ILLINOIS DEPARTMENT OF PUBLIC HEALTH

STATE BOARD OF HEALTH MEETING

Thursday, December 10, 2009
11:00 a.m.

Director's Conference Room
122 South Michigan Avenue, 20th Floor
Chicago, Illinois

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

BOARD MEMBERS:

DR. JAVETTE C. ORGAIN, CHAIRPERSON
DR. DAVID McCURDY
MR. STEVEN DERKS (via phone)
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
MS. ANN O'SULLIVAN
DR. VICTOR FORYS
DR. MOHAMMED SAHLOUL

ALSO PRESENT:

MR. DAVID CARVALHO
MS. CLEATIA BOWEN
MS. SUSAN MEISTER
MS. KAREN SINGER
MS. SHARLENE WELLS

P R O C E E D I N G S

CHAIRPERSON ORGAIN: We are going to call the meeting to order.

Peter, while you are getting ready, we're going to do some introductions. Thank you.

MS. BOWEN: Okay. Thank you. We're ready.

CHAIRPERSON ORGAIN: We're going to begin and we're going to -- everybody is going to introduce themselves. I know we've had some brief introductions, but we're going to do it anyway.

Kevin, let me start with you.

MR. HUTCHISON: Yes. I'm Kevin Hutchison from the St. Clair County Health Department and representing local public health agencies.

DR. EVANS: Caswell Evans, University of Illinois-Chicago, College of Dentistry and School of Public Health.

DR. FORYS: I'm Victor Forys, private

practice, internal medicine and orthopedic medicine.

MS. O'SULLIVAN: Ann O'Sullivan, the Illinois Nurses Association and Blessing Reiman College of Nursing at Quincy, Illinois.

DR. SAHLOUL: Mohammed Sahloul, Pulmonary Consultant Medicine, group practice, based in Oak Lawn, Advocate Christ Hospitals.

MR. CARVALHO: I'm Dave Carvalho. I'm Deputy Director for the Office of Policy and Planning and Statistics for the Illinois Department of Public Health.

And I'm not a member of the State Board of Health but I'm at all your meetings.

CHAIRPERSON ORGAIN: My name is Javette Orgain. I'm a family physician and Assistant Dean at the University of Illinois College of Medicine, Clinical Health Program and Associate Professor of Clinical Family Medicine Chair of the State Board of Health.

DR. McCURDY: Dave McCurdy. I am with

the Advocate Health Care as their direct organizational ethics with an office in Park Ridge and also teach part-time at Elmhurst College. I'm the co-chair of the Board.

DR. ORRIS: I'm Peter Orris. I'm Chief of Occupational and Environmental Medicine at the University of Illinois-Chicago Medical Center.

DR. KRUSE: I'm Jerry Kruse. I'm the Chair of Family Community Medicine of Southern Illinois University School of Medicine, Quincy, Springfield, Decatur and Carbondale, and I represent the School of Medicine.

MS. PHELAN: My name is Karen Phelan. I am probably the longest sitting member, and I am a consultant in public relations.

DR. WHITELEY: Herb Whiteley. I'm the Dean of the College of Veterinary Medicine at the University of Illinois, Urbana-Champaign, and I represent veterinary medicine on the Board.

CHAIRPERSON ORGAIN: All right.

Guests, please.

MS. WELLS: Sharlene Wells, Gerinatal Program Administrator for the Illinois Department of Public Health.

MS. GUILE: I'm Ann Guile from the Illinois Hospital Associations.

CHAIRPERSON ORGAIN: I'd like to take this opportunity to welcome our new members. As David Carvalho indicated, we hadn't had any.

MS. BOWEN: Can you hear on the phone?

DR. VEGA: This is Tim Vega.

CHAIRPERSON ORGAIN: Oh, good. Good. Thank you.

DR. VEGA: I'm wondering if there's a volume control or something like that.

MS. BOWEN: Yes, we've got it up here as high as it will -- can you hear now, Dr. Vega?

DR. VEGA: Yes, I hear you very well.

MS. BOWEN: Okay. I need you to talk louder. I have Dr. Vega and Steve Dirks on the line, please.

MR. CARVALHO: Can I make a suggestion, Cleatia.

If Tim and Steve find it hard to hear with the speaker phone connected in Springfield, perhaps we should connect up here instead of down there.

MS. BOWEN: Okay. That will be fine.

MR. CARVALHO: Well, don't hang up. Let's see how it works because I don't have the codes to do it. You'll need to give me the codes before we cut them off.

CHAIRPERSON ORGAIN: Cleatia, go ahead and give the codes.

MS. BOWEN: It's 1-866-434-5269.

MR. CARVALHO: Ms. Court Reporter, off the record.

(WHEREUPON, a discussion was held off the record.)

MR. CARVALHO: Madam Chair, if I could introduce -- we're doing introductions today -- our new Assistant Director, Theresa Girotti.

MS. GIROTTI: Good morning, everyone.

Nice to meet all of you.

MS. BOWEN: We can't see.

MS. GIROTTI: Sorry. Hi. Nice to meet all of you.

Unfortunately, I have another meeting but I will be here as long as I can and I can give you an update on H1N1 and where we are right now, if you would like.

I've been on the job for four days; three and a half, actually. It's not a full day yet. Okay. I don't like this camera thing.

But it's a pleasure to be here and I look forward to working with all of you.

CHAIRPERSON ORGAIN: You're the assistant director for --

MS. GIROTTI: For the Illinois Department of Public Health.

CHAIRPERSON ORGAIN: And say a little bit more about yourself, if you don't mind.

MS. GUILE: Sure. No problem.

I am a -- I've been in

education and social service for about 20 years. Most recently I was at Chicago Public Schools. My last day there was last week, last Friday. And have a, by education, a bachelor's in psychology, special ed, a master's in education and about to finish a Ph.D. in education. Hopefully, defending in January.

I am a mom. I live in Chicago. I grew up in -- I don't know. Anything else?

CHAIRPERSON ORGAIN: No, that's good. Appreciate it. Thank you very much.

MS. GIROTTI: Thank you.

CHAIRPERSON ORGAIN: Welcome.

MS. GIROTTI: Thank you.

CHAIRPERSON ORGAIN: We have had introductions and now we can move on to Agenda Item No. 3.

Tim, can you hear me?

MS. BOWEN: Can you hear now, Tim? Dr. Vega?

DR. VEGA: Yes, I can hear you.

That's fine.

MS. BOWEN: Okay. He says he can hear. So can Steve.

MR. DIRKS: Yes.

CHAIRPERSON ORGAIN: Steve, can you introduce yourself, please?

MS. BOWEN: And Dr. Vega, would you introduce yourself also.

DR. VEGA: Okay. Again, I'm Tim Vega. I am a family physician. I work in Peoria, Illinois. I am involved with employee health and wellness, and I run a clinic for severely ill employees.

MR. DIRKS: Hi. This is Steve Dirks, I'm with the American Cancer Society.

CHAIRPERSON ORGAIN: We will move on to agenda item No. 3, approval of the September 10th meeting summary.

Any additions or corrections? Peter.

DR. ORRIS: Yes. Dr. Orgain, now that we have these wonderful red action items zeroing

in, have you got a follow-up on the question of the State giving the vaccine at some time in the future? Was that resolved?

MS. O'SULLIVAN: Yes, it was resolved but --

CHAIRPERSON ORGAIN: Wait just a second. What we can do is approve the meeting summary and then move towards any further discussion of the items.

DR. EVANS: So moved.

DR. ORRIS: Second.

CHAIRPERSON ORGAIN: Karen.

MS. PHELAN: I just have a grammatical change and I can send it over to Cleatia later.

CHAIRPERSON ORGAIN: Okay. Thank you very much.

MS. BOWEN: Dr. Orgain, may I interrupt for one moment?

Dr. Arnold is presently parking his car. He said give him five minutes, and he should be upstairs for the meeting.

CHAIRPERSON ORGAIN: Thank you very

much. He's in Springfield?

MS. BOWEN: No. He's in Chicago. He's parking his car and he should be up in the meeting in a few minutes.

DR. ORRIS: We got him on GIS right up there.

CHAIRPERSON ORGAIN: We've moved the meeting summary by consensus, and in terms of -- in terms of Peter's question, now that we've moved the meeting summary, what I'd like to do is then answer those questions on the meeting summary that Peter asked, since we're on it.

Ann, you had some answers.

MS. O'SULLIVAN: What I know -- David probably knows a lot more.

All right. From a nursing perspective, the issue was clarified through the Department of Professional Regulations -- Finance and Professional Regulations to continue to do what we've always done in regards to immunizations.

DR. ORRIS: It was to use the student

nurses as well as the others?

MS. O'SULLIVAN: Correct.

And with the general supervision of faculty. So my assumption would be it pertains to -- and that's what we did all fall. So there was a huge uproar throughout the nursing college community, which I'm sure there was in others. It was going very quickly.

CHAIRPERSON ORGAIN: Okay. Okay. So let's move on to the next part of the agenda, although Dr. Arnold will be joining us shortly. Let's -- is Elissa online?

MS. O'SULLIVAN: She asked us to report.

DR. KRUSE: She asked me to, yes.

CHAIRPERSON ORGAIN: All right. Perfect. Thank you. There is nothing short.

Let's go to Item No. 7 on the agenda. That's pretty short.

MR. CARVALHO: The meeting dates.

CHAIRPERSON ORGAIN: The meeting dates. So we can dispense with the meeting

dates. These are our standard meeting dates for 2010. March 11, June 10, September 9 and December 9.

MS. O'SULLIVAN: David, has the Rules Committee ones been set yet; do you know? Because you and the policy -- Rules and Policy kind of mix in between these. Do you know if you have yours?

DR. McCURDY: We don't have anything to my knowledge. I don't remember that we established any.

CHAIRPERSON ORGAIN: Does the Policy have any?

MS. O'SULLIVAN: No. We are waiting. So we'll set some in the next couple weeks.

DR. McCURDY: We cue up to these.

MS. O'SULLIVAN: Right, we cue up to these.

DR. EVANS: Madam Chair.

CHAIRPERSON ORGAIN: Yes.

DR. EVANS: Are we adhering to the value of teleconferencing for these various

meetings?

MS. O'SULLIVAN: Yes.

CHAIRPERSON ORGAIN: You mean for rules and for policies?

DR. EVANS: Right.

CHAIRPERSON ORGAIN: Yes, they are teleconferenced.

DR. EVANS: Very good.

MR. CARVALHO: Can I offer a suggestion, Dr. Orgain. I know when we adopted the policy that authorized teleconferencing for committees and for the Board, at the time we discussed how it was very helpful for members to be in person and encouraged people to be in person for the board meetings.

Since that time the State's budget situation has gotten fairly dire, as you may have read, and next year is to be even more dire. And so all of us have been asked to look at ways to reduce travel.

So if I might offer a suggestion if for your upcoming meeting if you

give consideration to leaning more on teleconferencing those four meetings rather than traveling for them for this coming year as the budget -- you are supported by general revenue funds, and that's going to be the tightest funds in the State budget. So subject to your consideration and discussion while you plan the meeting schedule.

CHAIRPERSON ORGAIN: May I ask, for those of you who are downstate, how close are you to videoconferencing?

MS. BOWEN: Dr. Vega, how close are you to videoconferencing? Would it be to your best interest to come to Springfield?

Are you there, Dr. Vega?

DR. WHITELEY: I can do it from my place. Just tell me where to phone in.

CHAIRPERSON ORGAIN: So what we will do is in the interim we will ascertain the possibility for additional videoconferencing as well as teleconferencing. I believe this network has that capability, and we will see how

we can set that up so that we can do either or. Take into considerations what David suggested in regards to budget.

Okay. All right. And so we will determine that. Thank you. Thank you, Dave.

MR. CARVALHO: Will do.

CHAIRPERSON ORGAIN: Is that Tim?

MS. BOWEN: Yes. Go ahead, Dr. Vega.

DR. VEGA: No. I'm sorry. I was speaking and realized I was on mute, I think.

CHAIRPERSON ORGAIN: We thought you had gone away. Thank you.

DR. McCURDY: We got your drift.

CHAIRPERSON ORGAIN: So I know that you are in Peoria and so what we will do is we will try to work something out between video and teleconferencing for the meeting.

DR. ORRIS: I just noticed as I began to put things in the book, March 11 is the day after the IPHA meeting in Springfield on the 9th and 10th. So if we could look at all of these

sort of as individuals because that might be one, if we are only going to meet once together, that might be one to do it.

CHAIRPERSON ORGAIN: Great idea. So that's the IPHA meeting. Okay. Thank you.

All right. So I think we should probably move back up.

DR. McCURDY: Dr. Orgain, just a comment about this. Would it -- would we imagine that we would still want to have the option and that people could go to one or another of the State locations for this purpose?

CHAIRPERSON ORGAIN: Absolutely. Absolutely. It's a recommendation, not a mandate. So absolutely. Thank you.

Why don't I go -- is it okay if we jump the agenda?

MR. CARVALHO: Sure. I can do the legislative update.

CHAIRPERSON ORGAIN: Okay. Go ahead, please. David is going to do the legislative update.

MR. CARVALHO: I'll do the legislative update while Dr. Arnold is coming up.

The legislative veto session occurred last month and the month before and very little happened specifically relevant to us, with the exception of the adoption of a bill relating to health care worker vaccination, and because of the urgency we also have a rule on that same topic that's on your agenda later today.

But in brief, the Department was concerned that while many health care settings offer vaccinations for influenza, both seasonal and atypical, to their workers that that might not be, in fact, true across all health care settings. For example, in nursing homes or some other health care settings regulated by the Department.

And so we sought and received legislative authority to require all health care settings authorized -- regulated by the Department to offer vaccines to their employees.

And the authorization under the statute authorized us to do that by rule and then you have later on your agenda that rule. So that bill was passed and was signed during the veto session.

I don't have any other notable legislation. Cleatia, did you have any other notable legislation from the veto session?

MS. BOWEN: No. Nothing was given to me, David.

MR. CARVALHO: Okay. Thank you.

CHAIRPERSON ORGAIN: What I'd like to do then is go up to the Policy Committee Report, if that's acceptable. I think that would be shorter again.

MS. O'SULLIVAN: The Policy Committee met on October 28. We didn't have that many people there, but we continued to work anyway. We discussed the SHIP plan. Elissa updated us on that and what all was going on.

We are going to continue to try to work on the patients that are medical

homes or health care homes and we will be looking for some more information from Dr. Kruse and Dr. Vega.

And then since then we have talked -- I have talked with Mary Driscoll regarding the just culture initiatives as regard to patient safety, and she and I and the Chair of the Metropolitan Chicago Health something or another, I forget what -- do you know what I mean?

MR. CARVALHO: The Metropolitan Chicago Health Care Council?

MS. O'SULLIVAN: That.

MR. CARVALHO: Yes.

MS. O'SULLIVAN: Are going to work together on seeing what we can bring back to the State Board of Health. We talked yesterday on that, and then we had a SHIP plan meeting yesterday. Elissa asked if Jerry or I or David would update people and Jerry said yes.

CHAIRPERSON ORGAIN: So are there any action items from the Policy Committee?

MS. O'SULLIVAN: No.

CHAIRPERSON ORGAIN: So from a perspective of the patient center medical homes, the Illinois Academy of Family Physicians will be hosting an educational session in the spring or summer in order to get that information out to the community, particularly health care providers, and that is in the planning stages right now. We are hoping that we can continue to ensure that the patient center medical home is physician led, primary care provider led and we'll continue to get that information out. Peter.

DR. ORRIS: Could I be involved, if you would? Or just let me know about the patient safety discussion. We're doing a project on the inter -- the inter -- overlapping in patient safety, worker safety and environmental sustainability in the hospital so I think it would be very interesting to read about.

MS. O'SULLIVAN: Are you aware of any

organizations in the State using the just culture philosophy in regards to patient safety? That's what we're trying to find out is if it is prevalent in the State, and we don't know that it is at all, and then seeing what we can do to introduce it.

Just culture I sent you guys stuff on a few months ago just having to do with how we report, how we act on medical errors that are made, patient safety issues that are made, how we educate, how we work through the systems.

DR. ORRIS: The part of that related to medical errors and apologies and full disclosure, etc. University of Illinois in Chicago is operating under that and has been for a year or so, but the rest of it I don't think is.

MS. O'SULLIVAN: And that's, although obviously related with patient safety, is separate from just culture. So absolutely.

DR. McCURDY: And Advocate Health Care, I know, has adopted a just culture

approach.

MS. O'SULLIVAN: Okay. So we'll take a look at that.

DR. McCURDY: They're in the process of implementing that.

MS. O'SULLIVAN: All right.

MR. CARVALHO: Ann, this is Dave.

If you'd like, Mary Driscoll who's our Chief of the Division of Patient Safety could see what she could find out about the extent of the use and adoption of just culture in Illinois.

MS. O'SULLIVAN: She is. We are working on that. We talked yesterday. Again, we talked before about it, and her primary objective was to get the report card folks. And so she said she might have a half a minute to work on this with us. Thank you.

CHAIRPERSON ORGAIN: Ann, particularly since we have new members for the Board, what we should -- we should consider is a configuration of our subcommittee and interest.

So for those of you who are new to the Board and persons who might be interested in joining particular committees, also, and orientation, we've attempted to do a retreat and that becomes difficult because it's an open meeting. But we need to take a look at goals and objectives and policy recommendations that we might want to make for the year and certainly if you can lead that in addition to SHIP. Because the SHIP is very over-arching.

MS. O'SULLIVAN: Correct.

CHAIRPERSON ORGAIN: But from the perspective of things that we might want to recommend as health care reform moves forward, particularly as you indicated one of those patient safety in the medical homes.

MS. O'SULLIVAN: And that's really been the primary initiative thus far that we've recommended. We have an agenda, and it's come out. But it's probably many, many months ago now, isn't it? How the year flies when you're having fun. So we'll take a look at that at our

first meeting of the year.

CHAIRPERSON ORGAIN: Thank you. All right. Thank you.

DR. VEGA: Javette.

CHAIRPERSON ORGAIN: Yes, Tim.

MS. BOWEN: Go ahead, Dr. Vega.

DR. VEGA: Yeah, Javette. The one thing that came out of the Policy Committee was like Dr. Kruse was indicating the medical home.

One thing that came out was the study that was going to be -- the pilot project that was going to be implemented and that project basically was terminated. They saw it as no savings in some areas of medical homes, in Medicaid savings, in other projects that they thought another pilot would be useless, and they are -- actually, the health care bill that's kind of working its way through Congress is very heavily related with medical home language because they see the quality and dollar savings. So the project is no more.

CHAIRPERSON ORGAIN: I'm glad you

mentioned that, Tim, because what we also need to do is educate the state community on Illinois Health Connect and Your Health Care Plus, which is driven by the patients in a medical home concept and that information needs to get out to the public. Jerry.

DR. KRUSE: I will make a comment on that and then give the SHIP update.

In the current federal legislation, there is a problem with the medical home language in both the House and the Senate bills in that it focuses on only high risk, high need, high cost patient. And so it only hits the PCCM part of the Illinois plan, and it does not hit the Illinois Health Connect Plan, which provides for medical or health care homes for all of the population, which is really the power of it all.

And we've discussed the Community Care of North Carolina where public health and patients that have medical homes were brought together through care coordination

nurses that focused on the high risk, high needs, high cost patients and the medical home itself which brought all patients under the umbrella. So there is a little bit of an issue there.

I agree with Tim. They recognize that it will increase -- that it improves outcomes, lowers costs, but there is a little bit of politics going on.

MS. O'SULLIVAN: No.

DR. KRUSE: Really. So you want the SHIP report now?

CHAIRPERSON ORGAIN: I was really trying to wait for Dr. Arnold.

DR. KRUSE: Oh, that's fine.

CHAIRPERSON ORGAIN: So particularly since that's -- he was present for the meeting. He was not present for the Policy Committee meeting.

MS. O'SULLIVAN: Dr. Arnold?

CHAIRPERSON ORGAIN: Yes. He was not present for your Policy Committee meeting.

MS. O'SULLIVAN: No.

CHAIRPERSON ORGAIN: Oh, okay. And he was not present at the SHIP meeting.

DR. KRUSE: Not this one but the first one.

CHAIRPERSON ORGAIN: Okay.

DR. McCURDY: We could start with rules and take one rule at a time.

CHAIRPERSON ORGAIN: Do you have a short one?

DR. McCURDY: Well, some of the rules are short, which of course guarantees nothing, but we can begin with the ones that seem to be the least controversial.

CHAIRPERSON ORGAIN: All right. Very good. Thank you.

MS. PHELAN: Which one might that be?

DR. McCURDY: So we are turning our attention to the rules that you see listed and my suggestion is we actually take these in order.

CHAIRPERSON ORGAIN: Okay.

DR. McCURDY: The first one, Children's Community Based Health Care Center Program. Shall we ask somebody in Springfield to give us a little background? Is there somebody there who could give us a little background on the first one? Children's Community Based Health Care Center Program.

MS. SINGER: This is Karen Singer. I am with the Division of Health Care Facilities and Programs. And the first rule I'm going to talk about is the Children's Community Based Health Care Center Program.

This is an alternative health care demonstration program. It is a facility that houses medically fragile children. They can be there for like respite care or their family members up to ten days, and then they also have a transitional program where they could be there 120 days to transition their health and to train the family how to care for each child coming from the hospital into their home.

The change that occurred within these regulations actually came about due to a statutory change, and that is that the -- there is no longer required a certificate of need to establish these homes within the state of Illinois. So that is going to be removed from the regulations.

There are currently two licensed facilities in the state. In this there are a total of 12 that are allowed, and we have one that is license pending at this time.

DR. McCURDY: Okay. Thank you.

As you can see, if you are looking at the Rules Committee meeting summary from November 19th -- by the way, you have two Rules Committee meeting summaries. The November 19th was our regular meeting. December 4 was a special meeting that was called to address an additional rule.

I'm looking at the November 19th Rules Committee summary, and you will see that the first rule discussed was this

Children's Community Based Health Care Center Program. It was, as I indicated to Dr. Orgain, not particularly controversial in our discussions. So we move to refer to the full Board for approval, and I would so move that we with the Board forward it to JCAR.

DR. ORRIS: Second.

CHAIRPERSON ORGAIN: Any objection? Let it be done.

DR. McCURDY: Shall I continue with the next one?

CHAIRPERSON ORGAIN: Yes.

DR. McCURDY: After the second one then it gets a little more dicey, just so you know.

This is the minimum health care standard for health maintenance organizations. And Karen, are you available to say something about this one also?

MS. SINGER: Yes. The health care member status health maintenance organization, the change that came about for these

regulations, some of them are just some typographical changes but the major change is on page 83.

The request came from several of the physicians in HMO organization that we would change the record review, medical record review to a random record review, instead of an every two years really to coincide with the HMOs select when those would be done and prior to coincide with the recredentialing of physicians in an HMO program, which is an every three years just mandated by state law.

Therefore, they would do their peer review or their medical record reviews to coincide with that time frame. So it's a random time frame and not specified at every two years, which kind of contradicted the every three year time frame. They still would be required to do the record reviews.

DR. McCURDY: Could you repeat that.

MS. SINGER: They would still be required to do record reviews. It's just not

set on a time frame. It's a random time setup where they would be able to do that and usually they coincide that with their recredentialing.

DR. McCURDY: Okay. So as you can see, our actions were minimal and primarily they were really editorial changes that we recommended. And at least as far I can tell, they have been made, and so I would move that we go ahead and pass this along also through the Board.

CHAIRPERSON ORGAIN: I just have a question --

DR. McCURDY: Sure.

CHAIRPERSON ORGAIN: -- on the rule itself. And if it's a record review primary care physicians, and there's a standard, but how did the specialists get excluded?

MS. SINGER: The specialists were never in the original rule.

CHAIRPERSON ORGAIN: I understand that to be the case.

DR. ORRIS: If I recall we were told

just to do the amendments, not to expand the scope.

CHAIRPERSON ORGAIN: Right. Is there ever a possibility of expanding such, just to say physicians and exclude primary care?

MS. SINGER: I guess that's a possibility.

CHAIRPERSON ORGAIN: That's on page 4.

MS. MEISTER: This is Susan Meister, the Rules Coordinator.

CHAIRPERSON ORGAIN: Yes, Susan.

MS. MEISTER: That type of change would be something that we might want to go back and look at for a future rulemaking. I'm not sure that we would want to decide to do that today.

CHAIRPERSON ORGAIN: I'm amenable to that, as long as we can take a look at it in the time frame that's allowed such that the change could be made, if possible.

Did you hear me, Susan?

MS. MEISTER: Yes. Do you mean before

we go to publication?

CHAIRPERSON ORGAIN: Yes. Yes. Is that possible?

DR. McCURDY: Dr. Orgain, where is this just so that we are all looking at the same thing.

CHAIRPERSON ORGAIN: I'm sorry. Page 4, C(1)B.

MS. MEISTER: We have an HMO Advisory Board but it's not in existence so...

I think we need -- if you're not -- if you're suggesting that we not approve the rule and let me go back and look at this issue, then we need to go back and present this with our program people and take it under discussion. I don't think that's a decision that we're prepared to make today.

DR. ORRIS: I would strike primary care.

CHAIRPERSON ORGAIN: I will strike primary care. I think that if there's a review, there should be a review of physician charts.

Is there any discussion on that?

DR. FORYS: As a primary care physician, most physicians really don't know what the rules are and they're very confusing. There's a '95 version. There's a '97 version. These two versions are different. They are points. There needs to be some simplification of these rules. They really don't serve the patients well or the physicians well.

CHAIRPERSON ORGAIN: Susan, I would like to recommend that we take a look at that and delay -- defer approval of these rules until we have that opportunity.

MS. MEISTER: Okay.

DR. FORYS: It's actually federally mandated.

DR. McCURDY: What is federally mandated?

DR. FORYS: The rules for the documentation of encounters with patients.

CHAIRPERSON ORGAIN: Yeah, but it's

not specific to simply primary care physicians.

DR. FORYS: It's specific to everyone.

CHAIRPERSON ORGAIN: Exactly.

DR. FORYS: But everyone has the same problem because the requirements, especially for people like myself who will soon be 55, that's not -- it wasn't taught in residency. It's still not taught in residency. There is no education and very few people are aware of the rules.

CHAIRPERSON ORGAIN: We understand. And if there is no objection -- Jerry.

DR. KRUSE: I don't have an objection. As long as we are doing this, my question is whether it should include all health care providers that deliver care; physicians and health care providers, if we are going to get it up to date.

MS. O'SULLIVAN: Interesting.

CHAIRPERSON ORGAIN: Very interesting. Did you hear that question?

MS. SINGER: Yes, I think we'll have

to look at the statute to see if there's statutory limitations needs to specifying that situation. So we will have to take that back for review.

CHAIRPERSON ORGAIN: Thank you. We appreciate that. Jerry. I mean Peter.

DR. ORRIS: What is the consequence of not going ahead with the rest of the rules at this point?

MS. MEISTER: If we don't go ahead then the two-year requirement would stay in.

CHAIRPERSON ORGAIN: Okay.

DR. ORRIS: So if we go ahead on it now, we at least extend that requirement to three years for the primary care physicians.

MS. MEISTER: Well, we extend it to a random which would be a time period selected by the HMO but would probably be three years to coincide with credentialing.

CHAIRPERSON ORGAIN: And in the interim, there can be a modification of the rule as we -- as it proceeds through.

MS. MEISTER: We would have to develop a different rule.

CHAIRPERSON ORGAIN: Okay. That's acceptable, Susan.

MS. MEISTER: Okay.

CHAIRPERSON ORGAIN: And so then I'll retract my recommendation to delay approval of this rule, as long as we can also simultaneously investigate the option for changing the language.

MS. MEISTER: We can do that.

DR. ORRIS: Maybe Dr. Forys would be involved in trying to simplify it.

DR. FORYS: Well, these are federally mandated schemata that are required to be documented in order to document a level of the visit and that would go with the severity of the visit, number of problems, and it's extremely confusing.

CHAIRPERSON ORGAIN: And essentially -- essentially, what I think you are recommending that you have to also go back to

what the statute indicates and to ensure that we don't violate the statute.

MS. MEISTER: That's correct.

CHAIRPERSON ORGAIN: So I think that we can move. I think that you have gotten the sense of what we'd like to do and we will move on that.

DR. FORYS: We would like to know what we are going to be tested on.

CHAIRPERSON ORGAIN: Come on. Let me just introduce -- Dr. David Arnold has joined us. The Director has joined us.

DIRECTOR ARNOLD: One question -- it was like two -- actually, two questions. One is whether we need to have some kind of movement to get some kind of educational component that is presented to the school system so that the residency program and medical schools and say that, you know, these are the things that you need to start teaching physical diagnosis and all that it needs to be integrated into how you approach the charts.

And then the other thing is also the second question is rarely if you do a review --

MS. BOWEN: We can't hear in Springfield.

DIRECTOR ARNOLD: I'm sorry. First I was saying that should there be a push to get some type of training document that is given to the medical schools and residency programs where they have to start to insist that residents are trained on, you know, chart preparation and the understanding of what this really means for them on an ongoing basis.

Where, you know, first of all, that's one of the things we never really look at the regulatory portion when we are in school and then we never really look at the financial portion. Those two things are just really out of the box.

And the second point is going to make -- the second point was whether we are also, when you do do the evaluations if you

extend it to people who are with special -- specialty care, specialists being reviewed, is that by a group of their own peers or how is that rolled out? Because it may be very, very different going from one specialty to another as opposed to primary care. So, I'm sorry.

DR. KRUSE: Well, my comment was -- is that at least for family medicine residencies there's a fairly significant requirement for practice management, and the regulatory and financial things are covered in great detail in most programs. And I can speak for our programs at SIU. They certainly are.

And just a few years ago that a number of hours that were required in that almost doubled and so it is certainly a movement from the residency review committees of the ACGME that is being moved forward with some of the -- (inaudible).

MR. CARVALHO: Doctor, can I just mention something, too?

It might be helpful to remind

everybody that the context into which this rule occurs, namely, under Illinois law anybody who wants to establish an HMO is supposed to apply to us and the particular provision we're talking about is the part that says in that application you, the HMO, must demonstrate that you are doing certain things.

And one of the things that we require that they demonstrate that they intend to do is set up this system of medical record documentation review and evaluation. So we aren't doing medical record documentation review and evaluation. We are requiring the HMO to tell us their plans for doing it. So that's the provision that you're focusing in on here.

Right now our rule says, your application is supposed to tell us your plans for doing it every two years, and the proposed change is your application is supposed to tell us your plan for doing it on some random basis. All the other issues that have come up are also interested in policy questions and fit into

other context, the particular context right here and that dovetails with what Dr. Forys --

DR. FORYS: Forys.

MR. CARVALHO: Forys mentioned which is when those HMOs set that up they've got a whole, you know, shelf of federal regulations that they are seeking to comply with, again, over which you have, you know, no control. But the point of control is when they apply, they have to tell us that they have plans to do what they have to do and the specific rule here is how often they do it.

CHAIRPERSON ORGAIN: I appreciate that but the statute -- go ahead.

DR. EVANS: In that context what is the superordinate oversight that, in fact, they have done what they have said they will do? Is there a state role in that or does that all come out of the federal side?

MR. CARVALHO: Once we accept -- and this is a question I'm posing to folks in Springfield. Once we accept the Certificate of

Authority from the HMO, what continued oversight of the HMO's actions and consistent with that certificate of authority do we undertake?

MS. SINGER: Once we have accepted their certificate of authority, we make a recommendation, obviously, to the Department of Insurance that they are required initially and also the Department of Insurance grants the certificate of authority, not the State Department of Public Health.

As far as in the regulations, there is a requirement that HMOs are to be reviewed or surveyed by the state on a routine basis. I think it's every three to five years. I can tell you that doesn't happen very often due to funding, and right now I'm the only person in that department of HMOs. So I do utilize some of my staff or surveyed our staff to do the surveys. We did two of them this last fall, but it's far and few between.

CHAIRPERSON ORGAIN: And also I think I heard that you said that the HMO Committee has

not met? Did I hear that as well?

MS. SINGER: There is no HMO Advisory Board in place at the current time. That is one of the issues which is what caused the problem with these regulations.

CHAIRPERSON ORGAIN: All right. Appreciate that.

So just to recap what we've decided, by consensus we will move to --

DR. McCURDY: So far we've moved. We haven't accepted it yet, so...

CHAIRPERSON ORGAIN: Yeah, we seconded it.

And there is no objection to moving it forward with the caveat that we continue to investigate the possibilities of expanding changing the language.

Any objection?

All right. Thank you very much.

DR. McCURDY: And now that we've completed the non-controversial rules, we can

resume to Dr. Arnold.

CHAIRPERSON ORGAIN: Absolutely.

DIRECTOR ARNOLD: H1N1 is never controversy.

CHAIRPERSON ORGAIN: We can welcome the Director, Dr. Arnold, and we appreciate you're able to be here.

DIRECTOR ARNOLD: Thank you very much, and I am really pleased about the group that, you know, was selected for the Board for this year. I feel, you know, great about everyone's background, and this is phenomenal. I think it's a -- you know, it's a historic opportunity. We are at a time of crossroads where there is someone in the White House talking about, you know, universal health care, and we are talking about preventive health care for the first time really in a very wide reaching way. So I'm really excited about some of the potential opportunities we have.

Of course, there are always, you know, those alarm bells and pitfalls that go

along the course when you change course and you start doing things differently. So I look forward to working with you throughout the year. I certainly will attempt to make all the meetings. I know the last couple of years a battle field here, but now we are starting to go get things a little bit more situated.

The first thing I was going to mention is, and give you a little bit of a background on, what's been going on with H1N1 since the springtime. The novel H1N1 flu hit us back in April. Just prior to that, back in February, I had my senior staff, 42 members go through the National Institute Management System of Training. So they were trained on six different levels with it, and some of them met with leadership from the CDC. And what this was to do is get them sort of coordinated to get them more in a situation where they could develop incident action plans to any man-made or natural disaster and also looking at some additional things that we have been dealing with

HIV, and STDs, obesity, you know, looking at diabetes itself and looking at multiple health complaints. Even violence is an issue.

In fact, if you go up from the age of one year old to 65 years old, the major cause of death is still accidents. You could add cancer, heart disease, and you can actually add into that strokes and still your accident rate is the predominate mechanism of death for people. So we actually will be looking at all these different issues.

The CDC's main focus is on obesity and it's also on the area of tobacco abuse. So we still have to deal with those things even within this H1N1 situation. So we are balancing things, making sure we still stay on focus. So that's the first thing.

The H1N1 situation we pushed the medications initially because we only had antivirals back in the spring to the hospitals and local health departments as the primary mechanism to distribute the medication. When

the -- when the vaccine became available, it first came out in an available form of the intranasal form. So that form you cannot use for certain subpopulations within the priority group. So pregnant women you couldn't use it for, people who had immunocompromisation, those kinds of things, those people were immunocompromised. So that sort of curtailed the use of it.

The one advantage it did have is that people who are fearful of thimerosal could still use it. They had no thimerosal in it and the single dose injector is the same thing. The multi-dose viles that usually have ten doses and it's the only one that has the particular thimerosal in it. So we had to balance that kind of issue in the community.

It went out to local health departments and also the hospitals first because we felt these were the places where people either had no insurance at all. We had a higher burden in those populations with health care

disparities, chronic illnesses, those types of things. Also, in hospitals would be, you know, the front line, but we did not want to shift all of the burden on the hospitals and the local health departments. We have 96 of them in the state that play a vital role all the time in everything we do. So they provide incredible services in the community. They know the ties, the people, how to make things happen.

So up to this point in time, we have about 2.3 million doses that have been distributed throughout the state. We have covered approximately 22 percent of the population. If you look at all the people who are in the health care -- who are in the state, about 3.2 million people reside in the city of Chicago. There's a separate shipment that goes to the city of Chicago. There are ten million people who live outside of the city of Chicago. That includes the rest of Cook County and also the 101 other counties.

So we actually had it

distributed to over 4,600 sites throughout this direct shipment and managed that process. There was no process in place. There was no process from the CDC. There was none from us, you know, as far as this mass distribution plan on that level for, you know, antiviral medications and, you know, immunizations.

So, when it first came out, we were supposed to get 120 million doses by the end of October. So far we only had 23 at that point in time in October and now we're up to close to about 46 million doses nationally and it's climbing.

So these doses are -- we are actually rolling the vaccine out now. Initially, one of the vaccine companies is making a vaccine with these qualines antivan (phonetic) and that's GlaxoSmithKline.

The FDA did not approve the use of that in this country, so they sold their vaccine to Canada. So we now have four manufacturers out of five. And even those four

manufacturers said their projections on production were much lower than what they thought. The yield wasn't as high.

They initially thought also that we would need two doses of vaccine even for adults; you know, those people who are adults and children. And what ended up happening is they found out that the immuno-authenticity of it was very good so that they could use just one dose for adults, but they still had to use it for children.

So we were looking at children nine years or less. Initially, it was six years or less, but we had different standards. So the children needed to have two doses.

So at this point in time we still have the vaccine being distributed through hospitals and local health departments. But approximately six -- about six -- five or six weeks ago we opened it up to private providers in specialty areas, the OB/Gyne because of pregnancy; people who are dealing with

respiratory diseases like asthma and also to people who were dealing with people who had cancer or any other kind of immunocompromised condition.

It was very important to get these groups because the people we were seeing who died from this, about 58 people have died thus far in the state, were people who had either -- were either pregnant or had a chronic underlying medical condition as a majority of it. But we did see children as being about one-third of those who were admitted to ICU's throughout the state.

CHAIRPERSON ORGAIN: And no adverse events from the vaccine is reported?

DIRECTOR ARNOLD: Yes. And no adverse events so far, thus far.

The vaccine is made in the same way that we normally make the regular seasonal flu vaccine. As a matter of fact, the seasonal flu vaccine is trivalin (phonetic) usually, and this is just a univalin (phonetic),

so it's just one. So I'd throw that out there.

I think the thimerosal issue was one of those that we could not lose ground on. We told them that basically we would not take the position that thimerosal was linked to autism. It's been shown in multiple major studies not to be. So we were going along with the scientific evidence on that, but we did tell them that, you know, if you did have -- you know, still have fears about it, you could still get the single dose injector or the nasal, so people wouldn't alienate people.

We are going to move forward, and as of the 15th of this month, we are going to open it up to the general public. We started sending out warning shots about, you know, coming and get your last chance, last chance to get it. Because we wanted to make sure we covered those priority groups. So 22 percent out of the 50 percent of priority groups -- okay. The 50 percent, the priority groups represent 50 percent of the ten million that we

are covering from the state level. Those -- that represents 5 million people out of the 10 million who are in the priority group.

So we have -- so that 50 percent that represents the priority group, we have done 22 percent of the entire population. So 22 percent, almost half of the priority group, if we have been following it strictly, has received the vaccine to date. So that's the projection.

So what we are looking at now is with the rollout, the vaccine production is increasing. We are getting more doses. We want to make sure we open it to the general public because we don't want that interest to wane.

There's some national polls on the websites that show that the interest is starting to fall off in the country, and we don't want that to happen. We want to make sure people go throughout the campaign to completion because next spring or next fall we don't know if this virus is going to change, you know, if

the genetic composition of it is going to change and make it more severe in its attack.

So we have to make sure that the campaign goes to completion. They are going to add it to the seasonal flu vaccine for next year. That's what the CDC is already making a statement that they will be doing it. So we are at a point now where we just want to make sure we do some damage control. Because with any kind of scarce entity, people have a tendency to, you know, react to it in different ways.

We also had an issue about whether the -- we were reaching out to disparately-impacted minority population. We have done a massive media campaign with the Latino community, African-American community, American Indians, Asian community and Polish community. We are going into subpopulations to make sure people are able to do this.

We have been doing a lot of local health department calls. They have been extremely instrumental in giving us their

viewpoints in, you know, how the things rolled out in the region. So we have been trying to balance the State, you know, 96 local health departments, 102 counties, and they have been doing a stellar job working with us.

So we feel like the campaign is progressing. We are sort of on the right course for it. And I think that we just want to make sure that this is -- the war drum is still beating. You know, we do have a decrease in our hospitalizations and in our ER visits and in the death rate. So all three have been trailing down pretty precipitously. So it's coming down.

We still don't know -- and I was actually with the CDC group yesterday. We still don't know what is going on with the seasonal flu in the background. They are sort of -- they really said no one has a crystal ball, and so we are still keeping an eye out for that because we don't want that to peak up the road with this decline with the regular -- the novel H1N1.

But with that, I've been talking enough. But if you have any -- you know, if you have any questions that you have specifically that you want to ask or anything that you have concerns about or want a suggestion, I would be more than happy to listen.

CHAIRPERSON ORGAIN: We want to give him the opportunity to hear the SHIP report. So I know that your -- I know that your time is valuable.

But if there are any questions with regards to H1N1, if not, then we'll move to the SHIP report so that you're able to hear where it's going.

DIRECTOR ARNOLD: Okay.

And it's one other thing I wanted to mention at this juncture because I think this would be a great group to be here for this, and the one thing I want to bring up is that we have the Nursing Home Task Force right now, and there is a potential to make some

really great movements in that direction for nursing home care in the state.

We're the only state right now that has the identified offenders program that actually screens people going into nursing homes. If you get above 50 percent of the occupancy being other than seniors, then it cuts off their Medicaid. So many of the nursing homes have been becoming -- have been having their beds depleted by alternative site housing, you know, assistant living housing. So they have been losing seniors from nursing homes. So the only way to make up the bed capacity is to bring people in with mental illness or with a history of actually being ex-felons. So if they leave the prison system, they can come in. You are mixing populations here.

So this is one of the things that we are talking -- we are trying to deal with on the task force right now. So you will probably hear a lot of stuff with that going on.

One of the potential

solutions, which I'm getting to the point now of why it was I really wanted to bring it up to you in particular, is that I have a suggestion I made to the task force, and you can actually think about it and think about how this would work out because all of you are somehow inter-related with this health care system from different perspectives.

The suggestion is I have approached a couple of deans from medical schools. I haven't approached the nursing schools yet. The residency directors and also some of the nursing home people is that when I was in medical school we never had a rotation in nursing homes. And that's going to be the population. We are going to be treating people that are getting older to understand the realities of where people are living.

If we had a rotation with medical students, nursing students, and residents in nursing homes, we could potentially prevent hospital admissions for preventable

causes, including decubitus ulcers. This costs our state millions of dollars a year. It would have a dramatic impact on Medicaid, on Medicaid monies, and they usually end up being very complex. It's a common pathway to death with these decubitus ulcers many times.

So it was an idea. Just throwing it out there and, you know, hopefully we will get more information on it. And then I will, you know, submit this idea. Because it's going to take multiple people to try to orchestrate that, you know, on multiple levels to look at it and see how viable an option it is and what would entail insurance, you know, payment of resident's fees, students, you know.

But, you know, it may be a viable option, and we could be the first state to have something like that in place. No other state has it. It would be a way of showing that we care about people, seniors. Because our population is getting older and one day I'll be in there so...

CHAIRPERSON ORGAIN: I think in the Policy Committee we were talking about them setting some goals and objectives for the coming year and just in terms of working with that.

I apologize. I must leave. David McCurdy will continue to chair the meeting and Jerry and Ann will do the SHIP report.

If there are no questions in regards to H1N1.

DR. SAHLOUL: I have a question.

CHAIRPERSON ORGAIN: Okay.

DR. SAHLOUL: Regarding the public concerns about the side effects of the vaccine, you know, I have too many nurses even and physicians who are concerned about the side effects, and I think there is a need for some education about that.

DIRECTOR ARNOLD: Yes. We actually have some things on our website where we send messaging through the HAN system to help, you know, Health Alert Network, in order for people to get help.

But also, one of the things that we have been doing -- and we actually have it now in movie theaters -- it's coming out as an advertisement to let people know about getting vaccinated. You saw it?

And we have myth busters. Did you see the myth busters? So we actually have myth busters. But it's in every movie theater in the state. Two and a half months it will be going. Every movie you see it will come on first. They have made -- we've made an agreement with them about putting that out there.

Now, it's difficult for me to understand the scientific medical basis of why someone in the medical field would say, "I don't want to get a vaccination," knowing the history of vaccinations and what they meant, you know, historically with polio and everything.

So I think that that has to be something that really is going to have to become a very deep educational viewpoint. Because what

bothers me about it is that if I'm in a medical institution and someone is -- overhears me or approaches me about it, and I'm in a position of expertise or authority and I say something, I think that that's actually detrimental to the patients. You know, it's -- it's, you know, like saying someone has severe chest pain and we want to do a cath and you say, well, those caths, you know, you want to watch out for those bruises on the skin. So I just -- I think it's really probably not a good, good thing. We need to figure out how to get that much more deeply ingrained in the educational system.

CHAIRPERSON McCURDY: But you have also not supported mandatory vaccination, if I may add.

DIRECTOR ARNOLD: Yes, yes. And part of the reasoning for that was because -- the reason why I said absolutely not is because many people, first of all, will sit -- they were seated in positions where they have already signed contracts with an organization, a

hospital, a clinic, and a provider group.

And what I felt would happen is that you would start getting pushback during a time when you need to bring people onboard. And the problem would be is that your unions may start standing up. Individuals may start standing up.

Actually in the tort law, it would be battery, a battery charge if you forced someone to get this. It would be coercion on people who later would come forward against institutions and say that, you know, I had this ILI like illness that's nebulous but it was because you made me get the vaccination. So there were multiple legal concerns that were coming down this pathway.

New York went ahead and did it. They were asking -- they were begging me in this state to do it. Multiple institutions said absolutely not. The best thing you can do is get your professionals in a room and urge them. Tell them the importance of doing this, why it's

important to save your patient's lives just by what you do, leading by example, all those things. Great to do.

But New York did it. They went to court. The court system -- the Supreme Court in New York City polled their statute and said this was unconstitutional. They had already given vaccinations to people in the state. They are still going forward with some of their lawsuits. And it's going to -- I'm not sure how high it's going to go, but they are facing some really serious, serious problems from having tried to institute that.

And also, they had a lot of providers who just opted out and said I'm not going to do it. You can't infringe on me.

And I understand from the scientific standpoint why you would say I would want it mandatory, but I think the practical situation would make it very, very cumbersome and at this point in time.

I mean, it's something that we

can talk about, you know, for future policy and, you know, for legislation. But it's still very, very difficult to automatically impose on someone that.

I know Dr. Orris but -- you know, by the mask, you know, like in the workplace setting you can say that, you know, either you wear this mask or you don't work here, you know. And it may be able to be written into contracts that if you work in this ICU you must be have an immuno-status, you know, prior to employment.

But to impose it on people who are already employed under contract, you're walking on a dangerous line. And maybe -- I mean, through the worker's comp agreement, it may just work out that, you know, you wouldn't be sued.

We were talking about we would not face any higher level suit other than the worker's comp claim that would arise from that.

But I am still worried about

that battery thing and, you know, IIED and all the other things they can twist into, you know, intentional infliction of emotional distress.

So I just -- I just thought that that wasn't -- it wasn't the appropriate time to do that. We are right in the middle of a crisis and we just want to make sure everyone joins it and that we got the least amount of resistance.

CHAIRPERSON McCURDY: Thank you. Any questions for Dr. Arnold?

DR. SAHLOUL: One of the complications of H1N1, which I've seen and many of my colleagues have seen also about at least a month ago increase of the ARDS, severe respiratory -- (inaudible) -- which led to the virus. And I had the unfortunate chance to take care of a couple of young patients relatively in a small hospital who had severe hypoxemia and we were not able to manage them in that hospital because of a hypoxemia or no -- (inaudible) -- outside or ikmo (phonetic), for example, which is one of

the things we can do for patients with severe ARDS. There was a report of increased use of ikmo for treatment of patients with ARDS in relation to H1N1 flu in Canada and the U.S.

I don't know if there is -- there is a plan to address this issue in terms of mapping which centers have ikmo and --

DIRECTOR ARNOLD: I think we need to do that because -- well, the CDC's position right now is that if you're going to try to use the ikmo, you need to have been using it for some time. You need to have the expertise in order to employ it correctly. And if you try to employ it out of -- you know, they're saying that we're going to start doing this. They felt that the risk and benefit ratio was really heavily against doing it. So they said that if you are already using it, continue to use it. But if you are thinking about starting it, they were sort of advising against it. There were a couple of position papers that came out on that.

But I would say that the -- I

think you're absolutely right. We have got to stop reacting against and start thinking about what happens next season when we have this. Because even with the regular flu, I mean, you know, you have 36,000 deaths. Well, 200,000 hospitalizations, conservative numbers.

I think that it would be advisable to do something like that, to start looking at how can we start getting people trained on that and, you know, doing the things that are, you know, are going to be priority in emergency. We do drills for everything, fire drills, and we should being doing ikmo drills, I guess. But yes, absolutely.

CHAIRPERSON McCURDY: Well, thank you very much. You may have to make tracks.

DIRECTOR ARNOLD: I'll be fine.

DR. KRUSE: So the State Health Improvement Plan planning team has had a lot of activity over the past few months. The full plan team met on October 21st and again yesterday on December the 9th. Four

subcommittees were formed and those four subcommittees have met by telephone at least twice. And so they were formed in response to a forces of change assessment and then looking at the ten priority areas from the SHIP plan from 2007. That all occurred in the October 21st meeting.

So these subcommittees are: One, state health profile; two, forces have changed; three, statewide themes and assessments; four, public health system assessment.

A variety of documents were examined by each of those subcommittees, and then they did some updates on the 2007 recommendations and then added 2009 additional refinements. So those documents were brought together for the December 9th meeting, and there was a report from one member of each group to start the meeting, but the major portion of the day was small group activity.

And then the small groups

there was -- there were members from each of the various subcommittees that sat on any one small group. So those small groups were charged to look at the 2009 findings, the 2007 updates and then to look at commonalties in those reports to see how they came together.

The interesting thing was that in each one of those groups the groups kind of took a different approach. They did the -- they certainly did the work, but they fairly independently came up with some themes that will probably dominate the rest of the work for the SHIP.

So we spent a fair amount of time looking at the ten priority from 2007 and one of the themes that came up is why are some things not on that list of the top ten priorities -- not top ten. There are ten priority. There is no top to it, actually. And these other things tend to be buried in the report and should they make it into the titles or a priority of their own.

So the things that will be considered as the planning process moves forward are mental health, maternal and child health, and chronic disease. Those things are not in the title of those ten things. Again, they are in the report, but they are not a category unto themselves or in the titles. There is -- one of the ten priorities is data.

And one of the things that came out was should actually electronic health records and health information exchange systems be a part of that title as well, so it achieves a significant priority status. That was one theme.

The second theme that came out was what we've heard about a couple times today was should there be the development of an over-arching framework for what SHIP does. How do we think about this? How do we organize delivery? How do we recognize -- how do we recognize that? And it actually --

CHAIRPERSON McCURDY: How is that

different from what was before?

DR. KRUSE: You know, it's a little bit different in that it received a lot more attention. Previously it was a series of priorities and recommendations that just went out there for people to see. You know, this one is what is the framework for the delivery of public health and the delivery of health care in the State of Illinois and how can examining that and doing some things that are efficient and effective actually make all of these other things occur more efficiently and effectively or even naturally in some cases, if you do that.

So a number of the groups got to the discussion which relates to the document that we, the State Board of Health, approved in our last December meeting one year ago that had to do with the organizing frame work, the organization of health care delivery. And it just relates to, again, bringing together public health, mental health care organizations, primary care practices and community care

organizations to cover the population and identify the people at the highest risk and to focus on starting to deal with the top ten or the ten priorities as well.

DIRECTOR ARNOLD: That's an extremely, extremely important point. With the FQHC's, the ATH's, all these things that are going on right now that -- I mean, nationally you're talking about the structure -- (inaudible) -- so we definitely need to be on the table.

DR. KRUSE: Well, what came up over and over in the reports, the word "fragmentation" kept coming up over and over. So this was seen as a method of making a statement about decreasing the fragmentation. And so I don't know how that will filter down, whether it will be a priority area or whether it will be some opening statement or something like that, but it certainly became one.

And then the third major theme that came out over and over again was how do we -- how do we implement it this time. What

recommendations do we make about implementation. How does this have more teeth than it had in the past.

So one of the ideas was, is that the State Health Improvement Plan should make specific recommendations to specific groups. The Governor or the administration should. The legislature should. Hospitals should. The Illinois Hospital Association or the icon should. Insurance companies should. Medical schools should. Nursing schools should. Community colleges should, etc. And try to focus on which one of these things can be, in essence, handed to somebody and say this is an important thing for you to do.

Now, one of the big discussions was, is how practical should we be. Should we try to assess which of these things should be done given the current budget status or should we make recommendations based on what we think is the best public health care system and best health for the people of Illinois.

And so, you know, balancing those two things will be a little bit -- a little bit of a task for the State Health Improvement Plan, but I think they are up for that, as a matter of fact.

So, in response to that, a fifth subcommittee was formed, the Implementation Subcommittee. And the Implementation Subcommittee will meet next week prior to the next meeting of the whole group, and there is a fairly aggressive meeting schedule for the entire group. January, February, April the entire group will meet, and public hearings will occur in May, we think, and then the final meeting of the whole group to incorporate public comment and finalize the plan is Monday, June 7th.

So, Ann or David, if you would like to add to that.

MS. O'SULLIVAN: I think you did an awesome job summarizing it. I would say there was cheering around the room over the idea of an

implementation plan, an implementation group even to the point where, I forget if it was you or Elissa requested, did anybody have a degree in planning and we would go forward from there.

MR. CARVALHO: They were trying to cajole one person who did have a degree in planning to join.

MS. O'SULLIVAN: Oh, all right. I missed that part.

MR. CARVALHO: Yeah, he raised his hand.

MS. O'SULLIVAN: All right.

MR. CARVALHO: The next step was that if anybody named Russ wanted to join the committee.

MS. O'SULLIVAN: All right. I did do that.

MS. PHELAN: Did he tell you?

MR. CARVALHO: Yes, he did.

MS. O'SULLIVAN: So anyway, it was a very lively meeting and I think that's been the one frustrating part of what's happened since

the last SHIP plan is how to get it, you know, to the implementation. We're at about the same place as we were when we developed that.

MR. CARVALHO: And since I said it in those meetings, I'll say it here, too, there's a ying and yang to implementation in the plan. If we are 55 good citizens expressing views on what ought to be done, that's what will be in the plan, but the implementation won't happen. If we are thinking about the stuff in there actually being implemented, then all of the folks who will be necessary to implementation will have perhaps a different thought to what should be in the plan.

So, for example, the last plan, if it said local health departments will all do XYZ and local health departments knew that was sort of reportatory, then local health departments nod at those provisions in the plan.

If there is a mechanism by which local health departments will do what's in the plan, their interest in the provisions of

that plan will elevate as well. So having the discussions about implementations simultaneous with the plan is essential because you can't switch and bait or bait and switch. But you also can't implement something that's not implementable.

So, it's great that we are doing it at the same time, rather than the first plan when we did it all after the fact and that didn't work.

DIRECTOR ARNOLD: Doesn't that give you basic physics talk on, you know, how a ship works. All the boards are nailed down together. So we have to make sure all the boards are --

MR. CARVALHO: And the other thing, as Dr. Kruse talked about, additional things that were being added. The other point we want to be mindful of is -- the expression I used was this is a priority plan, not an encyclopedia. So if we get to a plan that lists everything that anybody thinks should be an issue about health over the next four years, then it's no longer a

priority plan. It's an encyclopedia and the implementation becomes that much more difficult.

DR. KRUSE: I didn't mention that part of the next step before January was starting to prioritize some of these things, even to the exclusion of some or lumping of some, but just getting the terms right to give the right direction that really the SHIP wants to recommend to the State Board of Health and to move forward with the plan.

DR. EVANS: Dave, as though the discussion goes towards more tangible emphasis on implementation, what's the practical reality of tracking that implementation and having a record when the time comes of how many times you flapped your wings and did you fly where you wanted to fly to?

MR. CARVALHO: Well, that will need to be built in, although what I thought you were going, which is even more challenging, is funding implementation.

DR. EVANS: Well, that's meant in

practical reality.

MR. CARVALHO: It's probably easier to track than to fund. In fact, just a little example, at the same time the folks were talking about we need more data on this and more data on that. I had -- you know, the sad coincidence in timing to note that there's a particular data stream that our funding is reduced on, and we are actually precisely at the same time thinking about how are we going to cut back on that data stream. So funding is tied to everything.

DIRECTOR ARNOLD: And there is one thing that -- you know, there's a mantra that's coming up in the federal level, and I think it's coming up in the state level too is no metrics, no money. And you know, I think the best practices is that there has to be a focus here on best practices so that there -- but not just in our eyes but best practices in the eyes of the Federal Government, the CDC. Because their funding streams are going to come out and they're going to be looking for best practice

states, you know, how you're doing things. So if you want to tie it to implementation funding and metrics, we're looking at best practices. And Dave recognized it.

MS. O'SULLIVAN: The other thing, Caswell, is the point of the more that we have coordination of -- around whatever the priorities are the better chance of tracking and funding.

DR. EVANS: Certainly.

MS. O'SULLIVAN: So that was a big point there, too. That to get out of our silos, how many times did we say that yesterday, get out of the silos and see what else is going on and then prioritize based on that, plus collaborate based on that.

CHAIRPERSON ORGAIN: Hi, this is Javette.

CHAIRPERSON McCURDY: You want to chair again?

CHAIRPERSON ORGAIN: Well, before I totally hang up because I've been listening on

line, I wanted to -- and forgive me. I want to say happy holidays to everybody.

But additionally, there is a -- there is a request -- I'm sorry?

MS. BOWEN: Go ahead.

CHAIRPERSON ORGAIN: Okay. There is a request for proposal for regional information centers, and I think that we ought to make sure that whoever is assessed in securing that funding that we make sure that we are intimately connected so that we can deal with our health information needs.

MR. CARVALHO: Dr. Orgain, if you're referring to the regional centers for assistance on electronic health records?

CHAIRPERSON ORGAIN: Yes, I am.

MR. CARVALHO: Okay. I can give you a very brief update on that. There are two applications from entities within Illinois. We, Department of Public Health and HFS, have both reviewed them and offered letters of support on each of them and both of them will work very

closely with the Health Information Advisory Committee that currently is co-chaired by Public Health and HFS.

And, obviously, part of the reason why we're co-chairing it is to be very insistent on public health needs being addressed.

There is an application into the Federal Government also by the state for the funding that is available to states on the development of health information exchanges, and it's basically one of those if you crossed your T's, dotted your I's, you're going to get money sort of thing and I believe the state will be getting about $20 million.

You should anticipate over the next couple of weeks that the Governor will make an announcement about organizing that whole program in the Governor's office working with all the agencies to coordinate the state's efforts on health information exchange.

CHAIRPERSON McCURDY: Any further

discussion, Dr. Kruse?

DR. KRUSE: No, did you have something?

CHAIRPERSON McCURDY: Dr. Forys.

DR. FORYS: In the SHIP concept, ten is a lot of priorities. Usually if a president is elected, they will be happy with one thing in a year and here you've got a lot of balls in the air.

DR. KRUSE: It's a lot. It's an extensive report, and if you have seen the 2007 report. That will be one of the tasks here in 2009 is again really organizing that in a better fashion, so it will be implemented. It's a good plan with a lot of great stuff, but it's one big step.

MR. CARVALHO: Dr. Forys and Dr. Sahloul, hopefully, before we leave today I can give you a copy, a hard copy of the 2007. The SHIP -- the development of the SHIP is one of the responsibilities of the State Board of Health, and we go over some of those, too. But

that happens to be one. But if you want a copy, a hard copy.

Dr. Orgain, before you leave.

CHAIRPERSON ORGAIN: Yes.

MR. CARVALHO: I noticed as I was entering, at first I thought it was rude that I was entering your four meeting days into my PDA while the meeting was going on. But, fortunately, I noticed that the September 9 meeting is the same as the day of Roshashanna, which I think is one of those that starts the night before, but the day of is still a problem, right? Okay.

So you may want to consider a different date. If Thursdays are still good, the following Thursday is the 16th and I've got Yom Kippur starts the 17th. So the 16th is not a problem because the 17th is the sunset start. All right.

So, you might want to consider whether you want to have your meeting on the 16th instead of the 9th.

CHAIRPERSON ORGAIN: Then why don't you all take a vote on that while you're doing it. David McCurdy can take care of that. Just take a vote on it and I'm amenable to whatever date everybody decides on.

MR. CARVALHO: Okay. Thank you.

CHAIRPERSON McCURDY: Thank you.

CHAIRPERSON ORGAIN: Thank you.

CHAIRPERSON McCURDY: Let us complete the SHIP report and discussion.

Dr. Forys, did you have another comment?

DR. FORYS: The 2nd will be better than the 16th.

MR. CARVALHO: I will check that for the holidays. The 2nd next year -- just so you know, next year Labor Day is the 6th. So the second would be the Thursday. Would a Thursday before Labor Day be problematic?

DR. ORRIS: Well, Yom Kippur doesn't start until the 17th.

MR. CARVALHO: The 16th isn't a

problem for him, Yom Kippur. I think there may be a different issue.

DR. FORYS: Are you saying September?

MR. CARVALHO: September.

DR. FORYS: I'm sorry. I thought it was December.

MR. CARVALHO: No, September.

I'm sorry. You wanted to finish the SHIP report.

CHAIRPERSON McCURDY: Well, just to be sure, is there anything else and then we can move to this as a business item?

MS. PHELAN: Excuse me. I'd just like to know. Dr. Kruse, are you on implementation or Ann, are you on implementation?

DR. KRUSE: I am.

MS. PHELAN: Thank you.

CHAIRPERSON McCURDY: And the public hearings in May, there would be probably three of those around the state. Is that the plan?

MS. O'SULLIVAN: And State Board of Health members, probably those of us on the SHIP

are usually the chair of it, since all this comes back to the State Board of Health.

DR. KRUSE: The issue I brought up before was I think that they don't want them to interfere or come at a similar time to the -- (inaudible) -- hearings.

MS. O'SULLIVAN: Right. Keep them separate.

DR. KRUSE: So we don't know exactly that they'll be in May but in that range.

MS. O'SULLIVAN: I think they're looking at March. Is that what I heard?

DR. KRUSE: It's heard they might be moved up.

CHAIRPERSON McCURDY: Well, thank you to all of the SHIP project and carry on. No doubt about it. We look forward to hearing more.

MR. CARVALHO: While we are sitting here, I got an email from Elissa Bassler inviting me to the Implementation Committee meeting. So she's setting them up as we speak,

literally.

CHAIRPERSON McCURDY: When is that going to be?

MR. CARVALHO: I can't read it on the BlackBerry.

MS. O'SULLIVAN: She is supposed to be getting input from all the potentials for next week.

DIRECTOR ARNOLD: That's really amazing.

MR. CARVALHO: It's one of those meeting wizards. We're all supposed to say what dates we can do.

CHAIRPERSON McCURDY: Now by my watch it's about 12:30. Is that what we have? And we still have remaining on our agenda before adjournment, we have a couple of rules to go through.

MS. PHELAN: Are we changing the date, approving the change of the date?

CHAIRPERSON McCURDY: We can go ahead and do that, too, but I just want to be sure

everybody understands we have a couple rules that we have to get through.

So am I understanding correctly that September 16th would be a workable date? Dr. Forys feels it's as good as any other.

DIRECTOR ARNOLD: Excuse me. Thank you.

RESPONSE: Thank you very much.

CHAIRPERSON McCURDY: You're going to miss our discussion about the vaccine rule, but you will hear all about it.

DIRECTOR ARNOLD: Oh, I'm sure I will.

CHAIRPERSON McCURDY: Take care.

I'll entertain a motion about September 16th as a meeting date next year.

MS. O'SULLIVAN: I move.

DR. JACKMAN: Second.

CHAIRPERSON McCURDY: All right. We have a second. Who is the second?

DR. JACKMAN: Jane Jackman.

CHAIRPERSON McCURDY: Okay. Thank

you, Jane.

MS. BOWEN: Dr. Jackman.

CHAIRPERSON McCURDY: Any discussion? All in favor say aye.

RESPONSE: Aye.

CHAIRPERSON McCURDY: Opposed?

RESPONSE: Aye.

CHAIRPERSON McCURDY: Then we are on -- oh, we have one opposition. So we're good on September 16th next year. All right. And not the 9th.

All right. Then let us proceed to the remaining rules, and we already had, as I said earlier, the non-controversial ones, so to speak, so we thought. But now we have a couple where there was considerably more discussion. In one case because of length and in one case because of time penalty we'd say.

But we have the remaining rule on the Regionalized Perinatal Health Care Code. Is Sharlene Wells there to fill us in on that one or somebody else?

MS. WELLS: I'm actually here.
CHAIRPERSON McCURDY: Okay. Oh, hi, Sharlene. Sorry. I forgot your name. Go ahead.
MS. WELLS: That's okay.
CHAIRPERSON McCURDY: And can you speak up?
MR. CARVALHO: Why don't you come over here.
CHAIRPERSON McCURDY: This might be good because this doesn't pick up real well sometimes.
MS. WELLS: Actually, the Illinois Regionalized Perinatal Health Care Code has been in effect throughout outlying and describe the levels of care for maternity service hospitals in the State of Illinois for some time now. And what we've done with the rule is tried to bring the verbiage and the content and practice and trends current. So there was some amendments and some reviews done to that effect.
CHAIRPERSON McCURDY: Okay. Anything

else in particular you would highlight? That's it. Okay.

Well then, as you can see from the summary of the Rules Committee meeting, we had a number of questions, comments and so on, and let me just comment on a couple of those before we throw it open for discussion to others.

One is there is something in here, the third bullet point said there's a question concerning the definition of morbidity. Is it related only to trauma or might we say that it also, quote, from illness or some such, and that's a question that at least so far I don't see answered. Would somebody want to comment on that one?

And by the way, I apologize for not being able to tell you immediately where that is, but the morbidity --

MS. WELLS: It was in the definitions and it was answered.

CHAIRPERSON McCURDY: Okay. I didn't

understand that.

MS. WELLS: Trauma was taken out and pregnancy, related to pregnancy, a particular pregnancy.

CHAIRPERSON McCURDY: Okay. Now, the version of rules that we were sent does not have that. The version of the rules that we were sent still mentions trauma. I'm sorry.

MS. PHELAN: It's actually the same thing in six and seven. Page 6 and 7. Six in the old. Seven in the new.

CHAIRPERSON McCURDY: Yeah, I'm looking at morbidity on page 7, and it does not say what you said.

MS. WELLS: Did Susan leave? Susan, are you there?

CHAIRPERSON McCURDY: Susan, are you there?

MS. MEISTER: I did not get that change.

MS. WELLS: Morbidity means undesired results or complications associated with

pregnancy.

CHAIRPERSON McCURDY: We do not have that in our version. Okay. So I suppose one question is how different is the version that we have received from the version that actually is current? Don't know the answer to that but there is one instance where it's different.

Go ahead, Karen.

MS. PHELAN: I did go through a major portion of them, and they were indeed changed according to our request.

CHAIRPERSON McCURDY: And I know a number were. So I think one place where there was still a question, at least from what I saw was on page 53, the bullet point that talks about visual problems and the example of retinal -- retinopathy, I should say. There is a typo in there where the retinopathy phrase appears again in the second sentence, at least in the version that we have. So I mean, that's something that you can look at. It's on page 14. It's not a major item but that still needs

to be cleaned up, that section.

MS. WELLS: Okay.

CHAIRPERSON McCURDY: And I think beyond that it also says here the action was the Rules Committee wanted to know the source of funding that was mentioned because the language suggested all money that IDPH received for anything. And we actually thought that that was a wonderful provision, but we assumed that that actually didn't mean quite what it said. So I don't know if there is any comment that you would make about that one and maybe that's been -- on page 77(b)(1), for those of you who may not have seen it yet.

Right. Now actually I'm looking at the page numbers. I'm sorry. I said 77 but that's page 82, I should say. There we go. Page 82(b)(1). All new monies received by the department now allocated to perinatal care. So that actually has been corrected; is that right?

MS. WELLS: Yes.

CHAIRPERSON McCURDY: See, it didn't necessarily say that here. So that has been corrected. All right.

And I think we will throw -- I will throw it open to other comments or questions at this point. Yes, Dr. Kruse.

DR. KRUSE: Yes, I have got two things. One is just a general question.

What's the thought about how much administrative burden this might add to what's being done? Will this streamline things, make it better or will there be more administrative work?

MS. WELLS: We certainly thought it would streamline things.

DR. KRUSE: That's good.

Then my comment is specifically on page 19 in section 640.41, part B(3) and I would say that this -- this same language also occurs on Page 30 -- excuse me, 30 on page 69.

CHAIRPERSON McCURDY: The hospitals

having the capability for continuous maternal fetal monitoring.

DR. KRUSE: Yes. Hospitals shall have the capability for continuous electronic fetal monitoring. The last sentence in that section says, "Physicians and nurses shall complete a competence assessment of electronic maternal fetal monitoring every two years."

Now, I have a couple of comments about that. As time goes on, more of these special competency things are coming out. Now we just did one on disseminating intravascular coagulation in pregnancies.

And I think that we have to carefully consider when we make a recommendation like this. First of all, that it's an important recommendation is a clear thing. Electronic fetal monitoring has been present in widespread use since the 1970s. The interpretation of the patterns has not changed significantly over that time.

It's been clearly shown that

electronic fetal monitoring for low risk pregnancies is not necessary in any sense. For high risk pregnancies it's been shown that it identifies the infants that are at high risk for poor outcomes but has never shown that intervening because of electronic fetal monitoring has made a statistically significant difference in outcomes. It may for one individual but not another.

What I'm trying to say is that this is not a highly critical medical intervention and it's one that hasn't changed over a period of time. So requiring a course or recertification, a competency assessment every two years, in my opinion, should not be in these recommendations.

I think there are many other things in medicine, many, many other things in medicine that would reach that competency assessment need before electronic fetal monitoring interpretation would.

CHAIRPERSON McCURDY: And the

consequences of not requiring this would not be significant for the patients that are involved; is that right?

DR. KRUSE: Well, I won't speak from the nursing standpoint, but from the physician standpoint and obstetricians and family physicians who perform -- do maternity care, in maintenance of certification there is a requirement to continue to meet education in realms like this. And I just recertified a few months ago and there was plenty of this on that test, as a matter of fact. And I would think it's probably the same for neonatal nurses and maternity care nurses. I don't know.

MS. O'SULLIVAN: I don't know for a fact. My question would be what are the national standards.

MS. WELLS: And that was taken from the standard from the American College of Obstetricians and Gynecologists.

And one thing I would like to address, Doctor, is that we know that fetal

monitoring has changed from the '70s; that things that we thought were taking place back then we now know them to be different and that comes through the advent of this education.

And most of your professional organizations offer the training and the competency is online and changes have been recognized and that's where this clause comes from.

DR. KRUSE: Okay. I will say that there has been some change. I'm just saying that compared to the 1970s in some things in medicine there has been dramatic, dramatic change. There hasn't been that much dramatic change in interpretation of electronic fetal monitoring.

The other thing I'll say is the American College of Obstetricians and Gynecologists' recommendation, that's a professional group. That is not a governmental standard or standard from some regulatory group that makes it absolutely necessary for the State

Board of Health to put this in a plan.

This is a professional organization, and sometimes professional organizations will go overboard with their recommendations. I'm not necessarily making any comment on this one.

But when you separate professional organizations from regulatory or governmental organizations, there's a difference in the way that you might need to do those things.

MS. WELLS: Well, again, we do offer designation and we do designations based on the guidelines and the standards in that blue book, so to speak. So when we go out to facilities, we are going to check to see if they're up to date in their competency on certain things, and electronic fetal monitoring is one of those things.

MS. O'SULLIVAN: Has this been --

CHAIRPERSON McCURDY: Ann, go ahead and then Karen.

MS. O'SULLIVAN: I see this is underlined, so it's a new part of the rule.

MS. WELLS: Right.

MS. O'SULLIVAN: But you said when you go out doing it, you have been checking that.

MS. WELLS: It was before one year. So we kind of made it --

MS. O'SULLIVAN: Like every year they had to show?

MS. WELLS: Every two years. It's every two years now.

MS. O'SULLIVAN: But previously it was every year and now you're expanding it to every two years.

MS. WELLS: Right.

CHAIRPERSON McCURDY: Okay, Karen.

MS. PHELAN: My question is, Dr. Kruse, you mentioned it was located in two places, the fetal monitoring. Where was the other? I'm sorry.

DR. KRUSE: Page 30, Section 640.42(b)(4) and page -- oh, page 50,

640.43(b)(9).

MS. PHELAN: And where does it mention that it has been tested every year?

DR. KRUSE: I didn't see that when I read it.

MS. PHELAN: The change was -- Ann, did you just say --

MS. O'SULLIVAN: She said it was in here.

MS. WELLS: Maybe it was not in here. I'm not really sure. But I know before we asked that they had certification every year.

MS. PHELAN: Okay.

MS. WELLS: What was the other page other than 30?

DR. KRUSE: Page 50. It's the same paragraph. It's identical.

CHAIRPERSON McCURDY: Any other comments on this one from any members of the Board? Dr. Forys.

DR. FORYS: Sometimes professional groups will benefit financially from providing

courses in certain techniques and they definitely have a conflict of interest in some of the recommendations they make.

MS. WELLS: And we don't recommend any particular course. We just recommend some sort of competency. Most people choose A-1.

MS. O'SULLIVAN: But it could be something local at the institution.

MS. WELLS: I'm not sure what Joint Commission requires. Joint Commission does require something to this effect. I don't know if they recommend a certain professional group to do it.

MS. O'SULLIVAN: They recommend competency in whatever you do, a competency assessment.

MR. CARVALHO: I don't often do this, but can I interject from a patient perspective?

I mean, when my wife was in the hospital, we had an incompetent nurse tell her her uterus was rupturing because she didn't know how to read the electronic fetal

monitoring. So if we've got a standard that says at least every two years physicians and nurses have to demonstrate that they're competent in electronic fetal monitoring, I think from the patient perspective that's a good thing.

MS. PHELAN: I agree with you except I'd like to know why it was changed from one year to two and where it is that it was changed.

MS. WELLS: I don't want to misspeak. It may not have been in here, but I know we were asking them to have proof of a year. So it may have been decided to put it in this time with the compensation of checking every two years.

CHAIRPERSON McCURDY: Could it be they were thinking some of things that Dr. Kruse was mentioning in that. So, let me -- go ahead and then Dr. Kruse.

DR. SAHLOUL: What Dr. Kruse is suggesting is to implement basically changes based on evidence-based medicine.

DR. KRUSE: Yes.

DR. SAHLOUL: And if we need to implement that, then it can open a lot of cans to us because we have to be consistent throughout the regulations. So we need to change that to make it consistent with evidence-based medicine, which is nowadays. That may change also, and we need to look at every regulation to see if this was consistent with evidence-based medicine.

CHAIRPERSON McCURDY: One more comment and we -- by the way, we have another rule to consider and 1 o'clock will soon be upon us, so let us keep that in mind.

DR. KRUSE: I'll just say one thing. This is newly added. And so if we're adding something, we ought to consider the evidence.

Now, not everything has to be evidenced based by the strict definition, but that's what I would say about that.

David, in response to your question, if your wife were at low risk, perhaps, she didn't need to have the monitor to

be told that she was having a ruptured uterus at that time. You can go the other direction on that one as well.

MR. CARVALHO: We had a child with a very large head, but I don't want to get too detailed.

DR. KRUSE: That's fine.

MR. CARVALHO: Isn't this provision just saying hospitals shall have the capability? It's not saying every patient shall be subjected to --

DR. KRUSE: Oh, no, no. Hospitals should have the capability. I'm not disagreeing with that. I'm disagreeing with the last sentence. "Physicians and nurses shall complete a competency assessment every two years."

Now, I'll also say this. I have not completed a competency assessment, and I don't deliver babies ever in electronic fetal monitoring. I do it through the terms that I mentioned before, and I just think that this provision will not improve the public health.

MS. WELLS: Well, I think it -- I tend to be more supportive of having this in because we know that patients -- nurses and doctors oftentimes disagree. And if a nurse recognizes a pattern and if that physician tends to disagree with her, and that was the reason for including both nurses and physicians, so there was a joint collaboration in terms of being able to interpret what's going on with the patient.

CHAIRPERSON McCURDY: One more comment and we need to move on to other things, please. Peter.

DR. ORRIS: I'm going to ask my usual question about what's the effects of action, either if we take it or we don't take it here. If we take that paragraph out and solicit more input on that paragraph and pass everything else, does this go on and then get passed? What happens? How do we do this?

MR. CARVALHO: Well, you know, especially since we have new board members, maybe this is a good time to remind everybody

that --

DR. ORRIS: We're just advisory.

CHAIRPERSON McCURDY: That's correct. We pass nothing.

MR. CARVALHO: The statute provides -- we have 42 advisory committees. Some of them -- a couple of them have mandatory jurisdiction and those -- their rules don't come to you. For everybody else their rules -- every other program in the Department, the rules come to you.

And the statutory mandate -- and Susan Meister is our rules person and can correct me if I get this wrong -- is we ask for your recommendations, and we accept those where we agree with them. And where we disagree, we are required to give you a reason why we aren't accepting them. And so most typically we accept them and then occasionally we don't. But then we give you a reason why we aren't.

DR. ORRIS: Where does it go from us?

MR. CARVALHO: It goes from you back

to our legal department to get all the scriveny correct and then it goes to JCAR. When it goes to JCAR --

MS. MEISTER: Excuse me. Then it goes to the Secretary of State and it's published for a 45-day public comment period and then after that it goes to JCAR.

MR. CARVALHO: Right. I was about to say it goes through the JCAR process. I'm sorry.

MS. MEISTER: Right.

MR. CARVALHO: But the JCAR process has two public comments period. JCAR is the Joint Committee on Administrative Regulations, which is a 12 person legislative committee of three people from each of the four caucuses.

DR. ORRIS: Do they have line vetoes? They can take lines out? Or they have to reject the whole thing?

MR. CARVALHO: No. They get -- they have a lot of influence. They can say we won't approve this unless this is changed or we'll

approve this with this change.

DR. ORRIS: So there are several steps where this paragraph can be taken out after us. So if we highlight this paragraph and ask you to solicit opinion of the professional groups concerned with this -- because I took this and I brought it over to County and I said to the neonatal people, anything in this you don't like. And they didn't scream at me or anything, but that doesn't mean they noticed that.

So I would like to take it out and highlight it and solicit comment as it goes ahead. Then I would feel confident in saying, okay, let's send it all ahead. Otherwise -- maybe even saying we're taking this paragraph out and saying we have some question about it.

CHAIRPERSON McCURDY: Okay. Karen.

MS. PHELAN: We did talk about this.

MS. MEISTER: If I could say something.

As far as the public comment process goes, it's much easier to take something

out than it is to put something in. Because adding new language in response to comments during the comment process is seen as more of a substantive change in the process than taking out something is, and it's just easier to put something in and take it out in response to public comment than it is to put it in and not have the public get a chance to comment on it.

CHAIRPERSON McCURDY: So what would that mean in terms of what we're considering? I'm still not quite following you, Susan. That's a recommendation that we do something, I believe.

MS. MEISTER: Well, it just would be easier to leave the language in. See what kinds of comments we get on it, and take it out if the comments indicate that we should do so than to put it in and not have the public know that we put it in.

CHAIRPERSON McCURDY: May I speak for a moment here.

But we could make -- but we

certainly could say we move to forward this, but we want to highlight this area as one that deserves some concern in our judgment. Would that be fair?

MS. MEISTER: There is really no way for us to do that, as far as the public comment process goes, but you can certainly do that in discussion among your colleagues and in encouraging people who will be affected by these rules to read them carefully and to consider those provisions.

CHAIRPERSON McCURDY: Okay.

MR. CARVALHO: If I could -- although maybe he was, I'm not sure David was suggesting that in the Secretary of State's publication but rather -- you know, the action that this Board typically takes is to approve the rule or to approve the rule but ask the Department to look at this or that. Or approve the rule and ask the Department to take this or that out. And I think what you want this board's action to be something that incorporates --

CHAIRPERSON McCURDY: Take a look at this again.

MR. CARVALHO: So, for example, a motion to approve the rule but ask the Department to reconsider this sentence or something like that.

MS. PHELAN: We've done it before, and then you've come back to us.

DR. ORRIS: I think that -- I would make that motion and approve the rule. Ask the Department to look at this sentence again, zeroing in on this sentence, but also ask the Department to solicit comments from professional organizations concerning this.

CHAIRPERSON McCURDY: Which is beyond ACOG, for example, the one they've already consulted.

MS. O'SULLIVAN: Well, I want to see what the other standards are, too. What are the other regulatory in terms of the evidenced based part of it. That's what I would want.

MR. HUTCHISON: I second that motion.

CHAIRPERSON McCURDY: So we have a motion from Dr. Orris to consider this in light of that, and Kevin seconds.

Now, remember we haven't even necessarily finished looking at all the rest of the rule if we wish to do so. So far this is actually a motion to approve the rule as a whole without further consideration.

Are we ready to do that?

DR. VEGA: David.

MS. BOWEN: Yes.

DR. VEGA: This is Tim Vega.

I wonder if this is not a timeline that's already been pre-set or is this something that can be deferred to the next meeting to get further information? Because this was a big document, and I know that there is some interest downstate in this regard, and I haven't had the opportunity to get the feedback that we're talking about.

CHAIRPERSON McCURDY: Susan, what would you say?

MS. MEISTER: This is -- there is no set timeline at this point, but it's just a rule that we have been working on for several years, and we would just like to be able to move forward with it.

CHAIRPERSON McCURDY: The gestation on this one has been long.

MS. MEISTER: Yes. It's way overdue. It's overdue.

CHAIRPERSON McCURDY: Yes.

DR. ORRIS: Dr. Vega, you could still, as we have presented here, I don't know if you heard it on the phone, there is several other bites of this apple that people can take along the way after we give it to the next step. So you could certainly get more input before this thing gets finalized.

MR. CARVALHO: And, again, especially for the new members, you all know that regardless of what you do here as individuals, you can comment during the comment period by submitting a comment and waive the state

publication direct.

CHAIRPERSON McCURDY: We actually have a motion and a second.

Is there further discussion, either on this portion or on other portions before we proceed?

Well, are we clear on what the motion is?

DR. FORYS: No.

CHAIRPERSON McCURDY: So the motion is, as I would understand it, that we would move to forward this to the next level, which of course would involve including reconsideration by the Department of this particular paragraph, which occurs several places in the rule.

DR. ORRIS: That sentence.

CHAIRPERSON McCURDY: Okay. The second sentence in that last paragraph.

DR. ORRIS: The last sentence.

CHAIRPERSON McCURDY: Correct.

MS. PHELAN: Shall I read the sentence?

CHAIRPERSON McCURDY: Go ahead. Read the sentence.

MS. PHELAN: "Physicians and nurses shall complete a competency assessment in electronic maternal fetal monitoring every two years."

CHAIRPERSON McCURDY: Okay.

MS. PHELAN: That's the question.

DR. SAHLOUL: That was the position to remove this request, right, just to be clear about that?

CHAIRPERSON McCURDY: That we want that to be considered. That's what we're saying.

MS. WELLS: The time frame?

MR. CARVALHO: Well, since we choose not to take it out, we're supposed to come back to the Board with the reason for that. I think the rest of your discussion was if we choose to do that you want our explanation to include having consulted with other organizations.

DR. ORRIS: And the criticism was it

was burdensome with no public health benefits. So that would be the response on that.

CHAIRPERSON McCURDY: And Dr. Forys, you wanted to say something?

DR. FORYS: Well, I'm a little confused to what the process is, but I think Dr. Kruse has a point and the discussion would be great. And if someone can show us where the benefit is, then I think we can commit all of the nurses and doctors in the state to go ahead and spend two hours on something that they could be seeing patients, you know, doing more productive work.

MS. PHELAN: I agree. There might be statistics. That's why it was put in. There could have been some complications. There has to be a reason why it was put in, if it doesn't say themselves that it should have been done within one year because it is new language.

CHAIRPERSON McCURDY: Are we ready to proceed to a vote?

All in favor of proceeding as

we have described say aye.

RESPONSE: Aye.

CHAIRPERSON McCURDY: Opposed? Abstentions?

Then we look forward to put this one on to the next level and thank you so much for filling us in on some of the process. It's very helpful.

DR. ORRIS: You've got to understand that we are all sitting at every hospital that we have privileges on giving out enumerable numbers of these kind of competency things right now, all duplicative, all responsive to one or another body, etc. So that's I think what we're responding to.

MS. WELLS: But you didn't address neonatal resuscitation.

DR. ORRIS: No. Fortunately, I don't address that.

CHAIRPERSON McCURDY: Thank you again.

MS. WELLS: Thank you.

CHAIRPERSON McCURDY: We still have

one remaining rule, and this is one that we have to consider. We can't opt out on this one. This is about vaccination and who's here to discuss this with us today?

MR. CARVALHO: Several of us and I need to hand something out. And, again, to put this in context, as I mentioned during my legislative report, the Department went to the legislature to secure the authority to require all health care settings that we regulate to offer to their employees seasonal and novel flu vaccine. We went through a deliberative process here that Dr. Arnold summarized as to why we did not go with a statute to mandate it.

Because we felt that we as a Department getting involved in the issue in each health care setting as to whether they want to mandate it did not put us in the right role and because the issues surrounding mandating are complex and were best resolved at the health care setting level. So we sought authority to require that it be offered, but we did not seek

authority to require that it be mandated.

As part of implementing that statute, it occurred to us, as it has occurred in other states, that if you tell health care settings that it must be offered but you do no documentation to document that, in fact, it has been offered, that there are those out there who might tell you, oh, yeah, we offered it. Everybody turned it down. Or some people took it and some people didn't.

So we also built into the rule a requirement that it be documented that employees declined the vaccine. So you have in front of you a rule that implements both the requirements that it be offered and a requirement that, for lack of a better word, the declination be documented.

In the course of the discussion with the committee, we realized that the way we had drafted it would suggest that not only did you have to document that there was a declination but that the reasons that we offered

in our form for declination had to be the reasons that were available in every health care setting. Which is to say since our reasons included any reason, we were in a back doorway prohibiting mandatory programs which had not been our intent. I could nonetheless fairly summarize the committee's reaction to we like that.

So that notwithstanding, our lawyers went back to the drawing board, and some of you may have picked up at the table -- so if you did pick up at the table, I ask you not to take a second copy because we probably don't have enough -- a draft from Elizabeth and Susan that adds a sentence that indicates that health care settings may choose to develop more stringent policies.

CHAIRPERSON McCURDY: Do they have this in Springfield?

MR. CARVALHO: Our staff do. The people on the phone --

MS. BOWEN: I emailed it to the people

on the phone.

CHAIRPERSON McCURDY: But we probably should read it to them since they may not have seen it.

MR. CARVALHO: So let me read the sentence out loud. It's at the end of the proposed rule.

It says, "health care settings," which is a defined term that basically picks up everybody we regulate, "may choose to develop and implement more stringent influenza vaccination policies, strategies or programs designed to improve health care personnel vaccination rates than those required by this part." And since this part, as I said, offers multiple options for declination, the effect of this one.

Now in the interest of disclosure, because I also disclosed it to the committee, this was our position in the Department and I as an evangelist for this position took this position on a health care

organization that I'm involved with and that health care organization, in fact, did adopt a mandatory policy. So I'm not an evangelist here to protect their policy. I was an evangelist there to implement our Department's policy. Nonetheless, I wanted to put that on record so it would not be --

CHAIRPERSON McCURDY: If you were on the Board, you would recuse yourself.

MR. CARVALHO: I would recuse myself. But since we're down to 59 people in the Department who are -- there's nobody else I could hand off or give it to to explain this to you, so I did explain it.

Elizabeth, is there anything you would like to add to that or does that capture it?

ELIZABETH: No, I think you captured it very succinctly. I would say that we plan to implement this first in the emergency rule and then it will go through the normal JCAR public comment period also.

CHAIRPERSON McCURDY: This would be in the emergency rule right off the bat then, right?

ELIZABETH: Exactly.

CHAIRPERSON McCURDY: By the way, for those of you who are new, Elizabeth is Counsel for IDPH.

MR. CARVALHO: Elizabeth is our lawyer. Susan Meister is in the Legal Department. She is our Rules Administrator. Cleatia is our governmental affairs.

And because this is all new to you, the ordinary rulemaking process starts with us drafting. It comes to you. Goes to notice. Goes through JCAR. Ultimately, nine months later, under the ordinary system, is a final rule.

So we have authority when we think something is an emergency to adopt an emergency rule right off the bat. That is in place for only 150 days. It doesn't go to anybody, but what we typically do in an

emergency situation is adopt an emergency rule at the same time that we bring it to you so that we can start that nine-month process while the short life span emergency rule is in place. And, of course, because this is a statute relating to influenza and we are in influenza season, that's why we determined that there's a need for an emergency rule on the subject.

CHAIRPERSON McCURDY: Okay, Dr. Orris.

DR. ORRIS: Yeah. I think you guys ought to look at it again. I think you're using mandates -- not to practice law and to leave it on your end of the world, but I'm a little concerned about what the definition of "more stringent" is. And if you take it to be what I would consider it, you are now directing -- not directing, but permitting institutions to eliminate medical counter-indications and religious counter-indications for taking the influenza vaccine. And I'm not sure you want to get into that litigation, and I'm not sure that this wording avoids that for you.

MR. CARVALHO: If I could respond to two things.

The litigation that exists to date on religious exemptions, actually, one would not lose. The existing case law is there is authority for public health needs to override religious objections, and I actually have an article on the subject for you, if you'd like.

MS. O'SULLIVAN: David is always prepared.

MS. PHELAN: Thank you so much for that article, by the way.

MR. CARVALHO: And, again, some of you -- those on policy I distributed by email, but I also brought copies for those that were not.

On the medical, I suppose on the one hand we are, but on the other hand right now I suppose people could do that as well. So we are -- we aren't authorizing them beyond the statutory authority they may have now to do something so foolish as to require people with

like allergies to be vaccinated.

MS. O'SULLIVAN: So they could do it anyway?

MR. CARVALHO: Under existing law they could, yes. But we didn't want anything in the rule to suggest that they couldn't adopt a more stringent policy. But in the absence of any law and in the absence of any rule, they not only could. They already have.

DR. ORRIS: I'm not arguing that. There's a New England Journal article on it. But I do think that article, as I recall, rests on the fact that the public health -- the public health necessity trumped the religious situation, etc. That doesn't give blanket authority to public health authorities to decide that this particular intervention trumps it. So I don't think it avoids in any way the litigation around this particular issue for you. I don't know if this --

MR. CARVALHO: But, allegedly, we won't be involved in that litigation. It will

be in the health care setting.

CHAIRPERSON McCURDY: May I suggest that, perhaps, might it be possible to say something like more stringent policies, strategies or programs consistent with existing law and regulation or some such? That would then maybe help cover that.

MR. CARVALHO: I'm the policy guy. Elizabeth is the lawyer. Elizabeth, would that be --

CHAIRPERSON McCURDY: I mean something along those lines, some wording.

ELIZABETH: Consistent with --

CHAIRPERSON McCURDY: Existing law and regulation so that you would be covered and providers who would have to observe those kinds of things that they did in the case of Princeton thimerosal or whatever, if that was an issue.

MR. CARVALHO: As a reminder, existing law requires preferential provision of thimerosal free vaccines to pregnant women and infants under two, I think.

CHAIRPERSON McCURDY: Pregnant women who are employees then would probably be in that category as well, which I think would be an issue. Anyway, whatever it would take to address all of it.

ELIZABETH: I think that's doable.

MS. MEISTER: Yeah.

MS. PHELAN: I think the addition was great.

MS. O'SULLIVAN: That was my question. I heard some preliminary discussion as we were convening today about this in relationship to your deliberations and that's exactly what I wanted to know, too. Is this what you guys were looking for?

MS. PHELAN: Yes.

CHAIRPERSON McCURDY: Actually, we were not. I will say that we in the Rules Committee had some division in the house about this.

MS. O'SULLIVAN: All right.

CHAIRPERSON McCURDY: I think we have

some, I mean, frankly as the world does, different feelings about, A, mandatory vaccination, whether that's a good thing and there's differences of opinion about that, but then also whether this should be explicitly addressed in our rule or not.

MS. PHELAN: And our concern was that if hospitals had already mandated their staff, then what were we doing to them by saying just offer it. Just offer it and you can back out of it.

CHAIRPERSON McCURDY: Some of us thought we should go ahead and add this and some of us thought we shouldn't. So that's kind of where that came down.

Yes, Dr. Forys.

DR. FORYS: Could we change the word "part" to "amendment" so it's more English?

MS. MEISTER: No, that's a technical thing. It's not an amendment.

MS. O'SULLIVAN: She knows it. Just do what she says.

CHAIRPERSON McCURDY: She knows it.

Okay. Now, this of course is not the only provision in here, so this is the one that's going to get our attention and rightly so, but are there other things that people want to be sure to discuss.

I will simply call your attention to the rules summary, Rules Committee summary on this. We changed some language. For example, the word "accepted". We changed the declination of the vaccine. I mean, other than that, the changes we asked for are in here, as far as I can see.

So in light of that, I guess the question is -- the first question would be does somebody want to move the amendment, and then if we get the amendment in there, then we'll go for the rest of it. Yes, Ann.

MS. O'SULLIVAN: I move the amendment.

CHAIRPERSON McCURDY: Is there a second?

Further discussion?

And they're considering that other phrase that we talked, about as I understand it. Well, then all in favor say aye. Oh, wait a minute.

MS. PHELAN: She didn't hear it.

CHAIRPERSON McCURDY: Well, let me clarify for you. We suggested language something like --

MS. PHELAN: She just didn't hear the second.

CHAIRPERSON McCURDY: Oh, she didn't hear the second. Dr. Forys second.

Further discussion?

All in favor say aye?

RESPONSE: Aye.

CHAIRPERSON McCURDY: Opposed? Nay? Abstentions?

Okay. So we would move to include that in the rule that we will now look at in total.

So we're adding this amendment to the rule in the appropriate place, which by

the way I can't tell from here exactly where the letter F would go, but we assume y'all in Springfield know where that ought to be.

MS. MEISTER: Yes.

CHAIRPERSON McCURDY: It goes after some E, so...

Then for the rest of it, any further comment? Anybody want to move adoption?

MR. HUTCHISON: I move for adoption.

CHAIRPERSON McCURDY: Kevin moves adoption.

DR. ORRIS: Second.

CHAIRPERSON McCURDY: Dr. Orris. Further discussion?

All in favor say aye.

RESPONSE: Aye.

CHAIRPERSON McCURDY: Opposed? Abstentions?

Then we've covered all the listed business. Is there further business before we adjourn? David.

MR. CARVALHO: Just to bring to your

attention, in my legislative report I forgot to tell you there was another Bill passed that you'd probably be interest in.

Senate Bill 2043, we refer to it as the data sharing bill, and before you get excited it's not sharing data with you.

CHAIRPERSON McCURDY: Or about us.

MR. CARVALHO: Or about you.

It's requiring various health departments to put all of their data into the data warehouse that HFS maintains, and the legislative intent was that HFS could better develop plans for maternal and child health purposes, if they had data from all the other agencies resident in one place. And so that Bill compels us to put certain of our data in there.

The big bugaboo was the issue of confidentiality. We had -- as you know, we are happy to share data as long as we don't violate anybody's individual confidentiality, and we know how to do that. We were a little

worried putting it in somebody else's computer where maybe they didn't know how to do that. And so we have already reached the skids by having our Division of Epidemiology person starting trainings over there on how to ensure that confidential data is not released in anticipation of that Bill going into effect.

But at the end of the day, the power within that data warehouse at HFS will be able to be used for these data, and I thought you would be interested in that.

CHAIRPERSON McCURDY: Thank you. Yes, Kevin.

MR. HUTCHISON: I had sent a communication to Dr. Orgain, and she had to leave, but it's regarding an old business issue. This is the funding to local health departments, local health protection grants specifically for core services of infectious disease control, food safety and the like.

Dr. Arnold and the staff here have done a Yeoman's job last fall in the

legislative session of restoring that funding. The reality is, although it's in the budget, none of that money has been paid to local health departments.

Specifically, I forwarded information, and perhaps we can send it out to other members of the Board, Vermillion County Health Department. So it's not a small county health department, about 90,000 people. Danville is the county seat.

The county board is holding a meeting this month to consider, among other things, the decision to eliminate the county health department services because county boards are being forced to bankroll services to the State of Illinois that the State of Illinois isn't paying.

You heard Dr. Arnold mention 96 health departments across the state were the tip of the sphere on dealing with H1N1, food safety and a lot of other things. So I know this Board is aware of that issue.

The request that I made for Dr. Orgain and for this body is to, No. 1, we know the state health department -- we've heard this many times. Their staff is decimated or eviscerated may be a better word in terms of their capacity to pick up health protection services should local health departments be forced to close. Many have laid off. Many have reduced services and this is statewide. We know that there's a chain of protections.

Specifically, if it would be appropriate, I've had a request from the administrators of the Vermillion County Health Department for a letter of support from the State Board of Health. If it is appropriate, and maybe, Dave, you'll have to think about this, so to the County Board Chairman of Vermillion County, the State Board of Health going on record supporting the role of local health departments and encouraging them to continue to provide at least interim funding to keep the lights on at this certified health

department, my words, not his.

But there is -- the second thing is I would make a motion that our Board -- again, we have already gone on record supporting this. But, perhaps, a letter from the Chairperson of the State Board of Health. I think this should go to our Governor and elected leaders or the leadership. Dr. Arnold already supports this. He's already went to the map supporting the local health protection grant.

There's a lot of other funding we're not getting and that's not -- that's not an issue. We get it. Funding is a crisis throughout Illinois. Moms and babies' services and a lot of other things. But right now no funding has been received. We have gotten some funding from the Federal Government. We hope to. That's the only thing keeping us on the fronts lines of H1N1 or we wouldn't be doing that, if it wasn't for federal dollars because there is no local dollars.

So that's our plea. Two

parts. No. 1, a letter of support to Vermillion County Board, if appropriate, and a letter from this Board at least advising and making known of this urgent situation to the Governor and the elected leadership.

DR. KRUSE: I second that.

MR. CARVALHO: And I have a finesse that I think will get around it and board members might not know what Kevin is alluding to but everybody else has heard it a lot.

The jurisdiction of the State Board of Health is to advise the Director. So, typically, the State Board of Health isn't advising other people. But a finesse for this purpose would be for you to recommend to the Governor -- I'm sorry, to the Director that he convey to the Governor your concerns, and then I'm sure he'll be happy to do that. And similarly, to recommend to the Director that he convey to the Vermillion Health Department your concerns, and then I'm sure he would be happy to do that, too.

MR. HUTCHISON: With that caveat --

CHAIRPERSON McCURDY: We wouldn't be drafting letters here but that would be something --

DR. EVANS: Well, I mean recognizing -- and not to diminish the immediacy of the problems of the Vermillion Health Department, but the same issues are playing out in all of the other health departments.

So, perhaps, that wording could be expanded to be specifically pertinent to Vermillion but have it in the context if we sent it to all health departments because the message and the risk is the same.

MR. CARVALHO: Actually, I interpreted what Kevin wanted us to do is to convey -- for the Director to convey to the Governor the concerns of all local health departments about the non-payment on this and then specifically to also convey to the Vermillion Department because their board is literally considering this right now. Should we become aware of other boards

considering abolishing their local boards of health, I would assume you would want us to convey the same concern.

MR. HUTCHISON: And the subpart of that letter would be to encourage through Dr. Arnold and the Governor to expedite payment of the local health protection grant.

Typically, it comes in two installments, six months at a time. We haven't had any and so that that -- we know. We get it that the State's broke, but we also get it that the State does have money and public safety and other things are being funded.

And if we -- the fire isn't going to spread from Cairo to Cicero, but infectious disease will, and that's what we are talking about, a statewide public health system, a chain of protection, that when one link breaks we are all vulnerable.

MR. CARVALHO: And would someone from the Board of Health like to be the initial author of such a letter?

MR. HUTCHISON: I would be glad to help.

CHAIRPERSON McCURDY: So we have a motion and a second. Do we have further discussion?

I would guess, Ann, this probably would also be something that the Policy Committee in an ongoing way might have an interest in helping.

MS. O'SULLIVAN: Sure. And the only other comment I wanted to make, not to detract at all from the health --

CHAIRPERSON McCURDY: We aren't voting yet but go ahead and comment.

MS. O'SULLIVAN: -- is the same thing is going on with acute care facilities. I mean, bankrolling the State and the services that are declining and the services to the uninsured, etc., etc. But I don't want to detract in any way whatsoever from the current motion.

DR. EVANS: Is there not though sort of a legal issue involved here? I mean, if an

entity has paid a fee for its licensure accreditation, oversight, whatever the State service is, it has paid for that. It has paid for the service, but if the service cannot be provided at the local level -- let's say a restaurateur pays for their restaurant licensure and examination and then the examination cannot be provided, the restaurateur has a legitimate claim that they have paid for a regulated service that then cannot be provided because the regulating entity has gone out of business. I mean, I have personally lived through that one.

CHAIRPERSON McCURDY: Put that in the letter. Yes.

DR. EVANS: I think that's a real issue for health departments.

CHAIRPERSON McCURDY: Let us go ahead and vote. All in favor?

RESPONSE: Aye.

CHAIRPERSON McCURDY: Opposed? Abstentions?

MR. HUTCHISON: Thank you all very much. I appreciate it.

CHAIRPERSON McCURDY: Then thank you, Kevin, for being willing to do this and meeting 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 1st day of February, 2010.

_____

DONNA T. WADLINGTON
CSR #084-002443