STATE BOARD OF HEALTH

THURSDAY, MARCH 11, 2010

11:00 A.M.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

DIRECTOR'S CONFERENCE ROOM – 5TH FLOOR

535 WEST JEFFERSON STREET

SPRINGFIELD, ILLINOIS

Court Reporter:

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MEMBERS OF THE STATE BOARD OF HEALTH PRESENT:

JAVETTE C. ORGAIN, MD, MPH, CHAIRPERSON (IN CHICAGO)
REV. DAVID B. McCURDY, CO-CHAIRPERSON (IN CHICAGO)

JANE L. JACKMAN, MD
JERRY KRUSE, MD, MSPH

PETER ORRIS, MD, MPH (IN CHICAGO)
TIM J. VEGA, MD (VIA TELEPHONE)

CASWELL A. EVANS, DDS, MPH
KEVIN D. HUTCHISON, MPH

JORGE A. GIROTTI, Ph.D. (VIA TELEPHONE)
KAREN PHELAN

MOHAMMED Z. SAHLOUL, MD, FCCP (VIA TELEPHONE)

ALSO PRESENT:
CLEATIA BOWEN
DAVID CARVALHO
SUSAN MEISTER

ELISSA BASSLER (IN CHICAGO)
<table>
<thead>
<tr>
<th></th>
<th>A G E N D A</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>I. Call to Order</td>
</tr>
<tr>
<td>3</td>
<td>II. Approval of Dec. 10, 2009</td>
</tr>
<tr>
<td>4</td>
<td>III. Director's Remarks</td>
</tr>
<tr>
<td>5</td>
<td>IV. Policy Committee Report</td>
</tr>
<tr>
<td>6</td>
<td>V. Rules Committee Report</td>
</tr>
<tr>
<td>7</td>
<td>A. Medical Homes</td>
</tr>
<tr>
<td>8</td>
<td>B. SHIP Update</td>
</tr>
<tr>
<td>9</td>
<td>C. Leadership of the Policy Committee</td>
</tr>
<tr>
<td>10</td>
<td>V. Rules Committee Report</td>
</tr>
<tr>
<td>11</td>
<td>A. U of I Hospital Infection Control Code</td>
</tr>
<tr>
<td>12</td>
<td>B. Sexual Assault Survivors Emergency Treatment Code</td>
</tr>
<tr>
<td>13</td>
<td>C. Lead Poisoning Prevention Code</td>
</tr>
<tr>
<td>14</td>
<td>D. Swimming Facility Code</td>
</tr>
<tr>
<td>15</td>
<td>VI. Legislative Update</td>
</tr>
<tr>
<td>16</td>
<td>VII. Discussion Item</td>
</tr>
<tr>
<td>17</td>
<td>A. Local Health Department Funding 13/93</td>
</tr>
<tr>
<td>18</td>
<td>VIII. Adjournment</td>
</tr>
<tr>
<td>19</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
</tr>
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<td></td>
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<tr>
<td>23</td>
<td></td>
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<tr>
<td>24</td>
<td></td>
</tr>
</tbody>
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(Meeting began at 1:00 P.M.)

CHAIRPERSON ORGAIN: Can we just do a roll call? Let's start with -- we know that Dr. Kruse is in Springfield (sic). So we're beginning. We're officially starting the meeting.

Rev. McCurdy is going to take over for me at about noon. I'm sorry. I have a death in the family, and I do have to excuse myself.

But let's do a roll call. We know that Dr. Kruse is in Quincy, and maybe we can start in Springfield.

MS. BOWEN: Yes. Ann O'Sullivan will be absent today. Dr. Whiteley is traveling. Dr. Girotti said he would try to get in by phone, and Dr. Kruse is in Quincy, and he will be speaking shortly.

CHAIRPERSON ORGAIN: So roll call in Springfield.

DR. JACKMAN: Dr. Jackman.

MR. HUTCHISON: Kevin Hutchison.

DR. VEGA: Tim Vega.

MR. CARVALHO: Dave Carvalho.

MS. BOWEN: Cleatia Bowen.

MS. MEISTER: Susan Meister.
CHAIRPERSON ORGAIN: And here in Chicago.

MS. BOWEN: Hello?

MS. BASSLER: Elissa Bassler.

COURT REPORTER: Just a minute, please.

DR. GIROTTI: This is Jorge Girotti checking in.

MR. CARVALHO: We're trying to let the person on the phone introduce themself, Elissa, if you could wait one moment.

Go ahead on the phone.

MS. BOWEN: Go ahead, Dr. Girotti.

DR. GIROTTI: This Jorge Girotti at University of Illinois. My phone is acting up so I hope I come across okay.

CO-CHAIRPERSON McCURDY: You sound good so far.

DR. GIROTTI: Thank you.

MR. CARVALHO: On the TV in Chicago, so our court reporter knows who's speaking, it's awkward, but if you could state your name or in some way indicate who you are by waving, but state your name would be good before you speak.

MS. BASSLER: Elissa Bassler.

CO-CHAIRPERSON McCURDY: David McCurdy.
CHAIRPERSON ORGAIN: Javette Orgain.

DIRECTOR ARNOLD: Dr. Damon Arnold.

MS. PHELAN: Karen Phelan.

DR. EVANS: Caswell Evans.

CHAIRPERSON ORGAIN: So I think we're good to move on in terms of the agenda. Thank you all for being present.

Now, is Dr. Kruse still on the line?

DR. KRUSE: Yes, I'm still here and --

CHAIRPERSON ORGAIN: Thank you. Just wanted to be sure. All right.

Approval of the meeting summary. Any additions? Corrections? Deletions?

CO-CHAIRPERSON McCURDY: One possible correction, I think. There -- in the summary, under the SHIP update, which is on page three, there's reference to four subcommittees, and one of them is called Forces Have Changed, according to this, but when I went and looked at the transcript of the meeting, that phrase does show up in the transcript, but there's also the phrase Forces of Change. And I'm guessing that that is correct.

MS. BASSLER: It is Forces of Change, yes.

COURT REPORTER: Who said that?
CO-CHAIRPERSON McCURDY: Dave McCurdy to begin with.

MS. BASSLER: And Elissa Bassler concurred.

CHAIRPERSON ORGAIN: Any additional corrections or deletions?

David Carvalho?

MR. CARVALHO: Yes.

CHAIRPERSON ORGAIN: In the call to order, does it have to indicate that I leave at 12:00 o'clock or is that just something that -- that's not formally needed, is it?

MR. CARVALHO: No. At that point we can just have Rev. McCurdy indicate that he's now assumed the chair.

CHAIRPERSON ORGAIN: Okay. Just wanted to be sure. So we can -- for today as well. Thank you. No other changes or corrections.

Consensus to acceptance with the changes?

VARIOUS: Yes.

CHAIRPERSON ORGAIN: All right. Thank you very much.

We can move on to the next part of the agenda. Let's go to Dr. Arnold.
DIRECTOR ARNOLD: Okay. Basically, I just wanted to thank everyone for, you know, your continued support and everything you're doing.

We have a -- we had the budget address yesterday.

COURT REPORTER: Could you speak up, please?

DIRECTOR ARNOLD: Oh, sure.

We had the budget address yesterday, and after many months of doing battles with issues, it seems as though we have preserved the Local Health Protection Grants. They are at 100 percent of what they were last year. We also got an additional $4.4 million for the IBCCP program which was approved last Friday. And, also, approximately 8.2 million for the ADAP program.

So from a fiscal standpoint, the areas that we are suffering in, which we went through yesterday in the budget, are some of the programmatic grant areas that we have to address as a group.

COURT REPORTER: I'm sorry. Director, could you speak up, please.

DR. SAHLOUL: This is Dr. Sahloul.

(Discussion off the record.)
DIRECTOR ARNOLD: Okay. So yesterday we were going over the different budgetary areas where we had to do some potential cuts or restraints in those particular areas. Of interest is probably the effect of maybe the overall cuts on education, $1.3 billion, that can affect the academic institutions that support a lot of the functions that we perform. So those things have to be thought about, I think, even from the public health perspective, to look and make sure that -- that how -- how is that going to impact us as an organization.

But other than that, we are doing relatively well. We could always do better. We're going to have a total of about 8.9 percent cut in the funding this year. So the agency itself absorbed a lot of -- some of the pain to make sure that everything else is preserved, but the 96 local health departments are really the cornerstone of delivery of care, and it's essential that they operate. So that we were not willing to sort of compromise on.

We also are moving into a time period where Elissa's team, with the IPHI, has been putting together this plan, along with the Department, but the issues that are arising are mainly obesity seems
to be the topic of interest. It also -- second one is tobacco abuse, and the third one is injury prevention. So in my discussions with the CDC and SO and HO, those are the three --

COURT REPORTER: I'm sorry?

DIRECTOR ARNOLD: -- those are the three areas: the obesity, tobacco abuse, and injury prevention.

The good thing about that is that I think that it gives us the opportunity to look at overarching programs and looking for programmatic platforms which address multiple issues within the same thing. I see basic cost savings in that. So, you know, sort of eliminating redundancies. If you give out a flyer for one thing, give it out for the other. Probably wouldn't want to give a Democrat and Republican flyer at the same time, but you give out -- you know, you're giving out services, and these things sometimes overlap.

But the good thing for us is that it's an umbrella, and it gives us a little bit more flexibility to start doing combinations and trying to figure out what's the best approach or a tact to public health concerns as one orchestrated
instrument, you know. So I think that this gives us a lot of opportunity.

The ILBOH (phon.) -- it says injury prevention. That includes everything that you could think of that causes death other than by direct disease to the body: motor vehicle accidents, suicide. It includes gun control. So violence. It includes slips and falls, you know, for senior citizens. Any kind of accidental poisonings or overdoses. So all those things are considered to be, I think, within that pool.

And so it gives us kind of a great opportunity to look at those categories, and I think following those guidelines well help us tremendously because they -- it's like looking on a roof for a quarter when you dropped it in the basement. I know Dave loves all these analogies. He may like that one.

But, you know, if the CDC says the quarter's in the basement and HHS says it and everyone is saying it, the White House is saying it, you know, we need to start, you know, looking at those programmatic areas because I think we -- if we align things along with that programmatic lineup, we
could go in and get a lion's share of some of the federal money.

We have been 38th for decades out of 50 states for funding. I mean, it's just -- it's unconscionable that a place that has such a large -- large cities and such -- a place like Illinois, the birth place of the Internet.

So I think that we actually need to be more aggressive and to looking at bringing some of those entities together and to get things down to local health department to get them more involved in that. You have advocacy groups that they can also work along with, but the flexibility allows them to have some flexibility and some degree of feeling of control over the process. They should be working with some of those advocacy groups because it can be an extension for the local health department.

But I don't like funding 81 different organizations, and they come up to me and, you know -- the question I ask an organization is not the how because the how is the scientific part. You know, how do you put a condom on? How do you stop HIV transmission? How do you treat diabetes? The question I have is why. Why, as an individual,
should I follow what you're telling me to do?
Because if you can't change my behavior or my
perspective, you can bring science all day long, and
that's why the numbers are so bad. Because the
people will come back, brag about their organization
and what they did in the community, and then why are
the statistics like that? We're your metrics. So
everything is metrics and in D.C. they're echoing
what the Governor's budget -- you know, Governor's
Office Management and Budget is echoing: no metrics,
no money.

CHAIRPERSON ORGAIN: So that -- I want to
just segue because although the agenda, number
seven -- I think this speaks to agenda item number
seven that Kevin was -- in terms of local health
department funding. Kevin.

MR. HUTCHISON: Yes, very much so, and I
think we really appreciate the position that Dr.
Arnold and Dave Carvalho and the staff of IDPH took
relative to the budget that was proposed.

As Dr. Arnold mentioned, we are aware that
there was a significant reduction of about 8.9
percent at the state health department, and there
were some tough decisions that had to be made and,
actually, some important programs that had been
reduced, including many that are carried out by local
health departments.

I think, as communicated from Tony Corona,
who is the current president of the Illinois
Administrators Association, encouraging IDPH to take
a position in retaining priority for the Local Health
Protection Grant, the Breast and Cervical Cancer
Program, and the HIV Care Programs, we're very
pleased that our position really, I think, reinforced
the position that Dr. Arnold and staff at IDPH
already have taken. And I'm very pleased that Dr.
Arnold was able to prevail in his conversations with
the Bureau of the Budget and others so that this was,
in fact, approved by the Governor in his proposal.

So I guess my first thing would be to
thank Dr. Arnold and Dave and members of IDPH for
their support. I'd also like to thank fellow State
Board of Health members. This did come up in
conversation at the SHIP meeting, and I know Dr.
Kruse spoke to this issue a week or so ago when we
were in Chicago in the long-range plan.

And, finally, Madam Chairperson, if it
would be in order, I would certainly make a motion
to -- for the State Board to endorse the budget proposal that was developed by IDPH and included in the Governor's proposal that was submitted yesterday.

DIRECTOR ARNOLD: Thank you very much, ken, because that --

CHAIRPERSON ORGAIN: Is that a motion?

DR. HUTCHISON: If it would be in order.

MR. CARVALHO: Could I make a suggestion?

Could I make a suggestion? And I hope, Dr. Arnold, I'm not going at a wrong angle here.

DIRECTOR ARNOLD: Okay. Yeah.

MR. CARVALHO: As you know, the Governor put together a budget that has a lot of pain in it, and he knew he did. You need to know the pain that's in that budget that's in our department.

MR. HUTCHISON: Yes.

MR. CARVALHO: I think your motion is probably to support the provision relating to local health departments?

MR. HUTCHISON: Yes.

MR. CARVALHO: But I think there are other aspects of our budget that we are -- the Governor wants the public to know the pain that's in that budget. We are not trying to hide it, and we need
you to know about it. And that -- that needs to be part of the conversation so that you understand some of the other things that were done.

For example, the Community Health Center Grants that were zeroed out. The primary care -- the Primary Care Residency Program Grants that are zeroed out. The medical scholarships for students who are in school who are zeroed out.

So you -- before you -- before you endorse the budget as being peachy --

MR. HUTCHISON: Well, no, and my apologies for --

DIRECTOR ARNOLD: Those other programmatic areas are definitely suffering and the -- the -- the CDC's actually -- they are carrying them on. They're not taking new ones on. I think we have six or seven of them now, but they're going to second and third year. So it's a three-year cycle. And I think they get reduced by 50 percent for the subsequent year. So they both -- they are suffering from that issue.

But that's part of advocacy and part of what happens every year with the legislative cycle, you know, still trying to go back to the table. Unfortunately, this year we're $13 billion in the
hole, and other agencies have suffered a great deal as well; so --

You know, when you look at education, they're handing out pink slips and -- you know. So it's not a pretty picture for anyone really in the process.

One other point I did bring up is that you also -- when you have hard economic times and unemployment, public health and undertakers are the only two that are increasing any services. So we try to keep the tombstones away, and that's what public health is there for, is to protect the public. And so those -- that's going to require some, potentially, more resources, depending on how economics go, and no one can really predict that. No one has a crystal ball for it, but that's -- you know, that's where we are with that.

DR. EVANS: David, I was thinking along your lines and recognizing the -- these types of reductions and thinking about what Dr. Arnold is saying regarding metrics. My question, as I've asked sort of before or previously, is what -- what's the condition of the capacity to develop the evidence base, develop the metrics over time to show the
impact of these reductions?

And one of the things that I think public health has tended to suffer from is exactly in that dimension. Programs come online or programs are reduced, and often you are really in a very difficult position to show the immediate impact of that. And with other reductions -- particularly, in the basic infrastructure -- are we also compromising the ability to track these changes and to demonstrate the impact so that somewhere down the line you have some outcome data to show this action occurred, these reductions occurred, and this was the impact in terms of public health in our community and have some sort of causal track we can follow?

DIRECTOR ARNOLD: Oh, most definitely. I think that that is one of the things that, you know, in talking to the Governor's office about -- and, particularly, sitting down with David Buck -- but what people measure things in in politics is more money than it is pain and suffering and death, you know. The morbidity and mortality side is a little bit more elusive to them. They don't really understand all the connections sometimes like a public health official would in a community.
But what -- what's important is to look at it and to -- I think it's important about it is to look at it and to look at it from the cost benefit analysis side, and we're going to be having some talks about that with them.

But one example, if I said obesity is a national -- a national issue but it's also homeland security and a domestic security issue, most people would look at me and say, "What are you talking about? Department of Defense? How does that relate?" When I joined the military, 3 to 5 percent rejection rate in '84. Now it's 67 percent nationally. You can't raise an army; you can't raise a navy; you can't raise an air force. National defense.

Second one, if you can't pass a military physical, you can't pass a fire, police, or even a labor physical. Domestic instability.

So obesity has dimensions that are in all 19 critical infrastructure and key resource sectors, as noted by the Department of Homeland Security, directly impacting them. Public health is in every sector of society.

As a matter of fact, in England, they
passed a thing through -- and they approved it where every one of their policies has to have a public -- or have a health component to it. Doesn't make a difference what your policy is. What is the health impact statement? California is about to pass it. Everything that comes up, how is this going to affect the health of the people in the state?

CHAIRPERSON ORGAIN: I think what we can do, Kevin, I think that probably, based on David's additional information, I think that you were speaking specifically for those -- for target areas.

MR. HUTCHISON: Yes, ma'am.

CHAIRPERSON ORGAIN: But I would probably -- I would probably hold on that. David is going to give us a legislative update.

And I think that maybe we can move the agenda to the Policy Committee report. Ann O'Sullivan is not here, and there are two things that we need to do in regards to the report. Karen Phelan is going to give us the report, and we'll also need to take a vote on the leadership of that committee.

MS. PHELAN: Okay. So I'm filling in for Ann O'Sullivan, policy chair.

The Policy Committee met on February 3rd.
There was much discussion about items pending, and there was only one action item the committee presented before the Board -- wanted to present before the Board today, and that was item number III, Roman numeral III, and I think we're going to have to come back to that at the end because there's going to be some discussion about that.

As well, there was an update from David Carvalho about local health department funding, and, Kevin, you've taken care of that, I believe, just a short a while ago.

So the first order of business we discussed was medical homes, and it was presented by Drs. Vega and Kruse and with the help of David Carvalho. There was discussion about contact with Senator David Koehler, who introduced Senate Bill 3047, health care implementation legislation that would monitor the implementation of the federal health care reforms and make recommendations, and I believe the full text of that was included with the minutes.

And, Dr. Vega, do you have anything to add on that or an update? Or Dr. Kruse?

DR. VEGA: Yes. I did meet with Senator
Koehler and asking him what his intentions and plans were with what is going on in Washington. He is actively working to -- on plans on implementation strategies for what he sees is developing in Washington.

So the whole idea regarding speaking to him was to create a model or to give strategies towards medical home implementation or at least that strategies, and I think what Dr. Arnold was speaking about is exactly -- dovetails with this. Medical homes is all about data metrics and being able to look at populations built around the medical home and looking at obesity rates and what -- to what levels are your -- are your care plans effective or not. So it's very much data driven and I think -- so he was very pleased that we were thinking this way too.

So I think if the Policy Committee came up with sample language on what is a medical home, what will be our understanding of what we consider that, and how -- how the interactions -- one thing that came up was that the -- the -- we talked about duplication of services. Often the medical world and the public health world are working parallel without much connection there, and there is duplication and
waste of effort. And if those two lines of care were
more intermingled, there would be a lot of
efficiencies and probably better efficacy.

So just thinking that way and recommending
either language for payers, strategies for providers,
recommended links between public health and the
medical world, those are things that I think the
Policy Committee needs to kind of work on and bring
to the Board.

DR. KRUSE: You know, I would just add to
that a couple things. That goes perfectly with what
we heard at the Obesity Prevention Initiative
hearings as well. It just fits right in perfectly
this idea of decreasing the fragmentation and getting
better coordination, and I clearly think we really
need to discuss this at the Policy Committee.

But I did want to say a couple words about
the Community Care of North Carolina again today
because their 2008 audit is in and up on their
website, and they continue to be the best example of
pulling the public health, mental health,
patient-centered medical home, and pharmacy home
coordinating efforts together.

You know, they continue to pay
care-for-the-patient fees to the patient-centered medical homes which are defined very simply as a primary care office. They don't -- they don't get very complicated on that at all. And then they also pay money to the networks, which are basically the public health departments, for identifying the high cost patients that have more than three -- or three or more chronic illnesses. And they -- then they -- they have a requirement for those services to be linked with the medical home and with the pharmacy home as well.

So Mercer, the auditing company, showed that they saved $400 million last year. They beat the budget by $400 million. And so they're actually spending somewhat less than $100 million on the program, and they're doing better by $500 million with a net of 400 million to the state, and nobody else can really duplicate that at all. So it's very, very, very efficient. And they now have 950,000 of the 1.25 million public aid patients in this system. So they've almost got it completely covered.

Now, what they have on the website also is a comparison of 2004 to 2008 on some things. This is a new piece. So the generic pill rates of medicines
have increased from 55 to 69 percent. The number of developmental screens that were done in 2004 on children in this population was 50,000. In 2008, it's 235,000. So it's almost increased by fivefold. Asthma hospitalizations are down 80 percent. ER visits are down 50 percent.

And I just want to tell you this one. This one caught my eye. They asked people -- all the people in the program -- not just children, but the whole -- the whole program -- "How do you rate your health?" And in 2004, 24 percent of the people rated their health poor. In 2008, 8 percent of the people rated their health poor.

So that's why I think that a program like this, that brings all these entities together, really might have a big impact on things like obesity, as Tim said. And as more data is coming in on patient-centered medical homes through the Transfer Med Project, their eight papers are going to be published fairly shortly, and they have shown there's an even greater importance on the four essential functions of the patient-centered medical home than was ever shown before. So I think we should go over each one of those four things and how they relate to
that at the Policy Committee.

    Anyway, that's my most up-to-date stuff on
the medical home part.

CHAIRPERSON ORGAIN: Good information,

Jerry. Thank you.

MS. PHELAN: Right. Thank you so much.

Next we need to talk about SHIP, and Mary
Driscoll made a presentation to us, and, Elissa, if
you can up date us. There was a meeting March 5th?

MS. BASSLER: Sure. There was -- was it
March 5th? Again, the state had an approve-the-plan
meeting on March 5th.

My name is Elissa Bassler.

COURT REPORTER: Thank you.

MS. BASSLER: And we went through the
draft plan and made a sort of set of final comments.
So we're cancelling the April 9th meeting. I'm
trying to incorporate the comments from that last
meeting, and then by e-mail the team will take one
final look at -- at the -- at the plan, and then it
will go out for public hearing.

So to put on your sort of radar screen,
the State Board of Health or the hearing officers,
for those three public hearings that are required by
law. So once you -- as soon as you finish these
obesity hearings, we're going to roll you into a new
set of public hearings, I'm afraid, and the
Institute, under our contract for the -- the whole
State Health Improvement Plan will be helping to
coordinate those hearings and so on. So just as an
FYI, we'll need hearing officers from the Board of
Health.

I'm not sure exactly what Mary covered.

Just to remind everybody -- because you probably
don't hold this in your head anyway -- there's five
public health system strategic issues and eight
primary health concern issues in the plan. The
system issues are access; data and health information
technology; health disparities and social
determinates of health; measure, management, improve,
and sustain the public health system; and work force
and human resources.

And the eight priority health concerns are
alcohol/tobacco; use of illegal drugs and misuse of
legal drugs; mental health; natural and built
environment; obesity, colon nutrition, and physical
activity; oral health; unintentional injury and
patient safety; and violence. So those are the
strategic issues.

And I think the other key thing that's been happening over the last couple of meetings -- and Mary might have shared this with you as well -- is, through the whole process, the team has talked a lot about not just putting this plan out but making sure there's a next step and that there's an implementation process that comes after has been a constant theme throughout this planning process.

And I don't know, Dave may have -- the team, a couple of meetings ago, did vote that there should be a legislative -- a statutory requirement for an ongoing implementation/coordination group that would take on the next phase of this. So that legislation is -- you know, how to accomplish that legislation is currently under discussion, and Dave may want to say something further about that when he does his update.

I do want to just sort of piggyback for just a second on what Dr. Vega and Dr. Kruse talked about. The team created in this -- differently sort of from the last time. They talked about five areas that were sort of crosscutting, where these are things that need to be addressed or considered in
each of the strategic issues, and those five areas
are health care reform and health care policy; health
across the life span; social determinates of health;
community engagement and education; and leadership,
collaboration, and integration.

And the first of those, health care reform
and policy, and the last of those, leadership,
collaboration, and integration, really resonate with
the things that Dr. Vega and Dr. Kruse were saying
about -- a lot of discussion about as we -- whatever
health care reform at the federal level ends up
being, that the SHIP -- the implementation of that,
how Illinois moves forward that health care reform,
what Senator Koehler is talking about, that there are
real opportunities for the State Health Improvement
Plan in the implementation of health care reform.
And so there's some discussion of that now.

There's also a lot of discussion of we
don't exactly know what health care reform is going
to be so we can't really say exactly how it relates,
but there's a sense that in June we will when we come
back after the public hearings and maybe be able to
be more specific about ways in which there's
intersections between the implementation of health
care reform in Illinois and this State Health Improvement Plan.

And the other is the medical home concept, which has been a central initiative of the Board of Health Policy Committee, comes up in a number of places in the State Health Improvement Plan as well -- under access to care, under social determinates of health and health disparities, I think under work force -- along with some of the technology issues like electronic health records and health information exchange that I think go along with that are also coming up a lot here.

So it seems like there's a lot of things that the State Health Improvement Plan may have an opportunity to help promote the integration and coordination of those kinds of things and build on those federal initiatives and the other sort of external changes that are happening that connect up here, and this plan is really trying to make those connections; so --

CHAIRPERSON ORGAIN: Caswell.

DR. EVANS: I have a -- Caswell Evans.

I had a question based upon what Elissa has just said and the excellent presentation by Dr.
Kruse.

I recognize that the operational
definition is medical home, but is conceptual
definition for this closer to a health home or is it
a medical home? And I guess I'm particularly curious
about the specifics of the definition because I think
the distinction between a health home and a medical
home, in my mind, is substantial, and they're not the
same.

DR. KRUSE: I'll address that, Caswell.

The patient-centered medical home is --
there is a document called the Joint Principles of
the Patient-Centered Medical Home, and it's the
definition that's been used in all the health care
reform legislation. So it's an official legislative
type of definition.

If you look very carefully at the evidence
base for the patient-centered medical home that's
been articulated by the Johns Hopkins School of
Public Health researchers, those four essential
elements that I talk about, they -- they relate to
medicine and health, and you could clearly call it a
health home.

I'll speak specifically -- well, the three
are first -- first contact access, patient-focused care over time, comprehensive care, and coordinated and integrated care. And when you look at the definition of the coordinated and integrated care that they found would improve outcomes and lower costs, there were two elements. The care was coordinated within the delivery system -- within the walls of the delivery system, but there were also significant linkages to the outside to the point that all of the people who were -- all the health care professionals and others working there worked at the top of their degree or worked at the top of their license.

So they engaged all kinds of different health professionals to do this. It's, obviously, not -- not just physicians, although the way the teamwork is done might be a little different than we think about it.

So these could be called health homes, as far as I'm concerned. Medical homes is the legislative definition. The hospital system that we're working with right now, the integrating system, they call it healthy homes. They put a "Y" on the end of it.
The point of the matter is, do we need to use a common language when we're talking to the legislature or people get confused. As a matter of fact, the head of the House Energy and Commerce subcommittee on health, in late September 2006, called for the various organizations to get in the same room and come up with one name for this thing, and they picked -- the name that came out of that meeting was patient-centered medical home, PCMH.

Now, that doesn't resonate at all well to patients, and we don't use it with patients. But we do use it for legislative lobbying, you know, and -- Anyway, so that's my answer to your question, and it's just more of a semantic kind of thing than anything else.

DR. EVANS: Well, yeah, no, I recognize, that, Jerry. I mean, I know that that's sort of the operating term and definition. And I just think it was unfortunate that it was defined that way because I think it is really limiting. In my ideal world, it would have been called a health home, but I recognize the history of it.

I was just suggesting that as long as the conceptual definition includes those concepts of a
health home, I think it -- it broadens the utility of it. Recognize that we've got a title -- formal title of medical home. I just think as long as the concept of the health home is clearly articulated within that definition that makes the best of -- that makes the best of what we have.

CHAIRPERSON ORGAIN: I certainly agree with you, Caswell, and I think that it does conceptually. It's multi-disciplinary. It's intended to go across disciplines. It's intended to include -- and I think that it does.

Jerry.

DR. KRUSE: I was just going to say, actually, one good thing about having that name is that, when you want to build linkages with public health and mental health organizations, it shows that public health and medicine need to come closer together, and it does bring them together.

Now, you can get to the point where you put health in both names, which would be, again, fine with me, but, you know, when I'm using it in that way, I always say that that linkage between those organizations that I mentioned need to occur and not only between the organizations but between the
1 educational institutions of public health and
2 medicine. They need to be much closer together in
3 Illinois and in this country, and I think we need to
4 use these terms to that advantage, quite frankly.
5
6 DIRECTOR ARNOLD: It sounds like embedded
7 in that is that whole thing about the balance between
8 are you talking about treatment or prevention, and,
9 you know, are you -- are you looking at it from the
10 standpoint of, you know, trying to forestall or stop,
11 you know, the morbidity and mortality and to have
12 that as part of the intervention plan and --
13
14 CHAIRPERSON ORGAIN: So it's a not a sick
15 home.
16
17 DIRECTOR ARNOLD: So it's not a sick home.
18 So it's not a treatment home. It's a prevention --
19
20 CHAIRPERSON ORGAIN: It is a start -- it
21 starts at prevention --
22
23 DIRECTOR ARNOLD: Right.
24
25 CHAIRPERSON ORGAIN: -- and moves forward.
26 And so we certainly can -- we certainly get there
27 in terms of coordinating care, but we want to
28 absolutely -- and I think that's what Jerry's
29 indicating -- you start with public health and you're
30 trying to get there to start with prevention.
DIRECTOR ARNOLD: Right. Right.

DR. KRUSE: Actually, the second -- one of the essential functions, patient-focused care over time, the definition is, is that the care is -- the care emphasizes patient-focused care rather than the disease-focused care and -- and, you know -- and -- and the spec -- and, you know, the longitudinal spectrum of care rather than acute episodes.

Now, you would treat acute episodes, and you'd treat disease, but it focuses on the longitudinality of it and the patient centeredness of it rather than disease. There certainly is prevention in there, but when you say patient focused, it covers everything.

DR. VEGA: Yeah, this is Tim.

The more elegant medical homes -- and most of the primary care physicians understands this -- it de-emphasizes physician care, and it emphasizes this ongoing care, whether it's nursing, regarding medications or pharmacy, psychology, exercise specialists. I mean, the more elegant ones really have this broad multi-disciplinary approach, and let's face it, the elephant in front of is too big for any one of us to tackle.
And there needs to be these linkages to deal with the health and disparities and just the size of the problem.

MS. PHELAN: Thank you.

Elissa, do you want to talk about the hearings?

MS. BASSLER: Yes.

Could I just ask a quick question on the State Health Improvement Plan?

Dr. Kruse, we speak -- we always talked about medical homes. Should I be -- should I -- should that be patient-centered medical homes in the language of the State Health Improvement Plan? Should I put patient-centered modifier on that?

UNIDENTIFIED: Yep.

UNIDENTIFIED: Yeah.

DR. KRUSE: You know, I would put patient centered the first time, and then you can use medical home after that, and then put in the definition. And we'll actually put the four essential functions in the definition because they're critical to what everybody's going to do.

MS. BASSLER: Yeah. If you would send me that definition, I'll get that in the glossary too.
That would be great. Okay. So that was just a question.

So the other thing that Karen just asked me -- this is Elissa Bassler again -- asked me to quickly report on is the Obesity Prevention Act hearings.

The -- sort of following on the last State Health Improvement Plan which talked about obesity and physical activity, last year the General Assembly passed a piece of legislation, the Obesity Prevention Act, which had some programming that was subject to appropriation, and there were no appropriations. So that is not going forward.

But it did require holding three public hearings to look at what's already going on in the state, identify opportunities for collaboration and existing plans and initiatives, to mobilize and engage stakeholders, and sort of move the issue of obesity more to the front burner is really what I would say the hearings are designed to do. And, hopefully, those of you who are there, you know, will help with leveraging those to make sure that that happens and obesity stays on the front burner.

So the Institute has partnered with the
Department of Public Health and the Board of Health to help logistically with those hearings, and they have -- we had one in Chicago on February 26th, we had the second in Springfield on March 8th, and the third hearing is next Monday, the 15th, in Carbondale. And Dr. Arnold has been so great to be at both of those so far, and I think he is planning to come down to Carbondale next week. And various members of the State Board of Health -- Dr. Orgain, Kevin, Karen Phelan, Dr. Kruse, Dr. McCurdy, Dr. -- I can't remember -- Sahloul -- have been -- have been hearing officers at various of those hearings, and State Representative Beth Coulson has also been to the two hearings. I don't think she's able to come to Carbondale on Monday.

So those have gone very well. We had over 160 people attend the hearing in Chicago and nearly 50 people testify. In Springfield, I think we had between 80 and 100 people attend and about 30 or 35 people testify. You know, these will go down as the further south we get, so we'll probably have fewer people, although some folks in southern Illinois have been doing a lot of work to organize turnout for that.
I think concurrent -- just as a sort of -- to say -- concurrent with our work with the Department to help make the hearings happen, the Institute has also started to bring together a coalition we're calling the Illinois Alliance to Prevent Obesity to start to build that statewide multi-sector, multi-agency coalition -- multi-organization coalition of the stakeholders in public health. So we're really looking at these hearings -- the Institute is using the hearings as an opportunity to help to organize and mobilize that alliance, that coalition.

And so we're inviting people to sign on to a sort of set principles around that and so on. So we hope that we'll have the advocacy community beginning to be organized to support efforts around obesity, physical activity, and nutrition that can roll into the implementation of the State Health Improvement Plan and start to make those connections and promote policy and collaboration and coordination.

I think that's a message -- I think Dr. Kruse mentioned -- that's really coming out in these hearings is there's a lot of stuff going on,
but the leadership and the mechanisms for linking those things, figuring out what our best practice is, generating the efficiencies that you get from coordination, promoting coordination and efforts across state agencies.

I know that there are actually obesity-related bills out there, and I don't know, David, if you've been able to take a look at those. There's something for Department of Agriculture. There's something for the State Board of Education. There's some stuff that's the Department of Public Health. So that sort of internal state government coordination around this is also important and coming up.

DR. SAHLOUL: This is Dr. Sahloul. I'm sorry to interrupt, but I attended one of the hearings in Chicago.

COURT REPORTER: Wait a minute.

DR. SAHLOUL: I don't understand the process. What is expected from these hearings? I mean, there were all kinds of recommendations. Would that be incorporated in a report or something to be sent to all Board members? What would be the next step?
MS. BASSLER: Yes. They --


Doctor, there were two people talking when you started. Could you tell the court reporter your name and how to spell it?

COURT REPORTER: I've --

MR. CARVALHO: You've got it? Okay.

Sorry. Go ahead. That's not Dr. Girotti, though.

COURT REPORTER: Oh.

MR. CARVALHO: That's some -- yes.

Doctor, could you introduce yourself because I don't think people knew you were on the call.

DR. SAHLOUL: Dr. Sahloul, S-a-h-l-o-u-l.

COURT REPORTER: Thank you.

MS. BASSLER: This is Elissa Bassler.

Yeah, the legislation requires a report. So the Institute will be pulling that together for IDPH, and I believe that it is to go to the General Assembly.

DIRECTOR ARNOLD: There's also the -- there's also the establishment from Senator Delgado's bill for a chronic disease task force. So there's a list that was submitted to him that had, like, ten
different groups or special -- specialists on this list, and it was put together by IPHA and different originations that submitted names. But they -- that group actually is going to look at chronic diseases as well.

So what I'm trying to do is, when I first started with talking to the Governor's office about the -- I have 59 boards and probably more than that. So I started going through all the paperwork, and a lot of them have crossovers and that kind of thing. So there are crossovers, and they talk about a lot of different issues but are talking about the same thing, and I think that that -- the power I see behind SHIP is that it's bringing people together to have a focal point where people are working together.

Because if we apply for grants and we start moving as a state, we -- this is historic opportunity for public health in the state, and if we blow it, we blow it. But if people work together and go, and we aggressively look at these grants and best practices and best models and try to put something workable together -- we already have an open doorway to -- I'm not going to say D.C. but somewhere over there. And we also have -- you know, we have the new
president-elect for APHA, that's in our state, Linda Murray.

So, I mean, there are a lot of things that are happening that are lining up that, if we take advantage of some of the underpinnings for health, we could be pushing things into the future and coordinating things, getting things so that Illinois state becomes the state for health.

This is the birthplace of the Internet, the blood bank, and I could start, you know, naming the Human Genome Project. I mean, these are things that are already globally recognized, and we need to retain -- we need to retain the edge that we have here technologically.

CO-CHAIRPERSON McCURDY: Case made.

MS. PHELAN: Excellent. Thank you. Thank you, Elissa.

Okay. The action item we have before the Board was noted on our agenda, and it's should the State Board of Health take a more active roll in prospective recommendations rather than the traditional role of reacting and reviewing.

CO-CHAIRPERSON McCURDY: I do not have that with my agenda.
MS. PHELAN: It's in our minutes.

CO-CHAIRPERSON McCURDY: Oh, okay. With the minutes. Okay.

MS. PHELAN: And that's what was requested.

CO-CHAIRPERSON McCURDY: Right.

MS. PHELAN: And I don't have any background on it other than that.

CO-CHAIRPERSON McCURDY: Yeah. That was discussed in the policy meeting, was it not?

MS. PHELAN: It was, and it was actually tabled and asked to be brought here.

DR. KRUSE: You know, actually, I brought that up. That was my agenda item. And, you know, the funny thing is, since that's been brought up, it seems that that's what's happening at this meeting already today. You know, we're taking a much more forward look than ever before just with all that's happening.

So I don't even know -- I don't know that it needs to be a motion. It's more of a philosophy or a way we approach things, but I think the ball is rolling. It really seems like it is.

MS. PHELAN: Excellent. Thank you. Okay.
CO-CHAIRPERSON McCURDY: Then there's one other action item here that needs to be addressed, and that is the leadership of the Policy Committee.

My understanding is that Ann O'Sullivan has indicated that she needs to withdraw from chairing the committee, and at the last meeting of the Policy Committee there was discussion, and it turned out that Karen Phelan was nominated to be the next chair of the Policy Committee. So that requires formal action by the Board.

I will entertain a motion to nominate the new -- a new chair.

DR. EVANS: So moved.

DR. KRUSE: I will make that motion.

COURT REPORTER: Who was that?

CO-CHAIRPERSON McCURDY: It actually was moved here by Dr. Evans.

DR. KRUSE: Oh. Okay.

CO-CHAIRPERSON McCURDY: But if you want to second --

DR. KRUSE: Yes, second.

CO-CHAIRPERSON: All right. Second by Dr. Kruse.

Are there other nominations?
Then can we move unanimously to acknowledge Karen Phelan as the new chair? All in favor say aye.

VARIOUS: Aye.

CO-CHAIRPERSON McCURDY: Opposed?

Abstentions?

Well, Karen, I think now you're in for it.

MS. PHELAN: Thank you so much. Thank you.

CO-CHAIRPERSON McCURDY: Congratulations, we think.

MS. PHELAN: Okay. And we move over to the rules.

CO-CHAIRPERSON McCURDY: Right. Rules Committee is next.

But I do have one question related to policy before we leave the policy area, and, Elissa, this also relates to the Obesity Prevention Initiative, and that is, when I read the legislation about the Obesity Prevention Initiative, I seem to remember something about a chronic disease task force.

MS. BASSLER: Uh-huh.

CO-CHAIRPERSON McCURDY: And is there
anything about that that -- maybe it's been mentioned here, but I'm not recalling that it does -- that we should sort of have on our radar screen as a Board?

DIRECTOR ARNOLD: Oh, we have the chronic disease task force that was set up by Dr. -- well, by Senator Delgado's bill and --

COURT REPORTER: Can you speak up? I'm sorry. I need you to speak up.

DIRECTOR ARNOLD: Yeah, I have this back pain so I'm trying to get through this. Sorry.

But we have a chronic disease task force that was set up with Senator Delgado. Yesterday I met with him, and we have the members for that. We have ten members plus an ex-officio that are on the board.

But with that board -- I am chairing the board, and one of the things I recommended to Senator Delgado was not to derail the process we have going is to put a seat, at least, on the SHIP plan so you have one person that's going to come in and talk about what some of the recommendations from that board are.

There's some really good people on it.

Bob Cohen from -- from the -- he's a -- you know,
he's a pulmonologist, but really very, very well
versed in asthma and, you know, activist for that.
So you got some really good people on the board. I
think that they made good selections. The YMCA is
sitting on there as well as one of the people who are
on there.

So the recommendations they have -- I was
asking that those recommendations from the board are
looked at and that the information that arises from
it is submitted to the SHIP so that we -- I want this
linkage so it's -- it's more weighted toward academia
on that side, you know, on the board, that sort of
thing.

So I said that, you know, the SHIP -- if
the SHIP carries the obesity issue and tobacco issue
and the injury issues, and we have an overriding
super structure that starts to address these problems
and organizes people, then what that board can do is
they're acting more like SME's, you know, subject
matter experts, in order to give some additional
guidance or what do they see in the field. Because
most of them are specialists in different areas:
pulmonary medicine, cardiology, those kinds of
things.
But, overall, it's really the -- as I say, you know, we have a saying in emergency response: All of those answers are local. And -- and so I say, you know, all obesity is local. It comes down to where you are. And so, you know, I think the SHIP is really the thing that bridges that gap between the how science and the why of the person out there who says why should I listen to what you're telling me.

CO-CHAIRPERSON McCURDY: Well, thank you for that.

DIRECTOR ARNOLD: You're welcome. I think it's going to be a good (inaudible).

So I'm trying to keep everything so we don't have a million different holes.

CO-CHAIRPERSON McCURDY: So the SHIP is kind of an organizing center for a number of things.

DIRECTOR ARNOLD: Right, it's more for subject matter expert issues and recommendations,

stuff like that.

CO-CHAIRPERSON McCURDY: Well, thank you.

And, by the way, I should be clear with you who may not be able to see us there. Dr. Orgain has left this meeting room. She indicated she may call in to be part of the meeting and perhaps she's
on the phone now, for all I know. Are you there, Dr. Orgain? Not yet at the moment, but she may call in.

And also Dr. Peter Orris has joined us here.

And so I believe we really can turn our attention now to the Rules Committee report. David Carvalho?

MR. CARVALHO: Yes.

CO-CHAIRPERSON McCURDY: I should probably ask you, before she left, Dr. Orgain asked me, at least, if it was possible for you to say something before we do the Rules Committee report. Now, since she has left the meeting, I don't know if that matters to her, but was there perhaps a reason that she -- on your end that she might have wanted you to go first?

MR. CARVALHO: To say something or to do the -- you mean the legislative update?

CO-CHAIRPERSON McCURDY: That's what I'm asking, yes. I'm not saying you need --

MR. CARVALHO: I don't remember --

CO-CHAIRPERSON McCURDY: We can do the Rules Committee report first.
MR. CARVALHO: Why don't you do the Rules Committee report first so that you can take action on that, and then my legislative update will adjust to the time available.

CO-CHAIRPERSON McCURDY: Okay. Well, then, let's do that.

The rules -- Dr. Orgain also asked me if we had rules that required extensive discussion, and, of course, as soon as I said, "Well, I don't think so," then, you know, we may have extensive discussion.

But we have four rules before us beginning with the U of I Hospital Infection Control Code, and I'll ask if somebody in Springfield wants to fill us in a little bit on that one before we consider it.

MS. MEISTER: This is a new rule in response to legislation that passed last year, and we really don't have any licensing authority over the University of Illinois Hospital, but this legislation, Public Act 95-282, gave us some limited rulemaking authority to address infection control issues.

The language of the rule is quite a bit taken directly from the statute, as indicated by the
italic type. The rest we took from a similar rule that addresses the same issues from the same legislation in our licensed hospitals under the Hospital Licensing Act. Those rules have been recently adopted, and they went through the Hospital Licensing Board which has approval authority over their rules.

So it sets forth the infection control guidelines from the legislation, and it's a rather short rule. It includes the definitions, the -- incorporate in the reference materials which include CDC Guidelines and the Infection Control Requirements.

MR. CARVALHO: Rev. McCurdy?

CO-CHAIRPERSON McCURDY: Go ahead.

MR. CARVALHO: Imbedded in Susan's comments were a couple of things that many of you may know but, since some of you are new, perhaps all of you don't know.

First off, that there's a Hospital Licensing Code that applies to every hospital except U of I. And then there's a Hospital Licensing Board that has jurisdiction of all rules under the Hospital Licensing Act.
So if you're wondering why haven't you seen rules relating to hospital licensing before, it's because the statute says you only see rules when there's not somebody else who's been charged with seeing those rules. And, in fact, somebody else has been charged in the case of hospitals, the Hospital Licensing Board.

So if there were a couple things you were wondering -- why haven't I seen this before, and, also, why I am seeing something separate for U of I -- it's because of that historical background.

I don't think there's anybody in this room who can justify that background, but it just is.

CO-CHAIRPERSON McCURDY: Like some other things, yes.

Thank you for that, David.

If you read -- had a chance to read the minutes of the Rules Committee or are following along as we go, you will see that we did act to refer that rule to the Board for approval after some amount of discussion and with some minor changes.

One of the things that's referenced here is the definition of "at risk"; that is to say, patients who are at risk for MRSA are included here.
And one of the things that has happened in this legislation is that -- and is reflected in this rule is that the categories of at-risk patients have been significantly expanded or at least expanded a fair amount.

And when I looked at the legislation -- just to give you an idea of what we're talking about with patients considered for the purposes of the legislation as at risk for MRSA: all patients admitted to an ICU, intensive care unit; all patients previously known to have been colonized with MRSA; all who were previously infected with MRSA. I have to say I'm not entirely sure I know what the distinction is. All patients receiving inpatient dialysis; all surgical patients who are getting implants; patients transferred from a nursing home and patients transferred from a health care facility; and last and not least in this list, patients who were previously admitted to a skilled health care facility within the last year. And, then, in addition, if patients are admitted to an ICU, they need to be rescreened for MRSA, and patients who are transferred from a nursing home need to be rescreened for MRSA prior to hospital discharge or before
transfer.

So it's a big bunch.

MR. CARVALHO: David? David?

CO-CHAIRPERSON McCURDY: Go ahead.

MR. CARVALHO: Could you clarify -- what were you reading from?

CO-CHAIRPERSON McCURDY: Oh, I'm sorry. I was reading from -- you had arranged for us on the Rules Committee to receive Senate Bill 2981.

MR. CARVALHO: Okay. Yes.

CO-CHAIRPERSON McCURDY: Which is referenced in the minutes, and I was reading from -- from that.

MR. CARVALHO: No, that's good because I was hoping that's what you were reading from.

Let -- in other words, that's not in the rule, and that's not in the statute. That's in a proposed bill. I will give you --

CO-CHAIRPERSON McCURDY: Oh, this is proposed. I'm sorry.

MR. CARVALHO: Yes. And I will give you an update in the legislative update, but the sponsor of that bill withdrew all of that language and instead changed her bill to merely extend the sunset
on the law.

In other words, the current law that applies to other hospitals that had a sunset because the theory was it was a trial. We were looking to see whether these additional measures of screening surrounding MRSA were necessary, and then we were going to look at the data to see whether it was a fruitful intervention.

That being the case, notwithstanding that, this bill was introduced to broaden tremendously the amount of screening that would be involved, and after certain concerns were raised about that broadening, the fallback of the sponsor was to extend the sunset -- in fact, to eliminate the sunset.

So the existing categories of high risk and existing scope of screening in the statute will go on, but the broadening that was proposed in the legislation is no longer being pursued this legislative session.

And, in any event, that statute is the one that applies to all the other hospitals, not U of I.

CO-CHAIRPERSON McCURDY: Oh, okay. Well, in the immortal words of that character on Saturday Night Live, never mind. My error for obviously
misreading the legislation, but, fortunately, we were
able to get that corrected. Thank you.

MR. CARVALHO: And, David, you read the
legislation correctly. There was an intervening --

CO-CHAIRPERSON McCURDY: Right.

MR. CARVALHO: -- event where she gutted
the legislation.

CO-CHAIRPERSON McCURDY: Well, I thought
it had been passed. That was my error; so --

MR. CARVALHO: Okay.

CO-CHAIRPERSON McCURDY: In any case, with
the minor changes that are listed here, the Rules
Committee forwards this to the Board for your
consideration and recommends that you approve it for
further forwarding.

DR. ORRIS: I've got one mistake in the
minutes in this --

CO-CHAIRPERSON McCURDY: Okay.

COURT REPORTER: I can't hear him.

CO-CHAIRPERSON McCURDY: This is Dr. Orris.

DR. ORRIS: One mistake in the minutes
from the Rules Committee. Dr. Evans kindly reminded
me of my need to recuse myself from the vote at the
Rules Committee on this particular rule.

CO-CHAIRPERSON McCURDY: Okay.

DR. ORRIS: Which I will do here again, but I just wanted to point it out. It somehow got left out of the minutes. Thank you.

CO-CHAIRPERSON McCURDY: Thank you.

So I -- at this point can somebody move that we approve this?

DR. JACKMAN: So move.

CO-CHAIRPERSON McCURDY: Second?

DR. SAHLOUL: I second it. This is Dr. Sahloul.

DR. EVANS: Second.

CO-CHAIRPERSON McCURDY: Okay. Any discussion?

All in favor say aye.

VARIOUS: Aye.

CO-CHAIRPERSON McCURDY: And this one is forwarded, and we will turn our attention to the next rule.

DR. ORRIS: And non-voting for Orris on that one.

CO-CHAIRPERSON McCURDY: And non-voting for Orris, right. He is consistent with himself.
Okay. The next one, the Sexual Assault Survivors Emergency Treatment Code. Someone in Springfield want to give us a little background on that one also?

MS. MEISTER: This is also an update to the rules in response to legislation, Public Act 96-318, and that legislation eased restrictions on consent for treatment for sexual assaults and for releasing evidence and information.

And the language that is being added to the rule is all new statutory language. It's all quotations from the law.

CO-CHAIRPERSON McCURDY: And, again, to the Board, you will see that the Rules Committee had some discussion about the meaning of the term "appropriate," and we learned that that, in fact, is the statutory language, which is not being amended.

And, then, also, we proposed that it be considered -- the names of crimes under the Criminal Code be put in quotation marks so it would be clear that that's -- that they actually were crimes under state law.

And with those recommendations for change, the Rules Committee asked to forward this to the full
Board for approval.

Entertain a motion to that effect.

DR. EVANS: So moved.

CO-CHAIRPERSON McCURDY: Second?

DR. JACKMAN: Second.

UNIDENTIFIED: Second.

CO-CHAIRPERSON McCURDY: Any discussion?

All in favor please say aye.

VARIOUS: Aye.

CO-CHAIRPERSON McCURDY: Opposed?

This one also is forwarded.

And so we'll go on to the Lead Poisoning Prevention Code.

Susan, do you want to say something about that one?

MS. MEISTER: These changes also incorporate changes to the Lead Poisoning Prevention Act concerning the lead content of child care articles, children's jewelry, and toys containing paint.

This is also mostly language from the statute. We worked very closely with the attorney general's office in drafting these rules because they will be our enforcement partners under this law.
The mechanism that will occur is that complaints may come to us concerning the content of paint, and the item will be analyzed and referred to the attorney general's office if further action needs to be taken.

So, as I said, the language is mostly quotations from the statute with a little bit of extra clarification as to what the component of the article would be and the definitions.

CO-CHAIRPERSON McCURDY: And to the Board, I would say you can see that, although the great majority of the language came from the statute, that did not prevent us on the Rules Committee from having some discussion of what was here, particularly, in line with what -- the enforcement area that Susan was describing. But except for some typographical errors, again, we recommend this one to the full Board for its approval.

I'll entertain a motion to approve by the Board.

DR. JACKMAN: So move.

DR. EVANS: Second.

CO-CHAIRPERSON McCURDY: Any discussion?

COURT REPORTER: Who seconded?
DR. EVANS: Caswell Evans.

CO-CHAIRPERSON McCURDY: Any discussion?

All in favor please say aye.

VARIOUS: Aye.


The ayes have it, and this one also we will forward on.

And that leaves us with one other rule which is the Swimming Facility Code.

Susan, do you want to say anything about that one by way of background?

MS. MEISTER: We recently adopted a pretty comprehensive amendment to the swimming -- what used to be the Swimming Pool and Bathing Beach Code concerning the drains and the conflict that our existing rules had with a federal law regulating the type of drains that can be used in pools that would prevent people from getting trapped in the drains.

We no sooner had adopted those rules when we got in feedback from the regulated entities saying that they were confused as to what particular sections of Section 820.210 they had to comply with.

And we had added a cross-reference to
Subsection 3(h) during the comment period in response
to a question. We thought that that would solve the
problem. It actually made it worse. They thought
they didn't have to comply with anything except (h).

So now we have to go back in and take out
the label for that subsection. So it's just one
little tiny change in Subsection 820.145(a) where
we're changing the cross-reference to clarify that
the pool has to comply with all of Subsection (f)3,
not just (h).

CO-CHAIRPERSON McCURDY: And the members
of the Board will note that even we on the Rules
Committee found nothing to change about this one. So
we refer it to you as it was -- as we received it.

I'll entertain a motion to approve it.

DR. EVANS: So moved.

DR. ORRIS: Second.

DR. EVANS: Okay. A motion by Dr. Evans.

Second by Dr. Orris.

Any discussion?

All in favor please say aye.

VARIOUS: Aye.

CO-CHAIRPERSON McCURDY: Opposed?

Then, this one also is carried.
And all of the rules that we had are being forwarded then to the full Board.

That concludes the listed agenda items, but I do want to mention one other item that has come to our attention, and my colleague Karen Phelan has raised this. Let me put it into words, and then you can comment also if you want.

One of the things that might help us on the Rules Committee -- and this really, in a certain sense, is Rules Committee business, but it was suggested that we have -- if we could receive advance notice of rules that are being worked on early in the process, then, if there's any legwork to be done in terms of researching the legislative background and so on, they would just give us a heads up so that we can act on that sort of thing a little sooner in the process.

Could that be possible?

MS. MEISTER: I can take -- I work in the legal office, as you know. I can take that suggestion back to our general counsel, and we can -- we can probably send you legislation. But the rules that we send to you -- we usually don't know until the week that we send them to you what we're going to
be sending.

So we may not be able to determine very much before your two-week mailing time that we have something that's going to be on the agenda. And I'd hate to have to send you something thinking we may be looking at it, have you go through the work of doing research and looking through the legislation, and then not having it on the agenda.

MR. CARVALHO: What Dave -- I think David is asking for something slightly different, and you and I have talked about this in another context. Just a report of what's in the shop. Not necessarily what's coming in the next meeting, but just what rules are underway in the shop on different topics.

You know, every year legislation is passed, so every year we start working on stuff. Some of it takes a year; some of it takes two weeks. Everything in between. Is there a way that that, like, compendium of what's in the shop --

MS. MEISTER: We could probably provide you with something general like that. It may be a year or two before the rule actually gets to you to look at. But how -- how often would you want that information?
CO-CHAIRPERSON McCURDY: I'll defer to Karen on that. What do you think in terms of what would be useful?

MS. PHELAN: Actually, I was just thinking some advance notice, a month or so or a couple -- couple of weeks so we can pull all the background. Because a couple of these rules, there were a lot of things that we needed to read in advance and refer back and forth to.

I mean, obviously, I appreciate the fact that we don't want to become inundated with things that might happen but don't occur.

MS. MEISTER: Yeah. I can let you know what rules we have on the table being worked on, but I won't be able to let you know that they would be on the agenda until we actually are ready to mail them to you.

CO-CHAIRPERSON McCURDY: Okay. David, is there --

MR. CARVALHO: Karen, if I could suggest, we should probably talk internally.

MS. MEISTER: Right.

MR. CARVALHO: Because Susan and I have had some conversations about, even for ourselves, it
might be useful to have some compendium for all of us internally to IDPH to know everything that's in the pipeline.

Back in the day, Governmental Affairs actually used to take responsible for monitoring that, and somewhere in the last 20 years that slipped off their radar screen. And so I've been talking with Steve, our new Governmental Affairs person, who is going to be joining us shortly, about some way that we can do that.

Because Susan's at the catching end of it. You know, as people get her stuff, she's caught it, but somebody internally needs to be monitoring before it gets thrown at Susan to make sure and nudge our individual offices to make sure all the things that they ought to have on their plate are.

Once we make sure our mechanism is 100 percent sure on that, whatever mechanism we develop to do that is something we can then probably summarize for you so you can see what's coming your way down the pike as well.

MS. PHELAN: Excellent. Okay.

MS. MEISTER: And we'll talk about it internally.
CO-CHAIRPERSON McCURDY: Thank you.

MS. MEISTER: See what we can come up with.

CO-CHAIRPERSON McCURDY: We very much appreciate the support that you give us and the efforts that you're making in this regard. So thank you so much.

At this point, Dave Carvalho, do you want to give us a legislative update?

MR. CARVALHO: I will and I --

CO-CHAIRPERSON McCURDY: -- perhaps we've already heard.

MR. CARVALHO: Right. And I will correct my earlier comment. I refuse to fill your next 45 minutes with legislative update.

CO-CHAIRPERSON McCURDY: I'm sorry. I didn't hear that.

MR. CARVALHO: I said I refuse to fill your next 45 minutes with legislative update. Earlier I had said do the rules first and I would use the available time to give you a legislative update. But I don't think you want that, nor do I. And, as importantly, our new legislative director was going to join you to actually provide
that update, and he's not here. I just sent him an
e-mail to have him do that.

In your location was the budget briefing
printed out?

CO-CHAIRPERSON McCURDY: Yes, it is.

MR. CARVALHO: Perfect. This is what Dr. Arnold presented to groups on Wednesday and alluded
to in his comments and what I made reference to
earlier as well.

As you know, as is always the case -- and
Dr. Arnold alluded to it, and I've said it in the
past -- this is the Governor's budget as introduced,
and therefore it is our budget. And so, of course,
own official position is this is the budget we
support, and that's what we will be saying to the
Appropriations Committee.

However, if you heard the Governor's
budget address, you know that he was in great pains
upon introducing this budget because it required cuts
to things that he was not cutting because they were
ineffective or not desirable for the state to do but
rather because the resources aren't there.

And Dr. Arnold and the rest of the
organization, at his direction, prioritized the
painful choices that had to be made between what you
can do and what you can't do when you have inadequate
resources. And you've already --

CHAIRPERSON ORGAIN: David?

MR. CARVALHO: Yes.

CHAIRPERSON ORGAIN: This is Javette.

MR. CARVALHO: Yes.

CHAIRPERSON ORGAIN: For those of us who
are on the phone, is that document online?

MR. CARVALHO: It's not online. I can
forward it to you, and I can also try to be mindful
in my comments that you don't have it at the moment.
So I will summarize -- but right now I'm just doing
the overview anyway, but as I get into the detail,
I'll be mindful of the fact that you don't have it,
and if I can multitask, I'll try to forward it to you
while I'm talking.

CHAIRPERSON ORGAIN: Thank you.

MR. CARVALHO: Thank you.

So choices like that did have to be made
just as last year choices had to be made. And so,
for example, a painful but obviously understandable
choice that Dr. Around made last year was, if we
don't have the money to do both prevention and
treatment, you got to do treatment. I mean, you
cannot take dollars away from treating people who
have HIV/AIDS and are on drug regimens, you know,
during their treatment.

And so if we don't have the dollars to do
as much outreach as we might have done in the past,
that's painful to cut those dollars, but you can't
cut people off of drugs.

And so similar choices had to be made as
Dr. Arnold --

DIRECTOR ARNOLD: And even in this year --

MR. CARVALHO: Yeah.

DIRECTOR ARNOLD: Even in this year we had
to do some cuts internally as far as redirecting some
of the funds from outreach and prevention into the
domain of treatment because the projections that we
had based on prior years were that we would increase
in the number of caseload by a certain percentage,
and that was generally around 4 or 5 percent per
year. We had 33 percent increase because of
unemployment.

So a lot of people were opting, you know,
to get into the treatment programs. So we actually
increased by almost 140 patients a month, and so that
really sent us into another time frame. So a 33 percent increase in one year.

MR. CARVALHO: And, as Dr. Arnold alluded, if you have to increase some lines and you have an overall cut that you also have to make, then, you have to even more concentrate cuts in others.

Other sorts of decisions that we've had to make in the past and made again this year is, if you have programs where you have dollars you're giving to entities over multiple years and each year you used to add new entities to the pool as other ones dropped out, you would try to keep the ongoing support to projects going and simply not add additional entities.

And so last year that was done in the community health center area. This year, with some of the challenges in funding, even some of the ongoing activities could not be sustained.

So, to summarize, our overall budget on the general revenue side went from 143 million to 130 million, which is an almost 9 percent cut.

On the other state funds, those are special funds such as fees collected into a special account. For example, the certificate of need
process collects its own fees and there's many others in the agency. Our overall appropriation there went from 103 million, approximately, to about 100 million, for a 3 percent drop.

And, then, our federal funds lines, the appropriation goes higher, but keep in mind that the appropriation can only be spent to the extent that the federal funds are received. And so the appropriations of federal funds are more -- include a little bit more speculation because, if you don't receive the federal funds, you obviously can't spend it.

So that line did go up in light of the fact that, if you do receive the funds, you can't spend it unless you do have the appropriation. So it is always wise on our part to appropriate the most amount we think we might receive so that we have legal authority to actually spend it.

When you add that all up --

DR. ORRIS: Is that stimulus --

MR. CARVALHO: Yes.

DR. ORRIS: I'm sorry. Is that stimulus money from the feds or other --

MR. CARVALHO: No, we -- some of it
includes stimulus money, and I'll make note of some
of that as I go forward, and it's on the second page.
But the large bulk of that is the ongoing federal
funding from multiple streams that we receive for
multiple different parts of the organization.

There's federal funding for bioterrorism
and preparedness. There's federal funding sprinkled
throughout our organization. The folks from local
health departments, you know, find themselves in a
similar situation. We have -- for example, Peter,
there's a little federal funding for the cancer
registry. There's federal funding for some of the
other activities in my office that are a little --

DR. ORRIS: I apologize. I wasn't clear.
I meant was the increase that we saw in federal
funding stimulus money or was it categorical support
as well?

MR. CARVALHO: There's both.

DIRECTOR ARNOLD: It's categorial. I know
that Ryan White was flat for this year. It was --
because we have about a 50/50 match with them. So
they gave about 30 million to the ADAP program.

COURT REPORTER: I'm sorry. I can't hear
you.
MR. CARVALHO: Dr. Arnold, you need to speak clear -- more slowly.

DIRECTOR ARNOLD. So the ADAP program, you know, we had about a -- we had a 50/50 match with ryan White. So it was about 30 million in the Ryan White. That was flat this year. So we did not see an increase. This year we'll be getting a 5 percent increase in that particular line item. So that -- if you combine 50/50 ratio with GRF, we have about 60 million, you know, total that we are arriving at now. So there is a balance in the 50/50 ratio on some things. But it was 20 million from Ryan White, 20 million from the state, 50/50 ratio, and what we actually were spending, because of the 33 percent increase, was about 60 million. So we had to find money from other programmatic areas because of Ryan White was flat. So this year I think (inaudible) 5 percent for them.

But we also had other programmatic areas where people started reaching out for grants. They started doing more to try to get their categorical things we've been talking about done.

But, historically, the state, I think -- before I start talking about this, Dr. Orris, is that
historically the state -- we have got to be more
aggressive in trying to get federal fundings. It's
one of the five pillars that the Governor outlined,
you know, is to make sure we maintain federal funding
streams.

So that we actually increased our total
federal funding amount by -- amount, and then we had
the money that came in from the H1N1 response through
the PHER money. We had the Public Health Emergency
Response money I and II, and we did not apply for
III. Many states did not apply for III because it
was so strict -- or we got III, and IV was not
applied for because most states said that it was a
waste of time because, by the way they were
distributing the money, it was not worth it for the
locals.

So there are multiple streams that I think
we sort of increase, mostly, as David was saying, in
preparedness and emergency response.

And these grants are really becoming a
problem because, in the future, they're looking at
going to the matching, and we don't know what they're
going to do next year for FY11 with the match
component.
The match component was supposed to be 5 percent last year. They cancelled it. They were saying that we're going to roll it over and make it 10 percent next year and then 15 the year after that and 20 the year after that. So we don't know where the federal government is standing right now with match.

And then they're going to a competitive cycle, and that's another reason why we have to really organize and do things so that we are on board with doing things and showing that we can make progressive change with metrics. Without doing that, we're going to be in a competitive cycle with other states, and they're going to say, "Iowa, you develop a system for the rest of the country," and we're going to be sitting here waiting for them to finish.

So it's really very, very important that, as David is reading through that, to realize that there are diminished funds. We are in a $13 billion deficit, and California is 80 billion if you want to feel better. I found that out yesterday. So there are -- there are several things.

I'm not going to interrupt. David, continue because I think you're doing an excellent
MR. CARVALHO: Thank you.

The overall structure of the budget, as Dr. Arnold indicated in his earlier remarks, was to identify several items that really could not be cut and needed to be protected, and those three were the Local Protection Grants -- those are an essential funding stream for all of the activities that the state relies upon to be conducted at the local health department level, and we have to keep that support in place -- the funding for HIV/AIDS treatment, and the funding for breast and cancer -- breast and cervical cancer screening programs.

So those funds were kept in place. Because of the significant size of those funds, that concentrated the cuts that were required into other areas.

Two other areas, however, that also needed to be protected were the three state laboratories -- there is no diminution in the need for what the laboratories do, and we simply can't cut that -- and then the Office of Health Care Regulation, which is where all of our regulatory activities for nursing homes and hospitals is focused.
And, as you can imagine, given what's going on in the state right now -- especially, on the area of nursing home and how the work of the Nursing Home Task Force has illuminated the shortage of resources in the area of nursing home regulation and the need for greater resources -- it would be a step in the wrong direction to try to cut that even more.

Accordingly, where the cuts were focused is listed on your report. And for those on the phone, I'll walk through it briefly. In our own staff and operational expenses, there's a $3.5 million cut. In prostate cancer awareness, a $1.5 million cut. In women's health promotion, there's a $1 million cut. In community health centers support, there's a $3.7 million. In ALS research, there's a $1 million cut. On the medical student scholarships, there's a $1.5 million cut. For the Family Practice Residency and Rural Health Grants, there's a $1.8 million cut. For immunization outreach, there's a $500,000 cut. And for SIDS, sudden infant death syndrome, there's a $250,000 cut.

Apropos of what I started to answer in Peter's earlier question, there are six grants totaling $6.8 million from federal stimulus money.
that are reflected in this budget, and they are
listed in your report. There's a small grant to the
state primary care office which is in the Center for
Rural Health. There's an $850,000 grant for a health
care associated infection program that is being run
in the Division of Patient Safety and Quality.
That's a collaborative with a number of hospitals
around the state. There are additional funds for the
state loan repayment program. That's a program to
support the repayment of loans for physicians and
other health care providers who agree to serve in
underserved areas. There's $2.3 million for
immunization. That's to support vaccines. That's
largely distributed to local health departments and
providers. There's $3.1 million related to chronic
disease activities, and $100,000 to support
additional inspection activities in ambulatory
surgical treatment centers.
On the other state fund side of the
budget, $1.9 million is cut from the sickle cell
research line and $2 million is cut from the youth
violence prevention line that would go to the
Illinois Violence Prevention Authority.
There is an increase for the metabolic
screening fund for lysosomal storage disorder. As you may recall, as a result of a law several years ago, the several diseases in the category of lysosomal storage disorder were added to the newborn genetic screening program. And the way that statute was crafted, the Department had the lead time to acquire equipment, acquire staff, put a fee in place on births that could then accumulate funds to pay for this addition, and that all has taken place. And so those increased fees associated with this program are now reflected in our state fund accounting, and we're able to spend them to add LSD testing to genetic newborn screening.

And then there's always a little bit of addition and subtraction for tax check-off funds. As you'll note when you fill out your state income taxes in the next month, down at the bottom there's all sorts of check-offs. And there's rules about -- the legislature ads them, but, then, there's rules about, if they don't raise a certain amount of money, they drop off. And so every year there's some additions and some subtractions, and that's reflected in those that pertain to our accounts.

When you see -- those on the phone don't
have it, but you will see all the line item detail
that reflects the overall summary that I presented.
And I don't think there's anything in that detail
that I need to single out for further discussion.

So I'll stop right there if there are any
questions on the budget, and, if not, we can then --
we would then turn to Steve Mange, who I can
introduce as our Governmental Affairs lead.

DIRECTOR ARNOLD: One other thing I wanted
to add to the budget thing was that there are, you
know, five pillars that the Governor has outlined in
detail for us to pay attention to and for people to
consider in state government.

And one is cutting costs. The second
pillar is really creating jobs, new jobs. There's
also one for strategic borrowing that the state may
have to engage in. And to maintain the federal
funding at its current or increase, if possible,
level. And then also to increase state revenue.

And yesterday, in his budget address, he
basically was giving the information about, you know,
one of the major cuts was in education, the 1.3
billion. So that's a big issue for the legislators
to follow and look at and try to remedy.
But there is also the issue of, you know, the 1 percent tax that can cover the -- increase that could cover the cost of that, and one of the things that disturbs me is I was looking at Rhode Island, I think it is now, that has 11 percent tax. We're next to last. We're 3 percent state tax. So we're in the bottom of the pile or till. And the question is, you know, if there's a need to have an increase in state taxes. Other states have been increasing, increasing. I think Rhode Island went from 9 to 11 percent. So there's a reality there that I think that --

CO-CHAIRPERSON McCURDY: That's the State income tax?

DIRECTOR ARNOLD: State.

DR. EVANS: Of course, those headlines can be crafted any way. If you look at this morning's Chicago Trib., it reads 33 percent increase, which is what it is, which is a little different than a 1 percent. So, you know, the numbers get played around.

DIRECTOR ARNOLD: In the eye of the beholder. So 33 percent increase over 3 percent, right, is 1 percent. So -- so -- but the thing is
the reality is that, you know, I was saying that I'd rather pay more taxes than walk around in desolation because the desolation that results from these systems failing we don't want to face. We'll pay much, much more in the long run.

MR. CARVALHO: The one other thing -- all of these cuts are painful, and one of the things I do want to highlight for you because, as you read through it, you may draw the wrong impression on one thing.

There are many -- probably a disproportionate share of these cuts are in my office, actually, and in one of the divisions in my office and that's the Center for Rural -- Center for Rural Health.

DIRECTOR ARNOLD: (Inaudible.)

MR. CARVALHO: No, no, no. Actually, it is numerically correct. But what I want to point out to you so that you don't draw the wrong impression is the Center for Rural Health is called the Center for Rural Health, but its activities really touch both rural and underserved communities.

And so this is not focusing in on rural areas to subtract money. The funds that go to
community health centers go to community health
centers in underserved areas of metropolitan regions
and to rural areas. The funds that go for a
physician's service in underserved areas go to rural
and urban underserved areas. And so all of those are
disheartening, but they aren't focused upon rural
areas. Rural areas were not singled out. They
affect the whole geography of the state and all of
the underserved areas of the state.

And I'm just a little sensitive to that
because I know that, because of their names on these
line items, people think, "Oh, this is all targeted
at rural," and it's not.

And, similarly, the line, for example, for
the Metropolitan Chicago Poison Control. That is a
statewide program. It happens to be housed in an
organization called Metropolitan Hospital -- Chicago
Hospital Association, but it serves as a hotline for
poison control throughout the state. We are
sensitive and have always been sensitive to
geographic equity, and I wanted to point that out.

DR. ORRIS: What happened with that?

MR. CARVALHO: Pardon?

DR. ORRIS: What happened with that line
to the poison center?

MR. CARVALHO: Well, it's at the same level it was last year. That was a cut from the prior year, but the prior year was an increase over the year before that. So -- so -- so the Chicago Hospital Poison Control Center line in this year's budget is the same as last year's.

CO-CHAIRPERSON McCURDY: Thank you.

DIRECTOR ARNOLD: And, actually, it goes back to one of the points that Dr. Evans was making too, is how can we demonstrate the effectiveness of public health. Now, the poison control center saves millions of dollars a year for unnecessary emergency room visits, and so it has proved itself -- its worth. So were we to withdraw the money from a program that's sustaining itself, that's one of those cost effective things that we can demonstrate, that the withdrawal of the program will cost us much more in the long run.

CO-CHAIRPERSON McCURDY: Thank you.

Any other comments or questions from Board members?

DR. VEGA: Yeah, Dave, I wanted to thank you for asking to hold our powder regarding our
approval of this till we saw the pain, because I see the pain now.

And I think the -- some of the things -- one of the programs regarding scholarships towards family -- towards rural practice or urban practice, wasn't that a repayment program? Funding from repayments of scholarships that otherwise were not served or is that --

MR. CARVALHO: We have two -- actually, we have multiple programs in place, and we have even twice as many of those on the books. It's a popular statute to pass. It's not as popular to actually fund; so --

DR. VEGA: Yeah.

MR. CARVALHO: But the ones that are on the books and funded are in two principal categories: One is loan repayment, and one is scholarship. And the scholarship funds do not get repaid, and so, of course, that requires new money constantly in order to extend new scholarships. The loan repayment is different. As you say, people who -- well, actually, the loan repayment isn't different. I was thinking of yet another program. Loan repayment requires replenishment too because if Dr. ABC is getting his
loans paid for by us, we don't ever see that money back. We've not extended a loan. We are paying his or her loans for him. Both of those require new money to extend additional --

DR. VEGA: Well, I think the -- there is a lot of data saying, if you have a primary care physician in an area, it's a small business. So people get -- people get employed, and then there are services that feed into that. So there's a multiplication effect.

But, also, primary care physicians tend to stay in the state, and I think if there was a coord -- you know, if there was overarching coordination of saying we want to have people to work on 122nd and Harlem, you know, or I should say further east, Pulaski or something like that, in Chicago or down in Carbondale, that training primary care physicians in those areas, it's much more likely that a person will stay there.

Now, this is where I'm kind of talking about coordination. We have to kind of come up with a program to remedy the training of neurosurgeons or of highly specialized physicians who leave the state, and this is state/federal funding. So, in a way, if
we coordinated it well from the beginning, we
wouldn't have to come up with little patches like
this and shoot ourselves in the foot.

So if there was -- if there was some
ongoing discussion regarding the work force needs,
you know, even some of the things that are pointed to
on SHIP, saying, you know, we need this type of work
force to do this. Can our educational institutions
that we have such a wonderful supply of work towards
this so that a lot of these things won't hurt as much

CO-CHAIRPERSON McCURDY: Excuse me. I
believe Elissa Bassler has a comment here.

Elissa, go ahead.

MS. BASSLER: Oh, I was just going to say
what you're saying there, which is that the State
Health Improvement Plan the last time and this time
talks about work force assessment and planning across
not just physicians but across, you know, variety of
medical and health fields, public health as well.

And there is -- there has been a small
effort out of Northwestern and the Hospital
Association to particularly sort of build on that to
look at the physician work force. And they had a
summit just yesterday, a physician work force summit.
So there are some work force efforts sort of growing out of the previous SHIP. I think there are issues, again, of that work force work being dispersed across a variety of places in state government and then -- and the sort of extent of it in general isn't adequate.

But the SHIP, as you point out, does say exactly what you're talking about, which is we need to plan for the work force. We need to understand what our work force is now. We need to plan for what the future needs are going to be, and we need to then have a plan that we can then create systems and programs and initiatives that will address what are identified as work force needs.

DIRECTOR ARNOLD: It was, I think, about two years ago when I joined the agency -- you know, I'm a veteran as well -- but I pushed -- you know, we were pushing and sort of got people interested in a bill that gave the equivalency to some of these state surgeons for the Army side and also, you know, with public health. And we got the equivalency bill passed and the Governor signed it last summer for EMT's and paramedics.

So when people are coming back from
overseas -- these thousand and the 1200 people --
that are in rural areas, and they're living in the
city, rural areas. They will most likely stay in
those areas. Those are their networks; their
families are there already.

And so the equivalency training -- we're
actually coming up with the guidelines now for what
that will look like for their ability. They can
cover -- get covered with the GI bill for some of
their training.

So I think the work force development may
require a better look at the local communities and
someone -- if someone is really tied to that
community. Do we need to earmark people who are in
the educational system there, the high schools, who
are going to stay there instead of, you know, asking
someone from outside to come in and work here.

MS. BASSLER: There's also discussion in
the State Health Improvement Plan about pipeline
programs in K through 12 and starting to sort of
engage kids in health careers earlier.

CO-CHAIRPERSON McCURDY: Dr. Vega, any
other comments you had?

DR. VEGA: No. I think this is great. If
we, you know -- if we are going to make cuts, 
let's -- we're paying for it twice. So let's pay for
it once the first time, and it makes sense to -- I'm
just glad that people are speaking this way and
hopefully action will take place in the future in
this regard.

CO-CHAIRPERSON McCURDY: And I see Kevin
Hutchison has a hand up. And, by the way, Kevin, if
you also want to segue into the local health
department funding, if that's an issue or some more
things to be said there, feel free to do that.

MR. HUTCHISON: Okay. The local health
funding. I think, you know, we're all faced with the
reality of the state's fiscal situation, and it's
those hard choices that we have to make. I know our
local boards of health, local health departments are
making those choices as well.

So in this budget, although the Local
Health Protection Grant was sustained, which we feel
is essentially, if you take that 17-plus million
allocated across the population of Illinois, it's
about a buck and a half or a little less. There's a
large -- larger portion of that being invested by
local municipalities, county governments for these
essential services. But as Dr. Arnold indicated
earlier, we are the front lines of response to
infectious disease, H1N1, water safety, and other
kinds of elements. So as important as that is, that
is our core service as a governmental public health
entity.

We also are having some pain with some of
these other cuts that are being made in health
promotion. We see the downside of reduction of work
force availability in terms of access to care. It
may be a discussion point later on at a future
meeting, but, for example, the county health rankings
that was distributed recently. Our county
specifically had an abysmal rating, and it's just not
acceptable, and one of our issues is access to care.
It's the availability of work force.

So I think this is obviously not a rosy
picture in terms of a budget, but I think the hard
choices of trying to maintain population-based
intervention specifically with local health
protection, that's what I was speaking to earlier on
in terms of an appreciation for Dr. Arnold and the
state health department's support of that,
recognition of its importance.
And, then, secondly, that was -- that was the intent of my motion was to really focus on expressing support of that portion of the budget, not really endorsing the cuts to the other side of these important programs that the Department had to make.

So that was my only follow-up, Dr. McCurdy, on that point.

The question I was going to raise -- and it's kind of relevant to the issues that the State Board and our Policy Committee has raised in the past -- and this is on tobacco and on the smoking cessation. I know -- I believe Dr. Arnold mentioned this is one of three areas that CDC and the federal government is looking at. And I noted that, in the proposed budget, last year's appropriation was 17.9 million. This year's is 14. I wondered if that was a result of either redirecting existing dollars, or is it actually the tobacco settlement funds going down and this is a preservation of proportion of that funding.

I guess that's a question to Dr. Arnold or to Dave or maybe it's -- I just notice there is a decrease in real dollars coming to the state health department. Maybe those dollars are being redirected
other places, but it brings up the issue we've had before of the tobacco settlement funds being used for prevention and versus paying other bills that the state has.

DIRECTOR ARNOLD: Yeah, what I can do is I can get -- you know, I get Gary to give you the specifics on it. But I know that the tobacco fund monies that we're receiving -- I'm not sure what kind of schedule they're on, whether there is a diminution over time or how that's structured completely. But I know that tobacco funds -- we get a portion of that within public health, but a significant portion of it goes to other programmatic areas that are somehow related to it. It may be DCPO (phon.). I'm not sure. But I can get something together, and we can bring that back to (inaudible). And I'll have a meeting with you, and then, you know, Dave can bring, like, sort of an outline of that back so they can see where -- because it -- tobacco is one of the major issues, and that's going to be something that we want to hit that line, you know, and there may be other programs the CDC has that we need to be sort of knocking on the door about.

CO-CHAIRPERSON McCURDY: Okay.
MR. HUTCHISON: Thank you.

DIRECTOR ARNOLD: Thank you.

MR. HUTCHISON: Dr. McCurdy, I will formally withdraw that earlier motion, and then we can have any other conversation that the Board feels because I didn't want to get ahead of the curve; so -- but I do still stand on record supporting and appreciating IDPH's position in the budget on specifically those three important areas of breast and cervical cancer, HIV, and Local Health Protection Grant.

DIRECTOR ARNOLD: Thank you, Ken.

CO-CHAIRPERSON McCURDY: We'll add, you know, that. I think we can make sure we have it in the meeting summary, and that would be -- that would be a good thing. So thank you for that.

And, Dave Carvalho, I know you wanted to make an introduction, I believe, before we conclude.

MR. CARVALHO: I did, and I apologize for saying that we wouldn't take up the rest of your time since we have now taken up the rest of your time.

CO-CHAIRPERSON McCURDY: Well, we got ten minutes here if you really want to stretch it.

MR. CARVALHO: We do.
Like to introduce Stephen Mange. Stephen is our -- Steve is our new Governmental Affairs chief, and he overseas all of our relations with the General Assembly.

And so I asked Steve if he could give an overview of both the status of our initiatives in the Generally Assembly this year, which I think I mentioned them to you before, but not everything makes it to the finish line. So Steve is going to give you an overview of where our initiatives are, and then also highlight some of the more significant pieces of legislation that we're following either in support or occasionally in opposition.

So, Steve.

MR. MANGE: Thank you, and thanks for the opportunity to meet all of you. Dave has told me great things about all the work that you do, and it's an honor to be in the position I'm in and also to be talking to you today.

MR. CARVALHO: And should I interject -- just only one time -- and that, since Steve has to be our greatest diplomat since he is dealing with the Generally Assembly, I should point out to him that there's a court reporter.
MR. MANGE: Uh-oh.

Well, you know, our -- our general approach this year really stems quite significantly from the fiscal crisis that we're in as a state and as an agency. And so we don't have a lot of time, but what I can tell you about both our affirmative legislative agenda and our efforts to deal with bills that come at us from every direction.

You know, the overriding theme is trying to address our fiscal situation, and so our affirmative agenda this year has been very much focused on trying to increase different sorts of fees that -- that we charge in different contexts so that the work that we do can be more self-supporting and less dependent on general revenue funds.

So I think the three main examples that I would mention, one, is an effort to impose a licensing fee on hospitals and to increase existing licensing fees on home health care agencies and on surgical centers, and all of that money is used to increase our efforts to ensure patient safety in those institutions.

We are very close to having -- this is a bill that was very graciously carried by Senator
Delgado, and, trust me, it's not an easy proposition to carry a fee increase bill this year. And so we're very grateful to him for doing this. And there was a lot of opposition initially from the Hospital Association, in particular, and I hope that by the next time I talk to you I'll be able to report that we came to an agreement -- kind of a compromise on generating not quite as much income as we would have liked for patient safety but -- but heading in the right direction.

The second bill I would mention is a bill that Senator Steans is carrying for us that amends the Structural Pest Control Act to increase -- both to include public schools and day care centers but also to increase the fees that we charge for licenses, registrations, and certifications in this area. And that bill, I'm happy to report, has passed out of the Senate and is now over in the House where it will be carried by Representative Osterman.

And the third example I would give is some amendments to our EMS Act which also increased fees, particularly, for example, fees that we charge when we inspect ambulances is a key part of that. And that act -- and this is true of the Structural Pest
Control Act as well -- also includes provisions updating and modernizing both of those -- both of those acts.

And so those are, I think, key examples of our affirmative legislative agenda.

And as far as dealing with bills that come at us from every direction -- and there's thousands of those, as you know -- you know, a big focus of our effort is to support thoughtful efforts to better address public health issues. The reality, though, is there's an awful lot of legislative proposals that come at us that may be well intentioned but either try to do things in a less than optimal way or very, very often impose new mandates on the Department of Public Health without providing any funding for those mandates.

So, essentially, many of these would require us to gut existing programs to support new programs, and one of the most difficult things that my team does is to go into committee hearings and say, you know, this is a great initiative but we can't afford to do this. This is going to either have to wait till another year when our budget is in better shape or at least put that -- put the magic
words in the legislation: "Subject to appropriation by the General Assembly, the Department of Public Health shall do such and such."

So, you know, it's very frustrating to have to oppose good ideas, but, you know, we just finished talking about our dire situation right now fiscally both here at the Department and with the state. So we spent an awful lot of time trying to swat down bills that are going to make our fiscal situation worse. Some of them, you know, may not be high priority items, but some of them really are genuinely well intentioned and even very thoughtful proposals.

And so, you know, for the long term -- for the long term I'm actually working to streamline the process that we have for tracking these hundreds of bills that we try to track.

And, also, you know, I came in the day before session started. And so I wasn't able to do as much homework as I would have liked/as much preparation as I would have liked on the affirmative side. And so we'll have the advantage going into next session of being able to spend the summer either resuscitating proposals that didn't make it this year
or developing new proposals and actually having the
time to reach out both to our allies and to potential
opponents to really get those in good shape for next
session.

So that's really the broad brush overview
of what we're doing right now, and I'd be happy to
answer any questions that you all might have.

I also am well aware of the time, and so I
won't take it personally if you don't have any
questions until our next meeting.

CO-CHAIRPERSON McCURDY: We have about a
minute for questions.

DR. VEGA: I have a quick one. Is there
any requirement for fiscal notes on any legislation
coming through?

MR. MANGE: So fiscal notes. We often
prepare what you would call unofficial fiscal notes.
So when we're going into a committee to oppose a
bill, we will have asked our staff people to actually
explain -- make an estimate of the fiscal cost, and,
then, officially, we do sort of official fiscal notes
when some legislator requests it.

So, you know, in terms of officially
filing a fiscal note that will show up on the
legislative tracking system, we go through a process
of doing those when asked to do so.

And I have to -- thank you very much for
the opportunity, and I actually have to run and hop
on a 1:00 o'clock conference call. But it was a
pleasure having an opportunity to meet you, and I
look forward to reporting back to you in June, I
guess, is our next meeting as to how we fared this
session.

Thank you very much.

CO-CHAIRPERSON McCURDY: Thank you.

Thank you very much, and unless there's
further business, I will adjourn the meeting.

(Meeting adjourned at 1:00 p.m.)
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TRANSCRIPT OF PROCEEDINGS 3/11/2010

Page 111

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worse 64:3 102:10
worth 77:15 87:15
wouldn't 10:16 90:2 97:20
wrong 15:10 80:7 85:9,19

Y
Y 32:23
yeah 15:11 33:16
36:15 37:16,23
42:17 45:9 48:9
67:13 72:12 87:23
88:14 96:5
year 8:13 9:15 16:18,19,22,24
24:13 38:9 52:17
55:20 66:15,16,17
66:22 71:21,23
72:11,13,20 73:2
73:8,10,15,16
75:20 76:6,7,17
77:23 78:2,4,4,5
82:21 87:3,4,4,5
87:13 97:20
year's 87:6,7 95:15
year's 87:6,7 95:15
95:16
Yep 37:15
yesterday 8:5,9,19
9:1 15:3 48:12
78:21 83:20 90:24
YMCA 49:4
youth 81:21

Z
Z 2:7
zeroed 16:5,6,8

$ 80:14,16
$1.3 9:5
$1.5 80:12,17
$1.8 80:18
$1.9 81:20
$100 24:15
$100,000 81:16
$13 16:24 78:19
$2 81:21
$2.3 81:12
$250,000 80:21
$3,1 81:15
$3.5 80:11
$3.7 80:15
$4.4 8:13
$400 24:13,14
$500 24:16
$500,000 80:20
$6.8 80:24
$850,000 81:4

# 084-002046 1:19
1
1 84:2,19,24
1.25 24:20
1.3 83:22
1.800.280.3376 1:24
100 8:12 39:19
100 8:12 39:19
68:17 74:3
103 74:3
104 3:19
11 1:5 84:5,10
11:00 1:6
12 92:20
12:00 7:10
1200 92:1
122nd 89:15
13 93:3:18
130 73:20
14 95:16
140 72:24
143 73:20
15 1:21 78:4
15th 39:5
160 39:17
17-plus 93:20
17.9 95:15
19 19:20
20 3:6 68:6 76:12,12
78:5
2004 24:23 25:2,11
2006 33:5
2008 23:19 24:23
25:3,12
2009 3:3
2010 1:5
2012 105:23
21 3:7 105:23
217.522.2211 1:23
235,000 25:4
24 25:11
25 3:8
26th 39:3
2981 56:9
3
3 19:11 74:4 84:6,23
3rd 20:24
3(b) 64:1
30 39:19 75:22 76:5
3047 21:17
33 72:20 73:1 76:14
84:18,23
35 39:19
38th 12:3

4
4 3:2 72:19
400 24:17
45 3:8 69:14,19
5
5 19:11 72:19 76:7
5th 1:8 26:9,11,12
50 12:3 16:19 25:6
39:18
50,000 25:3
50/50 75:21 76:4,9
76:11,13
51 3:9
52 3:11
535 1:9
55 25:1
59 43:8

6
6 3:4
60 3:13 76:9,15
61 3:14
62701 1:22
63 3:15
67 19:12
69 3:16 25:1

8
8 3:5 25:12
8th 39:4
8.2 8:15
8.9 9:14 13:22
80 25:5 39:19 78:20
81 12:18
820.145(a) 64:7
820.210 63:23
84 19:12

9
9 73:21 84:10
9th 26:17
95-282 52:20
950,000 24:19
96 9:17
96-318 60:7