STATE BOARD OF HEALTH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

STATE BOARD MEETING
HELD
THURSDAY, JUNE 9, 2011
11:00 a.m. - 1:00 p.m.

AT
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIRECTOR'S CONFERENCE ROOM, 20TH FLOOR
122 SOUTH MICHIGAN AVENUE
CHICAGO, ILLINOIS
and
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIRECTOR'S CONFERENCE ROOM, 5TH FLOOR
535 WEST JEFFERSON STREET
SPRINGFIELD, ILLINOIS
1 STATE BOARD OF HEALTH MEMBERS PRESENT:
2    Rev. David McCurdy - Co-Chairperson
3      Karen Phelan
4      Ann O'Sullivan
5      Dr. Herbert Whiteley
6      Dr. Peter Orris
7      Victory Forys
8      Dr. Jerry Kruse
9      Dr. Tim Vega
10     Dr. Caswell Evans
11     Dr. Jorge Girotti
12     Kevin Hutchinson
13     Dr. Monica Schnack
14     Babette Sanders
15     Dr. Mohammed Sahloul
16
17 STATE BOARD OF HEALTH MEMBERS ABSENT:
18
19     Dr. Javette C. Orgain
20     Dr. Jane Jackman
21
22 ILLINOIS DEPARTMENT OF PUBLIC HEALTH STAFF PRESENT:
23    Dr. Damon Arnold, Director
24      David Carvalho
25      Susan Meister
26      Jonathan Gunn
27      Cleatia Bowen
28      Don Jones
29      Barbara DeLuka
30      Julie Casper
31      Harold Duckler
32
33 ****
34 Reported by:
35      Karen K. Keim
36      RPR, CRR, CSR-IL, CCR-MO
37      Midwest Litigation Services
38     401 N. Michigan Avenue
39     Chicago, IL   60611
AGENDA

I. Call to Order

II. Approval of Meeting Summary of March 10, 2011

III. Director's Remarks

IV. Policy Committee Report
   A. Medical Homes
   B. CHIP Implementation Coordinating Council
   C. Center for Patient Safety
   D. Tdap Public Hearings

V. Rules Committee Report
   A. Heartsaver AED Grant Code
   B. Newborn Metabolic Screening & Treatment Code
   C. Hospital Capital Investments
   D. Psychiatry Incentive Program Code

VI. Legislative Update

VII. Adjournment
START TIME:  9:00 a.m.

(Off the record, all participants identify themselves.)

CO-CHAIRPERSON McCURDY:  Are you standing in
for Dr. Arnold?

MR. CARVALHO:  I will be.  This is Dave
Carvalho, Deputy Director from the Department of Public
Health, and although I just forgot to do it, I'll remind
everybody who is on the phone or perhaps even in
Springfield, if you can say your name right before you say
anything.  It sounds a little stilted, but it's very
helpful to the court reporter.

Dr. Arnold is over at his office, and we do
expect to see him here at some point in the next hours, but
I'll keep us apace and deliver more substantive comments on
his behalf at this time.

This is the first meeting of the State Board
of Health since the budget was adopted by the General
Assembly.  The Governor has theoretically 60 days to sign
it, but, of course, he needs to take action on it before
the fiscal year actually starts, so the clock on this one
is a little shorter than on some of the substantive bills
that I will be discussing later in the legislative report.
The -- without being too exact about it because I don't
have it all in my head, the Governor's introduced budget
was diminished by the Senate by about a billion or so
dollars and diminished by the House by about two billion
dollars, and instead of the two chambers getting together
and coming out somewhere in between, actually the House
bill was adopted. The principal differences between the
two, in addition to the overall dollar amount spent for
State Government as a whole now -- I'm not focusing just on
the Department of Public Health. But the principal
difference between the two was basically who got cut, or
maybe I should say what got cut. The House approach was to
cut deeply into State Government, and then at least with
respect to the Department of Public Health cut only lightly
into the people we pass money through to. The Senate
approach was to cut mildly deeply into State Government and
cut more deeply into the amounts that are flowed through to
other entities.

Since the House bill was adopted and that's
what is before the Governor right now, let me summarize for
you the impact on the Department of Public Health of the
bill as proposed. And as you hear this, if you're also
wondering strategy and what happens next, keep this mind:
The Illinois Governor has the authority to line-item veto
budget items in the budget bill which can reduce spending,
but he has no authority to make any amendments that
increase spending. So, if the Legislative choices, for example as you will see in this budget, were to reduce operational spending for the Department of Public Health in order to add in things that were Legislative prerogatives that were not sought by the Department, even if the Governor were to cut those Legislative add-ons, it wouldn't result in a restoration of the cuts that were made to the Department's operations.

So, first off, the Personal Services lines for the Department -- those are the lines that support the staff who work at the Department of Public Health -- were cut about 11 percent, and our preliminary estimate is that if you take into account the binding cost-of-living adjustments that exist in our current union contracts, that the amount of cuts to the Personal Services lines would require that not a single vacancy be filled that is currently vacant and that about 20 positions that are currently filled be eliminated. Since we have an agreement -- the State has an agreement with its unions not to do any layoffs this fiscal year, we don't yet have a strategy on how to deal with that conundrum, but we're working on it. But as you can imagine, not filling any vacancies for an entire year is feasible on the assumption that everything that's currently vacant happens to be the
least important positions that you have, and, of course,
that's not true; and, similarly, there are any number of
federal dollars that we have under grants that require a
State contribution or State commitment, and if the vacancy
that is empty happens to be the one that is the State
commitment that's supporting those Federal dollars, the
failure to fill that vacancy will put those Federal dollars
at risk, let alone the failure to fill the vacancy putting
at risk to actually do the work that is required under the
Federal grant -- sometimes overlooked but not an
insignificant fact. You actually have to do the work that
they've given you the money to do.

In addition, a million dollars was cut out of
the line that we use to pay our rent. The scuttlebutt,
apparently, was that because our introduced budget cut
certain items relating to ADAP, the AIDS drugs line, the
Legislature was so annoyed at that they decided we're
paying too much rent, so they eliminated a million dollars
of our rent. We do not, therefore, have the money to pay
for the rent for this building that we're in and, in fact,
if we vacated the building in three weeks, we still
couldn't save enough money to make up that million dollars.
So, we do not currently have a strategy on that either, but
that is also a feature of the budget.
As was done across most agencies, the travel line was cut in half. For us that's a $600,000 cut. Apparently in someone's mind in the Legislature, travel consists of excursions to conferences in Las Vegas or something. As you probably know, in our agency, travel is nurses going to do nursing home and hospital inspections, pool inspectors going to do pool inspections, plumbers -- inspectors going to do plumbing inspections. This is another one for which we do not currently have a strategy on how to deal with. Obviously, we can't cut our hospital inspections, nursing home inspections, pool inspections, plumbing inspections in half. We can't really phone them in. Conceivably, half the pools in the state won't open if we can't get somebody there to inspect them. So, we do not have a strategy as I sit here on how to deal with that either.

Our phone bill was cut in half. Senior management all too willingly volunteered to give up their Blackberries, but that probably is not a strategy. So, we need to figure out a strategy for dealing with half of our phone budget being cut.

Then into programs, the -- there are programs -- you probably heard us use the expression "lump sum", and what that means is while there are programs, such
as my office, where I have a line item for personnel and a line item for telephones and a line item for Social Security and all of that, there are other programs where there's just a million dollars for the lead poisoning program, and then all of the expenses that support the lead poisoning program are paid out of that lump. The lead poisoning program was cut by 50 percent. The women's health promotion was cut by 50 percent. The public health prevention program was cut by 40 percent. The APORS, Adverse Pregnancy Outcome Reporting System, was lumped together with the Adverse Healthcare Event and Patient Safety Program, so these two lumps were lumped and then cut 10 percent. The Center for Rural Health was cut 25 percent. Environmental Health Surveillance was cut 20 percent. The lab -- there's a special Lab Capacity Expansion Fund that was cut 20 percent. All those lump sum were cut in the aggregate 33 percent or for $2 million.

So, if you're keeping track, the personnel items were cut four and a half million dollars. The other operation items, like rent and travel and the like, were cut 2.8 million, and then the lump sums were cut 2 million. So the aggregate of those cuts is about 7 million -- I'm sorry, 9 million on a base of about 56.

However, the Legislature added back a couple
of things. So our $27 million ADAP line had $2 million added to it. You may have seen the news report that our budget as introduced had proposed that everyone who is currently on ADAP would remain eligible for continued funding of their AIDS drugs, but that new eligibility would be restricted to 300 percent of poverty and below. 300 percent of poverty and below is fairly common across the country. Illinois last year had raised its eligibility to 500 percent of poverty. So, the proposal was to go back to 300 percent of poverty for new persons enrolled, but the Legislature put $2 million back into that. The Legislature also added $1 million to transmit to the ALS Association, amyotrophic lateral sclerosis, and added a half million dollars to transmit to the University of Chicago for juvenile diabetes research.

So, at the end of the day, when you add this all up, the net reduction to our General Revenue Fund budget is about 3 percent, or four and a half million dollars, but it's accomplished by cutting nine and a half million dollars out of our operations and then providing six and a half million dollars back for legislative initiatives. The aspect of our budget that was contemplating that certain maternal and child healthcare programs at DHS would be transferred to the Department of
Public Health -- or, as we like to say, brought back to the
Department of Public Health, because as you probably know, they used to be at the Department of Public Health, and they were consolidated into DHS 16 years ago -- the Legislature decided not to take any action on that, but rather over the course of the next year, there will be a work group that studies the topic and considers which pieces, if any, should be moved back and at what pace and in what way.

I skipped over but I know there are people in the meeting who care about it, so let me double back. Among the pass-throughs that we have, such as the Poison Control Center and local health protection grants and vision and screening program, the Legislature did a one percent reduction on each of those under the theory of everybody needs to see some reduction in a difficult budget year, and so the local protection grant, for example, which last year was $17,100,000 this year will be $16,900,000.

So, that's the budget. We are also, of course, all looking at this at our own office level. I can tell you -- because it's the office I know about -- certainly in my office we will not be able to go forward with the Adverse Event Reporting Law, and it's been in abeyance for almost five years now, waiting for funding,
and we thought we had stitched together some resources, but these cuts make that not possible, and some of our Federal grants will be at risk if we can't fill the General Revenue Fund positions, because they are grants that require 25 percent State effort or something like that. So, we're in the early stages of figuring out how to deal with that. I never unpacked my boxes from when we moved over to this space, so I'm actually sitting pretty good on losing the lease. But that's a little facetious. I obviously -- even if we were to move out of this space, it would probably -- given the bidding requirements, procurement requirements, packing requirements and all of that, it would probably be a six-month effort.

So, that's the Department of Public Health's budget, and, as I say, it fits in this overall context of a State budget that's about $2 billion less than the Governor introduced.

Now, your interests -- although you sit on a Board that advises the Department of Public Health, your interests extend probably beyond public health, and although I don't have the details, as you probably know or should know, the cuts to health programs and other State agencies are also significant, dramatically significant, and the cuts in State operations and other agencies are
significant. I believe DHS has a cut of almost 20 percent, and as -- looking at how do we go with an 11 percent cut in operations and find 20 excess positions that are currently filled, I can't imagine -- you know, scale up those numbers to DHS and a 20 percent cut -- how they go about it.

On a positive note, we are working on a project right now involving a response to a Federal RFA request for -- I don't know what the -- when the Federal grant offers an opportunity, they issue something called an RFA. I never internalized what "A" stands for.

DR. ORRIS: Request for Application.

MR. CARVALHO: Request for Application, on something called a Community Transformation Grant, and it's an opportunity to try to address some of the winnable battles, significant issues that the HHS would like to see addressed, obesity, tobacco and the like. So, we are in the initial stages of pulling together stakeholders across the state, except for the more populous counties in Chicago who are eligible to apply on their own, and we're holding meetings -- some of you may have been participants in some of those meetings -- to try to focus on what strategies we should recommend as a part of this grant, and there's a requirement in the grant that 50 percent of the dollars of the grant be spent through a partner stakeholders. And the
grant potentially is significant. I think it can be as much as $10 million a year, although that's unlikely to be the amount. But it's a competitive grant, and Leticia Reyes, who couldn't be here today, is coordinating our efforts on that.

So, I just wanted to finish with one bit of potentially positive news in the wake of a pretty grim budget report. Is there any questions I can try to answer?

CO-CHAIRMAN McCURDY: Any questions for Dave?

MR. HUTCHISON: Any insight on what's going on federally? I know that there's a lot of rumor that some of the funds that IDPH gets from Federal sources, such as CDC, are probably going to be reduced as well, so that doesn't really look good for Illinois, but I think it's a reality that we all have to brace for.

MR. CARVALHO: Yes, the one I do know about is the Preventive Health Services Block Grant, which you are all familiar with because we bring our spending proposal under that grant each year to you, and we're currently hearing or have been told that there's a 20 percent cut in that, and that's another thing that we're working through internally. How exactly do we implement that? As you know, about half of the funds of the grant have been used to support activities in the Office of Health Promotion and
about half in the Office of Policy Planning Statistics, my office, and so it has been the source of funding to support the SHIP development, some of our patient safety initiatives, some of our statistical initiatives. So we are trying to sort that out as well but, as you allude to, there are potentially other cuts in the Federal stream that may come down the pike. We do not know what is in the mix in the discussions about the elevation of the debt ceiling, and so we kind of knew what happened in the budget proposal, but we don't know what is going to happen in the debt ceiling conversation.

What I was going to say was there are other positive things going on in the Agency, but I thought since Dr. Arnold may be here before the end of the meeting, I'd let him talk about the response to the flooding in the spring that we were participating in and the like. So why don't I stop there, if are there no other questions.

DR. SAHLOUL: This is Dr. Sahloul. In terms of the distributing or redistributing the impact of the budget cut, does the Department itself have the authority to shift some of these cuts from different programs, or do you have to stick to what the Legislators have done?

MR. CARVALHO: Very good question.

Ironically, for the last two years the way the Legislature
dealt with the budget program -- and I'm not using the exact numbers, but this illustrates the point. The last two years what they said is, "Okay, we've got $10 billion of expenditures and $8 billion of revenue. We'll just give you $10 billion of authority to spend, but only spend 8 billion of it." And so in the last two years, the Department of State Government and the Department of Public Health, as well, had great flexibility, because basically the entire budget was one big lump and we could move money around. So, the double-whammy was this year where they actually cut things quite dramatically, they also went back to the old form of budgeting where they did everything at the line item level rather than in a big lump, and so, most of the budget is in line item. A couple of things I mentioned where we have lumps are in lumps, and that gives you some flexibility. Where things are in line item, I believe our authority is limited to 2 percent. So, I think that there are some -- there's some authority to move certain things between certain categories up to 2 percent, but that's -- while that's good, that's not a lot of flexibility.

CO-CHAIRMAN McCURDY: Any other questions or comments?

DR. SAHLOUL: Dr. Sahloul. So, can you go
MR. CARVALHO: Yes. I'll tell you the process, and all of it is rich with political intrigue and strategy and all of that. So, for example, couple things you need to know. The 1970 Illinois Constitution made a change on how the Legislature works. Before 1970, the Legislature wasn't supposed to meet past June 30th. So, sometimes they would stop the clock to pretend it was still June 30th. And that was considered unseemly, so the new Constitution provided that if you want a law to take effect right away, you have to adopt it before May 30th, by a majority. If you want it to take effect right away after May 30th, May 31st, it takes a three-fifths vote.

So, this budget was adopted before May 31st by majority vote to take effect right away with only Democratic votes, and the Democrats have the majority in both houses. If the Governor were to veto the budget and say, "No, this doesn't work, come up with a better budget", now for the budget to be adopted and take effect right away would take a three-fifths vote. It would require further conversations with minority party, and since the minority party is not an advocate of increased spending but rather less spending, that wouldn't be a fruitful political path
to try to get this to change.

One possible strategy is, as you know the fiscal year runs from July 1 to June 30. So, halfway through your fiscal year, January 1, you're back to a majority can pass a bill that takes effect right away. So, one strategy is to do the best you can with this budget but then go back in January and say, "Okay, there's some additional appropriations that need to take place." That is a theoretical possibility. It has its own political calculations. You can imagine -- you don't want to look like you're defying the will of the Legislature by spending money at a burn rate that exceeds what they authorize and then coming back to them in January and saying, "Okay" -- for example -- "we spent all of the travel money in the first six months. Now if you want another pool inspected for the next six months, give us more money." You could do that. It's just a little high stakes and probably wouldn't be viewed as being very diplomatic. So, there's the theoretical possibility, Doctor, of going back and asking for more. The timing of when you do it determines how many votes are required, and the circumstances at the time you do it depends on how well it might be received. Whether you view it as having been more or less compliant with the budget but you had certain things that couldn't be dealt
with, or if it looked like you were just blowing past
everything would affect probably the Legislative response.

CO-CHAIRPERSON McCURDY: Other questions?

(Pause)

CO-CHAIRPERSON McCURDY: Dave, thank you for,
shall we say, grasping the nettle with the bad news and
saving the good news for Dr. Arnold, should he materialize,
and if he doesn't, you can pass it on to us, also.

MR. CARVALHO: All right. That sounds good.

CO-CHAIRPERSON McCURDY: Also, in addition to
Dr. Sahloul, Dr. Peter Orris has joined us in the interim.
Did anybody come in Springfield or Quincy that we may have
missed? You all were there from the gitgo? Okay.

UNIDENTIFIED VOICE: Dr. McCurdy, Ann
O'Sullivan came on during David Carvalho's presentation.

THE COURT: Okay. So I think we're updated
with everybody who is here. We have not yet approved the
Meeting Summary from the March meeting, so let's go back
and make sure that we attend to that.

MR. ORRIS: So moved.

MS. PHELAN: Seconded.

CO-CHAIRPERSON McCURDY: It's been moved and
seconded that we approve the Meeting Summary. Any
discussion?
CO-CHAIRPERSON McCURDY: All in favor say "aye".

("Ayes" heard)

CO-CHAIRPERSON McCURDY: Opposed say "nay".

(No response)

CO-CHAIRPERSON McCURDY: The "ayes" have it, and the Meeting Summary has been approved, and we can turn to the Policy Committee Report. Karen?

MS. PHELAN: Thank you.

Karen Phelan. Policy Committee met on April 13th, and you have your minutes before you. I'd like to get those approved, please.

DR. ORRIS: So moved.

DR. SAHLOUL: Second.

MS. PHELAN: Thank you very much.

CO-CHAIRPERSON McCURDY: It's been moved and seconded. All -- any discussion?

(Pause)

CO-CHAIRPERSON McCURDY: And all in favor say "aye".

("Ayes" heard)

CO-CHAIRPERSON McCURDY: Opposed?

(No response)
CO-CHAIRPERSON McCURDY: The "ayes" have it.

MS. PHELAN: Thank you. We thank Dr. Kruse -- it's nice to see you -- and Tim Vega for keeping our medical home update as our major focus for our Committee, as well as for the Board. And on your minutes you'll note that Dr. -- excuse me -- David Carvalho assured us that it is their focus as well, to keep that foremost, and, Dr. Kruse, is there anything you would like to add about medical homes?

DR. KRUSE: Oh, at the moment the main thing is that the ACO Regulations were out and had been commented upon, and I'll just say that we've also thought that -- we've always thought that one of the real important things about medical homes was the chance for care coordination payments, new incentives for paying for care other than fee-for-service, not only care coordination but also pay-for-performance. The care coordination has almost been eliminated from the proposed ACO Regulations, and they have very minute prescriptions for quality reporting measures. Sixty-five are required in the very first year. Really, really very sad and disappointing. Actually, I think CMS thought that integrated systems, like Geisinger and Kaiser, would jump right in on these things, but they sent letters to CMS saying they were not going to participate, even
though they had the infrastructure to do so. So there's going to be an about-face on that, and I don't know where that's going to go.

The only reason I mention that is that the care coordination payments and incentives for care are moving forward in other arenas. For the CHPR of the State of Illinois, Part C, there is an incentive subcommittee, and I actually was named to that committee. So, we'll do that work starting next week or the week after -- I can't remember. And then HFS is also establishing a care coordination subcommittee as well, and I get to sit on that one, too. So, as far as the structure goes and how it relates to our 2008 document, it is starting to move more at the State level, I think, than the Federal level. But the data just keeps continuing to pour in regarding the blended system of payments, about how it cuts costs dramatically and improves outcomes, both process and primary healthcare outcomes. So, we're just moving forward on that.

I don't know if Tim has got anymore to say about it either.

DR. VEGA: Yeah, I think that the -- some of the private cares are like Jerry said. I think one thing that is coming up that needs to be addressed and was in the
Policy Minutes is that we, from a State level, need a unified definition of what a medical home is, you know, like a general agreement that if someone is going forward, the providers can have one set of guidelines that they can use for the whole state rather than having one set of criteria for Blue Cross and Blue Shield, another one for Humana or whatever. So, we talked about having either a recommendation of what criteria would constitute that or, at least, make it an urgency for the insurance group that has been created to come up with an Illinois criteria that is similar to all of the other criteria on a national level, but something we can all agree on so there are not five criteria in Illinois.

DR. KRUSE: Tim, that is very good, and I know we were going to talk about that a little more and we haven't been able to. Certainly the NCQA criteria are getting a lot of steam across the country, but they are a little bit difficult to implement, particularly for smaller practices, and would exclude a lot of the primary care practices just because of their complexities. You know what? I think what I need to do is check with the Patient Center Primary Care Collaborative that's been spearheaded by several large businesses, the first of which is IBM. But I think they are coming up with criteria that are much
more reasonable, so maybe we can see what they've got on
the table. I don't know right now.

DR. VEGA: So maybe if we can have
something -- if it's okay, if we get together and have
something ready for the next Policy Meeting, maybe we can
find something that's reasonable and kind of paves the way
for better preventive care. That kind of seems to be where
we need to go. I agree that it seems to be shifting to the
states again.

DR. KRUSE: Yeah, that's right.

MS. PHELAN: Thank you. Peter?

DR. ORRIS: Thanks, guys. I do know you're
talking English because I recognize the individual words.
How they're strung together is beyond me, and I mean, for
instance, I don't even understand what the blended payment
is, let alone any of the initials you all used, and I'm a
reasonably educated consumer of this information. So, if
you would do me the big favor of backing up and seeing if
you can give us a paragraph precis about where we are today
in the ACO medical home, what's going to be required, what
do we think is going to happen. Give me a 10,000 footer
that will help me when I go to my County Medical Society.

DR. KRUSE: Okay. I'll take a first stab at
that. ACO is Accounting Care Organization, and they were
legislated in the Affordable Care Act and actually had mandatory funding. So, they're going to start January 1st, 2012, one way or the other. These rules and regulations that have come out are proposed rules, and they will probably be modified to catch more practices in more areas than they currently think that they will.

The fundamental tenet of Accountable Care Organization is that it must take risk for an entire population, be it -- well, in this case, Medicare, and there must be an emphasis on the medical home and on primary care. Other elements, they can put on there whatever they want to. But the deal is, their big financial incentive for this is called shared savings. So they could go with a fee-for-service system. The shared savings are determined by a formula that is somewhat like a pay-for-performance or pay-for-quality system, and they don't have any requirements for care coordination payments.

Now, stepping back from that, the blended payment system is one in which there is incentive to coordinate care, incentive to have volume and see patients, and incentive to have quality. In our system now, we only have incentive to see patients and do more tests, fee-for-service. So, the care coordination payments are the ones that incent inter-professional, inter-disciplinary
teams that do things like care for high cost, high risk patients in ways we haven't before and also coordinate the functions of electronic systems, the registry functions and things like that. And, of course, pay-for-performance are various quality measures of process and outcome.

I will also say that in the Affordable Care Act, CMS also has $10 billion of mandatory spending over the next nine years to look at innovative systems for paying for care, which might be some different combination of these blended systems. So, in addition to the ACO, they have the CMS Innovation Center that's got actually $10 billion in mandatory funding that they have to spend, unless it's legislated away. It can't just be taken away by administrative means.

So, is that enough of the alphabet soup?

DR. ORRIS: Well, yes, it sets the scene. Now, in Illinois for a moment, is there a proposal for being one of these test centers? And, if so, what kind? What are the incentives for the different practices for joining? How come the big networks that can do this without a lot of overhead don't want to do it? Is it costing too much? And, in other words, are the incentives not enough? Are there not enough clubs? What's the situation? Is nobody going to participate in this? And if
nobody participates, does that win, or does everybody have
to participate? I have a whole list of things but that
will --

DR. KRUSE: Okay. CMS wants people to
participate, so they'll change the rules to get people like
Geisinger and Kaiser in. It will be very, very difficult
for smaller practices to participate in this, and we just
heard from the American Academy of Family Physicians in the
Graham Center a couple weeks ago that still 85 percent of
primary care physicians are in groups of five doctors or
less. So, in our efforts in Washington, DC, we are really
trying to write commentary that would get a broader range
in under this. The reason that those large, integrated
systems are not doing it is that the quality reporting
measures with 65 things to report will just cost more than
they're worth. I think they already think that they're
making pretty good headway in the patient's medical home
world, and they think this will cost more than it will
benefit them financially.

DR. ORRIS: And are we doing anything -- are
we going to take advantage of that extra money for special
laboratory testing here in Illinois or whatever?

DR. KRUSE: I don't know the answer to that
question. This is basically for individual groups to get
together. This is not really for states. The one that
was -- I tell you what, actually some of the innovative
payment programs, through the Innovation Center, states
clearly can apply for that, and so -- state groups, so
that's one to think of. The other thing is if there is
something that has been authorized by the Affordable Care
Act but not funded -- and that's the Primary Care Extension
Program, and so there's now some money through the Agency
for Healthcare Quality and Research to get those started,
and Illinois is applying through one of them, through the
PCEP, Patient-Centered Primary Care Extension Program, and
there's going to be a summit next Friday here in Chicago at
the Holiday Inn Mart Plaza, and they have a bunch of the
nation's experts from all over the place to get this thing
kicked off.

So, there is a little bit of activity in
Illinois, and there is some opportunity, mainly through the
Innovation Center.

DR. ORRIS: Thank you. And isn't there an
advisory committee that was supposed to -- that we had a
representative on from IDPH? David, wasn't there -- about
the ACO plans in the state, there was some interagency
committee that was meeting? I think we asked about that
last time.
MR. CARVALHO: That was about the ACA -- I mean, the ACO is part of the ACA. There was an interagency work group on the implementation of Affordable Care Act that came out with its report on the Governor's web site a couple months ago, and then the Department of Insurance and Department of Healthcare and Family Services are taking the lead in implementing it. We're working with them.

DR. ORRIS: Are we going after one of these initiative grants at the State level.

MR. CARVALHO: As I sit here, I do not know the answer to that, but I can check that out.

DR. EVANS: Jerry, as performance and outcome standards are -- or expectations are kind of a driving influence in this process, what's being done to define those standards, and who is defining the outcome of performance standards for the outcome of care and the populations affected? How is that being handled?

DR. KRUSE: Okay. There's a couple of foundational kind of things that CMS and the others are using here. One of them is a very recent publication about the effectiveness of integrated systems, care coordination and things like that. It was published by Kevin Grumbach and Paul Grundy at IBM, November 17th, and I would be happy to send that to the members of the Committee. It goes
through the evidence on the quality for all of these
tings, and CMS, Dr. Gilfillan -- actually, the guy who
runs the CMS Innovation Center is a physician, Dr.
Gilfillan, and he came to CMS from Geisinger. So they've
got a little bit of an in there. He's a good guy. And
I'll send that around.

The other thing is, the more historical
background on outcomes was summarized by the Council on
Graduate Medical Education, which is an HHS advisory
committee, and their publication came out December of 2010,
and the link to that I'll send as well, and those two
things would supply all of the information that CMS is
using to develop their quality and cost guidelines.

DR. VEGA: Peter, I think on a State level, we
have many organizations that are self-insured, especially
like bigger hospitals, and the self-insured hospitals or
organizations really look at quality indicators, and a lot
of them are unnecessary hospitalizations, unnecessary
emergency room visits, generic drug substitutions. These
are things that historically have bubbled up, and they
have -- they tend to be summarized at these national
levels, but going further back, that's kind of where the --
a lot of what is considered a good outcome versus bad
outcome historically bubbles up from.
DR. ORRIS: Thank you.

MS. PHELAN: Any questions?

Thank you, Dr. Kruse and Dr. Vega.

We're moving on to SHIP Implementation, and I understand, David, you're going to --

MR. CARVALHO: Sure. I'll note that Dr. Arnold is here, for your record.

The SHIP implementation effort is spearheaded right now by Leticia Reyes, and she's out at a conference, and she reports to me and asked me to report to you. If you recall, the statute provided for the appointment of a SHIP Implementation Council by the Governor, as well as appointment of two chairs within the state -- I'm sorry, within-the-state government chair and an outside-state government chair. We expect the Governor's office to make those appointments in a matter of a couple of weeks. You may have noticed that there is a -- the Governor, a few months ago, appointed a Deputy Governor, Crystal Thomas, who had recently been the Regional Representative, Region 5, for the Federal Health and Human Services Department. She actually had before that been Medicaid Director in Ohio, but before that had been the Assistant Director and Policy Director at our Department of Healthcare and Family Services in Illinois. So, she has a lot of Illinois
connections. She's the Deputy Governor with special focus, of course, on health matters, working very closely with Michael Gelder in the Governor's office, and she is taking a special interest in this. And so we expect both her continued involvement as well as the appointment of the SHIP Implementation Council soon. We are contracting with Richard Sewell and the University of Illinois in Chicago, School of Public Health, to provide the infrastructure support for the SHIP Implementation Council. They'll play a role to that council similar to the role that the Illinois Public Health Institute and Alissa Bassler played to the SHIP development.

And for those of you -- I forget, is there someone -- we don't have a -- oh, yes, we do -- veterinarian on the Board at the meeting today.

CO-CHAIRMAN McCURDY: Dr. Whiteley is on the line.

MR. CARVALHO: I'm sure in nature there would be some metaphor that would be entirely appropriate for watching two units of government try to develop a contract. Probably has some natural analogies that you can come up with. We have spent months trying to get a standard form, Illinois contract through the U of I bureaucracy, and we're close. We're hoping that there will be some synchronicity
between the contract and the appointment of the council,
and we look forward to working with Dean Sewell and the U
of I School of Public Health on the SHIP implementation.
Several of you have applied to serve on the SHIP
Implementation Council, and I hope to see as many of you as
we can, trying to keep the Council from being too large but
still be representative in all of the dimensions we hope
for, geographic, discipline, racial, and ethnic, gender,
and et cetera. So that should happen in the next couple
weeks.

DR. ARNOLD: As the Co-Chair for the SHIP
collection, when I actually had that constructed, it was
with the intent that it would actually follow the Federal
process very, very closely so that we were on the same ship
as the rest of the country. So the State Health
Improvement Plan is a framework, not a plan, because --
I've been in the military for 26 years, and after retiring
from that, I realized that there was a lack of coordination
among other groups, and with that being said, there needed
to be some kind of consistency in the approach of the way
things are being done. This SHIP is actually going to link
the Federal level down to the local level, and I say
"framework", because unless you have money at the table,
unless you are able to knock on someone's door, which
several people hadn't done in 20, 30 years, you need something that actually is grassroots, that can actually function. So, implementing something means you have something that is actually running, not something that's speculative and a piece of paper on someone's desk.

So, really, the Implementation Council is supposed to be coordinating the activities as people are already embedded in the community, and as part of that, I was able to get Illinois State as part of the community demonstration project for the CDC. They said that actually what I devised was genius, they've never seen anything like it before, they want to put money behind it, and also the Robert Wood Johnson Foundation and several other entities, outside, private entities, that are willing to develop public-private partnerships to make sure things go forward.

So, this idea that I had is something that I think is part of the platform for the State. It has nine different areas that can be addressed, and you can actually go on our web site, look at the actual SHIP document and five priorities and nine different areas of concern. Of course, obesity, tobacco abuse, and injury prevention are one, two, and three for the CDC. Those are the ones that are costing us the most in the way of money being spent.
Lieutenant Governor's office, I also have a project with the YMCA. They're coming to the table to develop a structure that I think will serve as one potential model that can be actually replicated around the country, and CDC is very, very excited about this concept. So, there are several things that can come out of this, but I think the Board of Health giving some guidance and some views on it is important so that it can progress down the lanes, going to the ocean, as it may be, where the real things happen.

So, it's -- really, when we say "implementation", I don't take that word lightly, and I don't take the word "plan" lightly. If you don't have the resources or the capabilities of actually implementing anything, you have a framework and you have a suggestion list. So, this is really an exciting move forward for the State, and I think it's going to really yield something good for it.

CO-CHAIRPERSON McCURDY: I would just make one comment, as somebody who is in the acute care sector primarily, and that is, as you know, hospitals are now required under the Affordable Care Act to conduct community health needs assessments, and some are starting to actually have results from what they've done, and I think this is a unique moment in their history where some of them, at
least, are going to see things they haven't seen before. I
already have seen a little of that, and there may be a
window of opportunity of openness for more integration of
that world into this process. You all are probably very
well aware of this, but to me it is kind of striking what
some of them are saying, "Oh, we haven't seen this before",
either process or needs.

DR. ARNOLD: Absolutely. The one big
disconnect has been if you look at public health
intervention strategies as a type one strategy where you
have a theoretical, scientifically-validated process, and
type two is you're sort of trying to cloak it in something
you can actually distribute, and type three is contextual
implementation of a public health strategy, so is it going
to work here, is it really going to give us a result? And
I think we're at the point now where you have to be careful
what you ask to measure, because it shows you where you are
and you know what you're going to need to actually
accomplish the task at hand.

But I think you're absolutely right. Health
Impact Assessment, HIA, is a really heavy topic now, making
sure that people actually are looking at the data, to make
sure it's the best practices to implement those, and they
are actually giving not only the Federal government return
investment but the State, the local level, and providers as well.

DR. ORRIS: How much money is there then, either Federal or State, after we've heard this report on the budget, which was not exactly exciting.

MR. CARVALHO: I did your report on the budget. I left all of the good news for you when you got here. I told them about the budget problems.

DR. ORRIS: How much have you got for the SHIP?

DR. ARNOLD: The SHIP itself -- actually, the platform that has been established, I view this as being something -- you know before -- and this is one of the analogies I give to my Deputies when they come to me. If they say, "I need more FTE's, I need more money to get this thing done, this thing," I always give them an analogy, and I say, "I have a thousand pieces for the fastest car in the world in front of my house, and what I want you to do is come out and pour a thousand gallons of gasoline on it, and why don't you bring strobe lights and flags and see how fast" -- and they look at me and say, "That's crazy", and I say, "So is asking me for money and more FTE's, when you don't have a plan, a functional structural unit that you're going to actually pour this into. So, don't ask me to
enter the Indy 500 and pour gasoline into a beautiful Volkswagen. It's not going to run. You know, the Formula 5's are much faster."

So, I think this is really a situation where we have the structure and are putting the structure in place that can be very well recognized by the Federal government, the State government, the local government as doable, first of all. So, I think the planning process doesn't really take a great amount of money if you're making a process that is going to be a flow model, which I think they've really bought into on the CDC level. So, now, for example, with the YMCA farmer's market project, it actually saves the State's money. Instead of redesigning the wheel, everyone wants to make their own wheel. Instead of redesigning the wheel, what we need to do is restructure the wheel and look at the elements that are here and how are they working together. Are they really confluent, really reaching for the same goals, objectives, really moving the same direction? By just doing it with one particular model -- the YMCA has jumped on board. The president of the YMCA, the president of the American Beverage Association, the March of Dimes Foundation, the Robert Wood Johnson Foundation, the CDC, we're amassing about 11 different organizations. I even have the Plumbers
Association. And they said, "What the heck do plumbers have to do with obesity?" I said, "Well, they not only fix pipes in buildings, they also do irrigation systems, they do water quality checks and controls, they do food safety checks and controls on whether you have organisms that are being produced."

So, we start developing a model where it can be recognized by the Department of Homeland Security. USDA has billions of dollars sitting there, looking at bio-security, food safety, tying into the same model. It also produces jobs for local growers, transporters, sellers. There will be demonstrations at the YMCA's as a transport of the coordinated approach to children's health program into a wide structure. They are the largest group as far as numbers go with respect to daycare in the state, 132 sites. They want to launch this in the fall in 10 sites. So, sort of multiple things, and I know the funding is already there, the funding for it.

So, I think there are many things we can do by leveraging some of the resources within the state and within these functional units to make sure they're coming into alignment. But I think people reinventing the wheel all of the time is really one of the big obstacles. You don't have to reinvent a vaccine for H1N1. We have one.
But imagine people kept trying to reinvent the vaccine and everyone went on their own way and tried to do that. We'd never get the vaccine. So, I think it's a confluence of ideas, goals, and people's abilities, and bringing them to alignment, which is functional.

DR. SAHLOUL: Dr. Arnold, what is the role of this Board or the Board members in terms of planning or implementing this SHIP program?

DR. ARNOLD: Well, I think the role of the Board is really to be defined, because the SHIP process, as David was saying, is hoping many of you would be on this process, and it's still open for you to put your names in as well. The process hasn't been closed. But I think it's very important to be involved in, because the Board of Health is really looking at things in a very similar way to what we do in Public Health. They're looking at population-based dynamics. You're not looking as this is one case that we have to be concerned about, and so you're really parallel in process. The other boards that are out there, institutes and all of that, they may be specifically addressing one particular issue, HIV disease or diabetes, but I think the Board has potentially a great role in looking at this and especially with the -- and I see Kevin over there, who is phenomenal, having him on here, so the
local health department involvement. You have 96 local health departments that he's representing on this Board. So, I mean, there are some really great potential things that can be done, and I think the public health system can finally start looking at things as a functional unit.

The reason why we haven't been funded for decades in this state is because there has been no crystallization. It's been theories and ideas and pieces right here and there and not really writing things to a common platform where people say, "I see what you're talking about and this is something I want to invest in."

So, I think the Board has an incredible role in helping to guide or to help shape what you're seeing in the healthcare field, what you're pulling back from the different institutions, hospitals, local health departments, clinics, FQAC's, CHC's, whatever is out there. It's more critical now than ever with the ACA, because we don't know where all of the cracks are. We don't know where the safety net breakdowns are, and especially the fiscal challenges we have. So, I see the Board as being really involved in it, making suggestions, making sure that they are cognizant of what's coming out of the process, to have a better understanding.

MS. PHELAN: Any other questions?
Thank you, Kevin, for representing us.

Okay. We'll move on to the Tdap Public Hearings. I don't know who is going to talk on that as well, but I can tell you that the State conducted three meetings, the first being in Chicago. At the time, apparently, there are no controversial issues, so we determined that we had a little bit too much time allocated for that meeting. So, the Springfield meeting was adjusted, I believe, to two hours. We had absolutely no one attend. We did have, maybe, some written documents presented, and I believe, Kevin, you attended Mt. Vernon.

MR. HUTCHISON: Yes. We had one physician that came and reported and was a proponent of the change.

MS. PHELAN: So, hopefully, that will move along very smoothly.

MR. CARVALHO: If you recall, this is the process established almost 20 years ago, when the addition of certain vaccinations, immunizations was considered quite controversial. So, the legislative compromise was that you would go through this process of holding hearings. Obviously, 20 years have passed and the controversy seems to have died down, but we still have to carry through the process.

MS. PHELAN: That's all we have.
CO-CHAIRPERSON McCURDY: As Karen can attest,
some of us found it most interesting to sit there for two
and a half hours and have one person pass through. That's
kind of how it went.

MS. PHELAN: We've had other situations where
we had bus loads of people wanting to present oral
argument.

Thank you very much.

CO-CHAIRPERSON McCURDY: Thanks, Karen.

Thanks to the Policy Committee. And the Rules Committee
report is next on the agenda, but I wanted to give
Dr. Arnold an opportunity to add anything else to the
Directors report, if you wish to do so.

DR. ARNOLD: Oh, no. It's going forward. I'm
not sure what David --

MR. CARVALHO: I talked about budget cuts.

DR. ARNOLD: Actually, I have to leave in
about five minutes to give another presentation to the
Governor's office. The obesity and diabetes is really a
target that we have within the state now. This, I think,
is -- we're gaining more recognition from the CDC as a
state, and I think we should be the leaders in this
particular initiative. The way that we are forming this
platform, I think it's one of the nine different areas
within the SHIP document -- and make sure that you get a copy of the SHIP document. I'll make sure that Chad sends it to all of the Board members so you can take a look at it. It's a longer, lengthy document.

CHAIRPERSON McCURDY: So, this is a different SHIP document than what we've seen in the past, different from the report?

DR. ARNOLD: Right. You had the report, and this is really more of an executive kind of summary where it shows you exactly what the points are that are being made, what the nine platforms are. I actually have a diagram in my office that I could show you and bring in. But it's -- actually, you are sitting as a conduit between the Federal government and the local. And the type three intervention strategy, how effective are things out there, you know, what is it that we're being told to implement as far as best practices go? Are they really best practices in all situations? They really have no idea on the Federal level, because if we are disconnected on the State level from direct local activities or knocking on someone's door, think about how far away the Federal government is from what's going on in southern Illinois. If you look at southern Illinois, in particular, there are seven counties that have the health rankings that are very, very similar
to Mississippi, Alabama and Texas. If you look at the
health rankings in states, those three states of the five
states that are in that one line at the bottom of the
United States are the lowest health ranking states in the
country. Illinois is somewhat in the middle with New York
and with California. However, those seven bottom counties
are similar to the bottom of this list. The actual obesity
rate is about 70.1 percent in adults, 70.1 percent, and
that is really frightening. If I see one thing -- many
people here know I was in the military. But one of the
things that frightens me is that -- about two and a half
years ago, I mentioned this in front of Secretary Sebelius.
I was asked to be the speaker for the State health
officials, and the thing I mentioned was that it was a
national domestic security threat, and they were saying,
"What are you talking about, domestic national security
threat?" And I said when I joined the military in 1984, we
had a three to five rejection rate on induction physicals.
It's now 27 percent nationally. There were four centers in
the country about five months ago that reported only 30
percent of the recruits passed. High blood pressure,
diabetes, totally physically unfit. The CDC about nine
months ago said one out of three children born in the year
2000 or after will develop diabetes in their lifetime. If
you go to the African American, Latino community, one out
of two. American Indians, 90 percent. Can you imagine a
country where you have, let's say, close to 300,000,000
people where 100,000,000 have diabetes? It's the leading
cause of blindness, non-traumatic amputations, renal
dialysis machine usage.

As far as obesity itself, it's the second
leading risk factor for cancer, according to the American
Cancer Society. We can't afford to lose that battle.

That's why the CDC has put it as number one, although they
know monetarily the greatest impact -- if you add
everything else, tobacco has a greater impact than almost
anything else out there. So tobacco is in a position
number two, but they know that this number one, obesity,
can really bankrupt a country, can bankrupt all of us.

There are actually states where I found out that they have
companies move in and they did not advertise in the state
they moved into. They actually advertise in other states
for employees, and when they were asked about that by the
state that had already given them tax breaks and those kind
of concessions, they said, "Well, the people here aren't
healthy enough, so we went outside to find our employees."

They said that the medical healthcare costs would be too
much for them to bear.
So, we have got to do something fundamentally
to change what we're doing. Also, working with the
Illinois Board of Education, and I got the -- really
ability to talk to the CDC. They gave us a grant to
rewrite the health curriculum, K through 12, and maybe K
through 20, but we had the President of the Board there,
the superintendents, the appropriations chair for
education, Representative Davis was there, the Illinois
Public Health Institute. They said they have never seen a
model like this. It was judged by two Harvard people, one
from Princeton, one from the Kaiser Permanente and another
one from the -- one of the hospitals. I'm blank on the
hospital in Washington, DC. But we are actually in a
position, I think, to really change things, and it's really
fundamentally changing things how we do business and how
things are structured to look more like how private sector
corporations operate. They operate as a business for a
purpose, and if we have a structure that is actually
addressing things in this kind of format, where we are
making sure that we have checks and controls, matrix in
place, and are developing a system to develop this issue,
the return on the investment for this is that, first of
all, we don't spend the Medicare/Medicaid dollars
unnecessarily for things we don't need to be spending it
for, but it also frees up that cash flow to put them on other subjects that you know you have to take care of as well. We're actually always in this battle of diverting funds from one thing to the next to the next. What's the hot topic of the day? It's almost like we're operating sort of like CNN. It amazes me with CNN with Japan, earthquake, tsunami, and then a snow storm, and then a nuclear melt down, and then a volcano, and now we're in the Middle East, and this in two days, and no one ever focused on any one of those specific issues. So, we have to stop that kind of tracking and thinking and develop a model that says this is really one of our platforms. We want to find out who is out there. We did three public hearings to get a list of a few hundred people who are actually doing things in the obesity realm. The clock is part of this. We're looking out and reaching out to make sure that the people who have the subject matter expertise are at the table. The local health departments need to be heavily involved. I think they are part of a safety network that we cannot ever, ever lose. If we lose that, we are going to be in deep trouble. And if we were -- if we said that we had a hundred million people coming down the road with diabetes, if we were 90 percent effective in prevention, 90 percent effective -- and I can't think of too many systems
that are 90 percent effective -- you still have 10 million
people. Back in 1984, the global burden of diabetes was 50
million people, global for 1984. By 2025, it's going to be
500 million. There's going to be a ten-fold increase in
the number of people with diabetes in the world, according
to the World Health Organization prediction, at the current
rate we're going.

So, I think that there are some opportunities
here. It's not always just about money, but it's about
maneuvering and positioning and making sure positions are
aligned so that people who do have the money --
foundations -- I have foundations lining up now to
participate in this, because they said, "We're looking for
something to participate in." They are responsible to
their foundations, their boards, and unless you have
something that really makes it look like it's going to
work, it passes by us. So we get passed by Iowa on
projects that we're applying for? So, I think that this is
really an attempt to make sure that everything is in a
system that people can understand, follow, is transparent,
it has specific objectives and outcome and that people are
able to participate in the system with confidence that
they're going to get something out of this if they do it.

When the CDC goes in front of the Legislature,
it's a Senatorial body and Congressional body, and they say, "We need more money." They say, "We gave you a hundred billion last year. What did you do with it?" If we can't tell them anything, what are they going to tell us? They're going to say, "Well, just cut it." So, I think it's a responsibility we have, and I think the CDC feels this is a great step for them. You can actually report back whether the best practice is working or not with something you identify that they need to know about, that needs to be included in this manual.

So, we are the lead state for the community demonstration project for the manual. I had the Director of the Chronic Disease Section of the CDC listen to this presentation about this Y model, and she said, "Dr. Arnold, you can't see me right now. I know you're on the other end of the phone. But I'm smiling from ear to ear, and for decades I've been looking for someone to come forward with an idea like this. This is absolute genius. Send us your notes. We will be there."

CO-CHAIRPERSON McCURDY: Sounds good.

DR. ARNOLD: So, I think we have to really rally, especially at a time when we're dealing with a lot of fiscal problems, and unless we make a move and show them that we have a unified front, that things are very well
crystallized, we have a clear path of where we're going,
they're going to say forget it. I'm not -- first of all, I have limited funds. I have to show that I'm still effective. They've already cut my funds. So, from the Federal perspective, they're looking for someone who can actually pick this up, they can make an investment, and actually have an outcome that makes sense. It can actually help the local economy if we do the right thing. That's all.

DR. SAHLOUL: Can I get the information on how to join the council as a member?

DR. ARNOLD: Sure, and I'll have Chad come in. He's my Administrative Assistant.

DR. FORYS: And we were also promised the document, the SHIP proposal that you made to the CDC.

DR. ARNOLD: Oh, yes.

CO-CHAIRPERSON McCURDY: Thank you. I know you have to make tracks somewhere else.

DR. ARNOLD: Yes.

CO-CHAIRPERSON McCURDY: Hope to see you next time.

Well, thank you again for the policy discussion, Director's remarks. I think it's time to turn our attention to the Rules Committee, and I think the first
business item I think for us on the rules is to act on the
Rules Committee Meeting Summary. So, I will ask for a
motion to approve the summary, which has -- which you have
received.

DR. EVANS: So moved.

DR. SAHLOUL: Seconded.

CO-CHAIRPERSON McCURDY: Moved and seconded.

Any discussion?

(Pause)

CO-CHAIRPERSON McCURDY: All in favor please say "aye".

("Ayes" heard)

CO-CHAIRPERSON McCURDY: Opposed, "nay".

(No response)

CO-CHAIRPERSON McCURDY: Okay. Thank you.

That is approved.

And then let us turn our attention to the
rules which we have, and you'll see there are four of them.
Quite mercifully two of them were short and even short and
sweet. So, let us begin with the Heartsaver AED. That's
the defibrillator grant code, and does someone in
Springfield want to provide us with some background on that
one?

MS. MEISTER: This is Susan Meister. I am the
Administrator and Coordinator for the Department. We are -- one substantive amendment to this rule, and that's the requirement that the AED be placed into public service within eight weeks after receipt of the grant funds. The other two changes were technical ones, to replace a reference to a contract which we really don't use. We use a Grant Agreement Form. And then the other, last amendment is change the mailing address for the Department.

And, also, I want to provide a little bit of update to the Tdap public hearings. Those Administrative Rules have been filed with the Secretary of State, and they'll be published tomorrow for public comment.

CO-CHAIRPERSON McCURDY: So, will those come to us for further consideration, or is that not in our bailiwick?

MS. MEISTER: You've already voted on them.

CO-CHAIRPERSON McCURDY: Okay. I'll entertain a motion -- is there any discussion of this rule?

(No response)

CO-CHAIRPERSON McCURDY: I'll entertain a motion to forward this to the Joint Commission on Administrative Rules.

DR. SAHLOUL: So moved.

MS. PHELAN: Seconded.
CO-CHAIRPERSON McCURDY: Been moved and seconded. Any further discussion?

(No response)

CO-CHAIRPERSON McCURDY: All in favor say "aye".

("Ayes" heard)

CO-CHAIRPERSON McCURDY: Moved and seconded, and it has been approved. So we will move to the next one.

The next one is the Newborn Metabolic Screening and Treatment Code, and somebody want to give us some background on this one?

MS. MEISTER: This is an addition, testing for Severe Combined Immunodeficiency, SCID, and this is to implement a mandate for testing for these metabolic diseases, and the format for this is pretty much the same as the ones that we already have in the rule. It's -- the rule making also updates a couple of divisions that concern pilot projects that have already passed that are finished, and the fee, of course, is raised every time we add a new rule or a new requirement for testing to the rule. So, the fee will be raised from $78 to $88.

CO-CHAIRPERSON McCURDY: Was that Susan speaking?

MS. MEISTER: Yes.
CO-CHAIRPERSON McCURDY: Dr. Orris?

DR. ORRIS: I apologize. I had missed the committee meeting on this discussion, but I had two questions on this one. The first was, it seems to define what the health professional -- one of the qualifications for the health professional giving the advice to the parents related to this process, and I'm wondering why that has to be established and then certified by IDPH, as opposed to saying physician/pediatrician who does a Fellowship in genetics, whatever, from an accredited program, and the corollary to that is sort of the extensive discussion about what these tests mean, where IDPH seems to be opining about what these tests mean. It all seems too detailed and unnecessary at the state level, especially when we know how hard it is to change these regulations when one or another tests change, as we've heard with respect to a whole bunch of this stuff. So, why is this -- why is this so detailed, and why can it not be left up to the regular processes of certification, et cetera, in the profession?

CO-CHAIRPERSON McCURDY: I'll let you all comment on this from the Staff.

MS. DELUKA: This is Barbara Deluka. I'm a nurse with the newborn screening program. Traditionally
we've had dedicated, designated specialists, the pediatric subspecialist for all newborn screening disorders. They are extremely rare disorders, and particularly for severe combined immunodeficiencies, a positive screen requires immediate action on the part of the primary care provider and referral to an immunologist specialized in testing for this and with the capacity to provide stem cell transplants if the child is diagnosed. This has to be done within three months of birth, the sooner the better, before the child does develop an infection.

DR. ORRIS: If I'm a pediatrician and I'm a genetist, having finished a Fellowship, et cetera, or an immunologist, how many of your lists do I have to be on to be certified to be able to talk to my patients about these different diagnoses, and how do I apply to these lists, and how much of a burden is that on the profession?

MR. GUNN: This is Jonathan Gunn, the Assistant General Counsel for the Department of Public Health. The short answer is none. The Department lacks any authority whatsoever to regulate physicians or the practice of medicine. These are, as it says under letter J, that these are recommendations. These are not in the traditional sense an effort to regulate the practice of medicine but rather a recommendation in this area.
DR. ORRIS: All right. Thank you very much.

That answers all of my questions. I'm in favor. Are you going to tell anybody about these recommendations? Is there some plan in here about communicating them to the appropriate specialties, et cetera?

MR. KRUSE: David, I'd like to make some general comments about this, because these things come across our desk frequently, and we're now well over 40 in the number of these things that we test for, and I'm not going to speak against screening for SCID, but I think we need to understand the implications of this, and I've got some of the best research in the United States from UCLA, Duke, and the University of Wisconsin here.

The incidence of this disease is 1 in 100,000. So in one study that was done two years ago at the University of Wisconsin, they screened 47,500 children. You might not expect to find one but they had 96 positive tests, 96 that were abnormal or inconclusive and that would then need to go immediately to subspecialists, as said before, because it has to be taken care of within three months. And so on these 96 abnormal tests, they found three chromosomal abnormalities and they found one T-cell lymphoma and no SCID, none. So, in essence 92 were completely normal. And I think we have to consider how
much anxiety that produces in the patients and, again, as Peter said, what burden that puts out on the system and the physicians as well.

I will say, quite frankly, as far as explaining these tests, primary care physicians sometimes have an understanding of the rarity of this and what that means as far as false positive test goes as well as anybody. That doesn't say anything about the referral.

Anyway, you can look at the years of added life, if they're treated before three months, and the survival is 97 percent. If after three months, 67 percent.

And the Duke and UCLA studies took a look at this. At the Duke study they said this test actually cost $50 a test. There's 4,300,000 babies born in the United States a year. That would be $200 million a year to add 760 years of life and that would be $260,000 per year of life added, if we're talking about it in terms of dollars.

If you do 10 percent -- I mean, $10, as we just heard, from 78 to 88, if that is the real cost and the State is not really paying more for that, they're just charging that, then that's $52,000 per year of life added. Again, not that that should be the specific thing that we focus on, but it's something I think that is very important.

The UCLA study said if the screening test cost
no more than $5, had a false negative rate of less than .9 percent, which it does, and a false positive rate of less than .04 percent, which it doesn't, then it should be implemented based on, you know, the risk-benefit ratio, the whole thing. So, you know, we had cystic fibrosis come through here, which has some significant nuances, and I think we just need to really understand that we are looking at something that's a big cost and we're getting all kinds of tests here. It's very difficult to understand them all and to describe them, and I think we better start teaching in our medical schools how to understand false positive rates, false negative rates, and the implication of testing for something that's very, very rare and particularly the burden that imposes on the parents, once they have a test that is positive, until they know the outcome is really going to be negative, which is going to be virtually all the time.

So, I just had to get that one on the table.

CO-CHAIRPERSON McCURDY: So, that might be an argument against the --

DR. VEGA: I want to echo that. I think for those statistical reasons, I think there is enough expertise on the Board that we really have to take a look at these tests and see what some of the social and economic
outcomes are, and given that information -- because I think most of these occur through lobbying efforts, through lobbying efforts in Springfield, and laws get passed and these things get implemented, and the other aspects that Peter and Dr. Kruse are talking about just does not get measured or even discussed. I think even if we took one of these and take a look at some of the social and economic implications, or maybe just ones that don't fall in the criteria that Jerry was talking about, it's such a huge thing, I think we are doing everyone a disservice if we start looking at it like this.

MR. CARVALHO: This is Dave Carvalho. Let me jump in and put one little tiny bit of my legislative update out, because it's relevant to this conversation. But I think I need to give you some background. As you may know, we have -- and I never remember the name of it but we have a Metabolic Disease and Genetics Committee, or something like that -- do you know the name of it, Susan?

MS. MEISTER: It's the Genetic and Metabolic Diseases Advisory Committee that recommended we add these tests.

MR. CARVALHO: We have a Genetic and Metabolic Diseases Advisory Committee, which operates under an existing State statute that calls upon them to weigh all of
the considerations that Dr. Kruse and Dr. Vega have talked
about and to make recommendations to the Department on what
tests to add. They quite typically take their direction
from a similar committee at the Federal level that also
looks at the same issues that Dr. Vega and Dr. Kruse raised
about: First off, is there a science to do the test? Is
it scalable to mass testing? Is there something to be done
with the results of the test? What are the risks of false
positive? And what are the costs, et cetera?

The Federal committee has recommended

something like 27 or 29 or 31 tests. Illinois has been
among the states in the forefront of adding those tests as
they get recommended at the Federal level. This test for
SCID was recommended by the Federal committee last year, I
think in January or February, and then their recommendation
went final in May or June, and then our committee at the
State level went through the process under the statute and
came to a recommendation, and that's why the Department
developed this rule to bring to you. So, at least with
respect to SCID, that is the process that's been followed.

Now, I should perhaps contemporaneously bring
to your attention there's a bill on the Governor's Desk,
Senate Bill 1761, which is the alternative pathway that
things sometimes work their way into the testing process
that Dr. Vega alluded to, namely a Springfield process.

Several years ago, there was a bill to require the addition of Lysosomal Storage Disorders, LSD's. There were five of them. The only one I remember is Krabbe or Pick. In any event, we worked to build into that legislation certain thresholds so that we would not be required to actually implement the LSD testing until various thresholds have been met, thresholds such as tests had been developed and it was scalable and we had the fee in place to recover the resources in order to do the start-up costs, et cetera, and we are in the process -- and you -- you're familiar with this one from several years ago. We are in the process of implementing that. Senate Bill 1761 sought to add SCID to the statutory reference, so, in effect, a parallel path. Our committee was recommending SCID. This bill was also going to write into the statute that SCID become part of the testing, and then the bill also sought to add two other LSD's that weren't part of the original legislation, that are typically referred to as Hunter's Disease and Hurler's disease, also very low incident diseases, like Lysosomal Storage Disorder diseases.

So, we worked out a compromise with the sponsor of that to similarly include in the bill very important thresholds relating to testing being available,
that it be scalable, that we receive the resources
necessary to do it and the like. So, that bill is pending
on the Governor's desk. The -- both the sponsors and the
advocates behind the bill, I think, have come to the
conclusion that they do not have an interest in pursuing
the statutory path in the future. But, to be totally
candid with you, because it was part of the conversation,
there had been some concern at the legislative level that
our committee process had become non-functioning, and so
there was a legislative intervention. We have sought
mightily over the last year and a half to restore the trust
that we believe that committee deserves and the process
that they follow. Those of you who are familiar with this
topic know there are a lot of differences in opinion in the
medical community as to which tests should be the next
ones. There are people who devoted their lives to certain
diseases and see the suffering associated with those
diseases, albeit in a small number of occurrences. And so
that committee is quite energetic in their debate. We
anticipate that in the future, they will continue to look
over the list of things that the Federal government's
committee suggests be added, but we have chosen not to view
that -- this whole process as lemons but lemonade in the
sense that this process is going to supply our lab with
some capacity in the form of mass spectrometers and other
equipment that we actually might not otherwise have the
ability to add, and once we have this capacity and staff,
adding additional tests or using it for other purposes will
be a capacity of the lab.

So, I wanted you to know the whole environment
which this comes up. But this particular rule did not come
about through legislation. This came about through the
recommendation of the committee, whose name I keep
forgetting.

DR. VEGA: The process of us getting this to
pass or to implement is -- I always look at that as part --
and probably the smaller part of the repercussions of it.
We talked about ACO's. What I'm trying to think of is what
is the outcome of this? You identify these people early
and get these people -- children to right people, and
everyone is for that, but what is the repercussion if you
have something like Jerry was talking about where one out
of 97 tests are abnormal and the cost of implementing care
for 97 out of 98 people? So, when something is thought
through like this, is there an outcome to validate their
recommendation put on the back side of these rules? That's
what I'm trying to get at.

MR. CARVALHO: Sure. All I can say with
respect to SCID is that the Federal advisory committee made the recommendation that it be added and that the Illinois Advisory committee made recommendation for it to be added, and both of these used those kind of balances to the benefits to the children caught versus the negative impact on persons who for a period of time have a false positive reading, and came to those recommendations. I'm not a scientist. I can't go behind their recommendations. I just know that those were the results of both committees' deliberations.

CO-CHAIRPERSON McCURDY: This is a very important, not to say also very interesting, discussion. At the same time, I think we need to act on the rule, if we can, because we have others yet to consider and we're not too far from one o'clock adjournment.

So, at this point, I'm going to ask if anybody is willing to move acceptance and for approval.

MS. PHELAN: I'd like to review page 10 on the bottom, number 3.

CO-CHAIRPERSON McCURDY: Could we have the motion and then discuss?

DR. SAHLOUL: So moved.

DR. ORRIS: Second.

CO-CHAIRPERSON McCURDY: Go ahead, Karen.
MS. PHELAN: On the bottom of page 10, number 3, there was an adjustment that they made to update that information. I'd like for you to review it again. I'd like to put back "the phase-in project".

CO-CHAIRPERSON McCURDY: Say it again?

MS. PHELAN: "Phase-in".

CO-CHAIRPERSON McCURDY: What about it?

MS. PHELAN: I would like to put the dash back in to "phase-in", so it appears to be consistent with the old language. And, also, there is a period there that just needs to be taken out. I'm sure you probably caught that already.

CO-CHAIRPERSON McCURDY: So, editorial adjustment on page 10.

MS. PHELAN: Minor. That's all I have.

CO-CHAIRPERSON McCURDY: Consider that as a friendly amendment, if you will. Anything else? Are we ready to vote?

All in favor, please say "aye".

("Ayes" heard)

CO-CHAIRPERSON McCURDY: Opposed?

(No response)

CO-CHAIRPERSON McCURDY: Abstentions?

(No response)
CO-CHAIRPERSON McCURDY: I sometimes forget that, so this might be one. Well, then this one will also be forwarded and, again, an important discussion and considerations not to be not thought about. I will just say parenthetically, I discovered the name of a condition in here that I had never seen before, and I have no idea how anybody would pronounce hyperphenylalaninemia. There must be somebody who can say it ten times fast, but I certainly could not. Anybody who knows this stuff?

DR. FORYS: It's easy. Hyperphenylalaninemia.

CO-CHAIRPERSON McCURDY: There it is.

Hospital Capital Investments is our next rule. Who wants to speak to this in Springfield, please?

MS. MEISTER: This rule will sort of correct a process that involves the coordination of this program with a Certificate of Need or Certificate of Exemption process with the Health Facilities and Services Review Board, formerly the Health Facilities Planning Board, and this will allow an application to go forward if, during that application process, the hospital changes ownership.

CO-CHAIRPERSON McCURDY: Okay. We'll entertain a motion to approve.

MS. PHELAN: So moved.

CO-CHAIRPERSON McCURDY: Second?
DR. SAHLOUL: Second.

CO-CHAIRPERSON McCURDY: Okay. It's been moved and seconded. Any discussion?

(No response)

CO-CHAIRPERSON McCURDY: All in favor, please say "aye".

("Ayes" heard)

CO-CHAIRPERSON McCURDY: Opposed?

(No response)

CO-CHAIRPERSON McCURDY: And abstentions?

(No response)

MR. CARVALHO: If I could just say for the record, because my -- because of the way the statute was drafted for this, my wife's hospital was one of the beneficiaries of this, so I took no part in the consideration of this, nor your consideration of this.

CO-CHAIRPERSON McCURDY: Okay. Thank you.

Let it be duly noted in the record.

Okay. The next one is one about which we've had a little bit of correspondence for the Committee, and this is the Psychiatry Incentive Program Code. Somebody in Springfield, please speak to this one.

MS. MEISTER: This is a new rule, implements the Psychiatry Practice Incentive Act, and it's a grant,
loan and loan forgiveness program, to recruit and train psychiatrists in practices of area in Illinois that demonstrate the greatest need for that care. There was a little bit of a -- there was discussion at the Rules Committee meeting about the provisions in the rule related to the Notice of Application, and we did some amendment to that language in between the Rules Committee meeting and this week, and David McCurdy contacted us and asked for a little bit more clarification. So, we did send out yesterday an updated copy, and the changes to that are in Section 977.120(b) in regard to the Notice of Application, and in Section 977.130, Notice of Application. Basically, the amendments will clarify that once the Department determines that an applicant is eligible to apply based on review of the Notice of Application, the applicant will then have 30 days to submit an application.

CO-CHAIRPERSON McCURDY: And just one question. An intermediate version that we saw said something about the Notice of Application data being good for one year, and I see that has gone out, and it seems that makes sense that it would. Am I correct in that?

MS. MEISTER: Yes.

CO-CHAIRPERSON McCURDY: And, by the way, I want to say thank you also for calling our attention -- or
at least my attention to the fact that the issue was in two
different places. I had really not put all of that
together. So, the fact that you made changes in Section
120 and Section 130 is helpful as well.

There was also a question about the mental
health shortage area, and we received a document about
that. Actually, I should have commented on that, because
it was part of the Rules Committee summary. And then we
received a revised version of that, and I don't know if
anybody -- as long as we are looking at this, part of the
background that may be important is there is a document
that we received, which is kind of a summary of mental
health professional shortage areas, and it is -- and we
received one version, then we received another. Does
somebody in Springfield want to give us -- fill us in on
that?

MS. CASPER: The chart originated after a
question from the Rules Committee about the shortage of
mental health professionals, especially as it pertained to
especially psychiatrists, as it pertain to the Psychiatric
Incentive Act and the rules that were going on with that.
We went to the web site from which we pulled much of our
health professional shortage area information. It was
listed by county, which is how we pulled it, with both the
practitioners practicing in the shortage areas and those that were not there that we needed, how many shortages we had. Upon reviewing that, we realized that each of those counties were listed, for example, in your chart where there's a catchment area. In the alphabetical order list, each of the counties was listed with the shortage next to it instead of a cumulative number for all of those. For example, in this first catchment area, 03-03-03, that has Logan, Mason and Menard in it, each of those counties would have shown a full-time employee of one and a shortage of one, instead of just one total for the catchment area. So, this revised chart that you received is the correct shortage and full-time employee equivalent for mental health shortage areas in the state.

CO-CHAIRPERSON McCURDY: Let me ask you one other question, and that is "mental health professional" evidently does not equate wholly to "psychiatrists", right?

MS. CASPER: That is correct. However, you know, just to be certain that we had as correct information as we can, especially since it's the Federal government that pulls many of these numbers, we contacted them and were told that over 90 percent of the shortage areas are determined by the number of psychiatrists alone.

CO-CHAIRPERSON McCURDY: Okay. That's good to
know. So I grew up in Stark County, for example, and I'm looking at catchment area 01-07-07. There is one mental health professional, probably a psychiatrist, somewhere in that four county area?

MS. CASPER: Correct.

CO-CHAIRPERSON McCURDY: Okay. Well, these changes being made, again, let me entertain a motion to approve, and then we can have a second, and then if there is a need for discussion, we can certainly have it.

DR. EVANS: So moved.

DR. SAHLOUL: Second.

CO-CHAIRPERSON McCURDY: It's been moved and seconded. Is there further discussion?

DR. KRUSE: David, this is Jerry in Quincy again. I do have a few things I would like to say.

On the bottom of page 20, I applaud this for saying it gives a priority for programs located away from communities in which medical schools are located. We need more of that, no doubt. But on the next page it says, "having programs located in hospitals that have affiliation agreements with medical schools located within the state." There are a few psychiatry programs that are not affiliated with medical schools, and in other specialties there are even more, and they're accredited by the same agency that
accredits the ones affiliated with hospitals. I see this
is probably part of the statute, because it says Section
15(2) behind it, italicized. As we go forward, I think
that discriminates against very good programs that happen
not to be associated with medical schools -- and here I am
speaking as the medical school representative for the State
Board of Health. How do you like that?

The next one is on page 27, and under Section
977.210, Eligibility for Application, Point A-4, "Agree to
practice full-time in a designated shortage area as a
psychiatrist for one year for each year of loan." I just
want to say in the NCA, the National Health Service Corps
has changed from full-time practice to say 70 percent
full-time practice and up to 30 percent clinical teaching,
and what that does is that allows programs to be
established in these areas and that multiplies the effect
of getting more psychiatrists and more programs that you
need in that area. And so I would say that as we go
forward in the future, that whatever influence we can have
to say 70 percent practice and 30 percent clinical teaching
would probably actually have more of a benefit for what we
were looking for on that one.

And then my last comment is on page 30 and 31,
under the Scholarship Repayments. These students are
penalized if they take money under the psychiatric loan,
but there are shortages of other physician specialties that
we have programs for that may in some way need to be rolled
into this. For example, general practice, family medicine,
general internal medicine, general pediatrics have clearly
been established as shortages by the Council on Graduate
Medical Education for HHS, and would these students have to
pay back their loan if they didn't go into psychiatry but
did go into general surgery, family medicine or general
internal medicine? That would be a shame.

Anyway, those were my comments.

CO-CHAIRPERSON McCURDY: Would anybody in
Springfield -- thank you, Jerry. Would anybody in
Springfield or here like to comment further on any of that?
A lot of that, of course, is statutory language, maybe all
of it.

DR. GIROTTI: Just to follow up on that last
point and in the spirit of the previous conversation about
looking at evidence before we put forth rules, I think at
the national level, as Congress is putting more money into
convincing clinicians to practice in under served
communities, the preference is for loan repayment as
opposed to scholarship, because it is difficult to tell a
first-year medical student, who is very unclear about what
they would like to do in the future, that there is money
here for you if you go into psychiatry and now you sign on
the dotted line. And two years later you change your mind,
you're already in a program with the State now. So, I
guess it's too late for this particular rule, but I think
in the future, if you have the expertise as part of your
Board of Health, it would be important to look at the
evidence that we come across before we set forth any rules.

MR. CARVALHO: This is Dave Carvalho. Jorge,
the Department for the last eight years has absolutely
agreed with your sentiment, that we think that loan
repayment is a better way to go than scholarships for
precisely the reason you mentioned, that the scholarship
program locks a person in before they've even been to
medical school, with a commitment to what area of medicine
they're going to practice and exacts quite a penalty if
they try to change their mind. We've encountered
resistance in changing it -- it is legislation, it's not
our rules -- in part from the medical schools who say they
like to have in the tool box the ability to steer someone
towards a scholarship who might be intimidated by the
prospects of taking out a lot of loans. So, if you and Dr.
Kruse who are both in academic medicine could lobby from
that end, we might be able to get some traction in
Springfield. We have encountered resistance from the higher education community to shifting. And then the specific thing about why this is a psychiatric -- actually, it's also kind of a medical society higher education thing. We have the existing program on primary care doctors, and folks tried to get that bill law changed to broaden it to include psychiatrists, and the medical groups for family practice and primary care doctors and all did not like the idea of the psychiatrist students feeding from the same trough, and so the legislative compromise was, "Okay, we'll create your own program so that they are separate and feeding from a different pool of money," which, you know, made sense to the organizations, maybe less sense to a twenty-two-year-old thinking about, "Do I want to sign away that I'm absolutely going to become a psychiatrist versus sign away that I'm absolutely going to become a primary care doctor?"

So, for all of those reasons, we absolutely would be supportive of moving in the direction of loans, but it is all statutory at this point and that's what we're responding to in these regs.

CO-CHAIRPERSON McCURDY: And it's also apart from whether there is a pool of money in the trough.
MR. CARVALHO: Right. I don't believe there are funds for either program, to tell you the truth. I believe the funds for the scholarships for primary care were eliminated last year, and I don't believe there are any funds added for psychiatric scholarships either.

CO-CHAIRPERSON McCURDY: Well, we're right near one o'clock. Is there further discussion?

DR. FORYS: Yes. This is Dr. Forys. As the father of a new medical student, son starting medical school in the fall, and looking at options on how to fund his education and reading through this, I think that you have to be crazy to take one of these scholarships, and the whole process here of three times return to the State on investment makes it very, very difficult to see how any of this can ever be implemented. I think it's one of these dead wood issues that gets printed on paper that is never going to work, and I think someone should lobby the Legislature to stop cutting money and start -- and at the same time stop cutting trees.

MR. CARVALHO: Just so you know -- and I know, because the cuts were during your tenure here so you haven't seen before. In fact, the program for primary care doctors has been very successful. Dr. Whitaker was himself a scholarship student, and that's how he got through
There's hundreds of doctors who we paid for their medical school. We do have, however, a delinquency problem because precisely what Dr. Kruse said, which was a small number of the persons who financed their medical education this way do decide, for whatever reason, that they want to practice in a different area, and that creates this problem, and some of them made the cold calculation that "If I become an ophthalmologist and make $800,000 a year a few years, I'll just pay back the State and it's still worth getting my whole medical school paid for", and then others tell us, "I can't find anywhere in the state that's under served and needs a primary care doctor". And Julie and her staff point them in directions, and we have tension. But -- so the program heretofore, at least on the primary care side, has been fairly successful. Notwithstanding its success, to continue the story, Dr. Whitaker wound up having to come back to Illinois to pay off that obligation, after getting married in San Francisco where his wife was, and they spent a year apart because he had made that commitment. So, he had a personal anecdote that also argued in favor of doing loans rather than scholarships, because it is not ideal. It has worked. It's no longer being funded, and we would rather move in the direction of scholarships.
MS. CASPER: This is Julie Casper, and I would echo everything Dave said. For years we always thought it was more productive to fund loan repayment, once physicians had decided on their specialty choice, instead of scholarships, but we also -- because of the resistance to that and because of some students not going at all because of the cost of medical student education, we strongly, strongly counsel those that apply about the penalties involved, and rarely -- when there was funding -- if at all, we take a first-year medical student, because we didn't feel like they had enough knowledge to even know what decision would be the right one. So almost to their benefit, we would defer them for a year to give them a chance to think about it. I do have some that default, but the vast, vast majority of them don't, and it's considered a successful program.

DR. VEGA: I'm a graduate and recipient of this also, and I agree that the scholarship program is an excellent program.

CO-CHAIRPERSON McCURDY: Are we ready to vote?
All in favor, please say "aye".

("Ayes" heard)

CO-CHAIRPERSON McCURDY: Opposed?
(No response)
CO-CHAIRPERSON McCURDY: Abstentions?

(No response)

CO-CHAIRPERSON McCURDY: Then the "ayes" have it, and this one also is forwarded to the Joint Commission on Administrative Rules.

And at this point, I think that concludes the Rules Committee Report, unless somebody has anything else to add. And it is about one o'clock, but we can certainly take a couple minutes for a legislative update, I would say, Dave.

MR. CARVALHO: I will be very quick, and right now I will be telling you what has passed the Legislature. At the next meeting I'll tell you what the Governor actually signed. So, I'll give you highlights, so if there is more that you want about any particular one, just contact me.

Three things that stalled, by the way, were medical marijuana, hospital licensing fees, and improving our pool inspection regimen. Those just ran into a buzz saw. But the things that -- and then the other thing that is a good thing that stalled was the exemption for gaming under the Smoke Free Illinois Act. That stalled in the Senate.

So, some of the things that passed that are on
the Governor's desk, subject to appropriation, a bill --

Senate Bill 1945 to create a comprehensive healthcare work
force council to look at the whole issue of developing a
plan for developing a healthcare work force. That is
subject to appropriation. We estimated it would cost $1.7
million over five years to implement. So, that may be a
theoretical bill.

The bill to use the National Health
Surveillance Network for multiple drug resistant organism
reporting passed and is on the way to the Governor. The
bill to allow us to collect names and addresses and last
four digits of Social Security numbers in our hospital
discharge data passed, Senate Bill 1282. That's very good.
We'll be able to do a lot of interesting things with those
data now.

Senate Bill 840, a very contentious bill about
sort of de facto deregulating the cottage food industry and
prohibiting the Department of Public Health and local
Departments of Public Health from regulating farmers'
markets and things like that was modified in ways that we
found ultimately acceptable, if not ideal, but there was
intense efforts to basically deregulate food sold in
farmers' markets, and we reached a compromise that we can
live with.
The reform bill last year, Senate Bill 326 on nursing homes, carved out what we call MR/DD's, which are homes for what historically has been called MR, mentally retarded, and DD, developmentally disabled. By the way, there's another bill that changed "MR" to "intellectually disabled", so we won't be calling "MR" "MR" anymore. But the same kind of reforms that was done for nursing homes was extended to MR/DD's under Senate Bill 145. A couple that you would be interested in, there was a resolution asking the SHIP Implementation Committee to develop a State policy agenda. That was promoted by Richard Sewell, actually a former member of this Board. So, maybe there will be a way to integrate that with your own efforts on State policy agenda, and especially if we can work through Richard Sewell and his effort on SHIP implementation.

There was a bill, House Bill 3134, on advance directives, updating it to bring it consistent to the Physician Order for Life-Sustaining Treatment, and that was passed. Your Chairman had asked me about that in particular, and it was passed, on the way to the Governor's desk. A bill to admonish doctors to include MRSA on the death certificate, if MRSA was an appropriate thing to include on the death certificate, is on the way to the Governor's desk. And then, finally, our bill, House Bill
3155, which was a clean-up bill to eliminate the six or
seven issues that our audit findings have always included
over the last several years. So the Auditor General comes
in and says, "You're not inspecting thus and such within
the timeline of the statute", and our response to the
Auditor General is, "The timeline is unrealistic", and the
Auditor General says, "Well, go get it fixed." So, those
kind of findings we put all in one bill and it got passed.

So, that is my report.

CO-CHAIRPERSON McCURDY: Okay. Thank you,
Dave.

Any questions, comments as we conclude?

I will just add by way of a reenforcement of a
notice you already received, and that is the broad
invitation to the Health and All Policies Symposium at the
end of June, I think June 28th, for half a day. If you
aren't familiar with that, you can certainly see me, but it
came from Alissa Bassler at the Public Health Institute and
then Leticia Reyes also forwarded it to, I'm guessing,
everybody on the Board.

So, move to adjourn?

DR. FORYS: Motion to adjourn.

CO-CHAIRPERSON McCURDY: Second?

DR. EVANS: Second.
CO-CHAIRPERSON McCURDY: All in favor say "aye".

("Ayes" heard)

CO-CHAIRPERSON McCURDY: And the mission is accomplished. Thank you, everybody, and thank you to everyone in Springfield from the Staff who joined in.

END TIME: 1:10 p.m.
CERTIFICATE OF REPORTER

I, KAREN K. KEIM, CRR, RPR, a Certified Court Reporter in the State of Illinois and the State of Missouri, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness 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 deposition 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 the action.

KAREN K. KEIM
CRR, RPR, CSR-IL, CCR-MO
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