STATE BOARD OF HEALTH
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CHAIRPERSON ORGAIN: Let's officially start by approving the meeting summary for December the 9th. Are there any additions or corrections?

MS. PHELAN: I have questions about the web site that was provided, appointments.gov on the first page, as well as in the minutes. I don't believe that's correct.

CHAIRPERSON ORGAIN: David.

MR. CARVALHO: Yes, ma'am, this is Dave.

CHAIRPERSON ORGAIN: On the meeting summary on the policy committee report, the fifth bullet where it says on November the 23rd, there's a web site that says appointments.gov. Is that the correct web site?

MR. CARVALHO: I would doubt it because the word "Illinois" is not in there.

MS. PHELAN: I can tell you what it is.

MR. CARVALHO: Yes, please.

MS. PHELAN: Appointments.Illinois.gov, G-O-V.

MR. CARVALHO: So some of you may find yourselves on an unexpected federal authority.

CHAIRPERSON ORGAIN: So wherever that is
in the minutes for -- then it needs to be
corrected, okay.

MS. PHELAN: So noted, Dr. Orgain.

CHAIRPERSON ORGAIN: Thank you.

MR. HUTCHISON: Dr. Orgain, this is
Kevin. Just a clarification on the minute
summary, I was in attendance at the December 9th
meeting in Chicago -- beautiful city.

CHAIRPERSON ORGAIN: So members present
did include you?

MR. HUTCHISON: Yes, ma'am. Thank you.

CHAIRPERSON ORGAIN: All right. We'll
make that adjustment as well for Kevin
Hutchison.

Tricia?

MS. REPORTER: Yes.

CHAIRPERSON ORGAIN: Dr. Peter Orris has
joined us.

MS. REPORTER: Thank you.

CHAIRPERSON ORGAIN: Are there any other
corrections or additions? If not, by consensus
we can move the meeting summary. No objections?

MR. CARVALHO: No objections.

CHAIRPERSON ORGAIN: Dr. Arnold.
MR. CARVALHO: Yes, this is Dave.

Dr. Arnold is in Washington, this is the ASTHO, A-S-T-H-O, Association of State and Territorial Health Officers' annual meeting in Washington. I know he was at the White House last night with his fellow health officers from the other states and they had a full day with Secretary Sebelius and OMB and other federal branches. I've not yet heard how that went, but Washington's always an interesting place to be and I suppose it's more interesting'er than usual right now.

As many of you may know, there are quite a few revenue streams that this agency and other state agencies have relied upon, both for our operations and for pass through to units within the state that are under attack, they were zeroed out in the HR-1 that the House of Representatives passed to cut $60 billion out of this year's federal budget. And frankly, there are some of the revenue streams that we've relied upon that the President's budget introduced this year did not include, including the public -- the PHHS block grant which, as you recall, we used to fund a variety of important
activities here.

If it's any consolation, that I think every president has zeroed that out every year for quite a few, and Congress usually puts it back, that may not happen this time. So there's a lot of reason to be in Washington and that's where Dr. Arnold is.

In his absence, let me bring you up to date on a few things going on in the agency. I asked to have distributed in Chicago, did you receive our budget briefing?

CHAIRPERSON ORGAIN: We're getting it as you speak.

MR. CARVALHO: Okay. This year as a little bit different. Typically we provide this budget briefing to our stakeholders before the budget.

Who joined us by phone?

DR. SAHLOUL: This is Dr. Sahloul.

MR. CARVALHO: Hi, Doctor, this is Dave Carvalho, I'm in the middle of the presentation from the director's remarks, we're talking about the budget. And for court reporter purposes, if you speak during the meeting, if you could say
your name before each time so the court reporter
can distinguish between you and the other
persons on the phone. Thank you.

DR. SAHLOUL: Thanks.

MR. CARVALHO: In short, our budget is
short from last year. As you can see, there's
about a 1 percent -- almost a 1 percent
reduction. As you all manage your own budgets,
who manage your own budgets know, even a budget
that's flat is effectively a cut because all
your personnel lines have built in
cost-of-living adjustments and the like, as well
as ordinary inflation. And so our overall
budget is reduced by 4, but many of our items
that are flat are effectively shrinking and some
of our items have shrunk.

One of the things that Dr. Arnold has
set as a goal for each of the last several
budgets, and so far a successful goal, has been
maintaining the funding for the local health
protection grant.

I was at a breakfast this morning with
administrators from the IAPHA and just in casual
conversation, reminded how even at maintenance,
this grant is fairly inadequate to the needs of
the local health department. One of the
administrators I was meeting with figured that
she receives about $60,000 of the $17 million
total grant and that the services she provides
that are associated with the grant cost her
about $180,000, I wouldn't be surprised if
that's fairly typical. And it has been a goal
of IAPHA and NIPHC and certainly supported by
the director in the agency to see that grant
grow. This just has been hostile soil for
growing things and maintaining the grant is an
accomplishment in and of itself.

So the budget as introduced maintains
the local health protection grant, it maintains
some of our other core programs at adequate, if
not robust levels.

Some of the reductions last year are --
persist in this budget. So in particular, in my
office where we saw last year quite a few cuts
to some of our medical scholarship programs and
work force support programs and community health
center programs, those items that were deleted
last year continue to be deleted. The only
saving grace in most of those is there was quite an influx of funds from the Federal Government in each of those categories under the Affordable Care Act, and before that, the stimulus bill. And so it is not a disaster that those were cut, but those cuts were maintained again this year.

Two of the large reductions this year at least in the dollar amount, related to combining some programs where we currently have items with revenue lines in two different areas of the agency and the proposal is to combine the lines into one spot and then try to achieve some savings by coordinating those.

So in particular, we have funding in the HIV area, in the breast and cervical cancer area, and the prostate cancer area, and by combining some of those lines that are currently either in the Office of Health Promotion or Women's Health or the Center for Minority Health into one area and then managing them together, we will have better flexibility to meet needs.

At the end of the day there are fewer dollars and so there will be fewer dollars available, but by combining them we hope to at
least not be caught where we're making decisions based simply on which pot the money is in as opposed to where the needs are.

In addition, some portions of our budget where we are in effect pass-through entity for funding going to others, our budget, as introduced, did not include those dollars. It will, of course, be up to the legislature whether to restore those dollars. But we sought to protect our core programs and in that environment, we could not put in the dollars for some of these pass throughs.

There are some increases, the most notable two relating to the long-term care responsibilities of the agency that were significantly expanded under Senate bill 326 last year. If you recall, in light of some really bad things going on in nursing homes across the state, the governor put together a task force to develop a response. And one of the key elements of the response was to increase the number of surveyors -- the number of surveyors that we have to review conditions in nursing homes, and in particular, to create a
survey-to-bed ratio that would be the standard in this state. That is a personnel expense, it can't be done overnight because there is extensive training that we do of our surveyors, but the down payment on implementing that is in this budget.

In addition, the legislature continues to add tests to the Metabolic Screening Program. As you probably know, at birth a blood drop is taken from each newborn and certain genetic tests are run for all 170,000 or so babies born in Illinois each year. And the process for adding to these tests has, of late, been a legislator who sponsors a bill to add a test.

We do have a process in place that involves a committee of experts, that is theoretically the process, but in reality lately of the process lately has been a legislator responding to constituent and adopting a bill.

And so oftentimes, there is new and cutting-edge equipment required, new reagents required and sometimes new staff required. So the cost of expanding some of these tests must be reflected in our budget and is.
The handout that I gave you goes through some of the line item detail. Those of you who have seen our budget over the years know that for historical reasons, our budget is a pastiche; very specific items with dollars associated and then very unspecific items with dollars associated. And that's just the way it's always been. And that --

DR. CASWELL: Good morning. Caswell Evans joining you, sorry I'm late.


Dr. Evans, if you could, any time you wish to speak in the meeting, just proceed it with your name so the court reporter can distinguish you from others on the phone.

DR. EVANS: I certainly will do that.

Again, I apologize for being late. I tried to get downtown, there's no way of doing it so I'm calling in.

MR. CARVALHO: The detail in the budget is on the last two pages of the briefing.
Unfortunately for person the phone, we will distribute a Xerox -- a scan of this to everybody so that you have it. I won't go through the line items, but if anything catches anybody's eye, I will try to respond to a question.

Just to finish right before that, as you know, the budget process is a long one, it is the last -- typically the last thing completed by the legislature. For those of you who have only followed the state budgeting process in the last five or ten years, you probably think of that as a process where the governor introduces a budget, hearings are held, and then after four months suddenly a thousand-page document is dropped on members' desks and they vote on it.

It was not always that way. In fact, it used to be a process where the budget was dealt with by committees line by line, amendments were added, committees adopted bills, they had targets established and all of it was then assembled towards the end. There is some talk that they may actually be moving in that direction. And certainly recently the revenue
committee of the House held a hearing to decide what dollar amount all the appropriation committees should establish as their goals, and then the appropriations committees are quite likely to hold the types of hearings and meetings they used to hold in the '80s and '90s.

So we may be seeing a budget process that's quite different from the one we have all grown accustomed to in the last ten years, and as we do, that should be very interesting to watch.

The priorities that we established in this budget, of course, are the priorities that we will advocate for in that process. And as we get to later in the meeting when I give you a legislative update, it will be the touchstone we use typically for taking a position on legislation; namely, if the legislation does something very beneficial but at a cost that is not currently provided for in the governor's budget, then it's a piece of legislation that we would oppose, albeit stating that we're opposing it for financial reasons.

So I'll stop there. If there are any questions on the budget, I'd be happy to
entertain them.

CHAIRPERSON ORGAIN: David, Dr. Orgain.

I see the community health centers received $3 million for tobacco prevention or am I reading that incorrectly?

MR. CARVALHO: Yes, you're reading it incorrectly, but it's a very understandable reading. What that means is that -- what that means -- what that means is the tobacco fund is the source of money for community health centers, but it is not the reason for the expenditure. The reason for the expenditure is some sort of programmatic expansion at the community health center and so that program has historically been funded out of the revenues from the tobacco fund, but those programs at the community health center, frankly, may have absolutely nothing to do with, for example, tobacco cessation activities. It's rather a source of funding, but not a programmatic activity.

CHAIRPERSON ORGAIN: Do we know how many community health centers there are in Illinois?

MR. CARVALHO: Do you know Julie?
MS. CASPER: This is Julie Casper. I believe there are 44 overall, but there are many satellites within those 44. For example, Access, which is based out of Chicago, is the largest federally qualified health center group, organization in the United States. So there are many satellite centers within those parent CHCs, community health centers.

MR. CARVALHO: And then you should also know that because the statues have been written this way, when Julie says community health center, she is normally referring to a federally qualified health center. As everybody here knows, there are other types of health centers out there who are not community health center, probably the most noted being the one called Community Health. But our statutes have all been written to direct our funding to federally qualified health centers and organizations like Community Health are not eligible for these funds.

CHAIRPERSON ORGAIN: So in this budget it would be more correct to have FQAC?

MR. CARVALHO: Yes. The statute defines
the community health center as a federally qualified health center and so everyone here uses that term. But you're right, to the outside observer, they might think that these were funds available to a broader community of facilities and that's not the case.

CHAIRPERSON ORGAIN: All right. Thank you. Any additional questions?

MR. HUTCHISON: Dr. Orgain, Kevin Hutchison, I have a question.

First of all, a comment on behalf of local health departments, we certainly appreciate the support of Dr. Arnold and IDPH for preservation water well protection grant funding. This is, as Dave suggested -- although, this does not cover nearly all the cost for infectious disease control, and food safety, water safety, and those core activities, it's critically important to local health departments across Illinois. So we appreciate IDPH's support of that.

Secondly, the question or a comment, my understanding is that this budget is predicated upon the general assembly passing, I think it
sent a bill through the short-term borrowing plan. And if that does not occur, then it is very likely it will be much larger cuts that would be required, at least that's what I'm told by my area representative.

So I guess my concern is or question is in terms of as the budgeting process goes through the role that the state board can take or any information that you might be able to lend to us to continue to advocate for these critical programs. Because if the short-term budget borrowing plan doesn't go through, my understanding is there could be lot more cuts.

And first of all, maybe you can clarify that.

And the last question is, it's my understanding that somewhere in the process here that some programs and activities that formerly were within the Department of Human Services were transferred to IDPH and I think there's something the board had discussed previously, I think diabetes control may be one of them and there may be some others. So you may want to speak to that realignment of some of these programs within the Department of Public Health.
MR. CARVALHO: Yes, I will address each of those and remind me if I forget along the way.

First off, there is -- the budget packet as a whole of which Illinois Department of Public Health is an all too minuscule part, is built on a lot of different pieces. And as Kevin noted, one of those pieces is the approval of short-term borrowing.

As most of you know, certainly any of you who are currently receiving funding from the state, the state is horribly behind. I believe, they are currently paying September invoices. And the governor has noted that, you know, from just an objective fiscal perspective, that it makes more sense for the state to borrow money at the tax-free interest rate that the state can borrow money, which is probably in the 4 to 5 percent range, than to pay late payments to its vendors at the 10 or 12 percent rate that the Prompt Payment Act requires.

I know I personally have received several checks in the amount of a dollar and a quarter or $2.50 because my expense
reimbursement checks are four or five months late; and while that's great, it's actually better interest rate than you get from a bank, it still makes more sense for the state to just catch up on all of its payments and pay the borrowing rate the state would otherwise pay, rather than this greater interest rate that it's paying to its vendors.

While that may make objective fiscal sense, it is lousy politics in the current environment. And so it requires a three-fifths vote for state to borrow. And when something becomes political as opposed to common sense, a three-fifths vote is hard to put together.

Now, what does it mean to the budget if that's not approved? In the most straightforward way, as Kevin said, it would require cuts. I suppose it could also be dealt with by the state just continuing to stiff its obligation -- the people to whom it's obligated, even longer and longer. You know, that doesn't make sense fiscally, it accrues interest and prompt payment, but extending the payment cycle is historically the way states have dealt with
revenue shortfalls and the failure for the short-term borrowing to be approved could reflect its way into the budget in any number of not great ways.

I can't believe that I forgot to mention the aspect of the change of housing for certain programs because I've actually been very involved in that topic.

As some of you who've been around for quite sometime know, the Illinois Department of Human Services was created in '96, I believe, by pulling programs from a lot of other agencies and in some instances by pulling whole other agencies. So the Department of Rehab Services or mental health programs were all pulled into the Department of Human Services. And at the time, the proposal involved pulling the entire Department of Public Health in, and for a variety of reasons not worth digressing to, the Department of Public Health was left to stand alone, mostly dealing with population level activities, and the activities within the Department of Public Health that could be viewed as more client-based were moved into the
Department of Human Services, along with the other client based services in the Department of Human Services. And in particular, the maternal and child health programs and community health programs were pulled into the Department of Human Services with certain aspects of them left in the Department of Public Health.

So for example, in my office, we got APORS, which is the Adverse Pregnancy Outcome --

MR. HUTCHISON: Reporting System --

MR. CARVALHO: -- Reporting System and PRAMS, the Pregnancy Related Adverse -- I never spell them out anymore, but PRAMS, P-R-A-M-S, all capitals -- and those are the data functions, the surveillance functions, but the actual program functions are over at DHS.

So we've got this divide where certain programs that used to be in public health or at DHS and certain aspects of the programs remain in public health. And the maternal and child health community, for some time, has viewed that as not ideal.

And so a recommendation to move some of that or all of those programs back to the
Department of Public Health has been kicked around internally for some time. The governor's budget reflected a first step in moving certain of those programs back to the Department of Public Health. The specific lines in the Department of Human Services that would be moved to the Department of Public Health are laid out in the governor's budget proposal.

At this point I guess what I could best say is there's ongoing discussion as to whether those are the right lines, whether maybe there are other lines that should be moved. And so this is in a state of flux, but that concept of moving some of those maternal and child health programs back into the Department of Public Health seems to have been well received in both the maternal and child health community and the public health community and the local public health department community. So we will see as it works its way through. Those of you who have observed these sorts of things over time know that the legislative process acts upon these kinds of proposals at its own pace, in it's own way and we'll see where it goes.
But that is an initiative that Kevin alluded to the fact that a little tiny baby step was taken last year of moving of the diabetes program. But what that move entailed was three positions and some money, and this program -- this move involves a lot more dollars, a lot more people. Neither number do I remember in my head right at this moment. But, yeah, that is a significant element of the budget.

Did I address all of the things on your list?

MR. HUTCHISON: Yes.

MR. CARVALHO: Thank you.

CHAIRPERSON ORGAIN: Thank you. Dave, I just want to move on to the policy committee report if there weren't any additional questions.

MR. CARVALHO: Great.

CHAIRPERSON ORGAIN: All right. Thank you for that report. And we'll move on to Karen Phelan who will give the policy committee report.

MS. PHELAN: The policy committee met
via conference call Wednesday, February 9th, and you've all received a copy of the minutes. Any comments based on those minutes?

    Thank you, Cleatia, for preparing those for us.

    Also Dr. Kruse gave us several updated medical home information and they were attached to our agenda for today. I don't know if you've had an opportunity to review those, but it's part of our agenda, if you will. Do we need to approve the minutes first?

    MS. SANDERS: So moved.

    MS. PHELAN: Seconded.

    DR. ORRIS: Consensus.

    MS. PHELAN: Consensus. Tim, Dr. Kruse isn't with us today, can you give us an update on medical home?

    MR. VEGA: Yes, sure. We had a review of what a -- some of the elements that Karen has in the report there. Illinois Health Connect is the Illinois Medicaid version of trying to implement some medical home practices into Medicaid and they have been so far success -- I don't know the exact number, but they've been
successful in creating some significant cost avoidance. I think they're probably somewhere -- and Dave correct me if I'm wrong -- but I think they're somewhere in the $350 million savings. And this was -- we thought this would happen, but you never know if it's going to happen until you actually do it.

About simultaneously with this, there have been some other medical home endeavors that have occurred and the link that is given in the report regarding the -- it's the PCPCC net outcomes report, is finally something across the country with various attempts at medical home implementation and it's been good to see a significant savings throughout. There's been some integrated delivery systems that have shown in the range of 16 to 20 percent reduction in ER visits and hospitalizations. There have been some private pairs that have shown the same thing. I think Blue Cross/Blue Shield is duplicating that across the country because they've seen savings. There have been some Medicaid-sponsored initiatives, more specifically in Carolina as well as the Veterans
administration and academic institutions.

So that link is a summary of the
perspective outcomes of medical home
implementation. So because of that, this is one
of the reasons Jerry and I have been pushing
this, we think this is a way to improve quality
for citizens of Illinois, reduce cost and
address disparities, whether they're rural or
urban, ethic disparities, income disparities, it
is a solution that with implementation could
serve a lot of purposes.

So for those people, the new members of
the board, we've been working on this and trying
to propose these efforts for a few years here.
A medical home is basically a patient -- a
patient center care and there's a team approach
to it, it eliminates barriers, uses electronic
medical records, care for community integration,
and so using a public health and community
health resources with the medical offices,
focused on quality and safety and some other
things such as enhanced financing and watching.
But it's a basket of services that, if
implemented, seems to work in reducing cost and
1 improving quality.
2 So we're hoping that -- some of these
3 things I thought were going to be sent to the
4 exchange implementation team, I'm not sure if
5 they've got that going yet. But this is very
6 good data for them to have in their hands as
7 they move forward. I don't want to go into all
8 the elements that we have there, but that's the
9 essence of it all.
10
11 MS. PHELAN: Thank you.
12
13 DR. ORRIS: That's what I wanted to ask
14 about the Exchange Implementation Team. We have
15 people there, I understand. And what is the
16 interaction between what you're doing and where
17 are we at with those exchange implementations?
18
19 MR. CARVALHO: Was that to me?
20
21 MR. VEGA: Was Peter addressing that to
22 me?
23
24 DR. ORRIS: It was sort of a general, I
25 guess you, or David, or whoever else. I don't
26 remember who is supposed to be there for us.
27
28 MR. CARVALHO: I can weigh in -- well,
29 I'll defer you to, Dr. Vega, unless you would
30 like me to --
DR. VEGA: No. No. I thought our role was simply sending them information, I did not think we had any representation on that team.

MR. CARVALHO: I will give you very brief update on where things are. Several state agencies were requested by the governor to develop an Affordable Care Act implementation counsel. That counsel held hearings and it issued its report about a week ago, it's on their web site but we can distribute the link or the PDF of the document to everyone.

It looks at the entirety of the Affordable Care Act implementation. To a certain extent, it was driven by the actual testimony at the hearing, so it's a report on the hearings. So if you read it, you will probably be a little concerned that there's a little less discussion of prevention than our tastes would like, but that's because there wasn't a lot of testimony on prevention and so it was reflecting the testimony.

In any event, that report was posted last week, those meetings continue, the Department of Public Health is involved in that.
And in accordance with the game plan developed by the counsel, there is pieces of implementation, or moving forward, under the leadership of the appropriate agency. So for example, the Department of Insurance has taken the lead on the development of the Health Insurance Exchange, which unfortunately, has the same acronym as the Health Information Exchange, so I won't use the acronym.

The Health Insurance Exchange would be the place where persons could go to a web site to find out what kind of insurance options are available that are consistent with the Affordable Care Act and available for subsidy for persons who require a subsidy.

Michael McRaith is the director of the Department of Insurance, is very well regarded in this area nationally and has taken the lead on that. There is legislation that's been introduced, if I can find the bill number, I will mention that sometime in the meeting. But it would create a health information -- excuse me -- a health insurance exchange. The department would be an ex officio, have an ex
officio representation on the Health Insurance Exchange. And the details of what would be done by that Health Insurance Exchange are in that legislation.

DR. ORRIS: Could I speak just for a minute, Dave?

MR. CARVALHO: Yes.

DR. ORRIS: It's my understanding that the actual, what's been introduced is more of a show than anything else, and they are now in active negotiation for what would go into that legislation specifically. And that there is a draft, though being held rather close to the vestment on their discussions. I'm wondering if we're able to access that draft, if you've seen it and if we can have some input with respect to that.

And second of all, whether the concepts of the medical home and what was being discussed by Dr. Vega are being looked -- being looked at for what should be integrated within that draft legislation. Too much?

MR. CARVALHO: You may know a little more than me. The legislation that I saw -- the
way I use the word, a "show" is usually a bill
that changes "a" to "the" and then an amendment
comes later and adds substance. The legislation
I've seen is fairly substantive and certainly
reflects some negotiation because it has
provisions -- and now this is just me speaking
-- has provisions that I would never put in
there unless somebody from the insurance
industry was breathing down my back. So I
assume those provisions were the reflection of
some negotiation and so I think the draft is a
working draft. Now, you --

DR. ORRIS: That's what I wanted -- this
is the third time this week this has come up,
both with the unions and the State Medical
Society, et cetera. And I would like to see --
and I think you're right, there are a bunch of
people in the room and they're talking back and
forth about it. But I'm concerned a bit about
the public health input and I would we would
like to assure that we or some of our people and
the medical home concept are getting reflected
within this dynamic.

MR. CARVALHO: Okay.
CHAIRPERSON ORGAIN: So let me just take it up from there, David.

MR. CARVALHO: Yeah.

CHAIRPERSON ORGAIN: What I'm hearing, the possibility that there is some legislation that can be forwarded to us so that we can take a look and provide input and find out what the next step would be in regards to influencing or before it gets passed, trying to make some amendments to that.

MR. CARVALHO: Yes. I mean, the reason why I hesitated is those of you that are familiar with the legislative process know, the process is usually more nimble than a board can be, or requires more nimbleness than a board can have. And frankly, the process often it involves fewer persons than one might think.

CHAIRPERSON ORGAIN: What we can do, however, is in line with what Peter said, we can mobilize the public health community to keep a watch and provide some additional direction to that, for those persons who are nimble, who might be in Springfield on a regular basis.

MR. CARVALHO: Yes, we can --
DR. ORRIS: We contributed to getting the smoke out of smoke-filled rooms, now I would like to contribute opening the door as well, if we could.

MR. CARVALHO: Right. Well, those are two different things. We will circulate what we know and what we have access to that is -- to you. I can't assure you that you will be at the table because I can't assure you that we'll be at the table.

But certainly our position all along has been to advocate for the public health interests at stake on all the pieces of the Affordable Care Act and this is no different.

CHAIRPERSON ORGAIN: All right. Thank you very much.

DR. ORRIS: Thank you.

MR. CARVALHO: Sure.

CHAIRPERSON ORGAIN: We can move on.

MS. PHELAN: Thank you. Thank you, Tim.

Mary Driscoll, we can move on to --

MS. BOWEN: She has a prior commitment, Karen, she has a prior commitment and will not be available today.
MS. PHELAN: Okay. What about Leticia?

MR. CARVALHO: She's here.

MS. REYES: She's here. I snuck in there. Good morning. And my name is Letecia Reyes. I just have a very brief report for you.

For the SHIP Implementation Council, Michael Gelder was sent a letter to all the directors of the various agencies that are in the legislation, they received their letter last week. And we've asked them to send us the names of their representatives for the SHIP Implementation Council by March 18th so we'll have a list of who will be part of the group that are automatically on. And then we are continuing to review applications. We did receive a significant number in the last couple of weeks, we're continuing to reach out to folks to make sure we have a good pool of applicants. We expect the governor will be reviewing the potential appointments by the end of this month and we hope to have appointed council by the end of this month or early April. And so that we hope to have appointed council by the end of this month or early April.

MS. REYES: She's here. I snuck in there.
to be able to get our first meeting done by the first -- by the end of April for the SHIP Implementation Council.

And that's where we're at right now.

And anything else, David, that you would add?

MR. CARVALHO: Just to backfill for some of the newer members, the SHIP Implementation Council statute provided certain representation from different agencies of state government specified in the statute. And so Michael Gelder, who Leticia referred to, is the senior health policy advisor in the governor's office. Since those agencies all report to the governor, he has sent the letter to those agencies saying give us a name.

The statute then also provided for representation of all the different stakeholders and that's what Leticia was referring to. We've taken names at the appointments.Illinois.gov web site and the governor's office will be sifting through those to make sure that the council is representative and then it can launch.

DR. EVANS: Is that process still open and receptive to interested parties or has that
window closed now?

MS. REYES: No, we're still accepting applications. I'm asking folks to try to get them in no later than March 18 because that's the deadline, where we'll have the state one, so then I have a list that we can submit to the governor's office for review. There is no deadline for applications. Obviously, for the first appointment, there will be continuing, you know, applications throughout the entire implementation council's life, but I think the 18th is a good deadline to look at so that that will be the first round of folks who will be appointed that we'll review during that time.

DR. EVANS: Just one more follow-up question. Just remind me again of the web site.

Illinois --

MR. CARVALHO: Appointments, with -- plural -- dot Illinois dot gov.

DR. EVANS: Thank you.

MR. CARVALHO: You will then have to search for the SHIP Implementation Council because it is the web site used for all appointments to every single board and
commission in state government.

DR. EVANS: Yeah, right. Thanks.

MS. PHELAN: Any other questions? Thank you.

UNIDENTIFIED: Final curtain call for Health Information Exchange from Wesley Valdes.

DR. VALDES: I'm currently the medical advisor for the Health Information Exchange, under the Office of Health Information Exchange and Technology. My real life is I'm the medical director for the Office of Telehealth at the University of Illinois. On the Health Information Exchange I'm also serving as the chair for the Telehealth Board Group and the Clinical Quality and Integration Work Group.

CHAIRPERSON ORGAIN: I invited Dr. Valdes primarily because the SHIP requires data information, a collaboration and if we are moving to implementation, I wanted everybody to know where we are with Health Information Exchange.

DR. VALDES: So I guess the easiest word to say is we're confused. No, just kidding. I think a lot of the impression from the
people involved in the Health Information Exchange effort is dealing with the enormity of the task and diversity of the databases and the various areas from where the data is potentially coming from and how to organize that from just a mess of data into something that's useful and organized and allows you to transfer data into something that's knowledge that allows you to do something with the knowledge.

That being said, for those of you who haven't been involved in that and may or may not know, the Health Information Exchange is currently envisioned as a three-tiered process. The lower tier, but the tier that probably is going to handle the most granularity of clinical data is being identified as an enterprise level Health Information Exchange. So that would be an example -- I should say an example would be like the Advocate System has nine hospitals and within themselves they share data, they are an enterprise unto themselves so they can share data among themselves, that would be an example of the Enterprise Health Information Exchange, the lower tier.
Another example might be Southern Illinois Health Care which has a lot of participants and players but figure out how to exchange data among themselves.

DR. ORRIS: What is granularity?

DR. VALDES: Looking at the individual lab data, so figuring out how to exchange a glucose level from one to another, things like that.

The second tier is being envisioned as a regional Health Information Exchange which initially started out in kind of carving up the state into various regions. So you had an effort in southern Illinois, you had an effort in northern Illinois, you had a couple of efforts in the middle of the state. Those are still in flux and creation. We were up to, I think, seven at one point and then a number of them started looking to collaborate together to save costs. So we'll -- it's kind of yet to be seen how the regionals works out.

Another thing people discovered was there is no regional in Health Information Exchange because if you had a northern health
information exchange and somebody from the southern end part of the state wanted to sign up for the northern one as opposed to the southern, there really is no reason it can't be done. So let's just say it's gotten interesting.

The higher level was the state's level for the Health Information Exchange and that's currently being envisioned to tackle things like a provider database. Looking at the standards, certainly the Health Information Exchange level at the state has various work groups looking specifically at finance, governments, other things.

I was asked to come in and help out because there wasn't a lot of focus on clinical, specifically, so I was asked to kind of start setting up clinical focus work groups. And there was already a conversation in the governor's office about what to do about telehealth, so that kind of got flipped into there. And then certainly looking at clinical quality and integration was one of the first clinical work groups that we've tackled, I should say.
There is a representation from the Department of Public Health, as well as SCHIP and others who are already working on the clinical quality data, coming together around a table trying to figure out, one, what does everybody already have; two, what information are they already collecting; and then how on earth would we share all of this data. Sharing is one thing, sharing it effectively is a whole different thing.

So again, those are ongoing conversations and we have those work groups monthly.

Is there anybody itching to ask a question after all that?

DR. ORRIS: You have representation from the workers' comp. and that's, as you know, a whole separate collection process that is often forgotten by the general health insurance and insurance exchange areas or health insurance.

DR. VALDES: I don't know that we have anybody specifically from a workers' comp. focus. There are several representations from various quality organizations, which in their
purview, would engage worker comp. to a point.

Certainly most health care delivery systems have some kind of a workman's comp. element to their delivery model.

For example, there's a person from Advocate; Advocate has a whole workers' comp. focus for occupational health, as does the University of Illinois. But I can't say we have someone specifically focused on the workers' comp. conversation.

DR. ORRIS: What I was thinking about at the state level, just paying some attention to bringing somebody in from that separate agency. Because again, integrating that data is difficult but would be highly helpful both clinically and a variety of other.

DR. VALDES: Is there somebody that you have in mind or the agency specifically?

DR. ORRIS: Linda Forest (sp) from UIC, we have done a lot of work with --

DR. VALDES: Okay. Excellent.

DR. ORRIS: Why don't you give me your E-mail address.

DR. VALDES: Sure. Let's stick with the
there is an Illinois dot gov address, it's just my name Wesley: W-E-S-L-E-Y, dot, Valdes: V-A-L-D-E-S, dot Illinois dot gov, which is probably the easiest one.

I would say that since the new year in the negotiation for the Health Information Exchange money coming from the federal government, at least right now, there is a fair laser focus on meaningful use criteria. Before that, there was lots of things we were fairly broad in what we were going to try to accomplish. After the new year and the negotiations with the Office of the National Coordinator, the first call I got was, well, we're very narrow focused now.

So right now it's mostly on meaningful use criteria. The clinical quality work group are only band-aids for meaningful use criteria. So while SCHIP has a whole lot of quality things that they collect and data, we're looking at specifically just four that are being required for use. The Medicaid work group is now completely focused on Medicaid meaningful use criteria and how to dispense those funds to the
providers in the state.

So the Health Information Exchange kind of has been given a mandate to at least focus on that for now. Hopefully, once that gets a little settled down, they will be able to tackle some other conversations and things. That was the brief.

CHAIRPERSON ORGAIN: Any other questions? Anyone online have a question for Dr. Valdes and if not, then David?

MR. CARVALHO: Sure. I just wanted to backfill because I'm not sure that everybody on the board knows all the background.

The statute to create the Health Information Exchange Authority was adopted and since your last meeting, the governor has appointed the persons to that authority. So the activity that used to be conducted under the auspices of a committee that I co-chaired with Laura Zaremba when she was at HFS, has now morphed into a formal HIE authority.

I believe Laura Zaremba is still coordinating the staff-level activities; and that that whole function is staffed up; they
have their own lawyer; they have their own technology person. But we're going to see that committee -- I'm sorry -- that authority now taking charge of this activity.

They are required under the statute to establish an advisory committee. The expectation was an advisory committee would mirror the advisory committee that has been functioning for the last several years that Laura Zaremba and I have reported to you on in the past. But we have now turned a corner where that authority is in place.

And then second, again, by way of background, as you may recall, under the several federal acts, the Federal Government is prepared through either Medicare, Medicaid and else wise, to subsidize persons, providers use of electronic health records, but the quid pro quo is you have to actually be using it in some way and the term of the art in the statute has been this meaningful use.

And so the definition that the feds have promulgated about what is meaningful use is the one that Dr. Valdes and the whole apparatus is
trying get in place, especially from the state end. If the providers have to do X, Y and Z to demonstrate meaningful use and X, Y and Z involve interaction with the state, if the state isn't prepared to do its end of the interaction, then all of the providers in the state are disadvantaged.

And so that's why when Dr. Valdes says that the state is focusing in on meaningful use, it's because the state has to make sure that we're there ready to do our end, so that the providers can do their end, so that they can qualify for those dollars.

CHAIRPERSON ORGAIN: So David, I want to ask Dr. Valdes, I will ask: Does the authority have the SHIP plan particularly in regards to the section regarding data? And I would think that as we talk about implementation of SHIP, that wherever there is any discussion about data, reform, health information, that those persons should have the SHIP plan.

MR. CARVALHO: Yeah. I can tell you that two members of the authority actually participated in the SHIP process; one is
Dr. Whittaker -- Dr. Cheryl Whittaker, not Dr. Eric Whittaker -- and then the other is -- and I always mispronounce his name, the head of the Chicago Department of Public Health.

UNIDENTIFIED: Dr. Choucair.

CHAIRPERSON ORGAIN: Dr. Choucair.

MR. CARVALHO: Dr. Choucair. Both of them are members of the Health Information Exchange Authority. And then, of course, the staff person, Laura Zaremba, was familiar with this. I will talk with Laura about making sure that the other members are aware of the SHIP plan and have it provided to them.

CHAIRPERSON ORGAIN: And bring it up to the level of discussion as the -- as Health Information Exchanges develop further.

MR. CARVALHO: Yes.

CHAIRPERSON ORGAIN: Or whatever those parameters are in regard to the plan. Thank you.

DR. VALDES: I think those names should be posted now on the HIE web site of the new health authority members that were announced. It's HIE.Illinois.gov.
DR. ORRIS: One concern, and it's clearly not to you, but through you or whatever. At the Chicago Medical Society it was a strong concern raised about by local practitioners that federal regs had directed this moneys for electronic medical records and the insured, and the exchange of these informations to federally-qualified health centers that serve underserved communities. And they were concerned that individual practitioner's offices would be left out of this process and would not get the kind of funding necessary to participate and to convert the EMR to EMR, et cetera. I just wanted to raise that for the record so it's here as well. The specifics of it, I don't know more about than that.

DR. VALDES: The federal registry is pretty clear on who can qualify and it does say its eligible providers are physicians for APN (phonetic) it's kind of across the board, while there are some rules that a physician or a provider working for a FQAC might qualify easier than a physician who doesn't.

There's actually two ways to qualify,
one is through the Medicare approach and one is through the Medicaid approach. To qualify for the Medicaid approach, which does have a greater number of financial reimbursements, you had to have at least 30 percent of your patients being Medicaid.

DR. ORRIS: Yeah, they reported to us 20. But that was their concern --

DR. VALDES: -- I don't think it's 20. But if they didn't qualify for that, then they can go the Medicare route which is a substantial amount of money. I think the Medicare route max'd out at $43,000, and the Medicaid route max'd out at $63,000, and they have different time lines in reporting, but....

DR. ORRIS: Thank you.

DR. VALDES: Sure. Anything we can do in the future, feel free to -- I live here, so...

CHAIRPERSON ORGAIN: Do we have any additional questions? All right. Perfect. Thank you, that was a great update, appreciate it. Next we'll have the Rules Committee report.

DR. McCURDY: I understand that
everybody should have received electronically or
a hard copy, a corrected copy of the minutes
that were just previously distributed. Please
follow the corrected copy for guidance as we
have discussion in this meeting. And I realize
you may not yet have had an opportunity to
review the corrected copy but I will still
entertain a motion to approve.

         DR. ORRIS: So moved.
         MR. McCURDY: And second.
         MS. PHALEN: Second.
         MR. McCURDY: Moved and seconded. Need
time to read or going to go ahead and vote? I'm
going to go ahead and vote.

         (Wherein the board.
         members say aye.)
         MR. McCURDY: Are these ayes? These are
all ayes. Okay. All ayes, none opposed.
Abstentions? We can barrel on. And please
follow along, there is some guidance here about
reviewing the materials we have.

Now there is some, I think, maybe some
confusion about which are the appropriate -- or
the up-to-date versions of the drafts of the
proposal. I know that we received here in Chicago, and you probably did in Springfield, a hard copy of the Family Practice Residency Code, a draft that was updated possibly as late as today. And so obviously that's the one we're supposed to follow.

And it does reflect some changes that were not present in the draft that I received in the mail. I don't know about what you all may have received electronically, but it appears that this version reflects at least more of, and maybe all of the changes that we had in mind and it should be reflected in the minutes.

So somebody in Springfield want to give us background for the Family Practice Residency Code, as is our practice?

MR. CARVALHO: Let me introduce. We've got with us, I think I mentioned this in the Rules Committee, unusually the three sets of rules that you're considering today all originate in my office. And so two of the real stars in my office, Don Jones and Julie Casper are here to share with you information about their respective rules. So on Family Practice
1 Residency.

2 MR. JONES: The proposal you have in front of you is a grant program to provide funding for medical students to pursue medical degrees. The proposal essentially is to just update definitions and to incorporate the requirements of the Illinois Grant Fund Recovery Act as it would pertain to the grants and scholarships that are offered through this part. We would be happy to answer any questions you have.

3 I would note for the record that for the current fiscal year and the upcoming fiscal year, there was no funding available for this program.

4 MR. CARVALHO: Just so you know, by the way, those of you who may not know either Don or me, neither of us talk this way in real life, but both of us have served so many committees that have court reporters, that we have engrained it into our way of speaking. Don and I worked together on the Health Facilities Planning Board and so we're used to talking in this choppy way for the benefit of the court
reporter, who by the way, would probably appreciate it if others of you mimicked it.

MR. McCURDY: We will try to learn from your example.

CHAIRPERSON ORGAIN: So let me just begin by the pages are numbered and I'd like for us to go to page 10.

MR. McCURDY: Page 10 of the new draft you received today.

CHAIRPERSON ORGAIN: Of the new draft. And as a family physician in a University of Illinois College of Medicine, I would have some concern about the definition of good academic standing.

I'm not sure if you got information from the various universities and colleges of medicine. However, there are a number of different tracks for medical students.

We, unfortunately, if a student gets to the end of their first year and has to repeat one course; oftentimes they have to repeat the entire year. We have not gotten to the place where -- even after they have taken it a second time. We have not gotten to the place where
that course is given separately where the
student could take it. They are required to
repeat the entire academic year.

So I would have concern about that
definition as it relates to page 28, if you can
go to that. And I would recommend that the
strike out in C be removed on page 28.

MR. McCURDY: The board wants it to be
removed.

CHAIRPERSON ORGAIN: Yes. It should be
maintained.

And then in E, we have the option for
students to decompress, meaning they can take
their first year in -- over two years and they
would automatically have then a five-year
program. And should they have to repeat, that
would mean that would be a six-year program
automatically. So those are some of the nuances
at individual schools that would make this a
hardship for a number of students who have gone
into family medicine.

MR. JONES: Dr. Orgain, because of the
differences, would it be better if we dropped
the proposed definition for academic standing?
CHAIRPERSON ORGAIN: That would be useful because each institution defines what they mean by good academic standing.

MR. JONES: We were trying to standardize that, but if it varied across disciplines, it might be better to drop it.

CHAIRPERSON ORGAIN: It might be better to drop it or just say as defined by the institution.

MR. McCURDY: Yes.

MS. MEISTER: I think if we added "as defined by the institution," that would help to save our questions from JCAR as to what that term means.

CHAIRPERSON ORGAIN: That would be grateful -- that would be -- excuse me. That would be perfect not grateful. I would be grateful.

MR. McCURDY: Page 28 you would also like to --

CHAIRPERSON ORGAIN: On 28 I would just like to delete the strike out, maintain the language and reconsider E, based on my concerns.

Drop it, if you can.
MR. JONES: We can do that.

CHAIRPERSON ORGAN: Appreciate it.

Those are my only comments.

MR. McCURDY: Especially if there's no money in the program.

CHAIRPERSON ORGAN: Especially if there's no money in the program. I know you can't fix it, but we certainly need to.

DR. VEGA: Something I didn't even think about, but Dr. Valdes is absolutely right so I appreciate those comments.

CHAIRPERSON ORGAN: Thank you, Tim.

MR. McCURDY: You will note that there are a number of other comments referenced in the minutes -- or in the meeting summary. In case anybody was wondering, the item on page 10, question on the use of the word "alien." I can say the word "alien" no longer appears. But that was at one time blended into the definition of lawful permanent resident and it was determined that that would be unnecessary to remove the word "alien" there because it's not necessary for the definition.

A number of other things, I won't go
into them in any detail, members of the committee may wish to. Otherwise, I would entertain a motion with the board's endorsement to JCAR, with the changes that have been made, that have been agreed upon here.

MS. PHELAN: So moved.

DR. ORRIS: Second.

MR. McCURDY: Is there any discussion?

All in favor say aye.

(Wherein the board. members say aye.)

MR. McCURDY: Opposed? Abstentions?

We will move on to the next rule, and the next rule is the Rural Health Code. We will follow the order that's in the agenda. Who's going to discuss the Rural Health Code with us in Springfield?

MR. JONES: That would be me again, Don Jones.

Once again, this is a grant program administered by the department providing funding for rural hospitals and federally-qualified health centers that are located in rural areas. Once again, we are just trying to put
definitions into the part to make it consistent across different programs and to incorporate the requirements of the Grant Fund Recovery Act. And we would be happy to answer any questions you have.

        MR. McCURDY: Don, I do need to ask you in this case, to your knowledge, was a revised version of this circulated electronically?

        MR. JONES: From the discussion from the Rules Committee meeting, there was a couple of items that were questioned, those were addressed and sent to Susan.

        MS. MEISTER: Yes, an electronic copy with corrections was sent on all of the rules.

        MR. McCURDY: So the rules are reflected in everything that was sent, okay.

        MR. JONES: Yes.

        MR. McCURDY: So you can see in the minutes, concerns that were raised -- at the meeting summary, I should say, concerns that were raised. The one that -- I actually don't know that there's anything here I would zero in on necessarily. Any other comments from members of the committee?
UNIDENTIFIED: Is this funded?

CHAIRPERSON ORGAIN: This is just a question?

MR. JONES: No.

MR. McCURDY: Okay. So duly noted that we are working in the spirit of the hypothetical. I will entertain a motion to approve this and forward it to JCAR.

MS. SANDERS: So moved.

UNIDENTIFIED: Second.

MR. McCURDY: It's been moved and seconded. Any discussion?

Please say aye.

(Wherein the board. members say aye.)

MR. McCURDY: Opposed?

MR. CARVALHO: Just so you know, this has been funded in the past, in fact, even in the recent past. It's just currently it's not funded. So while we would love to keep our rules up-to-date, this wasn't purely an exercise in keeping rules up-to-date, it has been funded in the recent past.

MR. HUTCHISON: Dr. Orgain, this is
1 Kevin.
2
3 CHAIRPERSON ORGAIN: Go ahead, please.
4
5 MR. HUTCHISON: Just a comment, I guess
6 with the absence of funding, I’m saying what’s
7 already in place, what I’m thinking of the
8 Affordable Care Act implementation, there seems
9 to be certain emphasis on work force development
10 federally, so perhaps, this is an opportunity
11 where we have an up-to-date rule system in
12 place, that should there be an opportunity for
13 federal funding for medical work force and
14 scholarships, Illinois can access that.
15
16 CHAIRPERSON ORGAIN: And right now if we
17 take a look at ARRA, there isn't anything
18 currently. And when we go to HRSA, there had
19 been some work force grants available, but it's
20 limited at this time.
21
22 MR. HUTCHISON: Okay. Thank you.
23
24 MR. CARVALHO: We have received some
25 federal dollars under those several acts. If
26 you'd like, Julie is the one who administers
27 that and she could share that with you.
28
29 MS. CASPER: Illinois did receive our
30 funding for the State Loan Repayment Program and
that is educational loan repayment for a number
of professional categories. And there is not --
Dr. Orgains is right, there is not currently a
new program out for that. But we are still in
the two-year cycle where the professionals who
signed up with us are getting loan repayment
through the ARRA, what we call SLRP, the State
Loan Repayment Program. And we continue to have
a State Loan Repayment Program outside of the
ARRA as well.

CHAIRPERSON ORGAIN: Thank you. Any
questions?

MR. McCURDY: We had them all in favor,
ayes and nays. I don't know if there are any
abstentions. Are there any abstentions? If
there are not, then we will proceed to the next
one.

And the next one is the community health
center expansion. And Julie or Don, which of
you will speak to this one?

MR. JONES: At the risk of sounding
repetitive, once again, this proposal is to
incorporate term to make it consistent across
other grant programs and to incorporate the
requirements of the Grant Fund Recovery Act. The one exception in this part is there is a requirement in the Community Health Center Expansion Act to have a legal notice published when an application for grant funding has been submitted so that the public has an opportunity to comment on the proposal. We are incorporating language into this part to accomplish that. Those legal notices had been in the past, but the process for it had not been formalized.

We would be happy to answer any questions you have.

MR. McCURDY: And money for this one?

MR. JONES: Actually, for the current fiscal year, there was approximately $3 million, all of that came from the Tobacco Settlement Fund.

MS. CASPER: There are no general revenue funds and there used to be close to $3 million there, as well. But right now there is $3 million in tobacco that 28 federally-qualified health centers get access to.
DR. ORRIS: That's where the feds are going to be putting, in theory, money in.

CHAIRPERSON ORGAIN: Sorry?

DR. ORRIS: The feds are going to be putting money, in theory.

CHAIRPERSON ORGAIN: In theory. Okay.

MR. MCCURDY: And you will see in the meeting summary that there are a number of items that were discussed. However, I particularly want to call your attention to an item on page 19 of the document I have and presumably yours also. It was noted that notices given, legal notice, but also the applicant for funds provides notification to several entities which are listed here, and you see local health departments and the like, and FQACs.

In addition, the applicant is to send notice to Illinois State Medical Society, the Primary Health Care Association, the Illinois State Dental Society, and IPHA. And we recommended that the Illinois Academy of Family Practice Physicians be included as well. And I believe that that -- has that been added?

MS. CASPER: Yes.
MR. JONES: Yes.

MR. McCURDY: So that was a change that we thought was appropriate. And other than that, I have nothing else to add at the moment.

Any comments by members of the committee?

I will entertain a motion.

CHAIRPERSON ORGAIN: I just -- I don't know -- I'm not looking at where it's at, I just want to ensure that it's the Illinois Academy of Family Physicians.

MS. CASPER: Correct.

MR. MCCURDY: We want to get it right.

CHAIRPERSON ORGAIN: Page 20, thank you.

MR. McCURDY: Illinois Academy of Family Physicians, we knew it was IAFP.

CHAIRPERSON ORGAIN: It is and it is accurate. Thank you.

MR. MCCURDY: Okay. So I will entertain a motion.

DR. ORRIS: So moved.

MR. McCURDY: Is there a second?

UNIDENTIFIED: Second.

MR. McCURDY: All in favor, please say
aye.

(Wherein the board. members say aye.)

MR. McCURDY: Opposed? Abstentions?

I believe this concludes the report of the Rules Committee.

CHAIRPERSON ORGAIN: David, I think we're back to you for legislative update.

MR. CARVALHO: As you know, we're in the thick of the legislative session. The bills numbers in the house are already well into the 3000s, and the Senate into the 1000s and 2000s. This creates an enormous task on our part to keep track of all of the good, bad, and other ideas that are working their way through, as well as to try to advance the several affirmative agenda items than we have.

This year we were granted permission by the governor's office to pursue more affirmative agenda items that we have been allowed to in the past. So while they may not seem significant in the grand scheme of things, some of them have just been festering here for quite sometime.

So for example, as you know, the Auditor
General audits us every two years and finds things where we're not exactly doing what the statutes say; and oftentimes the reason is because the statute no longer makes sense.

For example, the statute says we're supposed to prepare a report on certain services that were moved to the Department of Human Services 14 years ago, and it makes no sense for us to report on services that we no longer are responsible for.

But the statute didn't get fixed, and so the Auditor General keeps calling us on it, and we keep saying we'll try to get the statute changed. And then the governor's office would never let us introduce the bill because they say we'll do it next year.

So next year finally arrived and we have one bill to do all those non-controversial technical amendments to our statute. Probably not that important to you, but it makes us feel better. So we're pursuing that.

Some of our affirmative agenda items have already died or at least have run into some obstacles. You know from past presentations
from me that every doctor in this room pays a licensing fee, every attorney in this room pays a licensing fee. If there were beauticians in this room, they'd pay a licensing fee.

Hospitals pay no licensing fee; and we have therefore, have no resources to have any inspectors for state licensing matters.

Our only hospital inspectors are for federal matters because the feds will pay us to do those inspections. We get 600 complaints a year about things going on in hospitals, 400 of those have to do with state laws, not federal laws; and accordingly, 400 of them do not get inspected.

We do not believe that is what the public expects of us, so we have sponsored legislation to impose a very modest licensing fee on hospitals, all of the resources to go to provide for state licensing inspectors. That modest fee was $50 a bed.

So for a critical access hospital, that would be $1200 a year. For the largest hospital in state, Northwestern, that would be $40,000 a year. That would provide -- that would have
provided us with sufficient funds for inspectors. That bill was tabled by it's sponsor, which is rather unusual, when the hospitals in his community said that the bill would kill them. We think the hospital association perhaps exaggerates on that point. Be that as it may, that bill has run into a roadblock.

We have two bills that -- some of the other bills are also probably not terribly interesting to you. There's two bills that I've mentioned that are on our affirmative agenda. One is the hospital discharge data that we collect on the 1.8 million discharges each year from Illinois hospitals, is currently collected by us in a way that that is partially de-identified; which is to say, we do not have the name, address, or Social Security number of the patient. We have the birth date, and the gender, and the race, so it's not entirely de-identified. But this de-identification makes it impossible for us to do analyses on hospital-acquired infections or on readmission rates among hospitals because one never knows
whether the form for one discharge is the same
person that you have another form from a week
earlier.

So we're seeking authority to collect
the information on names, addresses, and Social
Security numbers. As a result of some
misgivings expressed by some members of the
committee, as well as the ACLU, we have worked
out what we hope is an agreed upon amendment
which limits us to names, addresses, and the
last four digits of the Social Security number.
That's sufficient for statistical purposes at
getting a very high confidence level on
re-identification, but it overcomes the concern
some people have about Social Security numbers
being attached to these data; that those of you
familiar with these data know that the Social
Security number is part of the information
shared with the insurance company, is in the
file with the hospital. The only person who
doesn't have it is us. But we are able to live
with that change. So we hope that we've
addressed the concerns on privacy that were
expressed on this bill.
Another bill that we think is important for patients' safety purposes is right now we are reporting -- we are asked by the legislation that is in place to report on MRSA based on the hospital discharge data set. And that discharge data set is inadequate, partly for the reasons I've just mentioned, to report in a confident way about MRSA in hospitals and certainly on health-care acquired MRSA infections.

So we propose to change the statute to allow us to require hospitals to use the NHSN system, which stands for National Health Surveillance Network. It's been developed by the CDC in which many hospitals are currently using for other purposes. And our legislation proposes that MRSA and Clostridium difficile, otherwise referred to as C.diff., be reported to us using NHSN. We believe that will allow us to, first off, get better data; and second, have more confidence in reporting those data on the Hospital Report Card Act at the hospital level.

Right now we use the discharge data to show trends in the state by reporting it at the overall level. While we have misgivings about
the data, we expect the trend analysis on those
data are probably okay and we have been doing
that, but this bill would allow us to collect it
through this NHSN system and report at the
hospital level.

On the everybody-else level; namely, all
the other bills that are going through that
we're monitoring, we monitor hundreds -- perhaps
rather than going through highlights, if there
are any bills that you have an interest in that
you are curious what position are we taking, I
can share that with you today. But let's just
say, as usual, there are a lot of things going
through. And I think I've used this line
before, my favorite line about legislation from
a Republican legislator in the '80s was: If
there is such a thing as reincarnation, he
wanted to come back as a bad idea in Springfield
because then he would never die. So many --

DR. ORRIS: Peter.

MR. CARVALHO: Yes, go ahead.

DR. ORRIS: Since I drove in, in Chicago
with WBBF this morning, where are we at on
medical marijuana?
MR. CARVALHO: The sponsor of the principle medical marijuana bill is Representative Lang. He presented a bill in committee yesterday, in the House, that is substantial modification of the bill that he had last year which came very close to passing last year. So he has modified it to address some of the concerns. And in particular, it is not a grow-your-own bill, it is a dispensary bill. So the marijuana would be available from dispensaries, but it would not authorize you to grow your own.

There are other narrowing features of his current bill from his prior bill. After considerable discussion and debate, the bill was reported out by the committee on a strictly partisan vote, six to five, and is now on the floor of the House. Where it goes from there, you know, will depend on the negotiations that I'm sure Representative Lang is engaged in as we speak.

Our concern about that bill has always been the obligations that it imposes on the department to referee this whole process and the
substantial staff energy that would be required.

As with all bills, even bills that might be viewed as a good idea, if it's very costly to implement, we need the funds to implement them.

So if you should hear that the Department of Public Health has an opposition to the bill -- and I don't think we've stated an opposition to the bill -- but if you should hear we have concerns, our concerns are principally focused on the financial impact on our department and the desire to make sure that we receive the resources to implement it if we are asked to implement it.

Actually, one aspect of it you will all appreciate is, in the past, this bill has required us to complete the rule-making process in six months, and this is probably the only place where I can get 16 to 5, when I tell you that provision, the notion that we can get rules out and approved in six months is detached from reality.

(Wherein the Reporter asks for clarification from Ms. Bowen. No reply given.)
MR. CARVALHO: I recognize that this is all being transcribed by a court reporter so I didn't say that, Peter.

CHAIRPERSON ORGAIN: Me too. Me too.

David McCURDY has a question, then I have another.

MR. McCURDY: Two things. One is, David, as to our Rules Committee meeting, you made some comments about the Health Care Worker Background Check Act.

MR. CARVALHO: Yes.

MR. McCURDY: Is there anything you would like to say about that for the board?

MR. CARVALHO: Sure. I do not recall right at this moment where that bill is in the process but let me just tell you a little bit about it. As you know, we currently run a health care worker background check process where certain categories of personnel that involves them -- the way it's currently implemented, involves them being fingerprinted, background checks being done and then we have a registry. So that in the future, if they change jobs or the like, the information is almost
instantaneously available to their employer and that's as a result of the introduction of fingerprints into the process.

And there's a statute that lays out what types of offenses bar you from working in certain health care facilities and what types of offenses lead to a waiting period and a waiver process. So for example, for a relatively minor crime, it might say you can't work in a health care facility until two years have transpired, and then you can only work in the next two years if you get a waiver, but then you can work without any further wait if four years have gone by. So that would be an example for a minor one. And for a more serious crime it might say you can't for five years. And then the next five years you can seek a waiver, but after ten years you can work as of right. And for the most serious crimes, it says you can never work unless the director himself gives you a waiver.

The Federal Government would like to see this process expanded beyond the categories of providers that we currently are authorized under state law to check and, in particular, some
categories of providers that are currently
licensed by the Department of Financial and
Professional Regulation, such as nurses and
doctors and the like. And so there is
legislation to broaden this to comport with what
the Federal Government would like to pilot
through grants to the states and we have
introduced legislation to do that.

MR. McCURDY: Thank you.
MS. SANDERS: I have a question relative
to that. The question came up actually on an
educators -- physical therapist educators
listery that I participate in. If we had an
applicant who had a history, if they came to the
state ahead of time, would the state be able to
indicate whether, in fact, they would ever be
able to get licensed, or what would happen?
Certainly, the time they're in school, we
actually do have our students present a criminal
background check on admission at this point.

MR. CARVALHO: Yes.
MS. SANDERS: So I'm wondering if
somebody does have a history, if they can never
get licensed or they have to sit out for five
years after they got their license, that could certainly play into their decision whether to invest their time and money to go to school. So is that process available?

MR. CARVALHO: Yes. The change we made a couple of years ago sought to make the process much more objective, that's why we -- it used to be there were a couple years you were barred, and then thereafter, it was subject to waiver. And so a person would not necessarily know am I going to get a waiver or not; or what are the criteria for waiver; or how does the waiver committee view various situations. And so that's why we came up with this revised process that said there's a period where you're barred, there's a period where there's a waiver, and then thereafter, it's just as of right.

The question that an applicant might have, what crime is treated in which way, is information that you can find from our agency. I know the person who runs this program, her voicemail message says: I get deluged with calls, and so the best way to get information from me is probably to E-mail me and here's my
E-mail.

So it may be you have to be a little persistent to ultimately get the answer. What I don't know sitting here now is whether we have it up on a web site. But it is certainly in our regulations.

Now, all of you sitting here know finding something in our regulations is not a user-friendly thing. But our regulations spell out exactly which crimes, and it's not by adjectives and nouns, it's by statutory citation, you know, are the crimes in Section 3.27 of the Criminal Code, you know, your treated this way. So if the person knows what they were convicted of, there is a way to get the answer, it's probably not easy, but there is a way to get the answer.

MS. SANDERS: Thank you.

MR. CARVALHO: Your question makes me think maybe we should try to make it easier. And I will talk to the person who administers the program to see if we can make it a more convenient way.

CHAIRPERSON ORGAIN: You have a
question?

MR. HUTCHISON: Yeah, on terms of pending legislation, I know Dave is aware of this, but for members of the board, there's some, we feel, important legislation that's been proposed that's adverse to public health and food safety. Specifically, Senate bill 137 and House bill 1483, both of these address prohibiting the state health department or local boards of health, local health departments to have a regulatory inspection, activities associated with farmers markets and cottage food industries.

And while we certainly are encouraging people to eat healthy fruits and vegetables from a farmers market, in reality we are seeing many other types of foods, potentially dangerous foods being sold at these events and without any labeling, there's concerns about potentially major allergens that can be introduced and exposed to a consumer.

So if, Dave, if you could update IDPH's position on these proposed legislation.

MR. CARVALHO: Sure. I know in general
that we're opposed to that bill. But could you mention the number gain?

MR. HUTCHISON: Senate bill 137, and this addresses primarily deregulating what's called then cottage industries, home-cooked products; basically, it would just take away, as I understand, virtually all oversight of public health measures associated with those. Again, a restaurant, for example, could buy a product from a cottage industry, resell that to the public, and it poses lots of concerns for us, we think, of the myriad of different kinds of foods that could be prepared across the State of Illinois.

The second one is House bill 1483 which specifically exempts fraternal organizations and religious organizations for many and all types of regulatory oversight for farmers markets and dinners and things of that nature.

MR. CARVALHO: Yeah, we are opposed to those and, you know, I was just sitting here thinking as you said it, you can almost demonstrate how ridiculous that is by offering an amendment that said: And no local health
department or state health department shall have any obligation to track any food borne illnesses that results from such activity, which of course, would be ridiculous.

MR. HUTCHISON: Literally, one could interpret it to be that.

MR. CARVALHO: Yeah.

DR. VEGA: I think from the Public Health Department, I agree with that. But I think the issue those bills are trying to address are significant. And I think if the Public Health Department or even our group can thread that needle, it is kind of critical.

I mean, we have -- we're working -- I'm personally working with inner city obese children and part of the issue is they don't have access to fresh food, there's an abundance of locally-grown foods, but they don't have access to it. We have to work somehow to get the healthy foods in these food deserts.

So part of the regulatory process that we have has consequences also. So you know, as always, the truth is somewhere in the middle. So I think if we have something proactive where
the local health departments can have some --

some ability to assure safety, but realize the

need to facilitate these efforts in these food
deserts, that will be probably be the most

positive thing to come out of this.

MR. CARVALHO: Well, the sponsor of one

of these bills is your senator.

DR. VEGA: I know and I think that's

probably -- he is part of our inner city

childhood obesity consortium. And we have a
terrible problem in Peoria, and it's not just

the inner city poor. We have obesity in all of

Illinois, and as our First Lady is pushing that,
because it's a real problem, and it's going to

completely overwhelm the medical system if we
don't do something fast and now.

So there's Tim Vegas' two cents.

MR. HUTCHISON: I think we have had that
discussion on the public health community as

well. I think your points are very well taken.

We are certainly wanting to promote healthy

foods, eliminate foods that don't promote

vegetables and healthy fruits and being readily

accessible. In fact, the current farmers market
regulations encourage that and there is really very minimal regulatory oversight over those kind of activities. It's the secondary levels of food that are being sold commercially that create the concern.

So there may be an avenue -- in fact, Senator Luechtefeld has said House Senate bill 1852 has been introduced, it would create a mandatory task force to address it, to look at farmers markets and that would be, I think, one venue that the state board and public health could join with community people to really look at these issue.

I think we all want the same thing, we want healthy foods, but we don't want to expose people to unnecessary risk in uncontrolled products that are being brought in from other areas, or cooked at home under, who knows, what kinds of conditions.

It's my understanding there was a resolution passed a couple years ago to create -- regarding farmers markets and a task force, and it never got implemented, so that may be some of the impetus behind this legislation
to actually mandate the creation of such a task
force. So that's one possible avenue.

Another is certainly with the state
health improvement plan and also the obesity
control plan that has been promulgated and
adopted, there are avenues to address that. So
I think your point is very well taken. I think
the push back of any kind of regulatory
oversight, we don't want to push so far that it
really poses a health risk to the public, at the
same time we went them to eat these healthy
foods.

DR. VEGA: Yeah, well said.

CHAIRPERSON ORGAIN: David McCURDY has
another question.

MR. McCURDY: Dave, this is a question
about -- well, I believe it's HB 3134 which, as
I understand it, is a bill that would require
future versions of the advance -- DNR advance
directive form in the State of Illinois to
comply to the standards for POLST orders,
Are you familiar with that? Is that
something the department has taken a look at?
MR. CARVALHO: Yes. We haven't weighed in with a position in the legislature on that one and I don't know why not. So let me track down -- I have a list of all of our positions, it's 20 pages long.

MR. McCURDY: I mean, I just know people in the End-of-Life Care Community, and Chicago End-of-Life Care Coalition, and all those kind of folks are pretty much behind this kind of expansion of the scope of the DNR advanced directive form with the idea it would serve patients better in a variety of end-of-life care situations.

So for whatever it's worth, I just wanted to see if that was on the radar screen.

MR. CARVALHO: It is. It also requires that our forms be in Spanish, which if they aren't already, shame on us.

MR. McCURDY: That's right.

MR. CARVALHO: That's an aspect of it as well.

CHAIRPERSON ORGAIN: My last question, David: Is the SHIP Implementation Council funded in anyway?
MR. CARVALHO: The SHIP Implementation Council, we have taken some of the funding that we had for the SHIP process itself and moved that over to the SHIP Implementation Council at -- however, I should tell you that the source of that funding is the PHHS block grant.

CHAIRPERSON ORGAIN: All rightie, then.

Okay.

MR. CARVALHO: Yeah. So that could be problematic if that source goes away. But for the short run, at least, we have funding for the administrative activities of the SHIP Implementation Council. Of course, the modest funding for the SHIP Implementation Council to meet is not the same as the funding to implement something that they may conclude needs to be done. That's a whole other --

CHAIRPERSON ORGAIN: -- discussion.

MR. CARVALHO: Yes, a whole other discussion.

CHAIRPERSON ORGAIN: Okay. That gets us to the end of the agenda. There are two other things. On the member time sheet, just correct the dates.
UNIDENTIFIED: At the top in the box.

CHAIRPERSON ORGAIN: And is there any other additional business? Hearing none. Move for adjournment.

UNIDENTIFIED: Second.

CHAIRPERSON ORGAIN: Thank you.

(Meeting concluded at 12:50 p.m.)
CERTIFICATE OF REPORTER

I, TRICIA L. GUDGEL, a Certified Court Reporter, do hereby certify that the foregoing proceeding was taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this proceeding was taken, and further that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of this action.

________________________
Tricia L. Gudgel, CCR
IL CCR #084-004053
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