -- in other words, that's our -- those are our words, not the statute's.

CHAIRPERSON ORGAIN: Right.

MR. CARVALHO: And I believe, if I remember the conversation of the rules committee meeting, that this
was -- it doesn't have to be, but I think this was a learned borrowing from another place where --

CHAIRPERSON ORGAIN: And I would certainly as a physician suggest deletion of that, primarily because on call can be part of your workday, or it can be after your -- in other words, in terms of the 40 hours a week as a physician, that can also be included in your workweek, particularly as a family physician if you're doing OB.

DR. VEGA: I would agree with that. I think to kind of -- I think what you're trying to get to is making sure that people are actually practicing full time and not just 10 hours in the office and on call for 40 hours. So perhaps minimum hours of clinical time, you can express it that way, but I agree, I mean, you can be on call and it's hard work.

CHAIRPERSON ORGAIN: Very.

MR. CARVALHO: I know -- just random piece of information. I know that the recent Union contract at Oak Forest Hospital provided for a workweek of 50 hours, but then counted on call a certain number of hours towards that. This one we're defining full-time practice as a 40-hour workweek and said on call status does not count towards 40. How much of on call would
you think would be appropriate to count towards 40 if we're still trying to capture -- remember, the definition is full-time practice, so we're trying to capture somebody who is a full-time practicing physician.

DR. VEGA: I think you should just say a 32-hour workweek, and whatever call beyond that, at least it gets it down to --

MR. CARVALHO: Well, perhaps another way to slice it, then, is time spent on call shall not count towards clinical services. If elsewhere we're saying 32 of the 40 has to be clinical services, then if we don't include on call as part of the clinical services, then by implication 8 hours of on call could count and still make you full time. Does that -- the math, in other words, already the first sentence says 40-hour workweek where at least 32 hours are providing clinical services. If on call didn't count towards 32, it could still count towards the 40, so therefore you could still be full time even if 8 of your 40 hours were on call. Would that be logical or --

CHAIRPERSON ORGAIN: It is logical. And how you described it, for me it would just simply mean deleting the sentence, time spent on call status will
not count toward the 40-hour week.

MR. CARVALHO: The only thing --

CHAIRPERSON ORGAN: You would need to replace it.

MR. CARVALHO: Well, leaving the sentence and changing it would make clear, does on call count towards clinical or not.

CHAIRPERSON ORGAN: And we believe that it does.

MR. CARVALHO: Oh, you believe that it does?

CHAIRPERSON ORGAN: Yes, we do.

MR. CARVALHO: Okay. Well, how many hours -- getting back to Dr. Vega's point, then, if we're looking for a 40-hour full-time physician, how many of those hours can be on call before we're not talking about a full-time position?

DR. JACKMAN: Jane Jackman. The time spent in on call status will not count towards the 32 hours of clinical service.

CHAIRPERSON ORGAN: That is essentially what David said.

MR. CARVALHO: That's what I said, and I got some push back on that.

CHAIRPERSON ORGAN: Just thinking about it, no push back, just seeing how that would work in the
context of someone who does call twice a week, and so -- which is every fourth, or -- and there are a number of physicians who may be doing that. And so that's why I wanted to -- you know what I mean. So that could be twice a week. So I understand what you're trying to do in that regard, but those physicians who are clearly -- that may find themselves in that position of doing call twice a week, that doesn't account for that, that 16 hours, possibly, or more, and they are providing clinical service and staying up all night and other things.

MR. CARVALHO: They're probably going over 40, then.

CHAIRPERSON ORGAIN: They are going over 40. That's the point.

MR. CARVALHO: Which occurs to me that maybe this should -- right now it says medical practice with a 40-hour workweek, and it probably should be at least a 40-hour workweek.

CHAIRPERSON ORGAIN: At least.

MR. MCCURDY: David, may I ask -- I'm presuming that you had physician input when you were trying to set this up, so there must have been some rationale for the way it is.
MR. CARVALHO: I think it was probably the rationale for wherever this was borrowed from. In other words, we probably inherited their rationale. I think it was another -- it was a prior -- in fact, it's probably a prior program that's been through this committee process, and it exists in our other rules -- to a certain extent we borrowed the rules from other programs that we've already got running since this was an abstract program.

DR. VEGA: The owners -- I can't remember, the public health grants for physicians in under served areas, that's a program, and I think they kind of spell out -- I think it's like 32 hours, or -- I mean, they have a number which is a minimum number, so that's in the ballpark.

CHAIRPERSON ORGAIN: There's the assumption here that this is all outpatient care, and that is not necessarily the case. I think that what -- what -- I believe I saw something here, but I think that part of it -- yeah, it says in the ambulatory care setting, so that's all -- that means all outpatient. But you can still certainly be on call and providing care. It doesn't necessarily mean inpatient on call services.

MR. MCCURDY: Are there any other comments about
what is here? You can certainly see from the minutes a number of areas in which changes were discussed, and I see evidence of a number of those, including the addition of the definitions that are here.

MR. CARVALHO: By the way, just -- I know we've gone back and forth on this over time. What we sort of settled upon is when we provide a draft to the rules committee, then whatever changes we incorporate, we'd provide the revised version to the full committee rather than a red line that shows you changes to something you hadn't seen in the first place if you weren't on rule, but rather have the minutes reflect the discussion. And that way these two examples here are fairly simple rules. We have had problems in the past with rules that have so much to begin with, and then the changes as well, they became unreadable documents to use. So if that works for everybody, we'll keep that format.

MR. MCCURDY: I want to raise one question, and that is on Page 5, which is Section 581.220D3, and those were in the phone call, remember, in the committee, although the minutes don't actually reflect it, but we had a little discussion about the item about practicing full time in a medical specialty that
is in short supply. And the question about how in
short supply would be defined, and I know, David, you
mentioned that you would address that.

MR. CARVALHO: Yes, I did.

MR. MCCURDY: Again, I think in terms of the
rule, though, that probably isn't sufficient as it
stands. It needs to be some way to determine how --
how to identify how you would determine what short
supply is.

MR. CARVALHO: Yes. I apologize. We did say we
were going to think about how we were going to do
that, and then it's not reflected here.

MR. MCCURDY: And I would suggest we just simply
say to the Department, please add something in that
regard.

MR. CARVALHO: Yes.

MR. MCCURDY: And then I don't actually have a
change to recommend, but I simply want to remind us on
the Board that failure to fulfill the terms results in
draconian penalties, triple repayment of that which
you received. So -- and no explicit mention of
extenuating circumstances, like somebody fell ill and
wasn't able to meet the commitment and so forth and so
on, and we had that discussion also. And at least as
I understood it from what David or maybe Mark or others said on the phone call, it's kind of the informal understanding that the vigor of the pursuit of the debt might be modified to some extent by the circumstances of the person who owes. But I do at least want to call attention to that as a fact feature of this act, which might be a deterrent for some, I could imagine.

MR. CARVALHO: Well, we have some experience with similar provisions. They're actually -- it's more challenging in the environment of scholarships versus loans, because a scholarship, you're making a commitment up front, and your obligation is much further down the line, and your life circumstances change and the like. With loan repayment, frankly, we anticipate the issue coming up less often, because you're making the commitment contemporaneous with -- but it is the case, although we don't like -- certainly don't like to advertise it, that while we take a very hard line on the loan -- on the scholarship programs, obviously the enthusiasm of pursuit depends on the circumstances, and the people who simply blow us off are going to -- and they do, get pursued with great vigor, and the people who are
in difficult circumstances less so.

And it's a combination of the compassionate nature of the Department and practicality. No court is going to tell somebody who's an invalid to repay treble damages for not fulfilling their obligation.

But we do -- I think I mentioned to this committee before, we have a long run -- long range hope of converting scholarships to loan programs, because we just find -- the scholarship programs create too many enforcement issues, galling enforcement issues.

CHAIRPERSON ORGAIN: David, I do have another question.

MR. CARVALHO: Yes.

CHAIRPERSON ORGAIN: The idea for the loan is for those professionals to serve in under served areas?

MR. CARVALHO: As implemented in the rules, priority would be given to those who serve in under served areas. The theory of the statute was, what's the slogan, keep doctors in Illinois.

CHAIRPERSON ORGAIN: And part of -- going back to that definition of full-time practice, part of what is not included there are professionals who do home visits, particularly, and that could be all they do,
providing the same kind of service as well as, you
know, end of life care. And I think it says
ambulatory care setting -- ambulatory care setting
office, and we have a number of physicians who are
increasingly doing home care, and that was not
considered, and still providing the same service.

MR. CARVALHO: Yeah. I think it would be fair to
say it's not that it was considered and excluded, but
by virtue of borrowing from other programs that are
typically targeted, that got swept in.

CHAIRPERSON ORGAIN: That's not a full-time
practice, again, under the second paragraph or under
full-time practice.

MR. MCCURDY: Is there other discussion before we
move this? Then I would move -- Tim?

DR. VEGA: I would just like, if there is a -- is
it possible to review this in a year? The only thing,
as -- when you recruit people, sometimes to get the
best -- if you set up this full time, you are
automatically discriminating against women physicians
who often would prefer lesser hours and would be
willing to go to under served areas. So I think if we
make a first run and see, you can at least tweak it in
a year, because I would rather have a two-thirds
doctor in Carbondale rather than no doctor, and
your -- you really are discriminating against women
physicians.

MR. MCCURDY: My understanding is that --

DR. VEGA: I hate to use that word, but --

MR. MCCURDY: That's true. My understanding is
that actually we're still dealing with a hypothetical,
because there are -- no funds have been appropriated
to actually --

DR. VEGA: I don't want to change anything, but
just review it in a year.

MR. CARVALHO: Well, here is the thing: It might
be a stretch, because the reason why there's a
definition of full time is because there's a statutory
requirement that they be full time. So we're trying
to give meaning to full time. It would probably be
hard for us to define full time as being part time.
At least Elizabeth wouldn't let me do that.

DR. VEGA: If you take call into consideration,
you can do it.

MR. CARVALHO: At the risk of appearing flip, one
of my favorite humorous aspects of the cold war was
all the planning that went around how to deliver mail
after a full nuclear exchange. And I always thought,
how quaint that anybody was spending any time --

So at such a time as this is funded, we'll

think about how we might want to change it. But right

now we're just trying to make sure we don't hit the

compliance review by the auditor that says you guys

haven't adopted rules for this statute.

MR. MCCURDY: I move that we adopt this rule.

CHAIRPERSON ORGAIN: Recommend for adoption.

MR. GIROTTI: This is Jorge Girotti in Chicago.

I just had one more comment on this rule, actually a

question for David Carvalho.

MR. CARVALHO: Yes.

MR. GIROTTI: If I understand, at the bottom of

Page 5, expectations is that for one year of loan

repayment, that individual commits to three years of

service. Did I read that right?

MR. CARVALHO: That is what it says, yes.

MR. GIROTTI: Because that is a national program,

the National Health Service for -- I believe is one

for one, and in terms of -- and I realize it's

hypothetical right now, but if this is ever funded,

this might be a deterrent for individuals that would

probably be getting -- it sounds like maybe $8,000,

$8,300 for one year.
MR. CARVALHO: Actually, I believe if it were to be funded, they could receive $25,000, but then they make a commitment to stay for three years. This language is here because the statute -- again, back on Page 4, you can see has five criteria.

MR. GIROTTI: Okay.

MR. CARVALHO: And one of them is he or she must agree to continue full-time practice in Illinois for three years.

MR. GIROTTI: Right. It's just that with other competing programs, they have more beneficial terms, particularly since the type of individual that may be interested in this kind of program, at least from our medical school, the spring graduates left on the average with $150,000 in debt, medical school debt. So we're talking over a 10-year payment period, 15 to $20,000 per year of loan payment. So this is just a comment based on the reality of where they are.

MR. WHITELEY: This is Herb Whiteley. I agree with Jorge. The three year for one seems not appropriate to me.

MR. CARVALHO: Right. Well, I've resisted for 10 minutes, and you've finally pulled it out of me, that I think this statute was adopted to be adopted,
not to be implemented. But it is built into the
statute that it says a three-year commitment. But
sometimes that happens, that things are adopted to be
adopted.

MR. MCCURDY: Given the limitations of the
statute, I recommend that we adopt the rule with the
changes that have been discussed, and I see those in a
couple of areas. One is the issue of what we mean by
short supply, and the other is, of course, the issue
of full-time practice.

DR. VEGA: Second.

MR. MCCURDY: All in favor say aye.

MULTIPLE SPEAKERS: Aye.

MR. MCCURDY: Opposed? Extensions? I believe
this should conclude the report of the rules
committee.

CHAIRPERSON ORGAIN: Actually, I would like to go
back to the minutes of the committee. I wanted to
make sure that we clarify two items in regards to the
child health examination code and a smoke free
Illinois code that's part of the minutes.

MR. MCCURDY: Of the rules committee minutes?

CHAIRPERSON ORGAIN: Of the rules committee
minutes.
MR. MCCURDY: Go ahead.

CHAIRPERSON ORGAIN: The first one is that as we dealt with our meeting summary, our opposition was in regards to who could perform the exam. And I wanted to make sure that that was clear, whether it would be the optometrist and the ophthalmologist, and I wanted to make sure that that was clear.

Secondarily, I want also to make sure that it's clear that we didn't get a final letter in regards to the action that was taken on this, so we haven't received anything.

MR. CARVALHO: Really?

CHAIRPERSON ORGAIN: Nothing.

MR. MCCURDY: This would actually be a follow-up, not to what I see in here, but actually to the summary of the meeting of the Board meeting.

CHAIRPERSON ORGAIN: Exactly. Exactly.

MR. CARVALHO: Well, we got final approval on the letter. I guess we thought it had been sent out. If it hasn't --

MR. MCCURDY: I don't recall seeing it myself.

MR. CARVALHO: Okay. Yeah, we'll follow up. It went through almost as much internal review as the rule did, so I'm surprised that it didn't actually go
out. It went through quite a few revisions, that's for sure. We will follow up on that, but just to not leave the issue just hanging there, as you know, under the statute it says if we decide to proceed notwithstanding the Board's non-recommendation, that we will inform you of that and explain the reasons. And so we have a letter that informs you of that and explains the reasons, and in thumbnail, the reason is that the statute says so. So we need to move forward, and especially with the upcoming school year and the confusion out there about this and the newspaper articles and all, we simply had to move forward. But I will follow up and see why that letter hasn't been sent to you yet.

CHAIRPERSON ORGAIN: I would like to make a request that the statute, if it's short enough, also be forwarded to us.

MR. CARVALHO: Yes.

CHAIRPERSON ORGAIN: Because part of the concern for those who might want to make comments on the rule is the clarity of the statute.

MR. CARVALHO: Certainly. Where it's going to go is JCAR, and then there's an opportunity --

CHAIRPERSON ORGAIN: Exactly.
MR. CARVALHO: Now, I think we -- did we adopt an emergency rule at the same time?

CHAIRPERSON ORGAIN: The emergency rule had been adopted.

MR. CARVALHO: Okay. And so -- which is the other reason we needed to proceed forward, because an emergency rule has a limited time span. And if you don't have a regular rule in place then it creates an awkward gap.

CHAIRPERSON ORGAIN: Uh-huh.

MR. CARVALHO: Well, it expires in two days, so we will have an awkward gap. And the comment period on the rule began September 5th, so we'll get you the letter, we'll get you the statute. But as I say -- as I recall, the statute doesn't say you have to be an ophthalmologist or optometrist. The statute says you have to be able to do certain things, that as a practical matter, for all intents and purposes, most people who are not ophthalmologists or optometrists can't or don't do. They don't have the equipment, they don't have the training. So as a practical matter, it may be --

DR. VEGA: That's where the dispute is.

CHAIRPERSON ORGAIN: That's why we want to see
the statute.

MR. CARVALHO: But I think the rule doesn't say ophthalmologist or optometrist.

DR. VEGA: It doesn't.

MR. CARVALHO: The rule --

DR. VEGA: Who can do an eye exam.

MR. CARVALHO: Well, then there's nothing to dispute it.

DR. VEGA: And it's defined nationally --

MR. CARVALHO: I know we're overlapping each other's voices, but if the rule says anybody who can do it can do it, then this shouldn't be a dispute. Because if in fact people beyond ophthalmologists and optometrists can do it, then the rule allows them to do it.

CHAIRPERSON ORGAIN: And that was based on the information received at our last meeting. It implied that it was only ophthalmologists and optometrists, and that's why I would like to see the rule.

MR. CARVALHO: Sure. We'll get the rule and the statute and the letter.

CHAIRPERSON ORGAIN: And then just the smoke free. Where are we with that, please?

MR. CARVALHO: Well, I believe we are still where
we were since the rules committee. Has anything changed since that report from the rules committee?

Okay. And as of the rules committee report, which you see, JCAR did not list the following prohibition, and so, the following prohibition became permanent under this new regime, as you know, filing prohibitions is relatively new to this process. Under this new regime, that means that rule is dead. We could initiate word for word the exact same rule, and that's considered a new rulemaking. But that rulemaking is dead.

But what we are going to do in response to this, we were waiting, I believe, to see whether the statutory amendment was going to take place so that we would be issuing a rule that is consistent with the statutory change. The statutory change did not take effect, and so our position continues to be since -- as it has been since January 1, is, which is -- the statute is in effect, the statute provides terms that have the force of law. Everyone should be complying with the statute. The rules are nice to have, and we look forward to having rules, and the rules will exist, but everyone needs to continue to comply with the law, even the several people who hang outside the
side entrance to my building which don't seem to get
it.

CHAIRPERSON ORGAIN: Okay. Thank you. That
helps. We can move on to the next portion of the
agenda; however, is there any -- Alissa
Bassler (phonetic) on the line?

MR. HARVEY: No, Jim Harvey is sitting in for
her.

CHAIRPERSON ORGAIN: That's what I thought, Jim.
But what I'd like to do, is there anybody from the
policy committee that is prepared to just give a
summary or information from the policy committee
report that we've gotten that might be useful?
Otherwise Jim Harvey can proceed.

MR. CARVALHO: Introduce yourself, too. I'm not
sure everyone has meet you.

MR. HARVEY: Hi, I'm Jim Harvey, and I am
director of policy and partnership initiatives here at
the Illinois Department of Public Health, happily in
my sixth week on the job.

CHAIRPERSON ORGAIN: Please proceed.

MR. HARVEY: Thank you. Just quickly wanted to
give you a quick report on the state health
improvement planning process. We're running a little
bit behind schedule at this time, but we are poised to convene our first meeting of the newly appointed SHIP leadership team as early as October, and we're simply waiting at this point to get the nod from Dr. Arnold on the list of nominees, which we expect to get any time now.

The executive summary from the summit that was held on the 28th of July will be completed tomorrow or Monday at the very latest, and once we've gotten that, the draft, we will get the summary out to everyone. And got some great recommendations, including some new and emerging issues that have been highlighted in that summary. So we'll be getting that out.

And finally, just a reminder, please don't forget the annual meeting, which is October 14th and 15th in Springfield. And we hope that you will be able to attend.

MR. MCCURDY: When you say annual meeting -- this is Dave McCurdy -- do you mean the statewide partnership conference?

MR. HARVEY: That's correct.

CHAIRPERSON ORGAIN: Any additional comments?

DR. VEGA: Yeah. No, I think that the -- some of
the gist that came out of the discussions that were
kind of flavored in the minutes was that there are
Medicare funding opportunities to fund demonstration
products -- demonstration projects on medical home
issues regarding -- whether -- how they implement with
information flow, how they interface with safety, how
they affect diversity and disparities. So looking as
a health department, looking at the medical home as a
source of grant writing, since that is a hot topic in
Washington.

CHAIRPERSON ORGAIN: Any additional questions for
Mr. Harvey? Thank you.

MR. HARVEY: You're welcome.

CHAIRPERSON ORGAIN: Next item on the agenda,
Preventative Health and Health Services block grant
update. Do you have any documents that we can look
at?

MR. DIRKS: I have some, but I haven't had a
chance to make copies, so I most certainly can. I'll
give them to Cleatia here.

CHAIRPERSON ORGAIN: All right. Thank you very
much.

MR. DIRKS: I'll pull out when I get done and
make copies. I'm George Dirks, D-I-R-K-S, not like
Steve. I'm the block grant coordinator for the Department. It's one of my many jobs in the office of promotion.

Just a little update, because some of you may be familiar with this, some of you may not. The block grant is a grant for primary public health services that's issued to all 50 states, District of Columbia and 16 territories.

The current federal year dollars that are committed to this block grant are about a hundred million nationally. Of that, 5 million goes to support the infrastructure at CDC. Nine million of it goes for required -- I say required, being statutorily Title 42 required -- sexual assault, set aside money for each state. In Illinois, it's $304,000. That goes to a specific agency, which is the Coalition Against Sexual Assault in this state.

And then 87 million that goes to the 50 states and District of Columbia and 16 territories.

The apportionment of the money is based on population, and the only caveat being the population data is from the first years that this block grant was given out, which is 1981. So it is by no means based on current population. That's been an issue with this
block grant for many, many years. I've been the
coordinator for about five years.

Each year we have a coordinator's meeting.
This year the meeting was in Chicago. Actually, the
middle of August. We do that then because that kind
of coincides with the federal budget year, so we get
the updates and any updated information on the
applications we have to submit, which is yearly.

In that meeting, we had a long discussion
about several things which are relevant. The block
grant application has always had a stipulation that
each state health agency have an Advisory Board that
actually gets material on this block grant. It has
never really historically required that you okay it or
review it. That will change with the next
application. CDC is changing how they do business
with this application. And there's some interesting
things that I would like to tell you about from the
meeting.

So what I'm going to have to do, working
with David and Cleatia, is make sure that I get on the
schedule for at least two, preferably three of the
Board of Health meetings. Because we used to be able
to say we've made a good faith effort, even if your
meeting got cancelled. We're not going to have that option anymore. We're going to have to have it. In fact, one of the stipulations that will come in the new application, and I don't have it yet because they're still putting it together, is that I'll actually have to attach a list of Board members from the Board of Health to provide to CDC. That's a new requirement. We've never had to do that in 26 years.

David may have talked about this in prior meetings, but the other second point of discussion was the fact that CDC believes the appropriation for this block grant will get reinstated by October 1st. I say that because for the last five years it's been zeroed out of the President's budget, and then put back in at the last minute, usually about September 15th or so. The indication from the CDC people who were there was that it will come back in in September without any raise in money. It has been fairly stagnant for the last four years. Four years ago, they cut it by 20 percent. It has pretty much stayed at that stagnant level once it's come back in. The other option is not having it at all.

States can use this block grant, because that's the nature of the block grant, for anything
related to primary health objectives the CDC endorses.

As a way of information, there are 485 health objectives that CDC allows you to use, so you can pretty much use it for everything. And I actually have some information on how states use that money, including Illinois.

In Illinois, we get 2,300,000 in appropriation every year, 304,000 of that has to go for sexual assault set aside. That leaves us about 2 million. Of that 2 million, 975,000 goes to the Office of Health Policy for epidemiological studies, and the other million stays with the Office of Health Promotion. In Health Promotion, we use that to pay for programs that we do not have federal dollars or state funds to adequately fund, and it's specifically for this department, we use it to pay for vision and early hearing and vision screening. It pays for staff, and it also pays for our technical assistance to support the application process of monitoring those screenings. We use it to fund our injury and violence prevention program, and we use it to fund both our perinatal administrator, and we contribute money into the perinatal network grants, specifically Cook County and Stroger Hospital.
And we also use some money for physical activity and nutrition for the cash grants that we give out, which are grants to elementary schools. David, I believe he uses it for -- eye plan -- the eye plan program.

MR. CARVALHO: Some is for eye plan, some is for --

MR. DIRKS: And the bigger bulk of it is for the county BRFSS, county specific BRFSS.

MR. CARVALHO: As you know, the federal funds to do the BRFSS for the state as a whole --

MR. DIRKS: Right.

MR. CARVALHO: But we augment that by doing sufficient interviews at county level so you can get meaningful county data. If you do statewide data with the exception of Cook, you probably don't have sufficient data from any county to say anything statistically significant about the county. So on a cycle, we do a greater number of surveys in each county, and we pay for that using the block grant money.

MR. DIRKS: That's historically what we've used it for. The application process will change this year. They don't have the actual hard draft of the
application yet, and I think part of that has to do with they're having trouble making final decisions because Congress hasn't approved the budget, so trying to figure out -- we were told that at the coordinators meeting we will get the application, even though the federal starts October 1st, we'll probably get it the 15th to November -- October 15th to November 15th.

I'm going to split the difference, let's say November 1st. What we will do is we'll fill it out on-line and then send it in probably in December. My plan is to have the application ready and bring it to the December meeting for the Board to review, because I have to document that. I do not -- like I said, it will change very drastically.

Most states use it -- or states use it in different ways. We've used it to fund infrastructure, meaning staff. There is a push at CDC to get away from that, partly because it ties to the situation where it's been zeroed out, is they're -- they being the block grant people at CDC -- are being pushed by Congress to show goals and results. They're being asked to show measurable results, and that's very difficult to do when you give a block grant out. This application will have objectives we'll have to
address. There's more of a focus on interventions as opposed to infrastructure, staff. I don't know exactly what that means. I will see when the application comes out.

And then once the application is -- we normally get our first payment at the end of the first quarter, beginning of second quarter. They are becoming much more stringent, because it's becoming harder and harder and harder to get this thing reinstated every year and to keep it level. In our case, and you heard some of the conversations about the federal grants that we don't have in office of promotion, in our office, this grant funds 11 people including myself. If that were ever to get zeroed out, then it would be a major impact on our office, a catastrophic impact.

So this was a lot of the three-day discussion with the people at CDC and with their focus, and they have some specific areas they want us to address in the interventions which are different than before. A lot of their discussion was interventions that focus on not only under served communities, but unserved communities of public health.
There is -- Dr. Arnold and I -- Dr. Arnold did the opening remarks and was present for some of the discussion and some of the workshops. There was a lot of focus on some new publications out of CDC on social determinate research. I don't know if any of you are familiar with it. I have some knowledge of it, but not a lot. The presenter was a gentleman who is the health commissioner of the City of Louisville, Adewale Troutman.

CHAIRPERSON ORGAIN: Adewale.

MR. DIRKS: I stand corrected. He was for an entire day, and it was an interesting response, because most of the block grant coordinators are unfamiliar with this. If you have always been in public health, this is not something that public health as a field is focused on. It deals with things that are not primary public health services, you know. But he -- that was a huge focus. CDC has just put out a publication, which I gave Dr. Arnold on that. In fact, I think the copy we have isn't the published, it's a prepublished copy. They're wanting us to look at our interventions, but they're not requiring, but they're wanting us to look at that in that regard.

That's basically the update. That's the
status of the application, and that's the status as far as I know as of the end of August of the appropriation being reinstated.

Again, because of the new requirements to actually document this review by the Board of Health, which serves as the Department's advisory council, I will actually be doing more formalized documentation to David so he can bring it forward here. If I can't bring it here, then at least it's here. Once I know what that is, I'll have a lot of this for the December meeting, and plan to get it out to David as soon as I can.

Any questions?

We did the update because I'm not sure that with the changing Board members, that we've actually discussed what we've funded here. So that's kind of why I did that. If there aren't any questions, I'll get out of your way and make some copies.

CHAIRPERSON ORGAIN: Please. We would appreciate the copies, appropriate information. Thank you. David?

MR. CARVALHO: On the legislative front, not much has happened since we last met so I'll just describe what has.
Most of our legislation was signed. One bill that we didn't really have on our radar screen was amendatorily vetoed that put it on our radar screen, and that was the bill worked out between the Attorney General and the hospital association regarding discounts to people who are uninsured. The bill was originally targeted at persons under 600 percent of poverty and provided discounts of 30 -- let's see, a discount that would leave you with a bill that was 35 percent over cost. That sounds a little convoluted. Let me back into it again.

As most of you know, the charges on a bill from a hospital are typically way in excess of their costs, and then a discount to charges is negotiated with most insurance companies and PPOs and HMOs and the like. But what might seem anomalous, persons who have no insurance at all are often sent a bill that is at full charges. If they -- if they are processed through whatever charity care policy the hospital has, they would probably receive a bill with a discount in it. But if they don't qualify for the hospital's charity care policy, they will receive a bill at full charges. And I'm told that typically if you use the Medicare cost report that hospitals are required to
file with the Medicare program as a yardstick, that costs are typically in the area of 30 percent of charges. Now, they will vary from procedure to procedure and the like, but typically 30 percent of charges.

The bill as originally enacted would provide that persons after discount who were uninsured would be charged 35 percent over cost. The bill as amendatorily vetoed provided if you are under 200 percent of poverty, which by way of reminder, for a family of four is roughly $42,000 today, if you are 200 percent of poverty, then you would only be charged cost, not cost plus 35 percent, but the cost. And if you are up to 800 percent of poverty, you would be charged no more than 20 percent over cost, so you would receive a discount that would bring you down to 20 percent over cost. That 800 percent number would be 600 percent in rural areas.

So far, none of that impacts the Department of Public Health. The amendatory veto provision that affects the Department of Public Health removed the enforcement and monitoring of this program from the Office of the Attorney General and moved it to the Illinois Department of Public Health. So we would
be -- we would be responsible for the enforcement. This bill will now go back to the General Assembly for consideration of the Governor's amendatory veto.

MR. MCCURDY: What's the number on that, David?

MR. CARVALHO: The bill number, I believe, is 2380, and I'm trying to remember whether it's a house or senate. I will make a guess that it's senate, just because the number is low. It's Senate Bill 2380. But if it turns out that's not right, look at House Bill 2380.

The other thing that is transpiring as we speak, the House met yesterday to consider a couple of bills. One was the lottery lease, which doesn't affect us directly, but the other was a sweeps bill to authorize sweeps from certain special funds into the general fund. And several of our funds appear to be on the list for being swept in certain amounts.

So for example, I believe the health facilities planning fund, which collects the fees charged by the Health Facilities Planning Board for the CON process, is on the table for being swept of a million dollars.

Just by way of information, typically the
issue of a sweep isn't so much the physical impact on
the swept fund, but the principle of the thing. So
for example, the appropriation for the facilities
planning fund is this year $2.2 million. It has
$4 million in it. So sweeping a million dollars
doesn't in any way impact the appropriation. If
there's a dramatic falloff on CON applications, it
could have implications for next year's appropriation,
but it has no immediate impact. But for the folks who
are paying the fees that put the money into the
dedicated fund in the first place, it is not generally
well received that their fees into a dedicated fund
are being swept into a general fund.

So none of the proposed fee sweeps that
would impact our funds appear to have any implication
in the current fiscal year since, they only have
implication for potential future activities, and then
the objection people have to sweeps generally.

That is -- as near as I can tell, that's
what's going on. And that's why, if you came in
yesterday, you saw legislatures here in September in
an election year, which probably hasn't occurred in a
long time.

CHAIRPERSON ORGAN: Questions?
MR. MCCURDY: Yes. The Genetic Information Privacy Act --

MR. CARVALHO: Was signed.

MR. MCCURDY: -- has been signed?

MR. CARVALHO: Has been signed. And if there are regulations that we will need to issue under that, we will be bringing those in due course. As you know, there was a federal bill signed as well, and so the state bill may be redundant in many respects. They were traveling parallel paths in the two legislatures, and so -- in fact, I remember being at the committee when it was up, and the federal bill, I think, had just been signed days before, and so the state proceeded with their bill notwithstanding.

CHAIRPERSON ORGAIN: Are there any more questions for David Carvalho? I'd like to bring -- being none, I would like to bring to attention a number of things that we need to do for our next meeting. One is that the policy committee members need to be reminded that we have an annual report to the Governor, and certainly probably will include information from the SHIP summit. Elections will occur. I believe we forgot to do it again in September. And if everybody can reconfirm their committee membership and which
committee they are interested in being on as we move forward.

MR. MCCURDY: How should we do that?

CHAIRPERSON ORGAIN: Send it to Cleatia. If there's anything I missed in regards to where we are and what we need to do, please advise me.

MS. BOWEN: Dr. Orgain, I just wanted to remind everyone please turn in your ethics form. I sent you in your packet a prestamped envelope. I need that by the end of the month. That jeopardizes your membership on the State Board of Health. They are now requiring you to get those in rather quickly. Please send them to me.

MR. MCCURDY: A question in that regard. The first page of the materials that we received indicate that every area has an ethics officer within it, and I know in the past we've heard who that person was, but I want to be sure or at least have a name in IDPH who is your ethics officer.

MR. CARVALHO: Since Cleatia and I have never had any ethical issues --

MR. MCCURDY: Is it probably a lawyer?

MR. CARVALHO: The reason why we're giving pause is it was Marilyn Thomas who is our general counsel,
and who is now our acting chief of staff. And what I cannot recall was whether she reassigned Frank Urso, who was her deputy general counsel, to be the ethics officer so that she wasn't wearing four hats and only three. But it is either Frank Urso or Marilyn Thomas in our legal office.

MR. MCCURDY: Okay.

CHAIRPERSON ORGAIN: If there are any other agenda items or items to discuss from those who are on the line or here? Being none, move for adjournment.

MR. MCCURDY: Second.

CHAIRPERSON ORGAIN: Consensus. Thank you.
STATE OF ILLINOIS
COUNTY OF SANGAMON

I, Christina J. Riebeling, do hereby certify that I am a Certified Shorthand Reporter, Certified Court Reporter and Notary Public within and for the County of Sangamon and State of Illinois, and that I reported by stenographic means the proceedings and had on the hearing of the above-entitled cause on September 11, 2008, and that the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 29th day of September, A.D., 2008.

Certified Shorthand Reporter
Certified Court Reporter
Notary Public
(CSR # 084-004006)

My commission expires:
November 16, 2010