STATE BOARD OF HEALTH

THURSDAY, SEPTEMBER 10, 2009

11:00 A.M.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

DIRECTOR'S CONFERENCE ROOM - 5TH FLOOR

535 WEST JEFFERSON STREET

SPRINGFIELD, ILLINOIS

Court Reporter:
Robin A. Adams, RPR, CSR
Illinois CSR #084-002046
Midwest Litigation Services
2021 Timberbrook Drive
Springfield, Illinois 62702
217.787.6167
1.800.280.3376

MEMBERS PRESENT OF THE STATE BOARD OF HEALTH:
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JERRY KRUSE, MD, MSPH
PETER ORRIS, MD, MPH (IN CHICAGO)
TIM J. VEGA, MD (VIA TELEPHONE)
CASWELL A. EVANS, DDS, MPH
ANN O'SULLIVAN, RN
HERBERT E. WHITELEY, DVM, PH.D
KEVIN D. HUTCHISON, MPH
JORGE A. GIROTTI, PH.D (VIA TELEPHONE)
KAREN PHELAN

ALSO PRESENT:
CLEATIA BOWEN
DAVID CARVALHO (IN CHICAGO)
SUSAN MEISTER
JASON BOLTZ
ELISSA BASSLER (VIA TELEPHONE)
MARY DRISCOLL (VIA TELEPHONE)

I N D E X

CHAIRPERSON ORGAIN: Welcome to another session of the Board.

(Discussion off the record.)

We'll introduce ourselves. I'm Dr. Javette Orgain. I'm the chair, State Board of Health.

MR.CARVALHO: Dave Carvalho from the Illinois Department of Public Health.

DR. ORRIS: Peter Orris, University of Illinois. (Inaudible.)

CHAIRPERSON ORGAIN: Can everybody introduce themselves for the court reporter.

DR. WHITELEY: Herb Whiteley.

DR. KRUSE: Jerry Kruse.

MS. MEISTER: Susan Meister.

DR. EVANS: Caswell Evans.

REV. MCCURDY: Dave McCurdy.

MS. SULLIVAN: Ann O'Sullivan.

MR. HUTCHINSON: Kevin Hutchinson.

MS. PHELAN: Karen Phelan.

MS. BOWEN: Cleatia Bowen.

CHAIRPERSON ORGAIN: And did everyone get the information in regards to the videoconferencing?

VARIOUS: Yes.

CHAIRPERSON ORGAIN: Okay. Just wanted to be sure.

So I want to thank all of those of you who traveled from Chicago to Springfield. I'm sorry I couldn't go today due to some other commitments. This gives us an opportunity to actually have the director who will present this morning. So I'm thankful for that.

So let's move on in terms of the agenda. Any comments on the summary? Item number two on our agenda.

REV. MCCURDY: Move to approve.

DR. ORRIS: Second.

CHAIRPERSON ORGAIN: There being no recommendations for change or additions or deletion, consensus on approval of the summary?

VARIOUS: Aye.

CHAIRPERSON ORGAIN: No objections?

All right. Great. Thank you.

Susan is next on the agenda, and thank you, Susan. I understand you have to leave us early, so please go ahead.

MS. MEISTER: This is Susan Meister. I'm the administrative rules coordinator for the

Department.

We did not have any rules for this meeting, so the rules committee was not able to meet. I'm sure they were all very disappointed, but we will have rules for the next meeting.

So I thought I would give you an update on where we are with the large number of rules that were approved at the June meeting and also with what's going on with JCAR.

So, first of all, the -- for the rules that we approved at the June meeting, the Birth Center Rules are currently being reviewed by the Governor's office. They have had a couple of concerns with the construction standards. So we're waiting for some information from them in that regard.

And the same thing is true with the -- what we call the IRMI rule, Illinois Regenerative Medicine Institute Code. That's the grant program for stem cell research, and the Governor's office is also taking a look at those.

The Swimming Pool and Bathing Beach Code. These are the permanent rules that will implement the Virginia Graeme Baker federal law regarding the pool

drains. Those will be published for the first notice comment period tomorrow on September 11th. And those will replace the emergency rules that are currently in place after they've gone through the regular rule-making process.

The Physical Fitness Facility Medical Emergency Preparedness Code was published for first notice on July 24th and the comment period -- the first day that that could be over was this past Monday. We've received several comments, and we'll be addressing those when we send the rule to JCAR.

The Rules of Practice and Procedure in Administrative Hearings that set forth the requirements for hearings under the Smoke-Free Illinois Act. Those were published for first notice on September 4th. The comment period expires beginning on October 18th.

Children's Community-Based Health Care Center Program Code. That was a change in the requirements for reporting use of restraints and incidents involving residents, and that rule was also published September 4th. Comment period expires October 18th.

The September 15th JCAR meeting, which is

next week in Chicago, we have two rules on the meeting, and those are the Sexual Assault Survivors Medical Emergency Treatment Code and the Adverse Health Care Event Reporting Code.

Does anybody have any questions? Yes.

DR. KRUSE: Do we know yet when the commentary period will be for the birthing center?

MS. MEISTER: No. We -- we need to finish our discussion with the Governor's office, and then the rules will be filed with the Secretary of State for the comment period. So I can give you an update when that happens. We can -- I can let everybody know. I can let Cleatia know, and she can e-mail everyone.

DR. KRUSE: I would specifically like to know --

MS. MEISTER: Okay.

DR. KRUSE: -- because the obstetrical indicators are fairly clear, and I've got them in hand now.

MS. MEISTER: Okay. So I will make a note to -- to let Cleatia know when those are published, and then she can inform everyone so that you can submit comments. And that comment period is a

minimum of 45 days. So we expect a lot of comments on that rule, and it will probably take us a while to go through all the comments.

We'll report back to you with a summary of what kind of comments we receive, what kind of changes we're making in response to the comments before we proceed with sending the rule to JCAR.

DR. KRUSE: Do we approve that again or just --

MS. MEISTER: No. We'll just -- it was approved already at the June meeting. So we'll just provide information, and if you want a copy or anything like that, you can let us know.

MS. O'SULLIVAN: I heard you say a couple times that some of the rules were at the Governor's office, and I've heard that in some other groups about other rules. I don't ever recall hearing that before. Is that a new step in the process, or is it taking longer or --

MS. MEISTER: It's been in place for a couple of years --

MS. O'SULLIVAN: Okay.

MS. MEISTER: -- I think, that we send them before they -- usually, before they go to first

notice of publication, and then if there are any questions or concerns along the way, they may ask to see them again.

MS. O'SULLIVAN: Okay.

REV. MCCURDY: That was done with the smoke-free rules, wasn't it?

MS. MEISTER: The hearing --

REV. MCCURDY: It went to the govern -- government -- Governor's office.

MS. MEISTER: Yes. Everything that -- everything that has been published for comment has already gone through there.

CHAIRPERSON ORGAIN: So, Cleatia, when the comment period for the birthing center is open, please also send out the rule again so that, in addition to the rule, we'll have Dr. Kruse's information.

And, Dr. Kruse, could you also just make sure that Cleatia gets a copy so that we can all see it again?

DR. KRUSE: Yes.

MS. MEISTER: And the rules will be published on our website. I try to forward that information to our website manager as soon as the

publication period starts so you can access them on our website when they're published.

CHAIRPERSON ORGAIN: Susan, are you -- have you completed your report?

MS. MEISTER: I have. Thank you.

CHAIRPERSON ORGAIN: Thank you very much.

REV. MCCURDY: May I ask a quick -- Dr. Orgain, may I ask just one question of Susan? And that is, so of all of this that we've just heard, none of this, if I understand it right, would necessarily come back to the rules committee.

MS. MEISTER: That's correct. Once they've been through the rules committee and the Board has voted --

REV. MCCURDY: And these are all old rules. So in terms of what might come to the rules committee next, do we have --

MS. MEISTER: That will be all new things next time.

REV. MCCURDY: And how soon might that start?

MS. MEISTER: We, I believe, have a meeting scheduled in November for the rules committee.

REV. MCCURDY: Right. So it will be something before that?

MS. MEISTER: Yes. We'll be mailing you a couple of rules, at least, the first week in November.

REV. MCCURDY: Okay. Thank you.

CHAIRPERSON ORGAIN: You're welcome. Thank you for your questions.

And it's a great day. We have the opportunity to hear from Dr. Arnold. Dr. Doman Arnold, who is the director for Illinois Department of Public Health. So he's getting set up. He'd also like to give a presentation on H1N1, and in addition to general remarks, we'll also be hearing on -- a bit on H1N1.

MR. CARVALHO: Cleatia?

MS. BOWEN: Yes.

MR. CARVALHO: I think one of the questions that Dr. Orris is going to have on H1N1 is a legal question. So if you could alert Jason so he could come to the presentation.

MS. BOWEN: All right.

MR. CARVALHO: Thank you.

DIRECTOR ARNOLD: Hello, everyone. I'm

seeing you there in Springfield but is there another room that -- oh, that's it? Okay. Oh, some people on the phone. Two people on the phone? Okay.

Thank you for coming together. I have been sort of remiss with my 86 different disasters last year with making these meetings, but I know that this Board is extremely important and what your mission is in order to address the issues that are confronting the state from a public health perspective. So I'm hoping to work much more closely with you this year in meeting the objectives that are, you know, set in front of us -- some by statute, some by necessity within the communities, and some by some of our federal guidelines that we're receiving from HHS and now DHS and multiple other agencies.

This year we sort of moved to expand the scope of public health a bit in statute in that we added the chemical and radiologic components to the bill which did pass. We now have a bit of an expanded role with respect to the public health viewpoint.

Previously, we were very constricted to this Pasteurian view of bacteria and viruses, which we do take care of, but we sort of go way beyond that

with water testing, with the ability to talk about things such as obesity, which sort of fall off the viral and bacterial category, but we cover so many different issues from safety within nursing homes to mobile health department outreach. We do, of course, have the HIV and STD components and hepatitis B and C and other various entities such as TB.

But we are much wider than that. We deal with radiological as well since the disaster happened, according to the Homeland Security Presidential Directive 5, which actually made the Department of Homeland Security, and Homeland Security Presidential Directive 8 instituted the National Incident Management System. We also have some essential support function, ESF 8, and we also interrelate with ESF 6 in that they say that we are covering those regions -- unbeknownst to our planning efforts, that those things are in federal statute that we actually cover radiologic responses -- chemical and biological. So this actually gives a little bit of a wider scope.

My reason for doing that also was that we are particularly funded basically through HHS, Health and Human Services, which passes money to the CDC and

then to us. But we also are doing things in food and drug safety -- in those arenas as well -- so that the FDA, the Department of Labor, the Nuclear Regulatory Commission, the Atomic Energy Commission, Department of Energy, the USDA -- all these institutions have some relationship or role with respect to public health delivery and should have some -- bear some financial input into that process as well. So it's a movement towards making sure that they are responsive to our needs too as a public health system as we start building things.

We -- the Department itself currently has 1123 employees. We cover 96 local health departments in 102 counties. The hospital systems -- all that -- we have all these regulatory things that are going on as well that are based in statute, multiple boards. But the Board of Health, I think, is particularly important for the overview of what is going on in the public health arena. That they are intimately involved in some of the policy decisions we're making and the direction we're moving in.

I actually went through the list, and I was very pleased with everyone who is on the Board and, you know, sort of passed my blessing to the

Governor's office about that issue.

So with that, we have 289 programs to operate simultaneously. I keep reminding the federal government and the state government that, even though we're focused on H1N1 presently, last year we had 86 natural disasters. I'm expecting more this year. I don't think we've done away with that particular problem. So it's going to put a particular strain on our local health departments and on the -- on the agency as a whole to make sure we make an eight-hour (inaudible) requirement to develop some continuity of operations. Planning has to make sure that we cover those other issues that are germane and important to public health, essential function for public health.

What I'm going to do is go on to the overview of this H1N1 to give you a little bit of a current update of where we are.

CHAIRPERSON ORGAIN: Can the court reporter hear Dr. Arnold?

REV. MCCURDY: Yes.

(Discussion off the record.)

CHAIRPERSON ORGAIN: Okay. Very good. So we're going to move on to the H1N1 situation. We're going to -- I think the slides are on. I have to

make sure that the technology -- I know this is set up but hold for one second. Let me get them.

CHAIRPERSON ORGAIN: Cleatia, do you have your speaker at the maximum.

MS. BOWEN: Yes. Yes, I do.

CHAIRPERSON ORGAIN: Thank you.

REV. MCCURDY: It's plenty loud here.

DIRECTOR ARNOLD: Great. Thank you.

DR. WHITELEY: We're not going to fall asleep.

MR. CARVALHO: No, that happens after the slides come through.

(Discussion off the record.)

DIRECTOR ARNOLD: Okay. Can you see this on your screen now?

VARIOUS: No.

DIRECTOR ARNOLD: There's a little bit of a time delay sometimes with the slides. Are you able to see it?

VARIOUS: No.

(Discussion off the record.)

CHAIRPERSON ORGAIN: In the interim, are there any questions that you might have for Dr. Arnold? Comments? Ideas?

DR. ORRIS: Well, I have a question about H1N1 but I --

DIRECTOR ARNOLD: You can wait towards the end on that.

MR. BOLTZ: Dr. Arnold, this is Jason Boltz. I'm here for any legal discussion you may need as it relates to this matter.

CHAIRPERSON ORGAIN: I'm sorry. We didn't hear. You can see the slides now?

VARIOUS: Yes.

MR. BOLTZ: We do have the slides now.

CHAIRPERSON ORGAIN: Okay.

MR. BOLTZ: Dr. Arnold. I'm sorry. Excuse me. This is Jason Boltz. I just want to let you know I am here if you need any --

DIRECTOR ARNOLD: Okay. Great. Okay.

MR. BOLTZ: -- discussion.

DIRECTOR ARNOLD: Thank you, Jason.

MR. BOLTZ: You're quite welcome.

DIRECTOR ARNOLD: Okay. So what we're going to do is I'm going to go through the general view of what we have so far for H1N1. I will make some comments about what happened in the spring time frame so that you have a better overview of where

we're going and why we're sort of doing what we're doing.

This basically is going to be a general overview presentation. Some people have the medical background, so excuse me for being very -- this will be redundant about different issues, but we're going to go through and talk about the specific issues that we are facing in the general planning. Okay.

Okay. The first thing is that we are going to talk a little bit about the World Health Organization, Center for Disease Control, the State of Illinois H1N1 planning, how this planning is going forward at this particular point in time, our distribution plan, the vaccine availability, the delivery sites, priority groups and also the H1N1 cases that we've had to date within the state, how we're getting the funding and how we're distributing the funding and, also, what you can do to stay healthy, some of our media campaigns that we're working with now.

Basically, the pandemic was declared. It was declared as a level six, and it involved 70 countries. We got to the point where we felt that this pandemic back in the spring was amassing a lot

of fear within the community because it was being -- we were being told this thing was coming and consuming us.

So we have things which are endemic, which are normal background levels of disease; and then we have epidemics, which are like our seasonal outbreaks of flu; and then we have a pandemic that's global.

But most people who hear something that is global -- they think we're being invaded from Mars, that the entire earth is being surrounded by this one particular disease entity, without talking about the severity of it and what does it really actually mean with respect to your local environment and how will it affect you.

The seasonal flu -- it turned out -- it's turned out to be very similar to the seasonal flu, and its impact with the seasonal flu. We have 36,000 deaths worldwide -- no, countrywide in the United States. Over 200,000 hospitalizations every year. And so we're at the point where we're looking at this pandemic, and we were looking at it from the spring time frame. It's something that was very similar to the seasonal flu in its impact as far as morbidity and mortality from what we could tell from the early

numbers. The media -- so we had to calm the media down.

The reason why this was so important is that we are estimating that the health care system saved this state -- and the public health care system saved this state in the range of billions of dollars by averting panic within the state. If secondary consequences and tertiary consequences had been allowed to unfold from this particular event, it could have closed businesses down, schools down. The work force would have been directly impacted at all levels. We're already in an economic downturn. It could have been catastrophic with its impact.

So public health has a responsibility not just for taking care of a disease entity but the actual global impact within a community of what we're facing and our interventions in that. So we took that into advisement.

Now, the pandemic five six level came in 11th of June when the World Health Organization declared it. And I'll talk a little bit more about that and what the World Health Organization's view is, how it's varied a little bit from the CDC, and, from the state level, how we have to interpret

things, why they're different.

We also have the monitoring of the outbreaks. So we were grabbing information from all over the state, centralizing it into our data banks in the laboratory system. Now, the CDC has a standard where we're following two major events: the total number of deaths that are related to this, and also the hospitalization rate for H1N1 documented cases. So we're not doing a general -- just searching for H1N1 cases. We are taking in the reports from laboratories with seasonal flu and H1 being considered in the same category. We are not searching those things down because the surge on hospitals, the potential for that, can divert all of our efforts from data collection in those hospitals and take away resources from local health departments, from the hospitals, and those people should really be on the front lines with vaccinations, making sure that the people are being taken care of. So we are making sure that we don't divert everything towards an unnecessary practice of everyone running to try to grab information.

So the CDC moved back away from that, and we learned that from the spring experience -- that we

had to step back. That the collection of all of these data points was important, but we were telling people also stay home, to take care of themselves if they had a mild flu case. So for us to try to say that we're really collecting data that's giving us a true denominator is kind of difficult for us to really use that as an epi point at this point.

So the World Health Organization was advising countries in the northern hemisphere to prepare for the second pandemic wave and that's for this fall. We also know from the tropical climates that we're bringing that advisory up. The CDC now has been giving some information related to what's happened in the southern hemisphere for their winter time frame -- fall and winter time frame, and they're finding that the actual incidence of the H1N1 impact on their communities, although they had more people getting sick, it was still relatively mild. They did not see any evidence of a genetic drift, which happens naturally over time, or a shift, a major change in the genetic material in the virus. So at this point we don't see that going on.

There were three cases overseas where there was some resistance to Tamiflu, but they felt

that those were all isolated and did not portend any particular impact on us as a general populous.

The countries in temperate parts of the southern hemisphere -- they said that they do have some localized hot spots. So those are the things where they had more outbreaks. We're experiencing this now within our country. We've also had the same kind of heterogenous kind of mix of outbreaks in certain locations, and I'll talk about the GIS mapping a little. We actually had a phone bank, and we were able to GIS map all of our phone calls. And then we also GIS mapped the actual cases that we were getting as reports in hospitalization. Totally different. People who are in other areas were being affected by the media and were calling the phone banks, and they had no outbreaks in their local counties. So those two things got to be very consistent with our media messaging and realize that it has an impact on the way that health care services are distributed. So they actually had runs on hospitals in areas where they weren't seeing cases.

The CDC has taken aggressive action to respond to the new -- to 2009 with the advent of a possibility of a severe outbreak in this fall season.

They are to -- their main goals are to reduce the spread and severity of illness. They're trying to provide some of the clinical tools that we need.

We do have a lot of things online. We actually have a website that is www.ready.illinois.gov and that will direct you to an icon that has the -- all of the plans for the state. We have all of those online so that you can actually go to our website and take a look at it. Some of the documents we have internally within that website.

We are now talking about whether certain information is going to go onto the web -- the general website for consumption by the general public, but there's certain issues that I think, for public health officials, you should be looking at as well.

We'll be keeping an update on all the hospitalizations, death rates. About two months ago or three months ago I sort of moved the authority from -- from the city into the county as far as the death registry. So our death registry now is electronic statewide. We will be able to get that one particular number. As far as the cause of death, they're supposed to be entering that into the system.

So within 24 to 48 hours, rather than six weeks as it was taking, we will be able to get an accurate death number which will give you some portion or some feeling for your Ro, for your equation for looking at the severity index. It's sort of a measure -- epidemiological measure for how serious is this particular outbreak. So it gives you -- it gives you an insight into where the deaths are occurring, and do you have one particular locale, which we can geocode, that's having more deaths than another locality, is there a greater need to focus on the services that are provided in that local hospital, is that community being affected disproportionately with respect to the rest of the state. So that -- that one particular number, I think, is going to be really a valuable thing for us going down the road.

It also is not just geocoded for this particular H1N1, but will give geocoded information for the incidence of disease, deaths, what was the cause of death statewide. And you'll be able to geo -- we'll be able to geocode it for the particular areas. So that, I think, is going to be a valuable tool going down the road.

While the timing and spread and severity

of the upcoming -- you know, the H1N1 is going on, they anticipate also that the regular seasonal flu will be coming into play, which is really a major point that I'm going to bring up in a second that I think is really important for us to focus on. It's possible that a lot more people will get sick this season than normally occurs, and that's part of the basis for this.

We do have the enhanced surveillance, the tracking of flu activity, that we're going to be monitoring on a regular basis, and, again, that gets back to the deaths and the hospitalizations that we're talking about.

We also have community mitigation measures, planning at all levels for appropriate roles in prevention, guidance, and response. We have been in contact with all the health care systems, primary health care providers, local public health departments. We've been on regular calls with them throughout the process.

This began, actually, last year during the floods. We started having all of the local health departments on calls, talking to them about what are the things they need in order to get involved with

their local response efforts. So we felt that that was so valuable we started that again this spring with the H1N1.

And what they've been doing is filling out different tools that -- the CDC has a SurveyMonkey that actually allows them to register their particular needs for the H1N1 per season: How many vaccine doses they're going to need, what is the proportion of their population, and the climate disease. Those kinds of things are being collected so that we actually distribute this vaccine in a very efficient manner according to what their local health needs are. So that tool actually came out of this from the CDC, but we've been implementing it and bringing it into the process. My -- my staff -- actually, 42 members who were trained in the National Incident Management System levels 100, 200, 700, and 800, and then, back into the classroom, 300 and 400 levels and the CDC Meta-Leadership concepts.

This is really an essential part because the incident action planning scenario that we're fitting into the HHS and the Department of Homeland Security follows the NIMS pathway. The NIMS pathway, as I said before, was from Homeland Security

Presidential Directive 8, which was a revamping of the Incident Command System that came from the wildfires in California in 1984. It was a DOD model, Department of Defense model, about incident command and response. You know, so many people died, so many things were done where there was property loss that they had to developed an Incident Command System, which was transformed with the input from Fortune 500 companies after 9/11 into this new NIMS model.

It was serendipitous that they were actually trained in that because, when this came in April, they knew exactly how to fold into an Incident Command Structure.

So public health is becoming more and more involved in this Incident Command Structure for preparedness, but we also have the chronic disease and those roles -- acute disease roles to play as well and public safety. So we actually are making sure that this is sort of integrating into this model. So even though we're using this for an H1N1 response, it is the hope that this will become sort of the standard practice of how we approach health care concerns in general -- that we're starting to develop a response mechanism.

The schools and the Illinois State Board of Education, the Illinois Board of Higher Education -- we consulted with them directly with the implementation of CDC guidelines, wrote letters with them and for their staffs and for family members and children. So this is really an educational process as well -- that we're getting involved in their process of how they actually roll these things out to their day care centers, long-term care facilities. The correctional facilities are involved as well, the Illinois Department of Corrections. We're working very closely with IEMA, the Illinois Emergency Management Agency, in coordinating with other agencies on how this response will roll out.

We've also had very strong relationships and talk -- talks with the Illinois Department of Finance and Professional Regulation that regulates -- we don't regulate or license practitioners other than EMTs and paramedics. Everyone else is pretty much under the IDFPR purview. So as this is rolling out, many concerns were coming up about the expansion of roles of care providers, that we're going to need more people out there for vaccination implementation, for giving out the antiviral medications as well,

which we have been pulled back from in some part because antiviral medications should only be used for treatment, not for prophylaxis, because we don't want to develop resistant strains, for one, in midstream of giving out this vaccine. We don't want to also have people inappropriately using medications out in the field. So that -- that can have dire consequences for us as practitioners down the road.

Public health -- also surveillance, testing, response, guidance and vaccination, treatment -- all online. We have all of our outlines and plans as far as educational institutions, businesses -- all those things are online right now.

The vaccination campaign. We have a campaign for getting out to the general public, health care professionals, website development, and we would love to partnership with any of you on different ideas you have about this media outreach campaign, things that you think can be done in order to make sure that not only are the public notified about changes and updates and those kinds of things but also our practitioners, people who are out there who are service providers who are very closely aligned with the health care industry and with the

school systems and those sorts of things, our business community.

So as time goes on we're going to be unrolling -- we have media campaigns for the radio, television. We actually contracted with a circus. So we're going to actually be doing medical acts with the circus, public health service -- you know, yeah, for public health service messaging. We're going to talk about blood pressure, diabetes, and those kinds of thing. So they actually picked it up. They loved the idea. We're actually going to have acts in 57 performances with one circus. They're going to children's hospitals, they're going to schools, other than the 57 events that they have. So I think that those kinds of things, those innovations ,getting involved with the public at a very grassroots level.

The faith-based community. We have a pandemic faith-based group. We have 500 faith-based institutions we've worked with over this last year and a half too. They are -- 80 of them are broadcast ministers. One of them has a viewership of 20.6 million people. So we actually had them putting things in the spring into their missalette program, those kinds of things. Interdenominational so it

covers multiple religious groups. We had about 14 religious groups represented at our last meeting. So this on -- or faith or denominations.

The development of a media campaign is essential to reaching the public, increasing their understanding of the potential challenges in upcoming fall flu season. There are three components to this that are very, very important. Our message tagline right now is that it's easy as one, two, three. So we're trying to get the rights for the song right now with, you know, Michael Jackson's name being high right now, but it was ABC, it's easy as one, two, three. The one, two, three refers to one seasonal flu vaccination, two H1N1 vaccinations, and then three Cs: making sure that you, you know, cover your cough with -- sneezing or coughing into your sleeves or sneezing into your sleeve or a tissue with preferably disposing of it properly; making sure that you clean your hands on a continuous basis; and making sure that you contain yourself if you're ill.

Currently, the standards are saying that we have to stay home for at least six to seven days, and you have to be afebrile, without a fever, of 100 degrees or higher for at least a 24-hour period while

not being on antipyretic or fever-reducing medications. So once you've recovered, you can go back into the workplace.

We can start -- we already start talking to them about being very -- very creative about how to bring their work force that has already gone through the flu back into the workplace, so they can put them into key positions where they may be able to carry on functions without the fear of them getting sick again, to maintain this process internal. So that's, again, the easy as one, two, three.

The Illinois Department of Public Health continues to coordinate and collaborate with state agencies and private sectors in all aspects of H1N1 planning. To date, meetings and conference calls have taken place with the following, and I listed them again. These are all the institutions that we've been meeting with. We also met with some of the meeting -- people -- and I don't see it on here -- from the Meta-Leadership group from some of the business concerns that we've been talking to, and it's been very extensive with the number of people who are on this list. Also, the chambers of commerce for business. We've been meeting with them as well.

Tier one for the vaccination distribution plan. There are -- the CDC has announced 90,000 sites nationwide and in five territories that they will directly distribute these vaccination to. So we, in this state, have a distribution of about 2,782 sites outside of the City of Chicago itself. The City of Chicago gets direct funding from the federal government and gets its own direct supply. They have about 1,052 sites or so. I'll give you the exact number. But we are orchestrated now with all these distribution sites. We elected to have direct distribution sites. It gets rid of a lot of the -- just simple problems. The local health departments don't have to put out as much as far as coordination. We also have -- McKesson has been selected by the CDC. They are a great distributor of many health care products to hospitals and many hospitals already are on board with them. This outside entity will deliver these doses.

Initially, the CDC said back in the spring we're going to have 120 million doses. Now that has been decreased to 42 million because of production issues, and they thought at first they could use an antigen as well, and they found out the antigen will

not be applicable. And it would also require a lot more training for people to pick up an antigen and to draw up these syringes themselves. So if you started to increase the practice scope of people who are actually going to administer vaccine, it would be an additional skill set that they would have to acquire and the training of that could be prohibitive.

So tier two is the immunization promotion center. This is with IDPH, a warehouse that we have which distributes the vaccine. So if the system starts to become more cumbersome, we can go into a tier two strategy, which is a Vaccine for Children Program strategy that we always use all the time. As a matter of fact, the reporting mechanism that people are going to be using, which is part of that SurveyMonkey tool, will go through the Vaccine for Children Program in order for them to annotate the administration of the vaccine so that we keep a very close monitoring of this.

With the seasonal flu vaccine, we cannot monitor it as well because they get direct shipments that go throughout our system, but the H1N1 is coming down through the public health sector so we'll have better control over actually -- and get some good

numbers for a change on how effective our immunization campaign is with giving H1N1 out.

Tier three is the Strategic National Stockpile, and this, again, is from our emergency response section, our Office of Preparedness and Emergency Response. They have 11 different divisions. This is one of them. And they are the ones that have personal protective equipment and antivirals in case those are needed.

So, again, this is 45 million doses. It's wavering between 42 to 46, actually, the total number of doses. However, after that mid-October outlay, they will have 20 million doses per week thereafter. So there will be a time period.

My personal preference is that they march this campaign out to completion. That we continue with the H1N1 because what we'll get -- starting to get from the media is either the scare mongering, which we hope to control, but then the trivialization of the process, that, oh, this is just like regular seasonal flu, don't worry. If you get the seasonal flu, you -- it's just the same like getting the regular seasonal flu. So people may start backing away from the immunization campaign.

The reason why so it's important to implement it to its completion is because in the spring and maybe next fall this virus may change its structure, in which case we will be -- have a great leg up if we have a partial or complete immunity if a new strain emerges. So this is actually proactive in looking at the future if this were to come back in a different form. So we really want to make sure that this campaign goes through to completion.

Also, with the mid-October distribution time frame, the CDC is now talking about whether it's going to be able to roll out a smaller amount of vaccine earlier. So maybe early October, late September. We're waiting for confirmation. We don't know if this is going to be an actual thing happening. I think part of this is they're trying to ease the burden and the surge on the system for the priority groups and start earlier so that we can go, you know, into the October season. So they feel -- in part, the federal government feels that it's missed the curve to some degree, but in every epi curve you do have multiple bumps. So they feel that, even if we start in October, we still cover a significant portion of the epi curve. So it's very

important.

The local health departments have purchased their PPE for use by local health department workers, independent EMS units not associated with hospitals, and the local law enforcement will also get these through these local health departments. The hospitals have purchased their PPE for use by hospital personnel and EMS units associated with hospitals.

Now, this is a good time to talk about the mask and protection. The actual September 1st -- actually, September 1st a document came out from the Institute of Medicine talking about the use of N95 masks and the use of medical masks. Unfortunately, I have my mentor and person that drilled this into my brain back in residency training, Dr. Orris, about the N95 mask. What the N stands for is nonpermeable to oil. It's an industrial standard. Dr. Orris took me on many trips to show and illustrate that particular point.

But that -- what -- in industry, they used to have a silicon wheel that was used for metal grinding, and what you would use is oil as a dampen to keep down the dust, but you still had dust getting

through. So we had to develop this N95 mask in order to stop these particles from reaching your lungs, and it would result in silicosis.

So this N95 -- the 95 stands for 95 percent of the particles .3 micrometers or greater stopped from getting through. So it's not a foolproof method because we're talking about two different phases: Whether you're going to use a standard that's based on airborne particulate matter that is respirable that goes down into the alveoli, the sacs in lungs, or whether you're going to use a standard that's based on larger particulate matter that settles out very quickly because of the gravitational component, different splashes, those kinds of things, large particles.

Now, if you use the standard for the mask, the respirator, that comes from OSHA and NIOSH. So that's a different -- that's an industrial standard. The mask that we use for the medical arena, the medical mask, come from a standard that is based on the Health and Human Services contingent and the Institute of Medicine and their input and the CDC's input into the process that's used. That mask, the medical mask, has an efficiency about four to 90

percent depending on the study. So it's a very, very wide -- wide range. Things get around the mask and get in so you can breathe it. The mask was not engineered to protect the individual from exposure to organisms from the patient. It was really so that you would not cough into wounds. That was the initial intention.

The N95 mask is much more efficient in taking out particles but that -- again, the range is four to 90 percent. That's efficacy. That doesn't talk about efficiency of use. For someone to wear a N95 mask 24 hours a day for 180 days with three filters, you're talking about a huge, huge outlay by industry to produce all those masks and all those filters. If we use it just for the health care environment, that's one sector to use it for. But if we're saying that the potential for a contagium is six feet from a person who is either potentially infected with an influenza-like illness or -- so we're talking about people working tollbooths, or are we talking about people who are at banks? Are we talking about -- so these standards, if it were to be expanded to the general population, you're talking about over 12 million people needing N95 masks for

180 days. It is incredible, incredible thing.

So this IOM report is recommending the N95 mask be used, and they were sort of downplaying the use of regular surgical masks, but surgical masks -- the medical masks still can stop autoinoculation because one of the other routes is touching surfaces (inaudible) and then trying -- touching the mouth or the nose area or rubbing the eyes. So there are other mechanisms other than just airborne transmission, but transmission from environmental surfaces that are of concern as well.

They are all -- they also made a statement that we should be moving towards the institution of some of the issues related to administrative control shifts and those kinds of things, and environmental controls and engineering controls with blocking things out. So we -- we are looking at those particular things too. That report was sent to the CDC. So we're waiting for the outlay from that.

The reason why I'm bringing it up is it's such a major issue that the unions are looking at it as well. Hospital workers are concerned, EMS workers are concerned, our IDOT people are concerned. You name it. Every group has been coming to us asking us

do we use an N95 mask. So we're waiting for the final verdict from the CDC and what they're going to say the standard should be, but I think it's going to come down to common sense to some degree as well. You know, high -- those procedures which produce an aerosol mist or dust such as orthopedic procedures, those kinds of things, or ICU settings where we have very, very close patient contact -- that definitely those areas you want to consider it for. But, again, you start generalizing it, and you start having your cafeteria workers, and, you know, it can become cumbersome, very hard for hospitals to keep up.

I also mentioned that the hospitals and local health departments, because of the outreach for immunizations, are potentially subject to financial impacts because they're cancelling some of their procedures, potentially. They're shifting their staff to low-paying procedures such as immunizations, and they get 19 bucks, 25 bucks, as opposed to a mammogram.

And our other health care issues that we have. We've given out multiple grants. The Board has recommended a lot of programs that are in place as well. We cannot have those programs fall down in

the midst of this outreach because this outreach can be over an extended period of time throughout the year time frame. So they're looking at those issues. I told them they have to look at the funding for the programs that are already in existence, the core programs that we were talking about before, that they must be maintained through this response effort.

I went to these sites, so these are the actual numbers. 2,783 sites for the State of Illinois. That's -- for the State of Illinois that is excluding Chicago. Chicago has its own additional 1,045 sites.

The priority groups: pregnant women, household contacts and caregivers of children younger than six months of age, health care and emergency medical service personnel, people from six months to 24 years of age as well, and persons age 25 to 64.

And it is important to note that this is with concurrent medical conditions. Age is not an independent factor. What we're finding is that, unlike the traditional seasonal flu where we have children and seniors affected and people with chronic medical conditions, we're seeing this six-month to 24-year-old age group being affected. We're also

seeing the people who are caregivers to children less than six months. We don't want them transmitting it to the children. But we're not seeing this in the seniors. The seniors have been relatively unscathed by the advent of the H1N1 from the data we've amassed from the spring. So they're really changing our focus on the H1N1, making it different and distinct from our seasonal flu approach.

This is what we have so far: Hospitalized cases within the United States. 53 states and territories have -- have reported as of September 7th. We have five territories. It's kind of interesting. I'm trying to figure out what the other two territories are. But I know all the states have. Hospitalized cases: 9,079 cases nationwide. Deaths: 593. In the State of Illinois, we've had 412 people hospitalized with documented cases and the death rate has been 17. Most of those were people with asthma. So we're making a special effort towards people with asthma as well in our messaging and, also, people who were pregnant. We've had a couple fatalities from pregnancy. So those -- that's the population we really want to make sure that those people get vaccinated before anyone else.

So myself, I told them that, you know, I get my -- I'm getting my seasonal flu vaccination. The Governor has as well. But I think his office is going to make a statement to the effect that until these priority populations are done we're going to wait in line with everyone else. There was a great pressure from a lot of the agencies internally to -- throughout the state to get vaccinations for them and their children. And I said we are following the priority group. And the reason is that, if I get my vaccination and I'm not in one of those risk categories, I just allowed someone in that risk category to die. That's how I'm viewing it. They need to get taken care of first at the highest risk.

MR. CARVALHO: If you look at the hospitalized cases, Illinois, in most national data, is 4.5 percent of the (inaudible), and hospitalized cases we're exactly there. But on deaths, 4.5 percent would have been about 24, 27. So do we know why our death rates seems to be lower? Is it just somebody else's --

DIRECTOR ARNOLD: Because Illinois is the greatest state. It has the best health care system. No.

That's a great observation, but, you know, there's also the -- you know, it was Mark Twain who said there's lies and then there are damn lies and then there's statistics. Yeah.

So I look at the numbers, and one of the things is that we also -- remember, we give the quote that -- we always give this quote about 36,000 deaths nationwide and over 200,000 hospitalizations. I think that over 200,000 is probably more accurate than the 36,000 deaths. Because once we give a fixed number, we really don't know whether everyone's really tracing this out to the final note and actually entering the correct diagnosis where -- they say the person came in with an MI, they developed flu, and they died from an MI. So I think that, you know, some people are saying that maybe it's 56,000 that really are affected by the flu every year, and we don't really know. So I think there's some of that in the background, and then this is one sample. So we don't know whether it's skewed to one side or another and, you know, really where we are, or whether they actually accurately reported.

In Mexico, when they had the initial number, I think it was 168,000 -- no, a 168 deaths,

168 total. And they didn't know really what the denominator was. So it could have been 168 people who got the disease that died or it could have been two -- 20 million people in the city that got it and those people died. When they went back and looked at those numbers, they found out a lot of them were not flu. They were actually not recorded correctly. People were saying the croup or, you know, upper respiratory infection.

So I think that we have to really be careful about that analysis at this point, so -- but I think that it's -- at least it's somewhat consistent with where we should -- we're not seeing something, like, you know, a thousand deaths where we're missing the boat.

But on June 24th, the president signed the act into law, Supplemental Appropriations Act. That's Public Law 111-32. It allocated $7.7 billion to U.S. Department of Health and Human Services. They also went into the Public Health Emergency Response Grant and asked for a grant.

What I did was I equilibrated the grants based on a base amount and then a population-based amount for the first distribution. We have three

distributions of money that come to the state, and we can actually -- I'll give you the actual amount. But the first one I wanted to make sure that we got at least a $5,000 base. We could have done anything from zero to 10,000, but I gave a $5,000 base. And one of my concerns was that the rural health departments out in (inaudible) and rural areas be disproportionately impacted by this. And the reason being that if one doctor gets sick, one nurse gets sick, one health care provider, one laboratorian, that it can actually close down a local health department in a rural community. Whereas, in the city we have a little bit more of an ability to shift personnel around or to cross cover. So I wanted to make sure they had at least enough money to stand up initially.

Then the second wave of money came, and we gave them a base of about 2500 to make sure that they were able to meet their shortfalls.

The third group is coming through, and we're going to be doing more and more towards the population base to make sure that we're addressing the issue in major metropolitan areas like this area.

One thing that we don't have -- which we

don't have the 2010 census yet, but I think it's going to reveal that there has been a movement of some people out of the City of Chicago into the surrounding suburbs in the Cook County area. So we want to make sure that we're appropriately applying resources, and so we're working on old numbers right now from an old census data track. We're looking at some of the indicators that they normally use to track some changes in our calculations, but we want to make sure that we're effectively covering the communities that surround as well. So right now we're actually looking at that.

Another thing that came out with this was the PREP Act, and the PREP Act was actually for the Public Health Emergency Response funding, to make sure that we were having money -- or about the liability protections that are assumed by the federal government, and I think that's what Peter's question is going to be in a moment. So we're going to go through that.

This is actually what we got for the funding to date. There's about $2,953,181. We even went down to $1. The City of Chicago received about $839,620, and that's the total for all hospitals in

the State of Illinois. There are about 197 hospitals outside of the City of Chicago. The rest of the hospitals are in Chicago. So this is the total amount of money we have. Little bit -- almost $4 million.

The third round of funding actually is coming in. We're projecting that it's going to be a little bit higher than we expected. They're actually kicking in a little bit more money. So this is going to be good for us as a state. It's going to help us to make sure that we're putting processes in place that will work. So these are the actual numbers for the PHER 1 and 2 and 3 allotment.

The City of Chicago has their allotments as well. So for the entire state, we have $41.6 million, excluding the city of Chicago which gets 12.8 million.

Okay. And this is what -- know what to do about the flu, learn more about H1N1. I have another slide series that is more for a presentation that I should be giving at one point in time, but the reason why we are going through this site, we have the -- all the documents, as I said, can go through this site. We're trying to create a complete level of

transparency with all the documents, the planning, the policies that we're using. But we'd love your input, what you think would do better for the citizens of the state.

The next site is the flu site for the CDC, and so you have a direct link, but we can actually link through that -- our ready.illinois.gov site directly to the CDC site. So it's kind of another step.

The H1N1 planning also, from the legal level, I'll let Jason talk about that a little bit more. But last week I was in a meeting -- I'm actually on a COTPER board, the Coordinating Office for Terrorism Preparedness and Emergency Response, for the CDC, and also with ASTHO, the Association of State and Territory Health Officials, and then we have NACCHO on -- for a partner. National -- so NACCHO is the National Association of City and County Health Officials. But we had a meeting in Washington, D.C. last week, and they were a few issues I brought up. One was that the PREP Act is have -- we're having problems at the local level with the interpretation of liability protection. They assured me that the PREP Act actually is exempting

state law and goes down to the local level. Jason can talk a little bit more about that. He's been working very, very hard on state statute, federal statute, and how this is all overlaid. So I'm going to let him talk about that further about how that's being implemented. But they said that they would construct a letter and send it to NACCHO and ASTHO for distribution nationally. So Illinois was on the lead on that, pushing them to make sure that that comes down because we can -- we have to have the cooperation. I told them the two bottlenecks are funding and liability protection right now. That we have to make sure that the practitioners are -- feel safe in administering this vaccine.

That being said, I also said that we give chemo therapeutic drugs out every day, and we don't even blink an eye, but here we have a vaccine that's being produced. It's not an alien vaccine. It doesn't have antennae. It's being produced the same way we produce regular vaccines every year. So it's being produced in the same manner as the seasonal flu vaccine. We don't expect it to be different from that type of vaccine as far as outcome.

The thimerosal groups have been sort of

bringing their banners up, but it's been scientifically proven beyond a reasonable shadow of a doubt. Last spring they tried to get me to say thimerosal was an issue, and I said absolutely not. You're not going to make me say something that's unscientific and against public health policy and practice. So we averted that and told them -- told the legislators to go somewhere else for their answer. So that is something that is very important, get that point across.

If -- the reason why we're pushing the seasonal flu campaign so hard is because it does about four things, I think. One is it emphasizes the importance of public health in general and protecting the population. It causes 36,000 deaths and over 200,000 hospitalizations every year within the system. It potentially will stop that. It will also stop this population of people who are going to be susceptible to each one of these viruses separately, and, if they are in combination, give them more in the way of morbidity and mortality as a population. So it's important to stop that from occurring and to immunize the population so they don't take this back home to their co-workers and to children.

During this fall season and spring season -- Thanksgiving, Halloween, Hanukkah, Christmas, New Year's Day, Easter -- everyone takes their kids to their grandparents' homes and seniors. They are at more risk for the seasonal flu. And, also, these children are at risk for the H1N1 more so, but everyone's at risk. You're taking a loaded weapon into their home if the kids are not vaccinated and seniors are not vaccinated. So that message has to come across because they can be asymptomatic for seven to ten days, adults three to four days. So we have to make sure that people realize that you could be walking in and killing your grandparent. So that's going to be part of the messaging that -- it's not going to be quite as blunt as that because it's a geopolitical consideration. But that's the message that's really going to be getting across.

Also, the absenteeism in work. If you add the absenteeism rate from seasonal flu to the projected one for H1N1 -- 5 to 20 percent rate in seasonal flu, 20 to 40 percent in H1N1 -- you can demolish a company, devastate a company, if people come in concurrently, with the absenteeism rates. So very important to get rid of the seasonal flu, one,

and to push businesses to understand that the H1N1 can have a dramatic impact on their organization.

And I tell them, you know, with this -- with this vaccination campaign -- we've never done it before in history -- you have (inaudible) to watch the infrastructure of this country, with respect to the medical health care provision system -- systems, crumble if they start cancelling elective surgeries and they don't make the money they need to keep their doors open and have all their resources going out.

So we ask for flexibility, which we received from the Governor's office a go on is flexibility and the grant deliverables section for our grants that we give to grantees and the hospitals so that they have flexibility to move their staff into areas that are needed for vaccination campaigns and treatment of people who become ill.

I asked them also at the federal level for the same flexibility from the CDC grant profiles. So we're waiting to see if that is going to come into fruition from the federal level. But even though our grants are going out right now with statements that these are your deliverables such as the PHER grant and also the ASPR grant to hospitals, we are still

looking at much more flexibility and that that's not written in stone. And we're going to be working with our ASPR section to make sure that these things line up. There was some push back initially because the way the grants were similarly constructed as to prior years, but we're actually changing that a bit to make sure that we can accommodate the needs of the hospitals and local health departments.

Okay. So let's see. Do you have any questions or answers for me at this point? And then I'll move on to Jason for him to talk about the legal issues, and then Dr. Peter Orris is going to, you know, ask his question about liability protection. I thought once we had this in place then it would be a better framework for you to --

DR. ORRIS: The question's actually slightly different than --

DIRECTOR ARNOLD: Oh, okay.

DR. ORRIS: It's still a legal question.

REV. MCCURDY: So, Dr. Arnold, do you want questions now or do you want us to hold them till the end?

CHAIRPERSON ORGAIN: Now.

DIRECTOR ARNOLD: Now is fine. We can get

general questions, and we can more specifically drill down to the legal issue. I think that's one of the major areas as well.

REV. MCCURDY: Well, this is David McCurdy and I work in -- I want to ask a question and sort of make a comment from two angles of my involvement.

On the one hand, I work in health care and, as I'm sure you know, the private providers are at least somewhat fearful that their capabilities will be swamped by the worried sick.

DIRECTOR ARNOLD: Yes.

REV. MCCURDY: And so, of course, there's that. What sort of -- what do we make sure to tell the public? And they're crafting messages, as you know, that they're going to give to the public about when to call us and when to come in and when not to.

But, also, I speak as -- although I work in health care, medically, I'm a layperson, and so I'm reading some of the materials that we were sent, the printed materials about, like, common sense checklist for H1N1 and some of the swine flu questions and answers that we got. And I am a little concerned about both clear and consistent messaging --

DIRECTOR ARNOLD: Yes.

REV. MCCURDY: -- to help the public know. On the one hand, there's almost a if you're mildly sick, no need to come in, don't bother us. On the other hand -- then the other alternative in some of the material seems to be but if you're at death's door, then come in, you know. I mean, you have to be really, really sick. And so I'm wondering about the middle ground and what's going to help us in the public be a little clearer about how to assess that middle ground before we come to the emergency room or even call the doctor, you know, that sort of thing.

DIRECTOR ARNOLD: Absolutely. Absolutely. I think you couldn't be more on point on that. Back in the spring, what we've realized was that, you know, before the surge started -- and, actually, we started this before -- I think the CDC even changed its position, you know, before the state started --

(System shut down.)

CHAIRPERSON ORGAIN: What we want to do is take another about five minutes of questions for Dr. Arnold and then move forward on the agenda, but if we can do other five minutes of questions, that will be good.

DIRECTOR ARNOLD: Okay. Yeah. So to the initial question that you were asking previously. What we had started doing back in the spring was we realized that one of the things we wanted to do is prevent the surge in the hospitals. That was probably a fifth element that we could have added to the reasons for the seasonal flu vaccination campaign. Because if people get the seasonal flu vaccination, if they get that, hopefully, we'll avert the incidence of the seasonal flu in those people, and that would sort of help to also take away from that surge that we expect. People won't know the difference between H1N1 from the seasonal flu strain and the nH1N1 from the novel strain. So that's part of it too.

The messaging has to be consistent. What the problem we have is that the national messaging has to accommodate all states and five territories. And I brought this issue up with the CDC. That's one message. But when you get down to the local level, you may have pockets of outbreaks that are different that cause them to have different messaging within their local areas that is not just the state messaging as well. So we're working with local

health departments and the regions -- the local health -- the regional health offices are working with the local health departments to start talking about that messaging. But the messaging must be consistent with what the issue is locally, and that it's responsive to that particular need.

So I think you're absolutely right. It has to be a clear, concise message. We have to keep the media on message, on task. If there are changes that come down from the CDC and we go from a less threatening or a regular seasonal flu kind of situation with the nH1N1, then we will, you know, have that particular messaging, I think, which will be consistent with the state. But if they ramp it up and they say that this is becoming more of a problem, we're getting a more lethal strain coming out, we're seeing more deaths, that messaging has to be very, very consistent and follow very closely what the actual circumstances are.

So we actually are sitting down with the media. We're having meetings with them about making sure that we don't have this alarmist approach. We actually headed that off, and that was part of what I was talking about before about the secondary and

tertiary consequences.

There are 19 critical infrastructure and key resource sectors identified by the Department of Homeland Security presently. One of them -- I sent them a letter, which, to my dismay, is not on there -- is the sanitation issue. We also are meeting with the sanitation workers who are -- many of them -- or most of them, actually, are in the private sector. The reason is that we have more kinds of trash per person than ever before in history.

I went through the garbage strike in New York City in 1974, and it brought the city to its knees in four days. At that point in time the mayor, who was being requested to give them a 5 percent raise, ended up at the end of the garbage strike, which took about five days, giving them 12 percent to get them to go back to work.

The advent of a secondary epidemic wave on top of a pandemic could be devastating to the city. So I'm really very cognizant of the sanitation workers. 20 to 40 percent absenteeism rate potentially from just becoming ill, and on top of that, the fear. So we're trying to educate them

on -- they're worried about picking up contagious material. Can I get it from picking up trash from someone's home? That could have a devastating impact on our sanitation infrastructure leading to many, many more concerns, (inaudible) control concerns, those kind of things. So the messaging, I think you're absolutely right, must be on point, must be consistent, and try to prevent the surge from going to hospitals.

That's why, actually, when this SNS stockpile was initially structured to go in the hospitals, I provided it and sent it to local health departments. I said why are you telling people to go away from hospitals, to go to their local health departments and private providers, and at the same time we're sending all the stockpile to hospitals. Doesn't make sense. So that was part of the reasoning behind dividing that and making sure that local health departments -- and keeping 50 percent of that in obeyance and keeping that back in case we had local surges that we had to respond to. So that was part of the orchestration of that.

So the media messaging was very consistent for that. We kept them at our hip throughout the

whole campaign, and it actually helped quite a bit to stop a lot of those secondary and tertiary waves, which is why I said the public health system saved this state billions of dollars of lost work time, absenteeism from school, close down mechanisms -- business mechanisms.

So with that, Jason.

DR. ORRIS: I have a series of soup-to-nuts questions, actually. Feel free not to deal with whatever you think is important.

Let me ask the first one, though, which came to me this morning from David Marder, who is both director of employee health service and university health service at University of Illinois. At the U of I every year we're trying to increase the number of people that are vaccinated, and we're trying to get close to herd immunity this year -- close -- but that means several thousand more vaccinations than in the past. And so they're mobilizing a whole slew of extenders, as you mentioned. And they've run into an interesting new problem.

We've been not -- this is the Dr. Ryan Lewis, who is the associate dean for clinical nursing

practice studies. We've been notified that the Illinois Department of Public Health has determined that prelicensure nursing students may not participate in administering flu shots in any mass immunization clinics. They may only do flu shots or other immunizations in a situation in which a licensed provider is prescribing and assessing the patient -- history and physical -- and confirming immunization must be given.

The problem with that is that we are, of course, proceeding under standing orders. And, in fact, pharmacy students apparently can administer this under standing orders. What we need -- and, apparently, we've been informed that Daniel Kelber from the Department of Financial and Professional Regulation says pharmacy students can do it, but he indicates that the Nurse Practice Act does not address standing orders. So we need some clarification on --

DIRECTOR ARNOLD: Yes. Yeah, Jason has been working very, very hard on this particular issue with the Illinois Department of Financial and Professional Regulation. The problem, I think, partly stems from the fact that many times the

student nurses were working within clinical settings and could participate in normal vaccination programs, but this one is a mass vaccination which most -- I think most institutions really aren't set up for a mass vaccination campaign. So there was some discrepancy there. He's been working with them on that vaccination, but go ahead, Jason.

MR. BOLTZ: Thank you, Dr. Arnold. Again, for everyone who is not familiar with me today, my name is Jason Boltz. I am currently the general counsel at Public Health. I worked here for four years prior, and I've recently come back just recent -- this July.

In any case, Dr. Arnold is correct on so many different counts. There is a multitude of legal issues. One that we're discussing right now is concerning scopes of practice. It's certainly a significant one from the Department's perspective.

I think the gentleman just identified Daniel Kelber as an individual who has made some statements concerning these nursing students that apparently U of I is concerned about. It is true that nursing -- these nursing students or nursing assistants or what have you -- they are -- they are

within the scope and confines within the jurisdiction of the Illinois Department of Financial and Professional Regulation.

So for purpose of the Department's involvement, we are merely passing along their understanding of what that scope of practice would entail. It's going to be within their jurisdiction and authority to identify the limitations of what those folks can and cannot do. They license those individuals, and if they are identifying the limitations of their scopes of practice, it would be advisable to, you know, listen with good ears in terms of what they're saying because, again, they do license, they regulate, and it's within their jurisdiction.

DR. ORRIS: Well, let's stop right there, I guess. Listening with my new ears, as a physician, I venture to say that pharmacy students don't seem to me to be trained particularly better to give injections than nursing students. At the U of I, the nursing students will be relating on a one-to-nine basis with the medical director and there are APNs involved. I urge that this is inconsistent with Dr. Arnold's presentation about the importance of

mass screenings, and I think you ought to talk to these guys about it. I don't know where you're going to go with it, but I suggest so.

MR. CARVALHO: Certainly, a good point --

CHAIRPERSON ORGAIN: Just a minute. Jason, are you trying to speak?

MR. BOLTZ: Well, I was just going to say I think your thoughts and concerns are relayed each time we receive them. Certainly, Dr. Arnold's also correct in terms of the various entities we've spoken with throughout, whether they be another university, a school institution, a local health department. Whomever relays these particular concerns, the Department recognizes them. They recognize -- we recognize our role in terms of being the lead agency in response to this issue.

But, by the same token, the Department of Public Health understands and recognizes that we need to work hand in hand with other jurisdictional state agencies, and that does include the Department of Financial and Professional Regulation.

So we have brought them to the table. I think they've taken significant steps forward most recently in providing a list of recognized entities

that are appropriate currently for purpose of providing vaccinations or what have you. But, you know, while these issues are brought to the forefront, we need to continue to communicate, and we need to continue to communicate with the appropriate agency that's provided the authority for understanding, recognizing, and putting into play what the legally-recognizable jurisdictional limits are of a scope of practice, whether they relate to a pharmacist or a nursing student.

DIRECTOR ARNOLD: All right. And then, also, looking at the issue about paramedics being used, you know, and those kinds of things because there's some -- and also with the pharmacists -- they are limited with the age range. They cannot -- we're trying to see if we can potentially go down to nine years old because I think it stops at 14 years old.

MR. CARVALHO: I guess the question that he's asking is are we talking about pharmacists, pharmacy students.

DIRECTOR ARNOLD: Oh, pharmacists.

MR. CARVALHO: Pharmacists. So what I think Peter's concern was pharmacy students' ability versus nursing students. I would have to have -- I

would have to check --

DIRECTOR ARNOLD: Yeah, and it depends on their practice act. It depends on how they've written their document, you know. They've written their own -- that's their -- they actually go and approach the Department of Professional -- Financial and Professional Regulation with the -- what they would like as the scope of practice within their field. So they're the ones who establish the rules and the guidelines according to how their college particularly approach that issue.

CHAIRPERSON ORGAIN: Okay. And --

DIRECTOR ARNOLD: And what we're trying to do is really an emergency basis expand that scope of practice. Now, this scope of practice being expanded may not extend past the emergency period. So we have to find out whether we can scope -- you know, tailor something for an emergency response basis.

MR. BOLTZ: Now, let me say this: You know, I think we -- I think significant steps have been taken recently to identify where there may be problems or where there may be areas to evaluate the issue as it relates to vaccinations. And when I -- when I say -- when I say that, I mean more -- more

recently than not these very state agencies are coming to the table, are recognizing this issue.

Mr. Kelber is working hard now to evaluate and to understand where these limitations need to be and are at. I don't want to speak for him, but I can tell you he's on the issue now. I think now, though, is also the time to bring forth these concerns. I mean, I think a lot of folks, a lot of state agencies may have punted or passed the ball a little bit to the Department of Public Health in recognizance of its role with respect to this, but are now also understanding that their role in this isn't diminished or isn't something that they need to just pass the buck on. They are now coming to the table and understanding that, hey, listen, when things may change this fall, we need to be ready to make that evaluation. We need to know now, though, in what certain scopes of practice that we need to make a new evaluation for if certain other legal things happen.

We have some other questions here and I won't --

MR. HUTCHINSON: This is Kevin Hutchison, St. Clair County, working in public health, and we appreciate, Dr. Arnold and Jason, your work on this.

I think there's two issues here. One is the expanded scope of practice that may be needed, if necessary, under declared public health emergency should the governor declare it. That's -- and then we're looking at extenders for administration.

The second is the seasonal flu season that's already in place, and current practices where you have medical students and nursing students and other health trainees under appropriate supervision have been -- my understanding -- giving immunizations, no let alone, childhood immunizations. That's the standard practice and has been for many, many years.

We have an interpretation here that is quite -- very inconsistent with current practice, let alone expanding the scope. In our county alone, we have at least 600 nursing students that could be made available to help in seasonal flu now that we're being advised by, I'm sure, well intentioned but perhaps misinformed individuals at this agency. And I think I would certainly offer any assistance we can and perhaps as a body of the Board of Health, and we have medical schools represented here. We have the medical societies. I think we need to get

information into the hands of the individuals making this interpretation because this is a clear deviation from current practice in the State of Illinois and could not only dismantle our seasonal flu system capacity but our medical work force training and also, by extension, immunization programs for children.

MR. BOLTZ: If I may respond to that just generally because I understand what you're saying, and, certainly, it's an important point to be made. I think maybe a benefit as a result of this particular issue coming to the forefront is the opportunity to take a new evaluation of where these scopes of practice are. And because we are bringing the -- this agency, the Illinois Department of Financial and Professional Regulation, to the table to evaluate these issues, they can provide more clarity as to where those limits are.

But we cannot minimize that they're going to have a perspective on this, and we need to make sure whatever that -- whatever that interpretation may be is recognized and a discussion takes place. Because no matter which way we look at it, the law -- the way it's written right now -- has provided that

agency their -- the appropriate authority to make that evaluation. I mean, they, in fact, could take licensure sanction action against individuals who are identified as deviating from the law and that --

CHAIRPERSON ORGAIN: Wait. Wait. Wait. Ann.

MS. O'SULLIVAN: Speaking -- Ann O'Sullivan. Speaking as a nurse educator and a leader in the Illinois Nurses Association and very involved with the Nurse Practice Act, I think two points are clear here: The Department of Public Health is doing all it can to work with -- or at least from what I'm hearing -- to work with IDFPR. It is now incumbent upon us as Public Health officials, members, whatever to communicate with IDFPR on how this ruling is wrong.

There is nothing in the Nurse Practice Act or in the proposed rules that says exactly what the scope of practice is for nursing students. Because nursing students function under the guidance of their faculty and under the standards of practice of their faculty -- they're not working on faculty licenses -- under that guidance, they have the same scope as registered nurses do, basically, under the guidance

of their faculty.

And -- and, I mean, I know this isn't your call. It's IDFPR's call. So I'm not arguing with you. I'm just trying to give us information that would help us communicate with. I know the deans and directors of programs in the State of Illinois are having a retreat tonight and tomorrow. I just e-mailed my president and dean to let her know about this, to bring it up, to see what they can, you know, do with IDFPR.

I want to repeat Kevin's point. They have been doing this, although not in states of emergencies in the state and maybe not in mass numbers of hundreds of thousands of people, but nursing students have been giving mass immunizations for decades for flu and other childhood immunizations, and there's no reason this is any different, and it's not in the law.

MR. BOLTZ: And I appreciate your comments and I think --

CHAIRPERSON ORGAIN: Just a second, Jason. Go to Jerry.

MR. BOLTZ: Okay. Well -- that's fine.

DR. KRUSE: Well, I just want to say that

I agree wholeheartedly with Kevin and Ann about this, and I clearly understand that they have the authority. But I think the State Board of Health needs to take a strong action here by whatever mechanism it can to communicate to IDFPR that we -- that we think that this ruling needs to be overruled. Whether that means an in-person meeting, a face-to-face meeting of the boards, letters, whatever that might be, that's what we need to define.

Now, let me say one other thing. As we move forward, in the next few years and decades, we're going to be facing dramatic health care personnel shortages in virtually every health care field. And it is -- it's very important, to steal a phrase, that everybody is working at the top of their license to avert all kinds of shortages. So from my standpoint, this does not deal just with emergency situations. This deals with the way we view things from here on out in all situations, routine or emergencies, and we've got to take a very liberal interpretation of this in order to have the greatest benefit for the population, and I think that's -- that mission we have to focus on.

CHAIRPERSON ORGAIN: So let me just make

the rec -- let me just ask if it is the desire -- so that we can make sure that we get through some of the other things on our agenda -- is it the desire of the Board, particularly since we have the director here, to have this discussion -- to make the recommendation and to have a discussion with IDFPR in regards to the scope of practice and the need not only for personnel to be -- the scope of practice to be correctly interpreted such that, particularly for this season and others, that we have the number of personnel that we need to address the possible pandemic?

MS. O'SULLIVAN: Yes.

CHAIRPERSON ORGAIN: Okay.

DR. ORRIS: Second.

CHAIRPERSON ORGAIN: All right.

DIRECTOR ARNOLD: Okay.

CHAIRPERSON ORGAIN: So I think that the Director has heard that. I think we'll craft something from Ann and from a policy perspective as --

DIRECTOR ARNOLD: Also recognize that in the background there's another thing going on as well, and that's the emergency declaration from the Governor himself. We are pushing to get the

emergency declaration put into effect earlier to cover the administration of the seasonal flu vaccine activity because this is -- you're really working with mirrors here. Because if you have a seasonal flu campaign, it should almost mirror what the H1N1 campaign is going to be as far as scope and how many people are going to be required to administer it because they're trying to get complete compliance.

CHAIRPERSON ORGAIN: So then what is the emergency declaration going to specifically say?

DIRECTOR ARNOLD: Well, that gives the Governor specific powers, but we're working through that now. Jason is much more familiar with that, about what kind of powers does it give the Governor to modify and change rulings of laws that are in existence.

CHAIRPERSON ORGAIN: Okay. Okay.

MR. BOLTZ: Yeah. Thank you, Dr. Arnold. As you can tell, we're working on many, many fronts in order to have a coordinated effort to respond to this, and I do want to thank all of you for your input and your passion as it relates to the scopes of practice issue. No. I really think that it will be helpful for representing what those needs will be.

And, in fact, I have encouraged other entities to submit to Department of Public Health or whomever if you have a list of identified health care professionals that would be appropriate for an expansion of scope of practice if we finally get to an understanding of where the scope limits are.

Now, setting that issue aside, because it is a very, very big issue, and it will be touched on by the one that Dr. Arnold just alluded to, a disaster proclamation.

Currently, as the law is situated, it provides a mechanism under the Illinois Emergency Management Act for the Governor to issue what's called a disaster proclamation. Now, many of us think of the word "disaster" and have certain connotations attached it. It's more broad than -- more broader than that. The definition does include the verbiage of public health emergency, and that's defined as well, and it has already been interpreted through a separate definition by the federal government for the PREP Act where the -- where the federal secretary for DHHS has made a -- his own separate disaster declaration.

But in the State of Illinois, the Governor

has the authority, under Section 4 of that Act, to issue what's, again, called disaster proclamation. That is significant. If that occurs, it would provide the -- it would provide the opportunity -- it would trigger the emergency powers to be implemented for the Illinois Department of Public Health as well as the Illinois Department of Financial and Professional Regulation. What that would have -- what it would provide for is the scope of practice issue. It would provide for an expansion, a modification, relaxation of various regulations that the Department of Public Health and the Department of Financial and Professional Regulation are currently required to enforce, to authorize, to interpret, what have you.

Now, Dr. Arnold's already alluded to the EMS Act. That's the act that provides the Department of Public Health its authority to license and regulate paramedics, EMTs, so on and so forth. Now, that could be a health care professional, if I can call it that, that we could, under a disaster proclamation, modify their scope of practice.

Now, we are very limited in terms of who we license. That would be the key entity that we

would identify for such an action under a disaster proclamation. DFPR would have a much -- lot larger, much more wider expansive authority to look into modifying scopes of practice for other entities, for other health care professionals to respond to a disaster, to respond to a health care emergency. Now, currently --

CHAIRPERSON ORGAIN: Jason.

MR. BOLTZ: Yes.

CHAIRPERSON ORGAIN: Excuse me one second. Let me -- because of the timing -- I'm don't want to cut you off, but because of the timing, we have a few more issues on the agenda.

But I'd like to recommend, if this is satisfactory to the group, that I'll work with Dr. Arnold and work with you to get this information to the Illinois Department of IDFPR so that we can clarify some of those issues of scope of practice, clarify what has been the practice, and see if there's some kind of modification or remediation we can do to this issue currently. If that's acceptable to the group.

MR. BOLTZ: But before you make your motion or put it down --

CHAIRPERSON ORGAIN: It's not a motion. It's not a motion. It's just a recommendation.

MR. BOLTZ: Okay. And I understand that. I wanted to say that the Department of Public Health is already currently working with the Governor's office, with the Illinois Emergency Management Agency, and DFPR in order to work through the various issues that are attached to this proclamation. So I did want to let folks know that that is underway and it is ongoing.

CHAIRPERSON ORGAIN: Yes. And what we'd like to do is add some additional input into that process.

MR. BOLTZ: Okay. Sure.

CHAIRPERSON ORGAIN: Thank you.

MS. O'SULLIVAN: And, Dr. Orgain, I'd be happy to work with you if you'd like it.

CHAIRPERSON ORGAIN: Perfect. Thank you very much.

DR. VEGA: This is Tim Vega. I just had a clarification. I didn't quite get this. Are you -- is the scope of practice expansion that you're talking about assuming that there's physician and nursing work force exhaustion? Is that what

you're -- or are you assuming despite -- where the nurse and physician supply is not exhausted?

MR. BOLTZ: I assume only -- I mean, I'm not assuming anything. I guess, if it were a situation where the Governor made the decision to issue this proclamation, that he would deem it appropriate to issue a proclamation to provide for an expansion of scopes of practice or other relaxation of regulatory requirements. That evaluation would be made by the Governor in consultation, I would guess, with the directors of IEMA, of DPH, as well as DFPR. So, you know, it's a decision making that needs to take place and would take place at the very top of state government. But, again, I think -- I think that decision making helps from input from all sources, including this Board or other health care professionals that would identify the resource issues as it relates to the -- specifically, the administration of this particular vaccination effort.

DR. VEGA: Okay. Thank you.

CHAIRPERSON ORGAIN: Thank you very much, Jason.

Let me just again thank Director Arnold for being here, for giving us the presentation. It's

a pleasure.

DIRECTOR ARNOLD: I just want one -- one other thing about the vaccination, please. The issue came up of whether we should make vaccinations mandatory for health care workers. I think that's terrible. We are advising that people, you know, sort of stand up to the code of being a health care professional and get their vaccination. New York moved forward with that, and I told them that was -- you know, I spoke to the director there, I said, that's not a good idea, and they still went forward with it. And it's causing union issues, it's causing -- I mean, everyone's up in arms, and I think it was a bad, bad decision for them to make. So our stance is still, you know, it's not mandatory, but that it's highly suggested.

CHAIRPERSON ORGAIN: Loyola University has mandated (inaudible) health care (inaudible) and we haven't heard much. So I appreciate that additional information.

I wanted to also have everybody introduce themselves, but we've run out of time for that in regards to introducing themselves to you because I want to make sure that we get through at least a

little bit more of this agenda so that -- from the perspective of those who are there and those who are not.

Again, we absolutely appreciate you being here. Jason, we appreciate your information in regards to this issue.

MR. BOLTZ: Yes.

CHAIRPERSON ORGAIN: I think that ours was just simply a recommendation that we need to add more voices to it, particularly those of us who are in practice, maybe deans of -- deans of the universities, top-level administrators, et cetera. We appreciate your effort. Thank you.

MR. BOLTZ: Could I please just -- could I pass along my information to individuals here if they -- of this Board?

CHAIRPERSON ORGAIN: Oh, absolutely.

MR. BOLTZ: Okay. Again, my name is Jason Boltz, B-o-l-t-z. I'm the general counsel here. The number of legal services if -- you know, if I can be of assistance is 217-782-2043. If anyone --

CHAIRPERSON ORGAIN: 20 --

MR. BOLTZ: 2043.

CHAIRPERSON ORGAIN: Thank you.

DIRECTOR ARNOLD: Because we want to make sure we work very, very diligently to make sure that this legal process is sound because we're telling people that they can do things that, you know, can affect their careers, and we want to make sure that everything we tell them is actually what they can do because it can destroy their career.

CHAIRPERSON ORGAIN: Thank you much.

DIRECTOR ARNOLD: Okay.

MR. BOLTZ: Thank you.

CHAIRPERSON ORGAIN: Thank you very much.

So we're -- we're going to move the agenda on that and move very quickly because we have about -- I'm hoping that you all can give us just a few more minutes than the absolute, drop-dead time of one o'clock.

Elissa, are you on the line?

MS. DRISCOLL: This is Mary Driscoll. I just want to introduce myself. I'm the -- going to be the Department liaison on SHIP. So I can quickly go through some things, and then if Elissa does come on the line, she can add. Because, as you know, the IPHI is our point people on the SHIP.

So we have made the appointments to the

SHIP -- the director has made the appointments, and we have the new SHIP advisory committee. We have sent out letters to them, highlighting the State Health Improvement Plan, informing them of what it is, introducing them to the strategic priorities, and the new emerging issues, and the meeting of the new team is going to be called for October 21st and then the -- I guess that's -- that's the main update.

So, Elissa, if you're on the line and you want to add anything, and then if anyone has any questions, but we'll be giving you more updates as we go along with this.

MS. BASSLER: This is Elissa. Can you hear me?

MS. BOWEN: Yes. Louder, Elissa.

MS. BASSLER: I just -- I just wanted to sort of add that we -- the Institute has been putting together, as you know, over the past several months --

COURT REPORTER: I'm sorry. I can't hear you.

MS. BASSLER: I'm sorry. Can you hear me now? Okay. The Institute has been putting together several assessments that will help to inform the

process for the State Health Improvement Plan -- the (inaudible) assessments -- redoing or updating the assessments that we did before for the first SHIP.

So the National Public Health Performance Standard Assessment, which many of you came to that retreat, that -- the report on that is done, and IDPH is reviewing it. We have done -- collected all of the data for the state health profile, looking at all of the same indicators we looked at the last time, and so we have most of the body of that report done. We're going to be doing a little bit of work around any statistical significance in the -- we've updated it. So we have a new year's worth of data relative to what we had for 2006, and so we'll be looking at whether those -- those data and whether there is a difference, say, in the cancer rate or something, whether those are statistically significant differences.

And then we're -- we're finishing up and collecting some information for the Statewide Themes and Strengths assessment. So we've looked at what all of the local health departments have put in as their priority areas for their round of IPLAN. We're collecting some information on other state-level

plans that could help inform, and then we have some information mostly from the summit that we did last summer on the status us of the 2009 SHIP.

So those are the status of implementation, and so those are the assessments that we'll be providing. Some of them we'll be reviewing at the first meeting, probably not all of that, and then the other -- an important activity at the first meeting will also be for the team itself to conduct what's called the Forces of Change Assessment where we're looking really -- a sort of environmental scan -- what is going on, what is the context for a State Health Improvement Plan -- so that we can meet really what we're looking for out of this planning process which is some more action planning or implementation planning for the 2007 plan, as well as identifying whether there are some emerging issues that weren't included in the 2007 plan that need to be addressed in the 2009 plan.

And we're hoping to -- we're expecting -- but this sometimes gets pushed by the team -- it may get pushed by the team itself to get through this process all through by the sort of end of this spring, and that would include what the law requires

which are three public hearings for the State Board of Health to hold on a draft of the plan. We would hope that we'll have something somewhere in the neighborhood of April for those public hearings. You all probably remember doing those the last time as well.

CHAIRPERSON ORGAIN: Thank you, Elissa and Mary, for that update in regards to SHIP.

Next on the agenda would be David Carvalho for the appointments and reappointments.

MR. CARVALHO: Thank you, Dr. Orgain. I won't do a legislative update because we've sent you a memo that shows all the bills. If there's any questions you have about that, you know the site. You can go online to see the full legislation. I note that because one of the pieces of legislation expands the State Board of Health to increase it to 19 and including physical therapists and a chiropractor. So, in addition to that, I'm working with the Governor's office appointment person to get all the other appointments in shape.

As you know, all of you have terms that expired either in November 6, November 7, or November 8, but you continue on until or unless an appointment

is -- replaces you. And since none have, you all continue on. Karen has actually the record. I think she is approaching her fifth year of expiration (inaudible) status. Thank you so much. Thank you so much for hanging in there.

We -- I am working with someone in the Governor's office to put all the boxes in place so that we go back to having a fully-appointed, three-year staggered term set of appointments. Because the anniversary date is November 1, we'll probably try to start things at November 1 so that none of you are in terms that last two weeks. But we probably will have people in terms that last on paper one more year or two more years.

On the off chance -- and there's no reason you need to say it now. On the off chance there are any of you who are not interested in being reappointed, please let me know personally so that I can work that into my grid because it is -- as you know, this is an extremely categorical board with specific doctors, specific ages, specific representations, specific disciplines, and to put everybody into a box that works requires some juggling. And if there's anybody who doesn't want to

be in a box, it would help me to know that.

CHAIRPERSON ORGAIN: So while -- while Dave had indicated he'd like for you to tell him personally, I'm going to move the agenda to your item number VII. We've going to -- because of timing, as David indicated, in regards to legislative update, you have that information in your packet.

We need to go to item number VII for election of officers then and discuss the issue of committee chair. So if you're holding a committee chair position and you are not interested in remaining on the Board, as you indicate that to David, he'll let me know because we'll have to consider that in regards to committee chair unless you want to be so bold in terms of letting us know now.

Otherwise, we need to move to the position of chair of the Board and co-chair of the Board. I know I had indicated my concern about being the chair, but I'm willing to remain in that position if that is your desire.

So let us move forward with that in regards to election of those officers. David McCurdy, I'm going to let you take over now as the

co-chair for the position of chair of the Board so that if anyone is interested they can express themselves.

REV. MCCURDY: Can I just ask for one word of clarification? So this is for -- for a one-year term; am I correct? Or is this for -- no, I'm serious. For how long --

CHAIRPERSON ORGAIN: That's correct. You are correct.

REV. MCCURDY: Okay.

CHAIRPERSON ORGAIN: You are correct.

REV. MCCURDY: Well, I'll entertain nominations for the position of chair of the Board.

MS. O'SULLIVAN: Karen, should we do our normal thing?

MS. PHELAN: Yes.

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

DR. KRUSE: Second.

REV. MCCURDY: A nomination has been made and seconded. Are there other nominations? If not, I'll entertain a motion to close the nominations.

Mr. HUTCHISON: So move.

DR. KRUSE: Second.

REV. MCCURDY: All in favor?

VARIOUS: Aye.

REV. MCCURDY: Opposed?

I think, Dr. Orgain, that kind of means that that's it. Or to put it another way, qualms or not, you're in.

CHAIRPERSON ORGAIN: Okay. Well, thank you.

And now I'll continue. Any nominations for co-chair of the Board?

REV. MCCURDY: If I were nominated, I would serve. I will say that much.

MR. HUTCHINSON: I nominate Dr. McCurdy.

MS. PHELAN: I second.

DR. KRUSE: Move the nomination--

CHAIRPERSON ORGAIN: Any other nomination?

DR. KRUSE: I move the nomination cease.

CHAIRPERSON ORGAIN: All right. Okay. And since we have worked on a consensus basis, then let's just have one unanimous vote for Dave McCurdy, and if there's no objection, abstentions, then consensus. Is that consensus?

VARIOUS: Yes.

CHAIRPERSON ORGAIN: All right. Thank you. So we will -- we are -- if I can -- and if I

can speak for myself, we are happy to serve in our capacities for an additional year.

REV. MCCURDY: That is true.

CHAIRPERSON ORGAIN: And thank you for your vote.

If you have -- assuming that we're all reappointed, and we will be making sure that we contact you again, let me express my thanks to Director and to you all, particularly those of you who could have stayed in Chicago but were very diligent in traveling to Springfield. Thank you very much. We hope -- hope we can continue. One of our next meetings will be in Chicago, and please, if you have any agenda items, forward them to Cleatia.

Are there any other concerns or questions prior to our adjournment? Announcements.

VARIOUS: Thank you.

CHAIRPERSON ORGAIN: There being none, can we have a motion for adjournment?

REV. MCCURDY: S moved.

DIRECTOR ARNOLD: I have a couple minutes if you want to say hello or, you know, introduce people after the meeting.

CHAIRPERSON ORGAIN: Oh. Yes. Yes. I'm

sorry. We can actually officially close our meeting, and people can introduce themselves to Dr. Arnold, say a little bit about yourself.

So we are officially closed for the meeting.

(Meeting concluded at 1:10 p.m.)

CERTIFICATE OF REPORTER

STATE OF ILLINOIS)
) ss.
COUNTY OF SANGAMON)

I, ROBIN A. ADAMS, a Registered Professional Reporter, Certified Shorthand Reporter, and Notary Public within and for the State of Illinois, do hereby certify that these proceedings were taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and further that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

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Notary Public in and for
the State of Illinois

My commission expires May 21, 2012.