The Public Interest Law Reporter (PILR) is an innovative legal publication that focuses on reporting the most current legal topics in a news format directed to students, educators and practitioners. PILR is edited and produced by Loyola students and is housed within the Center for Public Service Law. Founded in 1995, PILR offers feature articles and news of legal developments in the areas of human rights, economic justice, criminal justice, the environment, and governance. In addition to an editorial staff selected through a write-on process, Loyola law students direct all aspects of PILR’s research, writing, graphics, production and business management.

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HONORING A COMMON HUMANITY: MAXIMS FOR ACHIEVING SOCIAL JUSTICE

SCHWEITZER LEADERSHIP AWARD*

Acceptance Remarks of PROFESSOR EMILY A. BENFER†

OUR COMMON HUMANITY*

Zimbabwe

The first time I became intimately aware of the common humanity that pulses through all of us was as a Peace Corps volunteer. My first post was
in Mashaba, a small community in Zimbabwe on the boarder of Botswana. It was named for the red soil on the ground that seemed to reflect the flaming sky above.

At the time of my service, over 1 in 3 people in Zimbabwe were infected with HIV/AIDS. To this day, Zimbabwe has one of the highest rates of AIDS orphans in the world.

I was the first non-Zimbabwean to visit the village. Many thought a ghost or an angel had taken up residence. My assignment was to teach sustainable farming practices but the people to call upon me the most were dying of AIDS.

I would sit on a stool or on the clay floor of a hut next to a straw bed and listen. I listened to the women and men – some as young as fourteen and others aged by illness – who spoke or mumbled or cried in the lyrical clicks of a language I didn’t understand. Perhaps they were confessing, perhaps they were asking for help, perhaps they were surrendering to death, or maybe they only wanted company in the final journey. I will never know and I never asked.

But as I took each outstretched hand, a collection of fragile bones, in my own, I was deeply affected by our common experience and the traditions of life and death that were universal.

**Thailand**

I experienced similar truths as a volunteer in Thailand. There, I found the soft, small hand of a nine year-old little girl in mine. Though we couldn’t communicate with words, Mue became a fast friend.

At first, she extended the offer of friendship through timid smiles and gifts. She brought me bunches of bananas, hard-shelled bugs, and flowers freshly ripped from the ground. Then, she brought me books, as many books as she could fit between her outstretched hands and chin. She was determined to teach me Thai and, every day, read to me from her school books.

Eventually, my 9-year-old teacher succeeded and I did learn to speak Mue’s language. But, even before language and without a common culture, I under-
stood her clearly from the very beginning. Every time she looked at me, I saw with perfect clarity the brilliant and pure love of a child.

In these most foreign of environments, sitting on a stool under the red African sky or surrounded by rice fields in Thailand, the humanity within each of us was unmistakable. Illness and fear and death, hope and laughter and love are truths of the human experience. In this way, I came to deeply understand our interconnectedness and the ties that bridge us from the very beginning.

Once we become aware of the common humanity pulsing through all human beings, in Dr. Schweitzer’s words, “[we] feel[ ] compelled to approach all life with the same reverence [we] have for [our] own.” As a result, “all life becomes an integral part of our own experience.” This means we take up the suffering, the disparities, the inequality faced by people as though our own. We recognize the individual life captured by a statistic, presented in a case or sitting before us in an exam room.

**Responsibility To Other Human Beings**

For me, like all of you, this awareness means I could not ignore the dark and heavy shadows of injustice or inequality cast over humanity.

I could not stand by while infants and children slept in cars and under freeways, risking their lives to the elements.

I cannot ignore the 1.9 million people – each an individual - in Illinois who live in poverty and suffer the devastating consequences of the social determinants of health on a daily basis.

This means that the 15.9 million children who are at risk of malnutrition in the United States and the 1 in 4 children in Illinois who have lead poisoning are each a child of mine.

Ultimately, the quality of society and our shared future depends upon this recognition and response to the integral nature of all of our experiences.
But I could not and have not and – if I can help it – will never go it alone. In fact, this award is truly shared by hundreds of individuals, each offering a unique contribution.

The Health Justice Project would not be possible without the leadership of physicians like Dr. Peter Mayock or Dr. David Buchanan of Erie Family Health Center or the unparalleled support of Loyola University Chicago School of Law and the Beazley Institute for Health Law and Policy, especially Dean David Yellen and Professor Larry Singer. It wouldn’t be possible without the tireless and innovative work of our Rodin Clinical Teaching Fellow and Supervising Attorney, Allyson Gold. These champions of health justice understand the value of interprofessional teamwork and clinical education and the importance of preparing students to become stewards of society.

One hundred and twenty-four students of law, social work, public health and medicine, 104 medical professionals at Erie Family Health Center and our partners at AIDS Legal Council of Chicago, Lawyers Committee for Better Housing, Equip for Equality and the National Immigrant Justice Center work tirelessly to overcome the social determinants of health for the patients of Erie Family Health Center.

The majority of these patients are Hispanic or Latino and living below the poverty line. These children, adults, elderly, and caregivers confront injustice on a daily basis. Statistically, they have 1 to 3 unmet, civil legal needs per household.

Together, we have addressed the root causes of poor health for nearly 1400 low-income people and their families in Chicago. We remove the conditions – such as infestations and mold – that cause respiratory distress. We compel the renovation of lead paint or the rapid transfer to safe housing. We address barriers to health related to public benefit denials and income and immigration status. We provide resources and educate patients about their rights.

With Loyola University Chicago Stritch School of Medicine and public health program, we train future health leaders to evaluate the underlying structures and policies thwarting progress. The students think critically about the causes
of social determinants of health and contribute to public policy that will advance health justice.

We do this because we recognize that social justice and social equity require the provision of health. Health is essential to our well-being and overcoming the effects of disadvantage. Without it, we cannot accomplish what we see as our responsibility and agency to do. We cannot access opportunity or realize our fullest potential. Every human being should have that chance.

Maxims

Standing here, in Jane Addams Hull House, where a community of immigrants from diverse backgrounds and experiences came together under the common ties of humanity, where the residents advocated for legislative reform on child labor, women’s suffrage, healthcare and immigration policy, where the roots of what we know as social welfare today grew and blossomed, I would like to carry forward that tradition of reform and offer a few maxims to help us realize the ideal world we envision. I learned most of these from my teacher, mentor and dear friend, Florence Wagman Roisman.

First, in your work, pay attention to themes and patterns and commit to making structural remedies. To most effectively address one patient’s needs, we must address the elements common to many. For example, patients experiencing respiratory distress, or dermatitis due to bug bites, or developmental delay due to elevated blood lead levels may all be affected by substandard housing conditions. In these situations, advocacy for healthy homes will result in lasting health and create change that treats the illness, not the symptoms. How can we throw away the “Band-Aids” and make it less likely that the same kind of problem will arise for other people?

Second, educate! Tell your stories. Tell your patients’ stories. Do not assume that other people have seen what you see or know what you know. Educate your family. Educate your friends. Write letters to the editor. Use digital media. Sometimes the consequence of poverty and inequality, especially when coupled with poor health, is becoming invisible and voiceless. Educate so that you might ensure others are heard when they can’t speak for themselves.

Third, vehemently reject the status quo. If it is “reasonable” is to cut 8 billion dollars from the food stamp program and to deny people other basic human
necessities, then it is time for us to be unreasonable. As Professor Roisman taught me, it is time for us to think outside the box by checking off “none of the above.”27 The current state of affairs must be unacceptable and we must not be complacent.

Fourth, believe in the next generation of change makers28 – people like Rachelle Sico and Elisa Pleasant to whom I am most grateful for their comments and who set an extraordinary example through their outstanding efforts to improve health. Young people are critical to social change. Their idealism is inspired and focused on imagining a new world. They are capable of achieving great things, as demonstrated by our very own Schweitzer Fellows. It is incumbent upon all of us to train the students and fellows to apply their visionary and leadership capacity to achieving a future free of disadvantage, health inequity and social injustice. Let us embolden them with our support and mentorship.

Fifth, celebrate the victories and the people who make them possible. We are all indebted to the people who believe in us, who encourage us, who give us the support we need to do this important health justice work. For me, I am grateful to my supportive husband and family who encourage me to look beyond obstacles and dream even bigger and to my 17-month-old son who inspires me to make this world a more just and peaceful place.

Sixth, always remember that your contribution matters. In Gandhi’s words, “Almost everything you do will seem insignificant, but it is important that you do it. We must be the change we wish to see.”29

Seventh, “take the long view.”30 In his book, Arguing About Slavery, William Lee Miller wrote “for slavery to be ended there had to be some individual human beings who did what they did . . . There were some people – a very small number, on the margin of society, condemned and harassed – who nevertheless made it the first order of their life’s business to oppose American slavery, and to insist that it was a grotesque evil that should be eliminated, and . . . in a little over thirty years, it was.”31

In the same way these words apply to ending slavery and segregation, they apply to ending poverty and health disparities in the United States today. If individual human beings commit to their elimination, it will be. It may not be
today or tomorrow, but it will be. As Dr. Martin Luther King said, “the arc of the moral universe is long but it bends toward justice.”

Eighth, work together. We will be more successful if we break down silos and draw upon our collective knowledge and experiences to respond to the health disparities plaguing our society and affecting our patients and clients in dangerous ways. In the same way we are tied to each other, we need each other in order to protect humanity and guarantee its future. Everyone in this room has something to contribute. It is up to us to find out what that is and to support one another in our quest for health justice.

Ninth, believe that change is possible. Tap into your youthful idealism. Set your eyes on the prize and believe. No matter what they tell you, no matter how high the barrier before you, believe. And then get to it!

Finally, wherever you are – on the floor of a mud hut, surrounded by Thai books, or on the city streets of Chicago – honor the spark of divinity in every human being, including you. When you see people in despair and learn of the sobering statistics, the stories of poverty and illness and the people swept into the shadows, recall that all life is an integral part of your experience. Every time we appreciate and value the humanity in another by standing up and stepping in, we fan that spark, increasing its glow.

Imagine. If we add these glowing sparks together, the brilliant light will most certainly cast out the shadows of the world.

Thank you.

*Emily Benfer received the inaugural Albert Schweitzer Leadership Award on February 27, 2014 at the Jane Adams Hull House in Chicago Illinois after a year long nomination and selection process. The award honors an individual who has done significant work to mitigate the social determinants of health in their community, and whose commitment to service has influenced and inspired others. Professor Benfer received the award for her work as the founder and director of the Health Justice Project clinic and the important strides she and her students have made in improving the health of low-income individuals and families in Chicago. Professor Benfer was nominated for the award by a former student, Elisa Pleasant.*
Emily A. Benfer is a Clinical Professor of Law and the founder and director of the Health Justice Project, a medical-legal partnership clinic, at Loyola University Chicago School of Law.

*Prior to speech the audience was addressed: “Thank you. I am deeply humbled by this incredible honor. To be recognized in this way by Health and Medicine Policy Research Group, the Chicago Schweitzer Fellows Program, my students and this community of incredibly smart, dedicated, experienced, creative individuals is overwhelming and profoundly meaningful to me. I revere Albert Schweitzer, not only for his work and life of effective service and constant action, but also for his commitment to honoring the “spark of divinity” in every human being. Ultimately, I believe it is recognition of and respect for that spark — our humanity — that is at the root of all justice work and necessary for the achievement of health justice.” When referring to the spark of divinity, I am describing Albert Schweitzer’s philosophy of the “Reverence for Life.” ALBERT SCHWEITZER, ESSENTIAL WRITINGS (2005). This phrase also describes a central tenet of Quaker belief that every human being possesses a “divine spark” or “inner light.” SCOTT LIELE, 46 PAGES: THOMAS PAINE, COMMON SENSE, AND THE TURNING POINT TO INDEPENDENCE 29 (2004). I first learned of this vivid phrase when Florence Wagman Roisman awarded the 2011 Cushing Niles Dolbeare Lifetime Service Award by the National Low Income Housing Coalition. See Florence Wagman Roisman, A Challenge to Bank of America, Speech presented at the National Low Income Housing Policy Conference during acceptance of the Cushing Niles Dolbeare Award, March 29, 2011 available at http://mckinneylaw.iu.edu/instructors/roisman/A%20Challenge%20to%20Bank%20of%20America%20Florences20Wagman%20Roisman%20March29%202011.pdf.

NOTES


8 For more information about the Health Justice Project, visit http://www.luc.edu/healthjustice.

9 Dr. Peter Mayock, internal medicine doctor at Erie Family Health Center, is a champion of health justice and an active member of the Health Justice Project medical-legal partnership. Erie Family Health Center, Peter Mayock at http://www.riefamilyhealth.org/peter-mayock-md.

10 Dr. David Buchanan, Chief Clinical Officer at Erie Family Health Center, was instrumental in developing the Health Justice Project and the medical-legal partnership between Erie Family Health Center and Loyola University Chicago School of Law. His involvement and support make our success on behalf of patients possible. Erie Family Health Center, David Buchanan, http://www.riefamilyhealth.org/about-erie/leadership-team.

11 Loyola University Chicago School of Law at http://www.luc.edu/law.

12 The Beazley Institute for Health Law and Policy is a nationally recognized center dedicated to the education of health law leaders and policymakers, and to the study and furtherance of the health law field. The Health Justice Project is housed within the Beazley Institute for Health Law and Policy. Beazley Institute for Health Law and Policy at http://www.luc.edu/law/centers/healthlaw/index.html.

13 Loyola University Chicago School of Law, David Yellen at http://www.luc.edu/law/faculty/yellen.shtml.

14 Loyola University Chicago School of Law, Larry Singer at http://www.luc.edu/law/faculty/fulltime/singer.shtml.

15 Loyola University Chicago School of Law, Allyson Gold at http://www.luc.edu/law/faculty/facultyandstaff/department/gold.shtml.

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17 Lawyers Committee for Better Housing protects the right to safe, decent and affordable housing on a non-discriminatory basis and access to such housing for low and moderate income households. See Lawyers Committee for Better Housing at http://www.lcbh.org.


21 Loyola University Chicago Stritch School of Medicine Public Health Policy and Management Program at http://stritch.luc.edu/mph/public-health-policy-health-management.


23 Through her inspired teaching, Professor Roisman fueled my passion for social justice and gave me the skills necessary to effect change. Through her support and mentorship as her student and every day since I left her classroom, I am reminded of the importance of every person’s contribution in the face of injustice. Indiana University Robert H. McKinney School of Law, Florence Wagman Roisman at http://mckinneylaw.iu.edu/faculty-staff/profile.cfm?id=47.

24 This maxim is adapted from Florence Wagman Roisman’s sixth principle of effective advocacy: “Look for structural remedies; try to create change that isn’t just a band-aid but makes it less likely that precisely the same kind of problem will arise for other people.” Florence Wagman Roisman, Thirteen Principles of Effective Advocacy, 63 RUTGERS L. REV. 985, 991.

25 See Roisman, supra note 27 at 995. (“The eleventh principle is: Educate, educate, educate.”)

26 See Roisman, supra note 27 at 992. (“The seventh principle is: Be unreasonable.”)

27 See Roisman, supra note 27 at 993.

28 See Roisman, supra note 27 at 995.


30 See Roisman, supra note 27 at 997. (“The twelfth principle is: Take the long view.”)

31 WILLIAM LEE MILLER, ARGUING ABOUT SLAVERY: THE GREAT BATTLE IN THE UNITED STATES CONGRESS 513 (1996) quoted in Roisman, supra note 27 at 998-999.

32 Dr. Martin Luther King, Jr., Where Do We Go From Here? In JAMES M. WASHINGTON, ED., A TESTAMENT OF HOPE: THE ESSENTIAL WRITINGS AND SPEECHES OF MARTIN LUTHER KING, JR. 252 (1986).
REEVALUATING THE “PHYSICIAN”– REASONABLE COMPENSATION FOR ALLIED HEALTH PROFESSIONALS ADVOCATING ON BEHALF OF THEIR PATIENTS IN ILLINOIS

by RACHELLE SICO

In Illinois, reasonable compensation for health care providers providing testimony as a nonparty witness only applies to “physicians” under Illinois Supreme Court Rule 204(c) (“IL SC R. 204(c)”). Other allied health professionals such as Physical Therapists (PTs), Occupational Therapists (OTs), Speech and Language Therapists (SLTs), Nurses (RNs) and Patient
Care Technicians (PCTs) who also advocate for their patients through third party testimonies do not receive reasonable compensation for the significant impact their contribution has upon their patient’s cases. In light of the Affordable Care Act, the role of allied health professionals is expanding. Many provide more involved levels of patient care, but according to Illinois rules of discovery they are not being justly compensated for their advocacy services. This article will examine the history of IL SC R. 204(c) and the application of the term “physician” in relation to reasonable compensation for allied health professionals that are subpoenaed to provide testimony in a deposition or trial as a non-party witness.

**History Of Illinois Supreme Court Rule 204(c)**

Currently, the IL SC R. 204(c) is regarding “Compelling Appearance of Defendant”. Section (c) carves out a specific exception for “physicians” who testify at a deposition or trial. The rule states the following:

> Depositions of Physicians. The discovery depositions of nonparty physicians being deposed in their professional capacity may be taken only with the agreement of the parties and the subsequent consent of the deponent or under a subpoena issued upon order of court. A party shall pay a reasonable fee to a physician for the time he or she will spend testifying at any such deposition. Unless the physician was retained by a party for the purpose of rendering an opinion at trial, or unless otherwise ordered by the court, the party shall pay the fee at whose instance the deposition is taken.

However, prior to 1985 compensation for testimony provided was defined by *Dixon v. People*, 168 Ill 179, 181 (1897) and it held that standard for 87 years. The Illinois Supreme Court held that a physician called to give expert testimony could not claim extra compensation because of his skill and knowledge. In *Dixon v. People*, Dr. Dixon was called in as an expert witness in a suit requesting damages for a trip and fall case. After appearing pursuant a subpoena, Dr. Dixon was asked questions at trial that asked his professional opinion regarding the proximate cause of the claimed injury to the incident. Dr. Dixon declined to answer until his professional fee was paid. The Illinois Supreme Court stated that “Reasonable expenses are settled by statute at a fixed sum for each day’s actual attendance, and for each mile’s travel from the residence of the witness to the place of the trial and back, without regard to the employment of the witness, or his rank in life [ . . .] Witnesses are not entitled
to special privileges on account of rank or employment." The Court dismissed the argument that Dr. Dixon was entitled to special compensation based on the skill and accumulated knowledge being his professional property that could not be taken without compensation. The objective of Dixon v. People was to instill a public policy warning, where if a physician were allowed extra compensation as an expert witness, then individuals pursuing other occupations that require special experience would have the right to demand extra fees for the presentation of their knowledge.

**Amendments To Illinois Supreme Court Rule 204(c)**

In 1985 and 1989 the Dixon v. People standard changed when the Illinois Supreme Court adopted amendments that allowed for reasonable compensation to physicians. The reasoning behind the change was to regulate the practice of compelling physicians to appear, to be deposed in their professional capacity, and to set guidelines concerning professional fees, which may be paid to physicians and surgeons for attending. Normally, expert witnesses are treated like other witnesses and are entitled to $20 per day and 20 cents per mile of necessary travel. Nonparty physicians and surgeons typically request a professional fee and a statutory witness fee to compensate for the time spent testifying at depositions. The intent of this rule is to regulate this practice and a party may agree to pay a reasonable professional fee to a physician for the time they will spend testifying at any deposition. Timing is an important factor to take into consideration. A fee should only be paid after the physician has testified and it should not exceed any amount, which reasonably reimburses the medical doctor for the time he or she actually spent testifying at deposition. The party that is taking the deposition is responsible for paying the professional fee and other fees and expenses.

**Landmark Case - Defining the Scope of “Physician” in Illinois Supreme Court Rule 204 (c)**

The Montes v. Mai case opened the door for further interpretation of who can be determined to fit the definition of “physician” under IL SC R. 204(c). In Montes v. Mai, Dr. Perez, a chiropractor, was subpoenaed to testify on behalf of a patient he had treated after a motor vehicle accident. Dr. Perez’s clinic submitted financial records to determine whether $550 was reasonable for his time. The Court disagreed and ruled that an hourly fee of $66.95 was rea-
reasonable, with no minimum payment or prepayment. Dr. Perez appealed this decision.\textsuperscript{23} The Court held that Dr. Perez, a chiropractor, was entitled to a reasonable fee pursuant to IL SC R. 204(c) governing the discovery depositions of nonparty physicians.\textsuperscript{24} The Court also held that the trial court’s decision that $66.95 was a reasonable fee, was not an abuse of their discretion.\textsuperscript{25} The Court’s reasoning hinged on the analysis that there was no Illinois case defining “physician” as the term used in Rule 204(c).\textsuperscript{26}

The Court’s interpretation of IL SC R. 204(c) involves the application of the same standards used in statutory interpretation.\textsuperscript{27} Therefore, the Court determined that words utilized by the Illinois Supreme Court should be given their plain, ordinary and popularly understood meanings.\textsuperscript{28} The Court turned to three different sources to aid in their interpretation of “physician” within IL SC R. 204(c).\textsuperscript{29} Firstly, Webster’s Dictionary states that a physician is “a person skilled in the art of healing: one duly authorized to treat disease: a doctor of medicine.”\textsuperscript{30} Secondly, Black’s Legal Dictionary states that a physician is “a practitioner of medicine; a person duly authorized or licensed to treat diseases; one lawfully engaged in the practice of medicine.”\textsuperscript{31} Lastly, the Court applied People ex rel. Gage v. Siman where the term “physician” applied to one versed in or practicing the art of medicine, and not limited to the disciples of any particular school.\textsuperscript{32} The primary example the Court referred to was that a Doctor of Osteopathy does not use medicine or operate on patients, but they are included as “physicians” under IL SC R. 204(c).\textsuperscript{33} Therefore, the Montes v. Mai standard applied the term “physician” as encompassing the treating chiropractor and therefore, he was entitled to a reasonable fee for time spent in a discovery deposition for the case in which he was nonparty witness.

**Statutory Application of the Term “Physician”**

Examination of the various statutory authorities that regulate the health care profession demonstrate that a “physician” is most commonly defined as a person licensed under the Medical Practice Act of 1987 to practice medicine in all of its branches or a chiropractic physician, which is an individual licensed to treat human ailments without drugs or operative surgery.\textsuperscript{34} Within the Illinois Medical Practice Act, case law is referenced in the footnotes that shed further insight into the extent needed to label an individual as a “physician.”\textsuperscript{35} Precedent Illinois case law has held that the term physician is bestowed upon an individual who is versed in or practicing the art of medicine, and it is not
limited to the disciples of any one school and anyone whose occupation is the
treatment of disease for the purpose of curing a patient.\textsuperscript{36} Comparably, the
Illinois Hospital Licensing Act maintains that a “physician” is an individual
licensed to practice medicine in all of its branches, pursuant to the Illinois
Medical Practice Act definition.\textsuperscript{37} However, the Patient Safety and Quality
Improvement Act lacks the definition of the term “physician” all together.\textsuperscript{38}
Instead the term “provider” is used to broadly indicate an individual or entity
that is licensed or authorized under the state to provide health care services.\textsuperscript{39}

\textbf{The Impact of Maintaining Compliance with Illinois Supreme
Court Rule 204 (c)}

Maintaining compliance with IL SC R. 204(c) is placed on the resources of
hospitals or health systems that employ the health professionals that provide
care to the patients undergoing legal action.\textsuperscript{40} Commonly, it is the General
Counsel’s office that prepares MDs, DOs, PTs, OTs, SLTs, RNs and PCTs for
a deposition or testimony in response to a subpoena from a patient’s attorney.
\textsuperscript{41} Subpoenas requiring providers to testify is common practice for a hospital or
health system and although the court takes into consideration scheduling pri-
orities, nevertheless the provider is still taking time away from providing health
care and patient treatments which can place a strain on the hospital or health
system.\textsuperscript{42} After further discussion with the General Counsel of a rehabilitation
medical center, it was discovered that in actual practice the fee letters describ-
ing both allied health professionals and medical doctors’ wages are sent to the
court and both have been honored at reasonable rates in Illinois.\textsuperscript{43}

\textbf{Conclusion}

The 1985 and 1989 amendments to IL SC R. 204(c) created a new standard
that for the first time set physicians apart from witnesses in every other profes-
sion and employment because they have the ability to obtain a reasonable fee
for their testimonial services. But the question remains, what sets “physicians”
apart? The rule fails to adequately define what training, licensure and creden-
tialing a “physician” requires or provides guidelines regarding what constitutes
a “reasonable fee.” At the most basic level of analysis, the term “physician” is
not defined under IL SC R. 204(c). The Illinois Medical Practice Act does not
help clarify this point, as evidence by the vague standard for physicians to
“practice medicine in all branches;” while also including chiropractors as “physicians” even though their practice is limited in scope, widely considered a form of complementary and alternative medicine, and treatment occurs “without drugs or operative surgery.”

The role of the medical profession has come to include broader responsibilities for allied health care professionals and it is recommended that both state and federal standards reevaluate the scope of the term “physician.” As evidence by closer examination of IL SC R. 204 (c), the law has failed to be consistent in the application of the term “physician.” An allied health professional’s testimony can significantly affect the way the patient’s case is viewed by the Court because many are intimately aware of the patient’s medical treatments and are responsible for the patient’s overall care. Allied health professionals play a large role in providing primary care, monitoring patient treatments, and charting the progress of the patient’s health on a daily basis. In actual practice, both allied health professionals and medical doctors are being honored with reasonable rates for their advocacy; however, the Illinois Supreme Court rule has yet to change the law to reflect this important consideration, which may lead to detrimental effects with the ever-expanding changes in health reform under the Affordable Care Act.

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NOTES

1 ILL. SUPP. CT. R. 204(c) (Current with amendments received through 2/1/2014).
2 Id.
4 ILL. SUPP. CT. R. 204(c) (Current with amendments received through 2/1/2014).
5 Id.
6 Dixon v. People, 168 Ill 179, 181 (1897).
7 Id. at 179.
8 Id. at 181.
9 Id.
10 Id.

Id. at 426.

Id.

Id. at 431.

Id.

Id. at 427.

Id.

Id.

Id.

Id.

People ex rel. Gage v. Siman, 278 Ill. 256, 257 (1917).

Montes v. Mai, 398 Ill.App.3d at 427.


Id.

People ex rel. Gage v. Siman, 278 Ill. At 257.

Illinois Hospital Licensing Act, 210 ILL. COMP. STAT. 85/10.7 (Current through P.A. 98-628 of the 2014 Reg. Sess.).


Id. (including physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, psychologist, certified social worker, registered dietitian or nutrition professional, physical or occupational therapist, pharmacist, or other individual health care practitioners).

Interview by Rachelle Sico with Attorney*, General Counsel at a Chicago-based Hospital (February 2014) (name withheld for privacy).

Id.

Id.

Id.


KAISER COMM. ON MEDICAID AND THE UNINSURED, supra note 3 at 3.
HOME ALONE: ALLOWING HEALTH CARE TO WORK FOR UNACCOMPANIED MINORS

by GRAHAM BOWMAN

INTRODUCTION

An estimated 10,000 children in Illinois do not have the luxury of waiting until they turn eighteen before needing to become an adult.¹ Many are forced to leave home as young teenagers, where they must begin what is an already daunting process for most young people—building a life for themselves. Take away the support and guidance that a parent or guardian can offer and it should come as no surprise then that many of these minors become homeless—jumping around between various shelters and friends’ houses as they attempt to finish high school or merely stay afloat.²
Unaccompanied minors face greater risks while away from home and experience adverse health effects at greater rates than other minors. Unfortunately, Illinois law does not allow minors to access basic health care services without a parent or guardian’s consent, which many unaccompanied minors cannot obtain.

The Chicago Coalition for the Homeless (CCH) developed legislation in the Illinois General Assembly this spring that would remove the parental consent barrier for unaccompanied minors and enable these vulnerable young people to access basic preventative health care for the first time. The bill, HB4501, was introduced by Representative Greg Harris and Senator Heather Steans and passed unanimously out of both houses on May 21, 2014. The bill is currently waiting to be signed into law by Governor Quinn.

**HB4501: Expanding Access to Care for Unaccompanied Minors**

HB4501 would amend the Illinois Minors Consent to Medical Procedures Act to allow minors 14 and older who are “living separate and apart from a parent or legal guardian” and who are also “managing their own affairs” to consent to outpatient, non-invasive medical procedures. The minor must also be identified in writing as an unaccompanied minor by certain professionals that work with homeless youth, such as a social worker or school homelessness liaison, or by an adult relative. Minors involved with the foster care system are excluded from this definition.

**Who Are Unaccompanied Minors?**

The Chicago Coalition for the Homeless estimates there are around 10,000 homeless youth in Illinois, based on a 2005 study. Young people usually leave home due to extreme family dysfunction, rather than a youthful impulse to go it alone. Many times, they leave in order to escape physical or emotional abuse, conflicts caused by a parent or guardian’s substance abuse, or family conflict over the young person’s emerging sexual identity. In some cases, the minor did not choose to leave at all, but were “locked out” or “thrown away” by their parent or guardian.
Once out of the house, unaccompanied minors typically have very unstable living situations and usually stay with an assortment of friends and relatives for brief periods of time. Some end up on the street. Eventually, as much as 53% of unaccompanied minors end up in the foster care system.

However, most minors nearing adulthood do not enter the foster care system. According to Julie Dworkin, the Director of Policy at the Chicago Coalition for the Homeless, “The Department of Children and Family Services is reluctant to open a case for a youth who is over age 16.” Instead, some unaccompanied minors in Illinois are identified by a Comprehensive Community Based Youth Services agency (CCBYS), which will attempt to re-unify the minor with their parents or guardian and place them in a temporary shelter in the meantime.

Some of the organizations that provide shelter for these CCBYS-involved minors employ health care providers that cannot serve the youth under their care. For example, Teen Living Programs (TLP) in Chicago employs a Nurse Practitioner, Telva Urban. Ms. Urban testified at the House Judiciary Committee hearing on HB4501, explaining that “[TLP has] numerous situations where a young person did not even have contact information for their guardian due to the guardian moving or being evicted and not contacting the client. In those cases, I am unable to give a client Benadryl for a mild allergic rash.”

**What Health Care Services Can Unaccompanied Minors Access?**

According to the Illinois Supreme Court, “although the age of majority in Illinois is 18, that age is not an impenetrable barrier that magically precludes a minor from possessing and exercising certain rights normally associated with adulthood.” Unaccompanied minors in Illinois can consent to some health care services without a parent or guardian’s involvement, but not the majority of preventative care or treatments for simple ailments such as those described by Ms. Urban.

Any minor who is pregnant, parenting, or married has the same right to consent to health care services as an adult. This means that they have essentially unfettered access to all health care services and do not need a parent to provide consent on their behalf. One notable exception to this rule is the Parental
Notice of Abortion Act of 1995, which requires minors to notify a parent or guardian when they choose to get an abortion.  

Minors that do not fit into one of these categories can still consent to certain health care procedures without a parent or guardian’s consent. However, the scope of services available to them is severely limited. With some restrictions, minors can consent to emergency services, some mental health services, some services related to parental abuse, and treatment for sexual health issues.

Emancipated Mature Minors

Minors can gain the ability to consent to any healthcare service if they are determined to be a “mature minor” in Juvenile Court. The Illinois Supreme Court recognized in In re E.G., a Minor, 133 Ill. 2d 98 (1989) that although a parent or guardian is typically required to provide consent on behalf of their child, some minors are of sufficient maturity and capacity to make independent decisions regarding their health care.

However, the procedure for being determined to be a “mature minor” is not easy and would likely require legal representation. The Illinois Emancipation of Minors Act allows a minor over the age of 16 “who has demonstrated the ability and capacity to manage his own affairs and to live wholly or partially independent of his parents or guardian” to be either fully or partially emancipated from their parents and therefore gain the ability to consent to all health care services.

In In re E.G, the Illinois Supreme Court noted that a court is only required to determine a child’s maturity for the purpose of consenting to health care when the legislature has not addressed the issue for itself. HB4501 seeks to do just that. By defining the circumstances in which a minor has the capacity to consent to basic health care services, HB4501 would allow unaccompanied minors to bypass going to court and access care immediately.

Conclusion

HB4501 would significantly expand access to preventative health care services for a vulnerable population that is statistically more likely to have health
problems than their housed counterparts. It would accomplish this goal by removing both a practical and legal barrier to receiving treatment—the requirement to either obtain the consent from an absent parent or guardian, or become at least partially emancipated in a judicial proceeding. If passed, Illinois would become the 17th state in the United States to give unaccompanied minors the ability to access basic health care services, and, in doing so, allow those youth to remain healthy and continue on their difficult and prematurely begun journey towards self-sufficiency.

NOTES

2 “Street youth often spend significant amounts of time in adult caregivers’ homes, shelters, and temporary quarters with friends or other family (Greenblatt & Robertson, 1993).” Paul A. Toro, PhD, Amy Dworsky, PhD, and Patrick J. Fowler, MA, Homeless Youth in the United States: Recent Research Findings and Intervention Approaches (March 2007), available at http://aspe.hhs.gov/hsp/homelessness/symposium07/toro/#Family
6 Id.
7 Id.
8 Id.
9 Johnson, supra note 1.
10 Toro, supra note 2; Johnson, supra note 1 at 32
11 “Youth consistently identify conflict with their parents as the primary reason for their homelessness (Whitbeck et al., 2002; Robertson & Toro, 1999), and they tend to report more family conflict than their peers who are housed (Toro & Goldstein, 2000; Wolfe, Toro, & McCaskill, 1999). These conflicts end to reflect longstanding patterns rather than problems that arise just before youth leave home (Smollar, 1999). Conflicts related to step-parent relationships, sexual activity, pregnancy, sexual orientation, school problems, and alcohol or drug use seem to be the most common (Owen et al., 1998; Robertson & Toro, 1999; Whitbeck & Hoyt, 1999).” Toro, supra note 2.
12 Id.
13 Toro, supra note 2.
14 Id.
15 Interview with Julie Dworkin, Chicago Coalition for the Homeless Director of Policy, to Graham Bowman (April 4, 2014).
17 In re E. G., a Minor, 133 Ill. 2d 98, 107 (1989).
18 410 ILCS 210.
19 410 ILCS 210/1.
20 750 ILCS 70/1.
21 410 ILCS 210/3(a)-(b).
22 410 ILCS 210/3(a)-(b); 405 ILCS 5; 325 ILCS 10; 750 ILCS 70; 325 ILCS 10; 410 ILCS 305/9; 405 ILCS 5/3-501(a); 405 ILCS 5/3-502.
23 In re E. G., a Minor, supra note 17, at 107.
24 750 ILCS 30.
25 750 ILCS 30/3-2.
26 “The trial judge must determine whether a minor is mature enough to make health care choices on her own. An exception to this, of course, is if the legislature has provided otherwise, as in the Consent by Minors to Medical Operations Act (Ill. Rev. Stat. 1987, ch. 111, par. 4501 et seq.)” In re E. G., a Minor, supra note 17 at 111.
27 Id.
28 U.S DEPARTMENT OF HUMAN SERVICES, supra note 3.
30 Other States with similar laws include: Alaska; California; Colorado; Hawaii; Indiana; Kansas; Maine; Maryland; Massachusetts; Minnesota; Montana; Nevada; New Mexico; Oklahoma; Texas; Wyoming. See NATIONAL DISTRICT ATTORNEYS ASSOCIATION, “Minor Consent to Medical Treatment Laws” (January 2013), available at http://www.ndaa.org/pdf/Minor%20Consent%20to%20Medical%20Treatment%20(2).pdf.
SOMEWHERE TO GO: PROTECTING FAMILIES FACING MENTAL ILLNESS THROUGH HEALTHCARE REFORM AND THE MEDICAL-LEGAL PARTNERSHIP MODEL

by AMANDA M. WALSH

INTRODUCTION

On January 26, 2014, CBS’ 60 Minutes ran a special on youth mental health titled *Nowhere to Go: Mentally Ill Youth in Crisis*. The special described many families’ inabilities to access and maintain adequate mental
health treatment for their children.\textsuperscript{2} Specifically, the episode addressed how many families are forced to allow their children to become wards of the state just to access treatment.\textsuperscript{3} Although the public reaction to recent mass violence inspired this TV special,\textsuperscript{4} these problems have existed for much longer.

In fact, the child welfare involvement of children living with mental illness solely to access mental health treatment has been an ongoing problem for decades.\textsuperscript{5} Additionally, parents living with mental illness also become entangled with the child welfare system.\textsuperscript{6} One major problem that has led these families to involvement with the child welfare system and face disruption of their family unit is the inability for the child welfare and mental health systems to work together.\textsuperscript{7} However, with the implementation of the Affordable Care Act\textsuperscript{8} and the Mental Health Parity and Addiction Equity Act\textsuperscript{9}, which address systemic barriers, now is the time to develop an effective and collaborative model for these vulnerable families. One such model is the Medical-Legal Partnership Model.

\textbf{System Involvement of Families Facing Mental Illness}

An estimated fifteen million children in the U.S. suffer from a major psychiatric illness, such as bipolar disorder, schizophrenia, and major depression.\textsuperscript{10} Unfortunately, less than 20\% of these youth receive mental health services.\textsuperscript{11} When youth are unable to access mental health services, they can experience delays of eight to ten years between the onset of symptoms and treatment.\textsuperscript{12} Attempting to bypass these waits, many families are advised to enter their child into the child welfare or juvenile justice systems to access state-provided services.\textsuperscript{13} Although no formal tracking system exists, a 2004 Congressional report determined that 3,700 children were placed into the child welfare system in fiscal year 2001 solely to access mental health treatment.\textsuperscript{14}

Parents are also struggling with mental illness and accessing treatment.\textsuperscript{15} For adults, it is estimated that one quarter are living with a diagnosable mental illness.\textsuperscript{16} One study found that “of the individuals who met the criteria for having a serious or persistent mental illness, 65\% of them were mothers and 52\% were fathers.”\textsuperscript{17} For these adults, only 29-65\% are able to access treatment, depending on their level of impairment.\textsuperscript{18} In another study, “nearly 50\% of people with an unmet need for mental health care cited cost as a barrier to care.”\textsuperscript{19} These parents interact with the child welfare system through
loss of custody and termination of parental rights proceedings.\textsuperscript{20} “Approximately three quarters of states specifically include mental illness as a ground for termination of parental rights where the disability makes a person unable to parent.”\textsuperscript{21}

Although the Adoption and Safe Families Act of 1997 \textsuperscript{22} requires states to make “reasonable efforts” to “preserve and reunify” families, states frequently fail to include adequate mental health or other disability-related services in such efforts.\textsuperscript{23} This failure is usually a result of a lack of collaboration between the child welfare system and the mental health system: “less than half of State Mental Health Authorities (SMHA) reported that they formally identify whether an adult client is a parent; only 27\% of SMHAs reported having specific services or programs designed for their adult clients who are parents.”\textsuperscript{24} This lack of coordination, in part, has led to an adverse effect on parents with mental illness, “with removal rates of children as high as 70 to 80 percent.”\textsuperscript{25}

\textbf{Using Healthcare Reform to Access Mental Health Treatment for Child Welfare-Involving Families Facing Mental Illness}

Families facing mental illness “frequently have substantial health and mental health needs, lack insurance coverage completely . . . or experience gaps in coverage . . ., and find the complex world of health insurance and health care difficult to navigate.”\textsuperscript{26} Key provisions of the Affordable Care Act (ACA) and Mental Health Parity Act can expand mental health coverage for children and parents facing mental illness. Under these Acts, new health plans are required to provide mental health and substance abuse coverage as one of ten essential benefits\textsuperscript{27} with federal parity protections.\textsuperscript{28}

Additionally, states can choose to expand Medicaid to adults living at or below 138\% of the federal poverty line, allowing these “newly-eligible” single, poor adults to access coverage for the first time under Medicaid.\textsuperscript{29} Under these new requirements, an estimated 2.7 million uninsured parents will gain eligibility for Medicaid.\textsuperscript{30} For parents with serious mental illness or other behavioral health disorders, Medicaid expansion will have the greatest impact on their ability to access health coverage and, ultimately, treatment.\textsuperscript{31}

While all children who are child-welfare involved receive Medicaid coverage,\textsuperscript{32} the ACA provisions will provide these children with access to simpler enroll-
ment and better continuity of care when seeking mental health treatment, especially as children from these vulnerable families move between “different relatives and in and out of formal care.”

ENSURING SYSTEM COLLABORATION THROUGH MEDICAL-LEGAL PARTNERSHIPS

Although the ACA and Mental Health Parity Act will provide increased opportunities for mental health care coverage, this does not guarantee system collaboration and family stability. The Medical-Legal Partnership model (MLP) can help to ensure such collaboration and provide services to simultaneously address the mental health and child welfare needs of families.

Through MLPs, attorneys and healthcare professionals “work together to improve the health and wellbeing of vulnerable populations.” One of the core tenets of the MLP is to focus on the social determinants of health, which “are broadly understood to be the set of conditions in which people are born, live, learn, work, play, and age that affect their physical and mental well-being.”

These social determinants can include resources such as income, housing, and education. Currently, many MLPs partner between physical health providers, such as hospitals, and attorneys. Although many of these health providers might also offer behavioral health services, only three of the 261 Health Care Partners participating in MLPs across the U.S. are listed as a mental health clinic or center.

An MLP designed to focus on mental health and partner between attorneys and behavioral health services can provide the continuity of care necessary to assist child welfare-involved families. One example of a MLP using a behavioral health-legal partnership model is BeHeLP, a partnership between Mental Health Advocacy Services, Inc. and Hathaway-Sycamores Child and Family Services in Los Angeles, California. BeHeLP, which was created by Eliza Schafler through an Equal Justice Works postgraduate fellowship, provides holistic legal services to low-income and immigrant families who have children with mental health needs. Schafler states, “Working with mental health professionals has been a great experience. They have a natural understanding the MLP model because their job is to recognize the deeper social issues that affect mental health and well-being.”
representation in child welfare proceedings, such as dependency, Schafler noted that a MLP could be created to incorporate such representation.\(^4\)

Through a similar model to BeHeLP, attorneys and behavioral health providers can ensure that parents and children are accessing treatment and care as a preventative measure to child-welfare involvement through holistic services, such as legal representation in areas including housing and public benefits alongside mental health treatment. If these families still become involved in the child welfare system, this model should offer legal representation to guarantee that reasonable efforts are made to ensure family stability for families facing mental illness.

NOTES

2. Id.
3. Id. (stating “They wanted to discharge my daughter. She needed to stay where she was safe and the insurance company would not pay and so I was told by our social worker in the hospital that if I gave my daughter up to Department of Children and Families, that then she would have insurance coverage through the state and she would be allowed to stay.”)
4. 60 Minutes, supra note 1 (stating that the failure of the mental health system that "came to the fore the murders at Sandy Hook Elementary School.
7. Id.
13 See Sandra P. Thomas, From the Editor—“Beat ‘Em Up, Lock ‘Em Up, Give ‘Em Up”: The Disgraceful Routes to Mental Health Services for American Children, 25 Issues in Mental Health Nursing 335 (2004).
16 Kaplan, supra note 6, at 6.
17 Id.
19 Id.
20 Kaplan, supra note 6, at 6.
23 Mathis, supra note 21, at 518.
24 Kaplan, supra note 6, at 6.
25 Mathis, supra note 21, at 517.
26 Golden & Emam, supra note 15, at 1.
30 Id. at 3.
33  **Golden & Emam, supra** note 15, at 12.
35  *Id.* at 198.
36  *Id.*
38  *Id.* (listing Area Mental Health Center in Kansas, Eskenazi Health Midtown Community Mental Health Center in Indiana, and Woodhull Medical and Mental Health Center in New York).
41  Telephone Interview with Eliza Schafler, Equal Justice Works Fellow, Mental Health Advocacy Services (May 2, 2014).
42  *Id.*
THE ACA’S PREVENTIVE MANDATE: FUNDING PRECEDENT PROGRAM IN RACE TO REACH COMMUNITIES BEFORE ILLNESS

by LACEY ASIA WILLIAMS*

The Patient Protection and Affordable Care Act (“ACA”) signed into law on March 23, 2010, has been notarized for its goal of providing quality and affordable health insurance for all Americans. While the ACA implements a health system to allow individual Americans better access to healthcare, it also promotes public health through its preventative service mandates that work to promote healthy lifestyles of entire communities and to eliminate
health disparities by providing affordable health resources and education through funding allocations to organizations and agencies. Such federal funding allocations are made possible by the ACA’s creation of the Prevention and Public Health Fund (PPHF). Associate Professor of Law at the University of Connecticut School of Law and former Asst. Regional Counsel for the U.S. Department of Health and Human Services, John Aloysius Cogan Jr., stated that the preventative mandate of the PPHF may be the ACA’s most significant public health feature. While public health spending comprises generally less than 5% of the total U.S. health care spending, public health in general is such an important feature to our health care system considering the top three deaths in the United States stem from curable causes: tobacco, obesity and alcohol abuse. Often, the unhealthy choices that are determinants of disease and death in the United States are not lifestyle choices but rather the consequences of the economic and geographic factors that restrict or prevent access to healthy food and safe environment in which to exercise. The public health reform of the ACA through its preventive service mandate is economically beneficial to the individual, to the community, and to the nation at large.

A great working example of the preventative service mandate’s power to affect the individual and the community as a whole is already underway. The funding allocations from the PPHF assist the Center for Disease Control and other agencies in providing data and workable templates so community organizations can implement services that positively affect its underserved populations that stand to benefit from it.

PUBLIC HEALTH REFORM THROUGH GUIDANCE OF THE CDC’S COMMUNITY GUIDE

In 2013, the Center for Disease Control and Prevention (“CDC”) received $254,783,651 from the PPHF to conduct research and use evidence based solutions to proactively implement community-based interventions across the nation. As of the end of the 2013 FY, the CDC has received $2.06 billion dollars in total from the PPHF. Through the ACA’s preventive mandate, a portion of those proceeds has gone to the CDC’s Community Guide. The Community Guide is a credible and vast resource with many uses and addresses questions like, what public health interventions have and have not worked? In which populations and settings has the intervention worked or not worked? Does the intervention lead to any other benefits or harms?
The Community Guide which was created well before the enactment of the ACA\(^9\), is a precedent mechanism of how federally funded research and evidence based recommendations are directly benefiting the community. The Community Guide was an invaluable resource to Blue Cross Blue Shield ("BCBS") in implementing its initiative in Minnesota to reduce adult smoking and exposure to indoor secondhand smoke; increase the percentage of adults who are moderately physically active; and double the number of Minnesotans who eat 5 or more servings of fruits and vegetables a day\(^{10}\). According to the Vice President and Chief Prevention Officer of Blue Cross and Blue Shield of Minnesota, the Community Guide helped to guide the planning and to ensure the strategies of the company were science based\(^{11}\). BCBS’s program has helped more than 100 organizations champion increasing access to healthy foods, design more walkable and bike friendly communities and decreasing smoking and exposure to secondhand smoke\(^{12}\).

The federal allocations of the ACA contribute funds to public health programs that work, as evidenced by the Community Guide which benefits from highly specialized companies like Blue Cross Blue Shield, down to small community organizations that lack both funding and resources to conduct evidence based findings and structure a program to increase local health based on those findings. For groups from both ends of the spectrum and the millions in between, the Community Guide acts as a template for structuring successful, individualized public health programming and activities promoting healthier, smarter lifestyles.

CONCLUSION

Through the collaboration with established agencies, the preventive mandates of the ACA extend its national platform to the financially under-recognized and under-utilized public health resources. Public health reform gains national attention with the preventive mandate that offers a direct impact on communities through the United States. Its multifaceted approach to preventing disease and injury through promoting stronger individuals and communities, propels our health system to think outside of the pharmacy and to incorporate public health reform through education, clinical interventions, health coaching, and behavioral implementations that are reaching those before a curable yet fatal disease does.
Lacy Asia Williams is a law student at Loyola University Chicago School of Law, Class of 2014. She earned her B.A. from Howard University in 2008.

NOTES

2 Vanessa Forsber & Caroline Fichtenberg, The Prevention and Public Health Fund: A Critical Investment in our Nation’s Physical and Fiscal Health, AM. PUB. HEALTH ASS’N (June 2012), http://www.apha.org/advocacy/reports/reports. The Prevention and Public Health Fund is the nation’s first mandatory funding stream for the prevention activities and public health programs. The PPHF is intended to provide a stable and increased investment in activities that will provide communities with the resources to maintain healthy lifestyles.
4 Id. at 359.
6 CTR. FOR DISEASE CONTROL & PREVENTION, FY 2013 Grant Funding Profiles, (May 12, 2014) http://www.cdc.gov/FundingProfiles/FundingProfilesRIA/.
7 U.S. DEP’T OF HUMAN & HEALTH SERVICES, FY 2013 Allocation of PPHF Funds, (May 11, 2014) http://www.hhs.gov/open/recordsandreports/prevention/fy2013-allocation-pphf-funds.html. The CDC is one of six agencies of the United States Department of Health and Human Services (HHS) that has received allocations through the HHS pursuant.
8 THE GUIDE TO COMMUNITY PREVENTIVE SERVICES, What is the Community Guide (October 17, 2013), http://www.thecommunityguide.org/about/index.html. The Community Guide houses the official collection of all Community Preventive Services Task Force’s (“Task Force”) findings and the systematic reviews on which they are based. The Task Force provides evidence-based recommendations on preventive services, programs, and policies for community populations. Their recommendations range from policymakers and practitioners to other decision makers in communities, including organizations, schools, healthcare institutions, and health plans, at the local, state, and federal levels. This task force has evaluated community education programs, behavior change programs, organizational and legislative policies, and health systems interventions.
9 THE GUIDE TO COMMUNITY PREVENTIVE SERVICES, History of the Community Guide (March 29, 2012), http://www.thecommunityguide.org/about/history.html. (“The Community Preventive Services Task Force was established by the U.S. Department of Health and Human Services (DHHS) in 1996 to develop guidance on which community-based health promotion and disease prevention interventions work and which do not work, based on available scientific evidence.”).
11 Id.
12 Id.