ILLINOIS DEPARTMENT OF PUBLIC HEALTH

STATE BOARD OF HEALTH MEETING

Thursday, June 11, 2009

11:00 a.m.

160 North LaSalle Street

5th Floor

Chicago, Illinois

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

BOARD MEMBERS:

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

ALSO PRESENT:

MR. DAVID CARVALHO
MR. HAROLD DUCKLER
MR. JIM HARVEY
MS. CLEATIA BOWEN (via phone)
MS. SUSAN MEISTER (via phone)
MR. BILL BELL (via phone)
MS. PAULA ATTEBERRY (via phone)
MS. KAREN SINGER (via phone)
MS. RUKHAYA ALIKHAN (via phone)
MR. JONATHAN GUNN (via phone)

CHAIRMAN ORGAIN: I'm going to call the meeting to order officially, since we weren't connected in Chicago before and our court reporter hadn't begun.

It's official -- it's officially beginning now, and I need a roll call of everybody who is on line to say who's on line.

DR. VEGA: Tim Vega.

MS. O'SULLIVAN: Ann O'Sullivan.

DR. KRUSE: Jerry Kruse.

DR. JACKMAN: Jane Jackman.

MR. HUTCHISON: Kevin Hutchison.

CHAIRMAN ORGAIN: And then everybody who is here can you just start.

DR. WHITELEY: Herb Whiteley.

MR. DERKS: Steve Derks.

DR. EVANS: Caswell Evans.

MR. HARVEY: Jim Harvey.

MR. McCURDY: Dave McCurdy.

MS. PHELAN: Karen Phelan.

CHAIRMAN ORGAIN: Myself, Javette

Orgain.

MR. DUCKLER: Harold Duckler.

MR. CARVALHO: Dave Carvalho.

CHAIRMAN ORGAIN: Now, we can just go on and start from the top in terms of the agenda. I apologize. We'll work on connectivity here in the future.

David, why don't you begin please. Dave Carvalho.

MR. CARVALHO: Okay. Well, everything is just going swimmingly in Springfield. As most of you know, we are in sort of an unsettled situation in multiple ways.

As a reminder to those of you who don't live with this all the time, the Illinois fiscal year starts July 1, and several years ago the legislative deadline was moved by constitutional amendment from June 30 to May 31st, so that you didn't have a situation many of you remember from years back where if the legislature didn't do the budget, we were in a budget crisis the very next day.

So the way that our Constitution works, it doesn't say the legislature must do their legislation by May 31st. It simply provides an incentive by saying that any bill to be immediately effective must pass before May 31st, if it receives a simple majority, or it requires a three-fifths vote after May 31st. So the consequence of moving past May 31st without a budget in place, the budget being the most obvious bill that requires immediate effectiveness, is that any budget will require three-fifths majority in both the House and the Senate.

And that's why from time to time when you see bills that aren't effective until, for example, sometime next year, they can pass with the majority vote without regard to the legislative deadline. But any bill that is written to be immediately effective, and the budget is the big one, has to have a three-fifths vote if it's adopted after May 31st.

The political dynamic of a three-fifths vote in addition to being a lot of people is that if anything were to be done on a partisan basis, there are just barely three-fifths -- one over three-fifths Democrats in the Senate and one under three-fifths Democrats in the House. But clearly, that large representation in both chambers were insufficient to get common ground on a budget before May 31st, and they are now in the position of needing a bipartisan majority to get a budget adopted after May 31st.

In the light of -- or in the face of these numbers and the situation, the legislature did adopt some budget-related bills, all of which are in some unprecedented postures in the sense that normally a bill passes both chambers and then it goes to the Governor. But all of the bills have been held on parliamentary procedures by votes to reconsider motions to reconsider and so the bills actually haven't been sent to the Governor.

But those bills, if they were sent to the Governor, would do the following in broad brush. They would preserve the appropriation authority for any federal funds in the state budget. They would preserve mostly the appropriation authority for any special funds in the state budget, but they would only provide 50 percent of the level of funding for -- I just misspoke.

They provide 50 percent of the level of funding for special funds in the state budget and 50 percent of the General Revenue Funds that are not personnel. The technical term people use is lumps, which is short for lump sums.

And if you've ever looked at our budget, you will know that some of our budget will say X for personnel in the division of thus and such, and Y for supplies, and Z for telecommunications and A for this. And other parts of our budget will say a million dollars to the Patient Safety Division. And then that

can be spent in any number of ways.

So the lump sums were -- the expressed intent of the legislative action was to preserve the funding for all personnel and to have the funding for the lump sums. And when I say preserve the funding for the personnel, it's only for six months, and I don't know if it was a stated theory. But certainly the observer's theory is that if you funded state government with adequate resources to exist for six months, the legislature could come back on January 1st.

The way the Constitution works is that starts the clock ticking again for purposes of that three-fifths vote requirement. It would be back down to a simple majority and after the deadline for people to file in primaries which occurs relatively early in the fall or in the middle of the fall. It might be easier to assemble the sufficient votes in the legislature to take care of the rest of the budget.

This may be getting into

inside politics but the thought is, as you probably know, if you've ever looked at a legislative map, there are only a handful of districts that are truly competitive. Most districts are totally Republican or totally Democratic and so those members who sit in the districts that are on the edge, sometimes referred to affectionately as targets, are the ones who are most unlikely to vote on anything very controversial. But the members who sit in districts that are safely in one party or another know that the real election for them is a primary election where they potentially could be challenged by someone in their party and whoever wins that primary is odds on favorite to win in the fall.

So the calculation is that the members who are in safe districts but still not comfortable with voting for the difficult things that need to be voted on in the budget would be satisfied to wait until after they see whether they have a primary challenger file in the

middle of fall for the February primary. And once they know the lay of the land, then they can decide whether or not they feel comfortable voting for a difficult set of measures to balance the budget.

So that's the situation. Last week we had the unpleasant task on Tuesday of pulling together what would our budget look like with a 50 percent cut I mentioned. And then on Wednesday it was determined that although the stated goal of the legislature was to provide sufficient funds to fund all the personnel line items, that in fact they had passed something that required full funding of the pensions as sort of their statement that the bad old ways of the past of not fully funding the State's contribution to the pensions that those days were over. So they hadn't included the money in their budget to pay for that payment.

So on Wednesday the exercise was to look and see what would 25 percent cuts in personnel lines look like because that would

provide sufficient funds to pay for their determination to fully fund the pension contribution.

Department of Public Health is an unusual situation. Oddly viewed by other state agencies as lucky because the majority of our funds are not General Revenue Funds. The majority of our funds are federal or special funds. And so the dollar amount and the percentage amount of our budget that we have to figure out how to cut that relates to GRF is proportionately smaller.

Now, as you know, we are an agency of about 200 semi-related programs and hard pressed to say which of those programs aren't important. And as you know in my office there is vital statistics and, you know, I skipped a heartbeat when somebody suggested, well, maybe we should just have asterisks for our data in 2010. But when you're weighing it against, you know, life maintaining drugs for people on HIV or with HIV or AIDS, when you're

weighing it against inspections of hospitals for when complaints come in that related to imperil or endangerment of patients or of nursing homes, those are pretty daunting trade-offs.

The legislature and everybody always like to use as a tally how much federal funds are captured, and so they crafted a budget to ostensibly ensure that all federal funds were fully appropriated and all federal funds were captured without necessarily fully taking into account that oftentimes you have to put up money to capture federal funds. So the Medicaid program, you know, at its most basic is a 50 percent match so you can appropriate the full amount but somewhere the GRF component of that 50 percent match has to come in. Some of our federal grants require matches of varying amounts.

And so if you were to stay true to the notion that you've got to put in your budget everything that would allow you to capture all your federal match, that means there

is that much less of your budget that has to bear the brunt of your GRF cut.

If I said that in a complicated way, if you're expecting to capture a billion dollars of federal money and you need a billion dollars of your GRF dedicated to capture it, then you have a $2 billion GRF budget, then all of the cuts have to come in the other half of that billion dollars.

There is also the stated goal of ensuring that we capture all of the ARRA money. It's not clear that the legislature has thought through what that means, and I'm sure there's some metaphor that I can use weighting to a neutron bomb.

But if there is nobody to around capture the ARRA money, if the staff have all been wiped out in cuts, somebody has to actually apply for it and some of it does have maintenance effort provisions. Some of it has state contribution provisions.

And so the challenge in

preserving all the federal funds and capturing all the ARRA funds -- I think I've probably gone on long enough for you all to conclude that this is a wholly unrealistic scenario.

But until three-fifths of both sides of the legislature conclude it's a wholly unrealistic scenario, half of the State Board of Health is in Springfield but none of the legislature is.

So that's clearly the most pressing thing on our agenda today. It really pushes off many of the more interesting things one would like to talk about, the fairly successful response thus far to the H1N1 flu. I think the public health community as a whole, the local health departments and public health, the State Department of Public Health really performed very well.

While the particular pathogen was not necessarily the one everybody prepared for, probably it was more thinking about a bird flu and more thinking about a more virulent

influenza, nonetheless the training and the -- they don't call it games. What do they call them?

DR. McCURDY: Exercises.

MR. CARVALHO: Exercises. Thank you.

Exercises were very similar. And if there is somebody in Springfield who can give better numbers that I can, they should chime in. But I think we had the product that we wanted to place out into the local health departments for distribution to hospitals and the like. I think we had it out, you know, 16 hours after a decision was made to move on that, and we learned a lot from it.

There is an after incident report. It's probably -- after incident is maybe being a little hopeful. It's probably mid-incident. But, nonetheless, there is after incident reporting going on and a few lessons learned.

I know one that I was particularly interested in is not everybody

agrees, for example, on what kind of information ought to be disclosed about a case. We at the State Health Department think that depending on the geography because of the ability to un-deidentify somebody or to identify them that unless you are in a very large geography you really shouldn't go beyond gender and age bracket, so youth, adult.

And some local health departments had a more expansive view and we had a case book example of one health department used a slightly more expansive view, and a local newspaper put two and two together with an obit that they saw in the newspaper and the information that had been provided by that local health department in another jurisdiction, and they specifically identified the person.

So that's something, hopefully, we'll get a little more consensus on going forward about how to identify. Newspapers of course, you know, want the person's dress size. And we may be involved in some tangles

with newspapers.

So H1N1 had really been the story of the day. It would have been the story of two days except a funny thing happened on the way to the budget. I'll stop there. Yield to any questions or let you get on with your very substantive agenda.

CHAIRMAN ORGAIN: Any questions from Springfield?

RESPONSE: No.

CHAIRMAN ORGAIN: What I needed to do --

MR. HUTCHISON: Dr. Orgain, this is Kevin. I had a question if I might.

CHAIRMAN ORGAIN: Please.

MR. CARVALHO: Kevin was part of the local health departments that responded brilliantly to this situation as well.

MR. HUTCHISON: Well, thank you, David.

I think Dave accurately reflects the coordination between state and

locals, but I would just echo on for record, and I think it's representative of many of the groups that are on the State Board of Health, that working with our local physicians and hospitals and medical providers, it really -- and I think our experience in our county was mirrored across the state. I think there was a real benefit in relationship to the training and the preparation that we had for pan flu over the past few years.

With that I would like to link the budget issue with H1N1. David, as you know, and other members may know, that the Local Health Protection Grant is fully funded out of General Revenue Funds. It's essential to support disease response but food safety and water safety and some other core services, including the Health Department's ability to do population-based services, you know.

It was almost at the same time we were dealing with the H1N1 we were on the tail end of the peanut problem that was

happening nationally with peanut butter recalls and peanut product recalls and doing field surveys of establishments to make sure those products were pulled off the shelf, etc., etc.

So we have an ongoing need to preserve infectious disease control services, food safety, water safety issues, while we were dealing with the H1N1 situation.

So when we are looking at the possibility or probability of this -- of some types of reductions in the General Revenue Funds, I think I could speak on behalf of not only our department but most all, if not all, local health departments, we're very much concerned about preservation of the Local Health Protection Grant, specifically.

But also, Dave, if you have any insight of what might be coming out of the Federal Government. I know there is some movement afoot at the national level and perhaps as to whether groups may be involved in looking at resources. And we may be needed for mass

vaccinations programs in the fall and parallel to that, Dave, again, maybe this is a research question.

But if you -- what is the source of funding in the Emergency Powers Act, any emergency fund in the State Health Department? Is that going to be funded in order to enable both state and local health departments to maintain and mount up a response to H1N1 in the fall?

MR. CARVALHO: Sure.

MR. HUTCHISON: That's the end of my question.

MR. CARVALHO: And I won't get them all in the first pass. So let me take a first pass and then double back to anything I missed.

We have identified the Local Protection Grant as something whose reduction would have all the negative impacts you described and more. Because if one of the goals of the exercise is, for example, to preserve the ability for the state to capture as much ARRA

funding as possible, one of the few pieces of ARRA funding right now -- and actually, I can go through ARRA at some point if you'd like; ARRA being the stimulus bill.

One of the few pieces of ARRA funding that we know is coming is increased vaccines. But as everybody in the meeting knows, we are a conduit for the vaccines. We don't administer any vaccines. We are a conduit and make arrangements for the local health departments.

And if they have been -- decimated even isn't the right word because decimated means only one-tenth. If they have been, you know, quadridecimated by a loss of local protection money, their capacity to do anything with the vaccines that we capture under ARRA is going to be very problematic, let alone their capacity to deal with the probable or anticipated bounce back of H1N1 at some time later this year.

All of those things are

potentially very bad, and it doubles back to -- I guess I intimated it and I'll be more explicit. What we are seeing is, presumably, a posturing going on between several corners of the legislature, as well as with the executive branch. And right now one of our jobs as a Department and advocate's job is to think through lest anybody become comfortable with, well, what we passed, that should work. To think through that the answer is no, it won't. And it clearly has, you know, terrible trade-offs in the first instance and then terrible consequences having made those trade-offs.

So I think -- I don't think you have to hedge at all, Kevin. I think it would be unanimous among the local health departments that any significant -- well, any reduction in the Local Protection Grant is a bad thing but any significant reduction is a terrible thing.

And I have already forgotten

the next two questions.

MR. HUTCHISON: Well, again, for members of the Board, many of you may remember but when the West Nile Virus epidemic came to Illinois, there was no provision to mount a response for that. So that the short-term solution was to reduce funding from the Local Health Protection Grant, shift it into West Nile Virus interventions because it truly was a public health emergency when this new disease manifested itself in Illinois. But what it was was a classic rob Peter to pay Paul scenario.

And Dave, you can maybe help elicit the history. But I think from that we learned and there was legislation that, as I recall, that created the Emergency Public Health Fund. So there could be resources set aside for a public health emergency.

So my other question, Dave, was if the General Revenue Fund is a great risk, which it is, and if the Local Health Protection Grant is in that mix, is there a strategy to

increase funding in the Emergency Public Health Fund to preserve resources to deliver essential services for these population-based interventions.

MR. CARVALHO: Yes. And there may be somebody in Springfield who is but I'm unfamiliar with any balance being in that fund. I think it's a safe bet -- well, it's a safe guess that there is not, and I will tell you why.

One of the bills I didn't mention to you was the so-called Fund Sweep Bill. So in addition to everything that I just described about what the legislature did before they left town, they also passed a Fund Sweep Bill, and one of the things -- you probably heard that expression before. Maybe most of you understand it.

But the idea is that there are many so-called special funds in the state. Oftentimes when, you know, a levy gets tagged onto used tires, it says that the proceeds of

that levy will go into a special fund in the State Treasury, not the General Revenue Fund, and then the theory is that that fund is dedicated for a special purpose. And the legislature appropriates -- let me use one closer -- you know, the CON Fund.

The fees that people pay when they do Certificate of Need applications goes into a special fund and then it supports the activities of the CON program. It can't -- well, it cannot directly be appropriated for any other purpose, and so if the fees that come in over time are in excess of the needs of the CON program, at any given time, then those funds simply accumulate and are inaccessible for other purposes.

What the legislature has done from time to time over the last several years, and although it's the executive that has typically gotten the heat for it, and the legislature has always been the one that has authorized it, is authorize by fund by specific

number a sweep into the General Revenue Fund out of those special funds.

And they did that again this time. I know they swept, I think, 1.4 million out of the CON fund, so that one I'm familiar with. And some of those sweeps while, you know, people would decry as sort of a bait and switch, you've got it passed for one purpose to be put in a fund for that purpose only but then you used it for general purposes, and that's not right.

In some instances the more important complaint is you took away money that actually was needed for something, and I will give you an example.

Under ARRA there's the possibility we might be getting some additional funding for workforce loan programs where you pay off the loans for people who agree to go in underserved areas, a program that many of you are familiar with. Some of you may have benefited from it or your institutions do.

There's increased money for that purpose under ARRA.

And it was the original intent of the Federal Government to administer that themselves as they do now in a lot of areas. But more recently, they've indicated that they might not have the capacity to do that themselves and felt out states for whether the states have capacity to do it.

Well, that program requires a match and so there may have been funds in one of our funds that reviewed as excess by the legislature for purposes of a sweep but if it is, in fact, swept that fund -- those funds wouldn't be available for this possibility of capturing ARRA money down the line. So the sweeps are also potentially problematic which is why in the absence of knowing for sure and, I will certainly check it, Kevin, I doubt if there's a fund sitting now with a balance called emergency fund that the glass on that window hasn't already been broken.

CHAIRMAN ORGAIN: Kevin, I think we're going to move on the agenda. Thank you for your questions and thank David for his answers.

What I wanted to do was make sure that we got to Ann's report so that everyone could hear before she had to leave. Ann, if you can come off mute, if you are on mute, and if you are still available.

MS. O'SULLIVAN: I am still available, and I am off mute and, hopefully, you can hear me.

CHAIRMAN ORGAIN: We can. Thank you. So please go ahead.

MS. O'SULLIVAN: The Policy Committee met in the middle of April, and we had our fairly normal agenda. Jim Harvey gave us an update, as did Elissa, on the SHIP report and/or SHIP update, and I see he is on the agenda to report on that additionally.

We have looked at -- one of the new things that we are getting involved in or trying to see what's going on is the Center

for Patient Safety and Quality. Mary Driscoll was on our conference call and talked about what's going on in the center and what they do and, you know, with fairly limited resources, I would say, what they are involved with.

And then we talked about the Just Culture, which is an initiative around patient safety and reporting without mandatory punishment but not without anything going on with reporting of patient safety issues.

The action that we took on that is that Mary will talk with the Chicago Patient Safety Council to see what they know about it, to see if they are involved in this at all, and that we might then -- the Board, anyway, might then find out more from them and work with them on some type of initiation of this system in Illinois. But I haven't heard yet back from Mary in terms of what she found out from them, but you can expect to hear more conversation on that in the future meetings.

Mary, I think, was going to

join some of our State Board of Health meetings, but I'm not sure if she's on this call today. And that's pretty much what we did. We had a legislative update from Denise. So we have no action items for the Board for today.

CHAIRMAN ORGAIN: So that since Jim is here, Jim, can you add anything in regards to SHIP, please?

MR. HARVEY: Certainly.

CHAIRMAN ORGAIN: Thank you, Mary. Thank you, Ann.

MR. HARVEY: Thank you, Ann. Madam Chairman, thank you.

MS. O'SULLIVAN: I will be cutting off as soon as I finish hearing what Jim is saying.

CHAIRMAN ORGAIN: All right. Thanks much, Ann.

MR. HARVEY: Just very briefly. Since our last report to you, I can say that while the new SHIP team has not been named, we continue to move ahead with as many deliverables as we possibly can from our agreement at IPHI. And in

the last few months, I'm pleased to report that we have accomplished a couple things.

One is that, as you know, the Department of Public Health and this august body, the State Board of Health, convened a public health systems partners meeting on assessment back in March. I think it was March 23rd. We had about 72 people that attended that assessment update meeting. Thirty percent of the people that attended were from the Illinois Department of Public Health; followed closely by 20 percent of the attendance coming from local health departments. That meeting was held out at Northern Illinois University.

We are generating a final report for you, and we are just about finished with it, and we anticipate having it prepared in its entirety in early July. If you want to look at what we have got so far, I did bring a copy today of what we have done so far on that report.

Just one item to note is that comparing the overall results by the Central Public Health Services between 2004 and 2009, the overall score increased by 12 point -- 12 and three quarters percent. 2004 report was 32.15 and 2009 the overall score was 44.9. So that was very encouraging, and I just wanted to share that with you.

In addition to that report, we are also near completing the State Health Profile Assessment Update as well, and I have a copy of that as well with me. So if any of you want to take a quick look at this, these are not for distribution yet because there's still a couple of items that need to be added to it and -- but I have it here if anyone wants to look at that. That will be available in early July as well.

Our goal here is to have these documents ready, as well as a draft update of the proposed action plan, for the new team so that we can move ahead as quickly as we possibly

can on the agenda for the new State Health Improvement Plan.

That will effect the original plan, of course. And so I can -- we are working to do all we can to have a draft update agenda in place when the SHIP team is, in fact, appointed. That's pretty much it for my report.

And just on a personal note, this is my last appearance before the State Board of Health, as I'll be leaving IPHI in mid-July. But it's been an absolute pleasure working for all of you. Thank you.

CHAIRMAN ORGAIN: Thank you. We appreciate your contribution and wish you success on your next move.

MR. HARVEY: Thank you.

DR. GIROTTI: Javette, this is Jorge calling in. I'm sorry I'm late.

CHAIRMAN ORGAIN: Thank you, Jorge. Welcome.

Questions for Jim or Ann?

DR. KRUSE: This is Jerry Kruse. I

have a question and then a comment for Jim.

The question is for those of us not in Chicago is there a way that we can receive an electronic version of the preliminary report or that we can access the report that you're handing fairly quickly in some other way?

MR. HARVEY: I will have to check. It's really not ready for distribution quite yet, Jerry. But it's probably no issue involved in getting you what we have got so far. So when I get back to the office, I mean I certainly have these in electronic version on my desk, and so I would be happy to send them to you.

DR. KRUSE: Okay. My comment -- actually, what I understood the dialogue that Kevin Hutchison and Dave Carvalho was having as well -- and I also missed the March 23rd meeting because I was at another meeting.

But my question for you relates to the document that we passed a year ago that was at the State Board of Health level that was entitled the Organization of Health

Care Delivery, Public Health Patients in Medical Homes and Community Care Organizations, which was to be an overarching framework for the State Health Improvement Plan to be written in.

I do wonder how that document is being used in the development of the State Health Improvement Plan, and it's -- it was even more relevant as the conversation occurred earlier because frequently when money is -- money is redirected toward public health, it does come out of other public health funds or funds that are related to primary care, community care organizations. And those entities that really give care to the community and to the public often have to fight for those funds and are particularly relatively under-funded compared to more specialty medicine and technologically oriented things.

So from the State Board of Health perspective and the State Health Improvement Plan perspective, I guess my question or my comment really is that somehow we

need to get the message to those who are distributing the money, the legislature in Illinois and the Federal Government, that those monies to those various community-oriented, public-health-oriented areas needs to flow freely. And if they need to be taken in a budget neutral fashion from somewhere else, they ought to be taken from other places, and I don't think we should be shy about asking for that, quite frankly.

CHAIRMAN ORGAIN: So that was a comment.

DR. KRUSE: That was a comment.

CHAIRMAN ORGAIN: I have a couple questions in regards to the report that was distributed that maybe we can get an update on the legislative -- the bills that are in the report under Item No. 7. So that means particularly House Bill 4237, House Bill 1905 and any of those.

MR. CARVALHO: I was going to do that in my legislative report. I wanted to make sure

you got the rules out of the way.

CHAIRMAN ORGAIN: Okay. Perfect. Yes, because we're running behind time. Thank you, again, both to Ann and to Jim.

What I need to do is go back to approval of the March 12th meeting summary, and then we can go into the Rules Committee Report.

And I want to thank Karen in the absence of both the Chair and Co-Chair of the committee serving in that role. We really appreciated you being available to do that.

And are there any questions, comments, amendments to the rules summary -- to the meeting summary. Excuse me.

DR. McCURDY: Actually, a couple things about the meeting summary. One was since I was out of commission in the March meeting I tried to go through the transcript, and at one point in the transcript there is a person whose name doesn't appear on the list of attendees. The name was Znaniecki, Z-n-a-n-i-e-c-k-i. So

on page 12 of the transcript. So I don't know who that is. But it says that person was in attendance and made a comment.

CHAIRMAN ORGAIN: Okay. For the -- I don't believe that we include everyone.

DR. McCURDY: So it may have been a guest.

CHAIRMAN ORGAIN: Exactly. It may have been a guest and we'll look into that. Thank you for that.

Are there any other additions or corrections to the meeting summary?

DR. McCURDY: One other thing that, again, I picked up from reading through it was -- and David may be able to correct me on this. But when I read the meeting summary on page 3, it says that David Carvalho had assigned Mary Driscoll to assist with the Center for Patient Safety Initiatives, which has been true for some time. But at least the main point I thought I saw in the transcript had to do with David asking her to work with the SHIP, in

supporting the SHIP planning, working with IPHI.

MR. CARVALHO: Yes. That would be correct. It should be SHIP.

DR. McCURDY: If that should be amended.

CHAIRMAN ORGAIN: So it should be amended.

MR. CARVALHO: Yes.

CHAIRMAN ORGAIN: What should the language read, so that we're clear?

MR. CARVALHO: Just replace Center for Patient Safety with the words SHIP.

CHAIRMAN ORGAIN: Okay.

MR. CARVALHO: S-H-I-P all capitals.

CHAIRMAN ORGAIN: Okay. Hearing no other additions to the -- or corrections to the meeting summary, all in favor of approving the summary for March 12?

RESPONSE: Aye.

CHAIRMAN ORGAIN: Any objections?

Then we have consensus. And now since I've been trying to get to the rules

and all my language, okay, David, please.

DR. McCURDY: Well, sorry to be the obstructionist on the rules.

CHAIRMAN ORGAIN: No, you're fine.

DR. McCURDY: I didn't even know where to begin myself, and I'm supposed to chair the Rules Committee. But as you can see, we had a raft of rules that we were considering in the span of two hours when we met last month and so as the old saying goes, we did the best we could, and we eventually lost our quorum toward the end of the meeting. So some rules, as you will see from the minutes, we did not even act on. Let me suggest that the first thing we should do is approve the Rules Committee minutes. Can we do that and I want to suggest a couple of points where there should be changes in the Rules Committee meeting summary, I should say.

First on page 3 in letter D about eight lines down there is the word "statue," which should be "statute," and it says

the statue is not -- it should be in place. And then -- did everybody get that?

And then the second change on the second bullet point just below that it says "who is permitted to lobby," and I would insert the word and "how" lobbying is distinguished from the general right of citizens, etc. So just insert the word "how" before lobbying in quotation marks.

And then the fourth bullet point, clarify definition of valuable considerations. That S should come off the end of the word "consideration." It should be singular.

Those are the only changes I would propose. Others may have others but let me go ahead and move that we approve the rules summary as we have it.

CHAIRMAN ORGAIN: No objection and then if we can have consensus. I hear no objections.

DR. McCURDY: Okay. Now that the easy

part is over. Now to the rules themselves, one of which, as you know doubt noticed, is well over a hundred pages. And that's with some changes which grew out of our summary and so let me turn to that first one, which is listed Birth Center Demonstration Program Code.

We raised some questions about it and so maybe the best thing to do is ask a staff person who is either here or in Springfield to address the questions which we were led to understand could be addressed today.

MR. BELL: This is Bill Bell with the Illinois Department of Public Health.

DR. McCURDY: Hi, Bill.

MR. BELL: The birthing center rules were due to Public Act 95-0445 which became law in August of 2007. And, basically, what that statute did was set up another pilot project under the Alternative Health Care Delivery Act for birthing centers allowing ten within the state.

Usually after legislation

passes somebody comes forward and says, hey, that was my legislation. Let me help you with the rules. That never happened. And so what I did was basically went out to the other states that had birthing centers and took and then cut and pasted and then ended up with a set of rules.

Near the end of that project, the Illinois Birth Center Task Force, which was convened under the Health and Medicine Policy Research Group out of Chicago, came forward and said that they were involved in getting the legislation passed and that they wanted to be involved in the rulemaking. So I shared the draft with them and we made a considerable amount of changes on the clinical side.

And the topping point or the confusing point at this point in time is on the construction side. There is, I guess, a difference of opinion on how that is to be approached. We see this as health care. And so, therefore, we put the life safety code part

under health care under the ambulatory surgical side and said that that's, you know, since it is health care and people will be there possibly overnight -- although there's a question on that also. But if someone is delivering that, you know, that they aren't going to be able to self-preservate, get up and walk out, if you will. So that's why we went with health care requirements.

This group is looking at trying to go to business requirements, which means that, you know, if there was a fire or some type of emergency, there is no defend in place concept. There is just leave the ability concept.

We don't feel that that's appropriate for the fact that these people will be -- or these ladies will be delivering and will not be able to get up and walk out if there is a fire. We are going with the defend in place concept.

So that is one of the issues

that came up was trying to decide whether or not there's the possibility of taking these rules out of the health care occupancy side of the life safety code and putting them into the business occupancy side. And we just don't feel that that is appropriate for the type of clients that they will be seeing here.

Does that mean that there is not some chance for negotiation on issues that they can bring up during the notice period on some of the issues in the physical plan side of things? Absolutely not. We will have to take a look at those, and if it makes sense or there's some wiggle room or equivalencies that we can come up with, we will definitely look at those. But the whole issue of business occupancy versus health care occupancy we feel that we stick with the health care.

DR. McCURDY: So the rules are written accordingly. And Bill, do you have any comments you want to make on the questions that we raised in the meeting which the summary says you all

agree to address today?

MR. BELL: There were several technical changes. I think we made all of the technical changes. There was a couple of questions where I think it was Dr. Orris was asking a couple of things about education, and we believe that those were already part of the regulations as they sit. I mean, we can definitely modify them a little bit more, if necessary. But we believe that what he wanted is there.

There was a question about how charitable care is measured, and I really don't have an answer for that one. Now, that one may be something that we will have to look at during the notice period because there is a provision in there that they have to provide charitable care compared to other providers. Well, this is a new program. So I guess what we have to be looking at is ASTC's and hospitals, and I'm not sure how that quite compares. But we will definitely take a look at it and look at that a

little bit more.

There was a question about environmental standards, putting in requirements for LEED and silver certification and energy star ratings and whatever. There is some of that material in there, but that's more of a business decision than it is a regulatory decision. So we left that alone just as it is.

And then there was some questions about the food and having to do with infant formula and we are still looking into that. I haven't gotten all the criteria yet. But, again, that's something else that I think can be addressed during the first notice period figuring that there will be quite a few comments, and there probably will be a lot of changes that will occur to these rules during the actual rulemaking process.

DR. McCURDY: Bill, it looked to me like you had addressed in the rule, made some changes regarding the opinion of the medical community regarding OB/GYN and nurse midwives

and also health and safety for employees at a number of points.

MR. BELL: Yes, sir.

DR. McCURDY: So on the basis of those things, knowing that there are loose ends here, but for the sake of moving it forward, let me move that we forward this to JCAR with the approval of the Board. But we should note that there are still some open questions that the Rules Committee had raised, which are still not fully addressed.

MR. BELL: I will be happy to bring back the issues or the comments that come in from the rulemaking process to the Board, if they want to look at them before we proceed to second notice.

DR. McCURDY: Sounds good.

DR. KRUSE: David, this is Jerry Kruse. Could I make a couple comments here?

DR. McCURDY: Please do.

DR. KRUSE: Actually, just so everybody knows, our department delivers about a

thousand babies a year, and we do a lot of low risk settings like this, and we actually have three certified nurse midwives on our faculty as well. So just a couple of comments.

The most important thing for birth centers is a clear definition of low risk and having the definition of low risk and dividing that from the higher risk patient and having some teeth or some penalties for those that don't pay attention to that definition.

Now, I don't know where that would come in this law, but it's absolutely essential. The Netherlands just had the most experience with this, and they have a list called the cluster man list that was initiated in the 1940s and worked well. And then around 1990 they had another one called the obstetric indication list, and it's worked very, very well.

I will say that the list on page 24 that you have got here reflects the obstetric indications list fairly well, and

that's a good thing.

My comments about that list on page 24 would be that you probably shouldn't lump pre-existing diabetes mellitus with gestational diabetes not controlled by diet. There probably should be two separate categories because they can be confused because anyone with pre-existing diabetes certainly should not be treated in a birthing center. And then it might be better to have a better definition of collagen disease, the number I on page 24, by which could be listed as connective tissue disease or autoimmune disease or you can get into the very specific things like antiphospholipid syndrome and periarteritis nodosa and lupus and all of the other things.

The other thing as I read this section that begins on page 22, at the bottom of page 22, Section 265.1550, there is a lot of good information in there, but it seems to be organized haphazardly. And let me just give my recommendations as one who might be involved in

making one of these birthing centers that it would make more sense -- and I'm not recommending really any change in language whatsoever, but I would say that items A, D, F, J and M naturally fall together for admission criteria.

DR. McCURDY: Tell us again, Jerry, where you are.

DR. KRUSE: I'm on the bottom of page 22, Section 265.1550, admission protocols for acceptance for birth centers.

DR. McCURDY: So reorder.

MS. PHELAN: That is A, D, F, J, M.

DR. KRUSE: A, D, F, J and M naturally fall together. A second category information that falls together are C and G which relate to things that you can't do like epidural anesthesia, general anesthesia and oxitose induction.

A third category would be H, I and N that talks about the relationship you need for the hospital to which you're going to

transfer higher risk patients, and then the last category would be B, E, K, L and O which relates specifically to the definition and the dichotomy of low risk and high risk, which is the most important thing of all for the birth centers.

DR. McCURDY: That sounds like that's a good set of recommendations which we could incorporate as an, shall we say, amendment.

Just a question, Jerry, about the collagen disease. So would your recommendation be that we provide in the definitions section maybe a definition that added some of those specifics or would you prefer a different label altogether?

DR. KRUSE: No. I think it could say collagen disease or connective tissue disease or autoimmune disease. It could be collagen/connective tissue/autoimmune disease and then the definition -- you know, I'm sorry. I probably skipped the definition but it should have --

DR. McCURDY: There is not a

definition.

DR. KRUSE: Okay. The definition from my standpoint probably should be systemic lupus erythematosus, antiphospholipid antibodies syndrome, scleroderma, periarteritis nodosa would probably cover all the serious ones that should not be cared for in a birth center.

DR. McCURDY: Do we have that? Do we need to repeat it?

UNIDENTIFIED SPEAKER: Yes, please.

DR. McCURDY: Okay. Could you repeat those again, please, Jerry.

DR. KRUSE: Okay. I will repeat them again. Systemic lupus erythematosus, antiphospholipid antibodies syndrome, scleroderma, periarteritis nodosa.

DR. McCURDY: Say the last one again, please. It's periarteritis.

DR. KRUSE: Periarteritis nodosa.

DR. McCURDY: Okay.

DR. KRUSE: Actually, at some point I can -- there's a book that I've got that I don't

have right in front of me called recent advances in obstetrics and gynecology edited by Bonner and Dunlap that have a lot of these criteria flushed out rather than general categories that might be of some use to you, Bill. So I might try to get that to you.

CHAIRMAN ORGAIN: And it will go into the meeting transcript. So if there's some spelling issues, we can ensure that the spelling is accurate.

DR. McCURDY: Okay.

CHAIRMAN ORGAIN: Additionally, I would also have to comment, and Jerry and Tim, for all of those of us who are family medicine, that there are varying levels of family medicine practitioners who absolutely, as Jerry indicated, do low risk pregnancy and woefully -- the language is woefully absent of that language in regards to family medicine being involved and so we would probably work with including that where appropriate.

DR. KRUSE: Let me just say this. On

page -- on 16 and 29 I noticed that and on page 29 at the bottom, Section 265.1750, Personnel, that's where they talk about the medical director, and the way it reads the person either must be certified in obstetrics and gynecology or have hospital obstetric privileges.

So that could include family physicians who have obstetric privileges. But it also would mean that an obstetrician who did not have obstetric privileges in the hospital could still be the director of one of these birth centers, and my question would be is that the intent of the definition on page 16 and 29.

CHAIRMAN ORGAIN: So those are the kinds of things that we will forward to you, Bill, for clarity in regards to the varying levels of obstetrical privileges for both the specialties OB/GYN and family medicine.

MR. BELL: Okay. That would be great.

MR. CARVALHO: Dr. Orgain.

CHAIRMAN ORGAIN: Yes.

MR. CARVALHO: Jerry, on scleroderma

would it apply to both localized as well as systemic or --

DR. KRUSE: No, just systemic.

MR. CARVALHO: Just systemic. Okay. So we should put that in there because we don't want to inadvertently pick up localized.

DR. KRUSE: Indeed. Instead of scleroderma we should probably say progressive systemic sclerosis, which would be the systemic part.

CHAIRMAN ORGAIN: Okay.

DR. KRUSE: I will send that along too, Bill.

MR. BELL: Okay. That's great. That will help a bunch.

UNIDENTIFIED SPEAKER: Javette, I had a question of Tim.

CHAIRMAN ORGAIN: Thank you, Tim. Go ahead.

UNIDENTIFIED SPEAKER: On page 45, the comments regarding structure, you know, the detail in regarding to structure of the

building. But on page 45, the transfer agreement and its relationship to emergency, I mean, even with the classification, a low risk pregnancy becomes high risk in a matter of seconds, and that section is so important that to condense it down to one paragraph is a bit scary.

So I'm not sure what is going to be done with that. Does that get expanded in the rules section or is that -- that seems an emergency transfer for serving section in itself is a high risk operation. So I think a paragraph related to that is really --

CHAIRMAN ORGAIN: Jerry, I don't have the information that you have in regards to that, and I am not certain that it would -- whether it would allow for additional information in regards to transfer.

Do you know if that's available in the document that you were using?

DR. KRUSE: Were you talking to Tim? Tim made that comment. This is Jerry.

CHAIRMAN ORGAIN: I was asking you.

UNIDENTIFIED SPEAKER: She was asking information on that since we didn't have --

DR. KRUSE: You know, I'm not sure. I would need to look that up in the book. What happens in the Netherlands is they don't have birth centers, but they do home births. 30 percent of their births are home births, and so their time for transfer to the hospital and for a Caesarian section to be done is also 30 minutes. So it's exactly the same as it's in this document. So there could potentially be a narrative about that in that book as well. I will try to find that for you.

CHAIRMAN ORGAIN: Yes. So that was the answer to the question. Thank you.

DR. McCURDY: So would it be fair to say that our preference would be this is statutory language, that we want to supplement the statutory language with something more explanatory?

CHAIRMAN ORGAIN: If available.

DR. McCURDY: If available.

Any further comment? Shall we -- are we ready to vote with the provision that we want to have a number of things addressed but that we are still willing to forward it. All in favor say aye.

RESPONSE: Aye.

DR. McCURDY: Okay.

CHAIRMAN ORGAIN: If no opposition then consensus.

DR. McCURDY: Well, there's a hundred pages now but much more to go. How are we doing for time?

MR. CARVALHO: Not good.

CHAIRMAN ORGAIN: Yes, not good.

DR. McCURDY: Not good.

Okay. Well, the next one that we would consider is the rule on Swimming Pool and Bathing Beach Code and in our discussion not a great deal of change that we had proposed as a committee here. So the one thing that was addressed specifically by the staff in looking

at this had to do with the expression surg weirs, but that is not one of the central things in this material.

So does anybody in Springfield want to offer a comment about this before we move adoption?

MS. MOODY: Yes. This is Conny Moody with the Office of Health Protection.

CHAIRMAN ORGAIN: Can you repeat your name.

MS. MOODY: This is Conny Moody with the Office of Health Protection.

CHAIRMAN ORGAIN: Thank you.

MS. MOODY: This rulemaking is presented because of changes at the federal level. Last year there was a passage of Virginia Graham Baker Pool and Spa Safety Act, which the Consumer Products and Safety Commission worked on to address entrapment issues that could potentially be caused by pool and spa drains. The drains that are used in commercial pools particularly are of concern to

us.

The federal requirement changed the main drains that pools and spas may contain and also changed the type of protective covers that are needed within a pool to prevent a child or adult from becoming trapped -- entrapped by that drain because their hair has gotten caught in the suction or their body has gotten caught.

So in order to ensure that the pool and spa owners and operators in the State of Illinois were able to comply with both the federal requirements, it was necessary to change our state rules, and that is the rulemaking that you see before you as of this time.

The Department has offered these rules to JCAR as an emergency rulemaking which, of course, was immediately adopted, and these are the permanent rules that follow that process.

We are currently in the process of inspecting pools and spas, of course,

because these facilities are open for the summer or are in the process of being open for the summer. And as we go around the state to inform pool and spa operators and owners about these new requirements, we are educating these facilities about the needs for the changes in the drain covers, and we are indeed writing citations for them if they have not yet complied with the special requirements. Because the federal requirements was effective in December of last year.

So we are doing a lot of educating. We are not fining or issuing penalties at this point in time. Rather, we are writing a citation and encouraging the pool and spa operator to make the necessary changes as quickly as possible.

One of the questions that was raised, as Dr. McCurdy indicated by the committee, was specific to surge weir. As we have made the adjustments, the amendments to the rules, we inadvertently neglected to strike a

reference. We struck the definition of surge weir, but we inadvertently overlooked the use of that term further into the rules, and we appreciated the Rules Committee identifying that oversight to us. We have made that change.

A surge weir is sort of the inlet around the edge of the pool that some pools have, I call it slop over, where the water kind of slops over the side but it's still contained in the pool. Those -- under the federal product code requirements, those surge weirs could possibly create a suction if you sit or stand on them and thus they are prohibited under the federal requirements. And that necessitated the need to delete those from our rulemaking also. Thank you.

DR. McCURDY: Thank you, Conny. I will go ahead and move that we forward this to JCAR with the Board's approval. As you can see, we brought all of our plumbing expertise and engineering expertise to bear on this rule. So, therefore, the discussion was a bit shorter. So

all in favor say aye.

RESPONSE: Aye.

DR. McCURDY: Then we will move on to the next.

And thank you, Conny, and also thank you, Bill, for the birth center demonstration rule.

Children's Community-based Health Care Center Program Code. Somebody in Springfield or here want to address that one for us, please.

MS. SINGER: This is Karen Singer from Division of Health Care Facilities and Programs.

The Children's Community-based Health Care Center Program Code is an alternative health care demonstration program and we made some revisions to the upcoming --

CHAIRMAN ORGAIN: I'm sorry. There's a lot of movement and so you're coming in and out.

MS. SINGER: I'm sorry.

Can you hear me better?

CHAIRMAN ORGAIN: Yes, thank you.

DR. McCURDY: Good.

MS. SINGER: Rules came about from requests for changes from the Department of Human -- no, Department of Health Care and Family Services in that a lot of these children in these community children's based programs are the best wards for medicaid clients, and they're really looking for some more oversight by the Department in relation to if there ever was a restraint issue used for children and also some more oversight on if the agency needed to do some more quality monitoring for medication administration and also reporting of adverse events that may occur in their homes to the Department within a timely fashion. So these are some of the revisions that were made to the rule.

DR. McCURDY: And for our part -- thank you.

For our part as a committee, we had some concerns, as your notes on our

meeting indicate, on the type of training staff would receive on the use of restraints because it was a fairly nonspecific reference to use of restraints.

And you may notice that on pages 7 and 8 of the revised rule letter N, there is considerable tightening of that material that even made me wonder if you all might get pushback on this in terms of the specificity. But I mean, it certainly seems to me to address the concerns that we raised in the meeting.

So that said, I would move that we forward these rules also to -- this rule also to JCAR. All in favor?

RESPONSE: Aye.

DR. McCURDY: Opposed?

Then we move on with this one.

Now, the next one is the Regenerative Medicine Institute Code. And as you probably noticed from the materials you got, there was both discussion of this and then some

post-meeting activity around it.

Members of the staff in Springfield, because we had to rush our discussion, there was a request that I send them some questions, which I did, about this material, which unfortunately for you all adds to your reading but perhaps won't add to much to our discussion.

In any case, can somebody in Springfield go ahead and make -- is it Bill Bell or can somebody else say something about this rule to set it up?

MR. CARVALHO: No, it's actually Tiefu Shen who's in flight. Tiefu works for me and he delegated to me.

So by way of background, the Illinois Regenerative Medicine Institute has existed for four or five years. It was originally created by executive order and funded out of some funds in the state budget that were available for this purpose. Those grants have already been made, reports back in follow up on

those activities all existing and in place.

The legislature then decided to codify all of that in the -- in statute which led to the necessity of adopting rules. And so what you see before you are the rules that both build on the activity of the IRMI, I-R-M-I, to date, as well as take into account learning from a few other states that do this.

There are a handful of states -- I don't want to go into the meeting with the whole issue of state-funded stem cell research and the like. But there are a handful of states that set up some activity when there were restrictions at the federal level using federal dollars.

So there are -- given the budget description I gave you earlier, we aren't sure when or if we should anticipate additional state funding. IRMI would be able to take funding from other sources if other sources were interested in providing it. But nonetheless, it's important to have in place the regulatory

framework to support the statutory mandate and that's what you have in front of you.

Dr. McCurdy had a number of questions, and as he said, people attempted to answer those in his memo.

DR. McCURDY: My feeling was that the questions were generally well answered and I was very appreciative of that. And I probably should add that in addition to -- I'll come back to the questions.

But in our meeting summary also, there is some other points that weren't necessarily part of the questions because they were picked up in the meeting summary.

My understanding is that there should eventually be an addition of the definition of stem cell line.

Still have some question about lobbying because when we read the definition of lobbying, it looks like kind of anybody who sends a letter to the government might be considered to be lobbying by that definition.

It seems that it maybe needs to be a little more precise.

You will see that in the response to the questions our issue about research donors is picked up and also valuable consideration and at least somewhat the rationale for what is included under valuable considerations.

And then the issue of non-human chimeras, there's a good deal of discussion given to that in the response from -- to the questions about that in the separate handout about that.

I guess what I would say is there are some typos that we had flagged in the Q and A and they seemed to have addressed the typos. Some of the definitions still need to be formulated, but there is intent expressed to do something with those.

The question of valuable consideration is addressed. And the question of what's included and excluded I think that's

going to be satisfactory myself.

Probably the one other thing that I should ask really is the part about lobbying, and David, you would be the expert on what this is. But the definition sounds like any communication by anybody about anything could be lobbying. So how do we distinguish that from something that has a sort of formal sentence in this document, if you have an idea about that.

MR. CARVALHO: Yes. Because of the legislative history of this, there was an acute concern on the legislature to shield this whole activity from the appearance of anything untoward or inappropriate. This issue was a very sensitive issue in the legislature. Frankly, I was surprised that they addressed it but -- and so I think that's why you see that expansive definition of lobbying because of that legislative concern.

But what we should do is we should see to what extent have we added to the

confusion by our rule or we merely tracked the hypersensitivity by the legislature.

MS. MEISTER: If I could interrupt here. This is Susan Meister, the Rules Coordinator, and even though it's not in italics type, we did take this definition from the statute that governs lobbying.

DR. McCURDY: Then in that case, again, all I would say is it would appear that anybody who might conceivably be involved in this activity who sends a letter to anybody in state government might be considered to be lobbying and I mean that's the -- that seems too broad. So at least I would raise that question as an ongoing one without needing it to be entirely addressed today.

DR. McCURDY: I would move on just to the note that there was a response to the question that we raised about cost to donors. To make sure that donors -- I mean, thinking about participants and research just in general.

As a member of an institution

review board, it always has disturbed me that often I think participants in research who are actually trying to do something for the common good often get charged for things that I don't think they ought to be charged for. And the fact that there is language here which seems to suggest that there could be charges to donors in this activity, seem to me it's close to outrageous.

And anyway, it's not there now. I mean, it appears that it's likely to be addressed here. David, go ahead.

MR. CARVALHO: It may come up again during the comment period. But when I talked it over with Tiefu, I thought perhaps what -- because he was borrowing from other places. What this was anticipating was whether -- there may be some areas of research where it is not really so much research as I have a problem that could be addressed by --

DR. McCURDY: It's therapy.

MR. CARVALHO: It's therapy.

DR. McCURDY: So therapeutic research does raise that question in a sense.

MR. CARVALHO: Yes. Especially since one of the theories is that this is a way you individualize treatment potentially because you are using a person's genetic material to generate a solution for that person and is it appropriate or not to charge the person under those circumstances.

DR. McCURDY: So we are imagining that there would be some donors who would be donating genetic material that would then be conceivably be translated into therapies they would receive.

MR. CARVALHO: Yes. I suggested to Tefu that donor was being used more in a medical word -- as a medical word than a legal word. Because he had said if you're donating it isn't that -- donating -- well, I think it means like medically donating not --

DR. McCURDY: Well, then maybe that needs to be clarified because otherwise it would appear to be somebody who's donating an embryo,

for example, which is a whole different matter than they're donating genetic material. Donating in the sense they are supplying it for the purpose of something therapeutic for them. So that probably needs to be sorted out, I would say.

MR. CARVALHO: We will do that.

DR. McCURDY: Other than that the whole matter of non-human chimeras or the mixture of human and non-human, I personally feel that that's reasonably addressed by all the references to the National Academy of Sciences and the fact that this material needs ways of thinking about it come from their stuff.

I found it useful to look at the material from Jewish sources. Actually, the rabbis have thought about these things, and they keep thinking about them. So it's helpful to have something else to look at besides the National Academy of Sciences that has this sort of, I think, also balanced perspective.

And without opting for a

particular religious tradition in this regard, I will simply say that there's a sense in which you certainly get a feeling from some of that; that it's not so different from what the National Academy of Sciences has to say.

So anyway, from my perspective I don't have a need to pursue that further. I appreciate that it's been addressed and that they are going to do that.

So at this point, and it's certainly in the interest of time, but also because for me to make substantive things to address, let me go ahead and move that we forward this. And then Karen, go ahead. If you have a concern, please raise it.

MS. PHELAN: On page 22 it just needs to be an adjustment with the numbers. We apparently have two number eights. But the punctuation was adjusted. Thank you.

DR. McCURDY: Okay. So we move that we forward this to JCAR, realizing there are a couple outstanding issues that staff will

continue to address.

DR. EVANS: Second.

DR. McCURDY: All in favor.

RESPONSE: Aye.

DR. McCURDY: Then moving right along. Thank you, everybody, and thanks to you and certainly in Springfield and to David for addressing this.

And we go on to the Physical Fitness Facility Medical Emergency Preparedness Code. Anybody want to address that for us in Springfield?

MS. ATTEBERRY: Hi. This is Paula Atteberry with the Division of EMS and Highway Safety.

These code amendments are brought before you because the Act was amended to include the term "outdoor facilities" or actually to deplete the term "indoor facilities." So both indoor and outdoor facilities are affected and are deemed physical fitness facilities.

In addition, the outdoor facilities that are owned and operated by certain park district boards and conservation districts are exempt from the outdoor being a physical fitness facility and also changed the law to say that trained AED users must be present during the physical fitness facility activities themselves and then we redefined the trained AED user. So delete the fact that EMS resource hospitals are deleted from -- it came about from the AED Act itself changing the law.

DR. McCURDY: So is there anything else?

MS. ATTEBERRY: No, that's it.

DR. McCURDY: Well, thank you very much.

MS. ATTEBERRY: You're welcome.

DR. McCURDY: Let me note that since our committee met, there was a change. Namely, the term "violators" has been changed to "alleged violators" in terms of action that would be taken toward people who have -- may

have transgressed, but they still have some due process remaining. And I guess that's the main change I would point to.

One question I have which in a way may follow from what we -- what was discussed at the March meeting of this Board has to do with the fact that if the AED is actually used, its use has to be reported and the rule, of course, says that. My question simply was do we -- is it always the case that anybody who might be a possible user of AED will know to report it. Is there any possibility that sometimes it will be used and nobody would know that's what they were supposed to do?

MS. ATTEBERRY: If you use an AED that somebody has been -- went down, was shot and the EMS definitely I would hope they would know to call 911 and then the bubble sheets and the computers of the EMS that's where we get our information from.

DR. McCURDY: So the EMS actually would report that. Okay.

MS. ATTEBERRY: Yes. Absolutely.
DR. McCURDY: That's really my only question. I would move that we forward this rule to JCAR.
DR. EVANS: Second.
DR. McCURDY: All in favor?
RESPONSE: Aye.
DR. McCURDY: Opposed? All right.
Well, that's five rules down and we have one remaining. The one remaining rule is practice and procedure in administrative hearings and does anybody in Springfield want to address that or perhaps here?
MS. ALIKHAN: Sure. My name is Rukhaya Alikhan, attorney for IDPH.
DR. McCURDY: Welcome.
MS. ALIKHAN: Thanks. I guess I might have to spell that name for the court reporter.
DR. McCURDY: Go ahead.
MS. ALIKHAN: First name is R-u-k-h-a-y-a. Last name is A-l-i-k-h-a-n.
DR. McCURDY: Thank you. Go ahead.

MS. ALIKHAN: Most of these procedures that you see in Part 100 are moving towards incorporating some of the language of Smoke Free Illinois, the Smoke Free Illinois Act, and the reason being is that Smoke Free Illinois incorporated the IAPA, Illinois Administrative Procedures Act. We wanted to make some clarifications in the Part 100 rules to make that inclusive of Smoke Free Illinois.

Specifically, one of the changes we did is we defined a contested case to have the meaning attached to it in IAPA, which does not include Smoke Free Illinois. So that way it doesn't leave any kind of confusion as to what type of hearing this is now under the newly amended act. That it is an administrative hearing.

Another change that we made was that parties to the hearing pursuant to SFIA should be the enforcing agency and the violator, and this is done specifically because under Smoke Free Illinois there is three different

enforcement bodies; one being local health department, the second being local law enforcement, and the third being the Department of Public Health.

So we wanted to make it clear that whoever the entity is that's actually citing the violator for prohibited smoking is a party to the hearing. It wouldn't by default be the Department because the Department is the over-arching state agency. So we did clarify that in 100.3 in parties to the hearing.

Another, I guess, major point or more significant point rather is -- let me find this.

Goes to the filling of an answer. We've made it such that once the hearing is requested, once we have sent out a notice for hearing to a violator and a hearing is requested, an answer need not be filed pursuant to Smoke Free Illinois. You do that with environmental cases and other types of cases. We decided that for the sake of

efficiency not to have the requirement that an answer be filed for a case -- in an SFIA case just to simplify the process a little bit more.

So now I guess that would be most of the points that I wanted to highlight. I don't know if there's any questions.

DR. McCURDY: No, a comment and a question.

The comment is there's nothing wrong -- I was talking about violators in the wrong rule. The term violators became alleged violators in this rule, not the previous one.

And secondly, just for our information and my information, what is a subpoena duces tecum?

MS. ALIKHAN: That's a subpoena for documents.

DR. McCURDY: Okay. Good enough.

I would go ahead and move that we forward this rule to JCAR.

DR. EVANS: Second.

CHAIRMAN ORGAIN: I would just ask

Steve if this -- I mean, we have had this discussion about enforcement of the Smoke Free Act. Does this allow for it --

MR. DERKS: Yes. That's what this rule is written in response to subsequent legislation passed this -- passed this past session.

MR. HUTCHISON: This is Kevin and maybe this can be answered later on.

But one of the issues that we wondered about in enforcement is that there is a mechanism for a fine under the administrative procedures. What happens if the party doesn't pay? And I don't know if these rules particularly address that. You know, if it's impugning the consequences of financial penalty. And what happens if they decide not to pay and what action will be taken by the State Health Department at that point in time?

CHAIRMAN ORGAIN: Could you repeat your name, please.

MR. GUNN: Jonathan Gunn,

J-o-n-a-t-h-a-n. Last name is Gunn, G-u-n-n. I'm one of the staff attorneys involved in this project.

And the way it would work is, for example, as a hypothetical someone would be cited for a violation. They wouldn't show up. They would request a hearing and then they wouldn't show up, if that's the kind of scenario that you're speaking of.

MR. HUTCHISON: Yes. And then if they were served a penalty, they decided not to pay it, ignoring each step of the way.

MR. GUNN: Okay. Presumably a default judgment or order would be entered by the Judge and affirmed by the Director and at which point the enforcing agency would be responsible for collections. So if it was a local health department, they would be responsible. If the citation was written by IDPH, then we would responsible. If it was local law enforcement, they would be responsible. And then at that point they would have a judgment in place.

There is the State Collections Act which has procedures for pursuing people that owed the State money, and essentially that would involve an action where they would be sued in court, in Circuit Court, just like any other collection matter.

MR. HUTCHISON: Okay. Thank you. That's very clear.

DR. McCURDY: Any other questions?

Are we ready to vote? All in favor please say aye.

RESPONSE: Aye.

DR. McCURDY: Opposed?

Then we will forward these rules. That concludes the rules and I believe it concludes our committee's report.

Thank you, Madam Chairman.

CHAIRMAN ORGAIN: Thank you. Thank you very much. Thank you, everyone.

We are now at quarter to 1:00, and we can have our legislative update from David Carvalho.

MR. CARVALHO: Sure. There is about 800 bills on the Governor's desk and many of them relate to health. I won't go into all of them. I will highlight the first ones that we're especially interested in. I'll also mention some of the ones that we discussed in the committee in the past that we're interested in as well.

There is -- there is four we are paying particular attention to. One would give IDPH additional authority to investigate the causes of health effects, health conditions or health ailments related to a chemical radiological or nuclear event. And that's House Bill 3922. That was an initiative of ours to clarify our involvement in a radiological and nuclear event. As with most of these things, hopefully, we'll never learn how important this is, but we wanted to get that on the books.

House Bill 4237 I'll glance over lightly. It may not be of much interest to you. It's a Bill the Department of Veteran

Affairs promoted. For a number of years now, we regulated veterans homes the same way we regulated all nursing homes, and in the last several years there have been a number of what we call Type A Violations, which typically revolve around a death of someone due to problems, and so we fine the veterans nursing homes just like we would fine any other nursing home. And when you fine a state agency, that becomes a little problematic, whether you're just taking money out of one pocket and putting it into another.

And so the Department of Veterans Affairs sponsored a bill to exempt them from paying any license fees, planning support fees, financial statements, and other things and also exclude them from some of the other regulatory sanctions of the Department and provided that the fines or penalties that we might levy against them could offset by the cost of coming into compliance and in other ways make changes to the way we regulate veterans homes.

That's been passed and on the Governor's desk.

Senate Bill 1254 is of special interest to the director, given his military background, and it's providing a pathway for people who are discharged from the military who have had emergency and medical training in the military to demonstrate that they have had that training and, therefore, sit for the EMT test. The details of that are spelled out in that bill.

And then one of interest to us and you, I'm sure, is House Bill 1292 that would add a chiropractor to the State Board of Health, as well as a physical therapist. I know this is all on tape and transcript, but I guess I'm surprised once the bill got introduced that we didn't see, you know, six other specialties piled on. So I guess we got out of their cheap with just a chiropractor and a physical therapist.

And then also incidentally --

CHAIRMAN ORGAIN: So it passed.

MR. CARVALHO: Well, it passed, yes. It's on the Governor's desk.

And it also, incidentally, eliminated the Hospice Board, and to be perfectly honest, I don't know the politics of that. I know there have been some battles in the hospice community between for profit and full hospice and partial hospice and different models, and I don't know why they chose to eliminate the Hospice Board, which was an advisory board on the issue of hospice.

Some other bills that you asked about in the past and I've described in the past, Senate Bill 1905 is the bill that would extend the life of the CON Board and that bill passed nearly unanimously in both chambers. It's on the Governor's desk.

I think what I described last time I described that there was a very odd process for selecting members and that process has been eliminated. So the selection of members will be done the same way it's

historically been done. The Governor appoints the legislature. The Senate confirms.

All the other provisions are in there as I describe them. So the setting up of a new Center for Comprehensive Health Planning to develop a health plan for the State, which would then be used as a touchstone by the Review Board. It would no longer be called the Planning Board. The Review Board for its consideration of certificate of need applications.

You would have a role to play in that the Center for Health Comprehensive Health Planning would develop a plan, would use a public process and all that, but would also submit that plan to you.

And if that other bill is signed, the chiropractor and the physical therapist who joined you to approve and other changes, the Center for Comprehensive Health Planning would be in our agency and in my offices.

However, the staff of the Health Facilities Planning Board, who are currently in a division in my office, would become employees directly of the Planning Board and the Planning Board would -- the chairman would become a full-time employee of state government. That would apply to the new Planning Board of nine, which is to be pointed under the act. The existing Planning Board of five spots, four of which are currently occupied, would continue on an interim basis, but they wouldn't get paid.

The Obesity Preventive Initiative, House Bill 3768, was also adopted and I'm suddenly having a memory loss. Steve, maybe you can help or someone on the call. Enrolled and engrossed, which is the final one?

RESPONSE: Enrolled.

MR. CARVALHO: Enrolled. Good. Thank you.

When the bill comes out of one chamber, they compile all the amendments that

may get made and that gets called engrossed and goes to the other chamber. And then when they make whatever amendments, that final one is called enrolled. Great.

The enrolled version -- I'm sorry. The final version of 3767 made a few modifications in the direction of helping us out with our concerns about the cost and the utility of the series of hearings. I think it reduced the number of hearings. It made clear that we can take in-kind contributions and all.

But by way of reminder, this bill would set up a series of hearings around the state about the issue of obesity and would include a role for the chair of the State Board of Health or his or her designee and three members of the State Board of Health to participate in those hearings. And it would lead to a report and the report would then go back to the General Assembly.

The intent of the -- this was an initiative out of SHIP of -- the last SHIP

and it was quarterbacked by IPHI and the intent, I think, is to use the model of Smoke Free Illinois to generate a willingness at the legislative level to deal with the issue of obesity in a meaningful way by developing some grass roots recognition of the issue by having hearings around the state.

CHAIRMAN ORGAIN: Funding.

MR. CARVALHO: Funding. You know, there's no funding for our Department.

CHAIRMAN ORGAIN: All right.

MR. CARVALHO: So there's no funding for the agency. I mean, for this bill.

You know, it's one of those things, the legislature by design is left hand right hand. Left hand passes substantive bills and right hand pays for them, and there's no requirement that the two happen at the same time. Many number of times you've heard me explain that the reason why rules were late was because they passed the bill but they didn't pass the funding.

Senate Bill 212, which is the EPT, which is the extended --

CHAIRMAN ORGAIN: Expedited partner.

MR. CARVALHO: -- expedited partner therapy, that's the process where you -- and I'm not using the technical terms. But you give the drugs to the person who you are seeing to give to his or her parters who you aren't seeing.

And that bill cleared both chambers, you know, tweaked a little bit to make the doctors happy in terms of exculpating them from liability for any malpractice for not seeing the other patient, and making the trial lawyers happy by tweaking it in yet another way, the usual dance in Springfield, and the bill passed nearly unanimously and is on the Governor's desk.

CHAIRMAN ORGAIN: One more.

MR. CARVALHO: Pardon?

CHAIRMAN ORGAIN: One more.

MR. CARVALHO: Okay. I'll only do one more. Oh, I only have one more. Good.

House Bill 3653 is -- hang on. I'm sure it's on the Governor's desk, too. Oh, no. It actually got re-referred -- so it didn't pass. Oh, yes. I'm sorry. Of course this one didn't pass.

This was a bill to take the African American HIV/AIDS Response Act fund out of our Department and put it in another department and that didn't happen.

CHAIRMAN ORGAIN: Okay. All right. Any questions for -- go ahead.

MR. DERKS: I know you're trying to move along.

CHAIRMAN ORGAIN: No, you're fine.

MR. DERKS: Can you comment on the legislation that impacted all state bodies, the employees, whether we are fumigated or not.

DR. WHITELEY: Terminated.

MR. DERKS: Fumigated, whatever.

MR. CARVALHO: Yes, you all and I, and you and I and just me have all been subject of various legislation machinations over the last

several months, and one of them related to a bill that started off as eliminating everybody who was in a Rutan exempt position in state government. Rutan exempt includes so-called double exempt, which means basically the very senior people in all the state agencies. Single exempt Rutan people digs quite a bit deeper into the state agencies, as many as 3,000 employees and all the boards and commissions.

And the original thought was to wipe out everybody but give the Governor 60 days to decide which to keep. And then as the legislative process worked on that bill, it narrowed to only be the Rutan double exempt, which is probably about 700 persons, but it left the boards and commissions, and I think extended the time period to 90 days. And so the Governor, again, merely by signing, you know, signing a piece of paper, would be able to retain any of the people who were on boards and commissions or employees in a Rutan exempt -- double exempt position.

And the bill also made clear that anybody who was in a Senate confirmation position would not have to go through Senate confirmation again by virtue of there being this elimination of them but restoration by Governor's action.

The bill is currently not -- the bill is currently not out of both chambers. I think it passed the House, but it's not in -- it's either retained by the House before it got sent to the Senate or it's in the Senate but didn't get action.

But, you know, one of the things -- and you remember last year where it was basically a continuous yearlong legislative session that the big bad news is that means you don't have a budget. The ancillary bad news is nothing ever dies. Because all these things that you used to be able to say, well, okay, they have adjourned and so it's dead is potentially alive anytime any quorum of both chambers gets together in Springfield and

decides to take it up.

You also never know, since the budget is never just about a budget, what other superficially unrelated actions may get handled at the same time. So somebody's price -- bad choice of words. So somebody's preference as to legislative A taking place before they are prepared to support the budget could revive legislative action A that you thought was not going to otherwise occur. And then there were also some tweaks that I will have to double check to see if they apply to you.

There's a Senate Bill 54 which makes some changes in the ethics laws, numerous changes not worth recounting. One particular problematic to the Department of Public Health relates to the revolving door, and there's a revolving door provision that prohibits any employee from going to work for a year for anybody where they had a substantive involvement in a matter involving that entity and that makes sense.

There is sort of a super duper revolving door provision that just says if you are the head of the agency and the agency had anything to do with anybody in connection with a license, a regulatory matter, or a contract over $25,000, you're barred whether you had anything to do with it personally or not.

And since, as you know, our statute requires the Director to be a doctor, and we license every hospital in the state, and we give grants to every health department in the state, and we are involved in contractual relations with many health advocacy groups in the state, and we give money to almost every university in the state, the interplay of those two statutes to basically require anybody who chooses to become head of the department to become unemployable in the state of Illinois for a year is a problem.

So that's where things stand in Springfield right at the moment.

CHAIRMAN ORGAIN: Let me just -- I

think that answers your question, Steve. So we get an idea of where we are, where we stand as a board.

And I just need to ask the question. Do we want to make any comments in regards to the chiropractor and physical therapist joining the board? Is there any sense one way or the other, any feeling one way or the other about that from the board members?

Okay. Just thought I would ask that question in terms of advocacy. We do have guests.

MR. CARVALHO: Keeping in mind that it would be in the minutes for your new colleagues in three months if the bill is signed.

CHAIRMAN ORGAIN: Yes. And I guess we have guests. If there are any questions or comments from our guests.

MS. KING: Yes.

CHAIRMAN ORGAIN: Please.

MS. KING: I was just wondering how you notify people of this meeting?

CHAIRMAN ORGAIN: That's a good question.

MR. CARVALHO: Is someone familiar with -- Cleatia, where do we post the notices of these meetings?

MS. BOWEN: The notices are posted on the internet, and they are posted in the IDPH office building.

MR. CARVALHO: Okay. So the Open Meetings Act has us post them in our office but then we also put it on the internet.

MS. BOWEN: On our website, the IDPH website.

MS. KING: My understanding is that the Open Meetings Act also requires you to post your meeting location, and one of the reasons I came to this meeting late is because your posted notice says that the meeting is at the Thompson Center. So, you know, in fact this meeting wasn't properly -- the public wasn't given proper notice.

MR. CARVALHO: Cleatia, did you hear

that?

MS. BOWEN: No, I didn't.

CHAIRMAN ORGAIN: Could you say your name and then I think -- and I'll just repeat. We were advised about the change in the meeting from its original site of the Thompson Center, and our guest indicates that it may not have been posted on the website for the change in the meeting.

MS. KING: It's not may. It was not posted yesterday and this morning, and it says the Thompson Center and so I went over there. They don't know anything about it.

CHAIRMAN ORGAIN: So it appears as though it was not also corrected on the website and we will attempt to do better in the future in regards to if there is any changes in the meeting site.

MS. KING: And then also I think you need to check and be sure that the law also says that you're supposed to post at your meeting location and at your -- and at the office.

MR. CARVALHO: Cleatia, the point was that it's supposed to be posted at the meeting location. So when this meeting was moved to this location, and I will talk with you offline, but the notice had to be changed and the notice had to be posted at the new location.

CHAIRMAN ORGAIN: So we appreciate those comments for improving our activities and if you can say your name. If you can tell us your name, if you don't mind.

MS. KING: Judy King.

CHAIRMAN ORGAIN: Judy King, thank you very much. So we apologize for that and we have made note.

MR. CARVALHO: Thank you.

CHAIRMAN ORGAIN: Thank you. If there are no additional items for business --

DR. McCURDY: Happy birthday to Dave Carvalho.

CHAIRMAN ORGAIN: Oh, is it today?

MR. CARVALHO: It is.

CHAIRMAN ORGAIN: Oh, happy birthday.

MR. CARVALHO: My daughter is --

CHAIRMAN ORGAIN: She's like time. Get out of here. Okay.

And for those of you in Springfield, David's daughter is here. Oh, thank you. What's your name?

MS. CARVALHO: Christina.

CHAIRMAN ORGAIN: Thank you. Happy birthday.

MR. CARVALHO: Once we adjourn and go off transcript, I know she has a question for you.

CHAIRMAN ORGAIN: So if there is no further business, we wanted to make sure we put that on official business.

Then I would move for adjournment. If there is no opposition, then consensus for adjournment.

DR. McCURDY: Consensus.

CHAIRMAN ORGAIN: All right. Thank you everybody for participating.

Okay. So we're offline now.

(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 13th day of July, 2009.

_____

DONNA T. WADLINGTON
CSR #084-002443