CDPHP TF: CHICAGO PUBLIC HEARING

CHRONIC DISEASE TASK FORCE

NOVEMBER 15, 2010

10 O'CLOCK A.M.

160 NORTH LASALLE STREET

SUITE C-500

CHICAGO, ILLINOIS 60601

REPORTED BY: STEVEN J. BRICKEY, CSR

L.A. COURT REPORTERS, LLC -- (312) 419-9292

A P P E A R A N C E S

DR. DAMON T. ARNOLD, Chair
MR. MICHAEL ISAACSON
MR. JOEL AFRICK
MR. DWAYNE MITCHELL

MR. ARNOLD: Okay. Good morning, everyone. Okay. Good morning and welcome to the Chronic Disease Prevention and Health Promotion Task Force of which I, Damon T. Arnold, chair.

I would like to start this session on time as we have much to cover in this public hearing. Before beginning the hearing, I would like to present some housekeeping ground rules for the hearing. Please place all cell phones and pagers onto silent or vibratory mode. Also, take all side conversations outside of this room during all phases of this hearing and during presentations as this will disrupt the progress of the public hearing.

A sign language provider and a Spanish language translator are also available should assistance be required. If you have any specific or special need for assistance, please let one of my staff members know. Additionally, the bathrooms are located in the hallway as indicated on posted signage. Male to the right. Female to the left.

Additionally, the bathrooms are there for your convenience. Please also note the

safety signs located in the hallways should an emergency arise, requiring an emergency response or building evacuation. To begin, chronic disease in the state of Illinois has resulted in a heavy economic and medical resources burden. It resulted in the loss of about $12.5 billion in Illinois during the study period leading to Public Act 096-1073.

However, the chronic disease impact is also evidenced by lost work time and social instability resulting in an additional $43.6 billion lost in Illinois as well during the same time period.

Further, projections for both the short and long-term medical, fiscal situation are dire at best. For example, currently, two-thirds of adults and one-third of children in the United States are overweight. Fifty percent of the adults have a body mass index of 31 or greater with an index of 30 being indicative of obesity. In fact, it is projected that one out of three children born in the year 2000 or after will develop diabetes in their lifetime. They will also average a shorter lifespan than their parents

for the first time in history.

For those of you who know me, I have noted previously over the years that the mouth is a common pathway to the vast majority of chronic diseases. It is the entry point for poor nutrition, alcohol, tobacco in all of its forms, illegal drugs, misapplied prescription drugs, poisons and even infectious diseases.

In order to address chronic diseases within the state of Illinois, the General Assembly through Senate Bill 2583, which was introduced by Senator William Delgado, created Public Act 096-1073.

This act amends Section 5, the Department of Public Health Powers and Duties Law of the Civil Administrative Code Illinois, 20 ILCS 2310/23-76, to create the Chronic Disease Prevention and Health Promotion Task Force. The charge of Public Act 096-1073 is to, one, establish a Chronic Disease Prevention and Health Promotion Task Force, two, hold at least three public hearings throughout the state of Illinois and, three, submit a report of recommendations to the General Assembly and Public Health Director by

the 31st of December 2010.

Consistent with Senate Bill 2583, the Public Act 096-1073, the Chronic Disease Prevention and Health Promotion Task Force consists of a total of 19 members. One, the director of the Department of Public Health who serves as the chair, two, the Public Health Advocate appointed by the Governor, three, the Secretary of the Department of Human Services or his or her designee, four, the Director of Aging or his or her designee, five, the Director of Health Care and Family Services or his or her designee.

In addition, four members of the General Assembly. One from the State Senate appointed by the President of the Senate. One from the State Senate appointed by the Minority Leader of the Senate. One from the House of Representatives appointed by the Speaker of the House and one from the House of Representatives appointed by the Minority Leader of the House.

In addition, there are ten members appointed by the Director of Public Health and who shall be representative of state

associations and advocacy organizations with the primary focus that includes chronic disease prevention, public health delivery, medicine, healthcare and disease management or community health.

The Chronic Disease Prevention and Health Promotion Task Force herein after is referred to as the CDPHP Task Force for documentation purposes. Currently, the CDPHP Task Force includes the following members; one, Dr. Damon Arnold, M.D., M.P.H., Director of the Illinois Public Health and Task Force Chairman, two, Dr. Quentin Young, M.D., the Public Health Advocate, three, Dr. James M. Galloway, M.D., Assistant Surgeon General, Regional Health Administrator for Region V, US Department of Health and Human Services and an alternate of Robert Herskovitz, who is a Deputy Regional Health Administrator, Region V, US DHS. Also, Senator William Delgado, State Representative Elizabeth Coulson, State Representative Cynthia Soto and Michael Jones from the Illinois Department of Healthcare and Family Services and Dr. Lorrie Rickman-Jones, Ph.D., Director of Mental Health

Services, Illinois Department of Human Services, Janice Cichowlas, who is with the Illinois Department on Aging, who is present here. Also, Michael Isaacson, Director of Community Health in Kane County Health Department, who is to my left. Dr. Paul Brandt-Rauf, M.D., Doctor of Public Health, Scientific Doctor, Dean of the University of Illinois School of Public Health, Dr. David Stewart, M.D., M.P.H., Professor and Chairman, Department of Internal Medicine, Southern Illinois University School of Medicine, Miriam Link-Mullison, Administrator Jackson County Health Department, Mr. Joel Africk, who is the President and CEO of the Respiratory Health Association of Metropolitan Chicago, Dr. Robert A.C. Cohen, M.D., Director of Pulmonary and Critical Care Medicine, Cook County Health and Hospital System, Chairman, Division of Pulmonary Medicine and Critical Care, John H. Stroger, Jr. Hospital of Cook County. Also, Dr. James Webster, M.D., M.P.H., Professor and Chairman, Department of Internal Medicine, Northwestern Feinberg School of Medicine, Jaime Delgado, who is the Project Director of Humboldt Park Diabetes Prevention Project, Dwayne Mitchell,

CEO of East Chicago Community Health Center, Governor State University, who is to my right. Also, there is one official appointment pending. The CDPHP Task Force has met twice to date. The first time was in the form of a video and telephonic meeting which occurred on September 28th of 2010.

During this meeting, Senate Bill 2583 and Public Act 096-1073 were reviewed and the charge to the CDPHP Task Force was stated. Also, preliminary ideas and suggestions were recorded as notes for structuring the framework of the CDPHP Task Force. Due to a quorum not being achieved at any one given location during this meeting, voting did not occur. Several documents were provided by the IDPH staff concerning information from the CDC and Illinois specific information concerning expenditures and the chronic disease burden for the state of Illinois.

As chair of the Task Force, I know that IDPH will create a website, which has been established and is currently under development for the CDPHP Task Force.

I noted that it should include

tables for the collection of information concerning, one, government organizational charts, two, a CDPHP Task Force organizational chart and general member information, three, general assembly legislative House and Senate bills, rules and laws impacting chronic disease within the state of Illinois. Four, the completed State Health Improvement Plan framework document, five, Federal and National best practices for chronic disease prevention and health promotion guidelines, six, the existing Illinois State community based best practice model and any documentation submitted to the Task Force membership, seven, a listing of national NGO's and relevant documentation such as for the institute of medicine, American Public Health Association, Association of State and Territorial Health Officials, National Association of City and County Health Officials, the American College of Occupational and Environmental Medicine, the American Medical Association, the American Public Health Association and the American Pediatrics Association, the American Dietetic Association and the American College of Emergency Physicians, et

cetera. Eight, the Federal, State and Private sector tools and resources and, nine, a calendar of events related to the Chronic Disease Prevention and Health Promotion Task Force.

In addition, Joe Africk recommended the creation of a chronic disease matrix for determining which diseases the CDPHP Task Force should initially consider for consideration.

During the second meeting on October 14th, 2010, the Chronic Disease Prevention and Health Promotion Task Force was assembled and with a quorum being present voted upon and adopted by-laws which govern and guide the functions and operations of the CDPHP Task Force. A copy of the CDPHP Task Force's first meeting documents and approved minutes, second meeting notes and the approved CDPHP Task Force by-laws are attached to this document for inclusion in the testimony stream being presented here today. In order to accomplish the objectives set forth by SB 2583 and Public Act 096-1073 regarding public hearings, this Task Force will seek input from the interested parties. The Task Force shall hold a

minimum of three public hearings across the state including one in northern Illinois, one in central Illinois and one in southern Illinois. The selected sites and times for these meetings and hearings are, one, Chicago, northern location, 15 November 2010 at Michael A. Bilandic building, Room C 500, which is presently occurring, 10 a.m. to 1:00 p.m. Two, Springfield, central location, 22nd of November 2010 at the Southern Illinois University School of Medicine from the time period of 10:00 a.m. to 1:00 p.m. Three, Mount Vernon, southern location, 30 November 2010, meeting site to be determined, 10:00 a.m. to 1:00 p.m.

Therefore, the CDPHP Task Force is assembled here today to listen to and record the first of these public testimonies. This testimony will in part serve as the basis for the establishment of a document containing Task Force recommendations that will be submitted to the Governor's office, IDPH Director and the State Legislature on or before December 31st, 2010. Consistent with the intent of the legislative act, the content of this report at a minimum will contain recommendations concerning the following

issues: One, chronic disease prevention and health promotion delivery systems reform within the state of Illinois, two, ensuring adequate funding for infrastructure and delivery of programs, three, the addressing of health disparities based upon economic, race, ethnicity and other factors. Four, the role of health promotion and chronic disease prevention in support of state spending on healthcare.

The source for the General Assembly's focus on the above issues for Task Force recommendations is contained in Public Act's 95-900, effective date, 8/25/08, and 96-328 effective date, 8/11/2009. Additionally, the Centers for Disease Control and Prevention in Atlanta have noted three priority areas of concern. One, obesity, two, tobacco abuse, three, injury prevention.

This focus was born in mind when developing the state health improvement plan which recognized five public health system priorities and nine priority health concerns. The health plan actually serves as a framework for further state engagement. The five public health system

priorities included, one, improved access to health services, two, enhance data and health information technology, three, address social determinants of health and health disparities, four, measure, manage, improve and sustain the public health system, five, assure a sufficient work force and human resources. The nine public health concerns identified included, not in rank order, one, alcohol and tobacco, two, use of illicit drugs and misuse of illicit drugs, three, mental health, four, natural and built environments, five, obesity, nutrition and physical activity, six, oral health, seven, patient safety and quality, eight, unintentional injury, nine, violence.

The SHIP document can be found at www.IDPH.state.il.us/ship. The diabetes program was moved from the Illinois Department of Human Services back to the Illinois Department of Public Health as of 1 July 2010 by an executive order of the Office of Governor Quinn. A Senate Bill, initiated by Mattie Hunter, which was unanimously passed and adopted by the legislature also strongly supported the position for restoring

the diabetes program back to the Department of Public Health.

This will greatly facilitate the reintegration of the antiobesity and diabetes objectives paving the way for better programatic funding opportunities, efficiencies and outcome for the state of Illinois.

We will proceed with the hearing according to the following format. This format is structured in the order to afford time for all of those wishing to provide testimony to have an opportunity to do so. One, each speaker will be allowed five minutes for the provision of their testimony. A timekeeper will indicate your time remaining. Please begin your testimony by stating your full name and spell it for the testimony recorder. Also, provide the name of your organizational affiliation and who you represent if this applies.

Two, any supporting documentations that the speaker wishes to submit for further Task Force review can be handed to the testimony recorder. Three, additional time, not to exceed three minutes, will be provided for any

questions the Task Force members may have for the testimony presenters. Please adhere to the following time-related guidelines in order to respect those waiting to testify. The order of the presentations will be organized into groupings. This is due to the fact that there are literally thousands of types of chronic disease states in existence. In addition, prevention spans the entire chronic disease intervention continuum. Prevention begins with averting the consequence of chronic disease itself through education, nutrition, exercise, screening and early diagnosis and cure.

However, it also spans the arenas of basic research and ongoing curative, maintenance and palliative forms of treatment intervention to prevent further chronic disease complications from occurring. Note that both categories of prevention are focused upon the reduction of morbidity, pain and suffering, and a premature mortality or death. With this in mind, the testimony will be separated into three timed components as noted in the agenda.

One, prevention strategies

focused on the prevention of occurrence of chronic disease, 10:30 a.m. to 11:30 a.m., followed by a five minute break. Two, prevention strategies focused on prevention of worsening of existing chronic disease states, 11:35 to 12:35, followed by a five minute break. Three, additional testimony related to either category within the remaining time allotted from 12:40 to approximately 1:00 p.m. If time lapses without sufficient time for those in attendance to present their information, consideration will be given for an additional meeting to be arranged for a future time period.

As the Act noted, there was a minimum of three hearings that are required. However, if we have more time that is required, we will consider another meeting within the locations.

So, with that, I'm trying to get people to categorize themselves into one of those two categories. You can testify at both times if you wish, but I think you can get your main points across, but the main crux of what you are trying to talk about should be in one of these two

categories so that we can have at least some kind of understanding of continuity across the spectrum.

What I have in front of you is a chart that will be available on the website. I am not going to go into the details of this chart because as you will see it will take ten hours with the complexity of it. There is a simplified chart, but it is actually outlining why I feel it is important for everyone to be on the same page. We are actually facing a formidable foe in chronic disease. If we do not do something about it, we will be facing the consequences and children will be facing the consequences of a system that will implode.

We are at a time where we no longer have time or can afford to not cooperate and work together to make sure things happen. I'll say more about that at the closing remarks, but, with that, I'm going to allow my panel members who are equally talented or more so talented than I am to have any comments that they would like to make, brief remarks before we start this session. They are all very, very talented.

This is why these 19 people are on this panel. They have some insight into what is going on in the community level. Some of them are actually engaged in community level activities, which have been successful, but I want to make sure that everyone is included in this model. The person that should be running the healthcare system is the person that opens the door when you knock on it. That's the patient. That's the person that's in the community who is in the school who is growing up in this community.

We need to be cognizant that those are the people that we're here for. So, with that, I yield the time to any of my panel members who would like to speak.

That's the first time I've heard them not say something. They are all very, very talented and very good. I see their minds are already organized. I think they're ready to go somewhere. So let's start with this. What I'm going to do is have people come up in groups of three or four. They can actually fill in this front row here for your testimony. So if you are ready to provide your testimony, the first group

will come forward and we're exactly on time -- actually, five minutes to spare. The first group I would like is for anyone who has prevention strategies focused on the prevention or occurrence of chronic disease. So if you are associated with a group that is dealing with nutrition, exercise or that is talking about some type of intervention on the educational level, those kinds of things, please come forward at this time.

We'll take it in the row of order, in this row order, and if you are -- if you don't have a seat presently, we'll just use these front seats to go across. My timekeeper is there. He has his signs already. So he is going to sort of buzz you and let you know your time has elapsed or is getting close to it.

We want to, again, stay very closely to this type of program. I said these categories may be a little bit confusing. As people address prevention, it spans the whole arena. For example, obesity has a prevention component which is heavily tied with the legislation and engineering. Other things we don't want such as high calorie diets or trans

fats, those kinds of things, high fat diets as well. But we also have exercise and nutrition as being a very, very heavy component in education, but we also have the treatment side where we either can cure something, we can maintain it or palliate it, the consequences of it. So, for example, if someone were to develop diabetes, we can do laser therapy for the eyes and stop proliferative retinopathy or we can have amputations. We can do other things that would take care of this person. What we want to do is really stay on the side of people never developing disease, but we have to be cognizant that people will develop disease and we have to be ready for both sides of this equation.

If prevention strategies do fill or take care of 90 percent of the problems that we have, we still have that ten percent that will require medical care down the road. So we have to be cognizant that this is a continuum and a continuous picture that we have to be supporting. So, with that, I'll have the first speaker step to the microphone.

MS. BYRD: Good morning.

MR. ARNOLD: Good morning.

MS. BYRD: I'm Dr. Jennifer Byrd. I'm the medical director for Aunt Martha's Youth Service Center. I'm here representing our company and Raul Garza, our CEO. I'm here to present a service integration model. There are handouts available for the members. I would like to remark that Aunt Martha's is a 38-year old organization. We have eight divisions and four sections. We provide housing and shelter for children, for young adults, intervention and support, provide healthy lifestyles in a safe, suitable environment and a great alternative to juvenile justice and, hopefully, reunification. We also have educational life skills programs that prepare children to enter school and also has parenting intervention classes and I'm here to discuss our health and prevention program.

Our health program was started in 1972 as a drop-in center for children and teens in Park Forest, Illinois. In 1976, we provided family planning services or we began that service. In 1978, we began to offer prenatal care. 1990, family case management was added. In 1997, we

achieved our first accreditation and have had successive accreditations thereafter for the last 12 years and in 1999 we achieved our FQHC status.

In our approach to increase access, we have provided or we are on pace to provide approximately 284,000 patient visits this year. In FY04, as you can see in your list there, we provided about 30,000 patient visits. We've had a hypergrowth throughout the last six years. Those have been targeted growths based on market forces and the need in the community. And as I said now, as of FY010 -- FY10, pardon me, we're on pace to see 284,000 visits.

MR. ARNOLD: You're telling me from -- for all this time, for six years, you have grown 900 percent?

MS. BYRD: Correct.

MR. ARNOLD: Go for it.

THE AUDIENCE: Excuse me. We cannot hear back here. I'm sorry.

MS. BYRD: I apologize.

MR. ARNOLD: Is that on?

MS. BYRD: So, as I was saying, we have grown and we had a hypergrowth period, but

with regards to our income and our payment source of our patients, we do like to feel as though we're keeping a balance of uninsured and underinsured patients and on your pie graph you'll see there with regards to the poverty level, we see about 88 percent persons who are 100 percent or more below poverty. With regards to our patient's payment source, we see about 55 percent of people who are receiving Medicaid and about 36 percent of people who have no insurance or who are underinsured and that is something we're very proud of to maintain.

With regards to health and prevention, we provide family medicine services, pediatrics, internal medicine, women's health, family planning, OB/GYN, oral health as well as dental hygiene, adult psychiatry, child and adolescent psychiatry. We're very happy and proud to have seven fellowship trained child and adolescent psychiatrists in our employ. We provide therapy services, adolescent substance abuse and treatment, adult substance abuse and treatment. We have healthy start and family case management programs.

What we're most -- one of the things we're most proud of is our integration service model. It's a unique model of prevention and screening as a part of our development towards our chronic care model which we choose to undertake and perfect within the next year.

We have two screening tools that are patient driven, PHQ, patient health questionnaire, which is a nine question tool that allows us to screen for depression. We also have an oral health screening tool, which is a six question patient driven tool. Those are completed in the waiting room. They're scored by our nursing medical assistants, they're reviewed by the physicians and we make active, immediate referrals into those services so that we're proud to say that 52 percent of our patients who receive primary care also receive oral health services, 58 percent of our behavioral health patients also receive primary care services and 40 percent of IBCCP patients receive primary dental or behavioral health services. We monitor those referrals. We track them internally. We have an electronic tool that allows us to screen and track

and referral not only the health division, but every division of Aunt Martha's is able to go to an electronic tool and refer into our services. So we're very proud of that.

Our ultimate goal is that every patient have the benefit of primary care, oral health and behavioral health services. That is true, synergistic healthcare and true healthcare homes for our patients. That is the crux of my discussion today.

I wanted to just highlight the fact that we integrate internally, but we also integrate externally and work with many community partners. Our newest example is with the National Latino Educational Institute. It's going -- it's a Chicago based organization. It's going to provide work force development and training, hopefully, to empower people from the community, provide health education for themselves and they can provide health education in our clinics.

This coincides with the receipt of our ARRA funding. We're going to select 20 members and it's going to be a very exciting collaboration so we're looking forward to that.

MR. ARNOLD: Phenomenal. One of the questions I have for you, do you have metrics of the care provided as far as patient outcomes or how -- any kind of cost savings analysis?

MS. BYRD: We are working to refine that model. That's my goal for this year. Actually, that's my responsibility for this year to be able to track outcomes and know the world of a diabetic, which ones have A1C that is greater than seven, and provide a tool by which we can get in touch with them. So knowing the world of a diabetic, the world of the hyperintensive, the world of the obese patient and come to know those metrics. So I'm working on a research program now that would allow me to do that.

MR. ARNOLD: Sounds like an incredible system. I'm looking at the total number of patients. Any questions from anyone else on the panel?

MR. MITCHELL: One question. Can you elaborate about the compliance of the -- compliance of your services as it relates to the quality or performance improvement criteria that you have through the federal government? I.e.,

how are you actually monitoring the A1C and the criteria that is established by the feds in order for you to receive your 330 funding?

MS. BYRD: Right now, we have an electronic system that does that for us. We generate reports based on diagnoses and we go to the medical records. We are two and a half years into a three and a half year conversion from paper records to electronic. So, at this point, we run a diagnosis code registry and we have a reviewer that goes to each facility and does a calculated tabulation. We did not want to wait for the electronic tool to be able to monitor that.

So we come to know that diabetic patient and those that are not meeting the requirements, they get a postcard. They will ultimately be receiving a postcard. That's the current model that we have. We'll be very happy to implement our next gen and have more capabilities to do that in the future.

MR. AFRICK: Dr. Byrd, I have a couple questions. I'm Joel Africk from Respiratory Health Association. With respect to tobacco cessation, screening or asking and

advising and referring people out, is that currently a part of your health prevention program?

MS. BYRD: Yes. I didn't mention it, but we have a social risk assessment form and as these doctors come on they do a sex, drugs and rock and roll screen. So it gives us information on tobacco use, drug use, sexual activity and those screens are looked at directly by the provider and they're referred -- referred to internal programs based on their usage.

MR. AFRICK: Great. If I can follow up with two more quick questions. One is, what are the different state education agencies with which Aunt Martha's currently interacts as part of its daily business?

MS. BYRD: We have funding from the Illinois Department of Public Health -- is one of our major sources. We also have a grant from -- for our team parenting services and also for our -- that is our RDCP program. That comes from the public health department. So those are the major ones.

MR. AFRICK: As part of the work of

this Task Force, we're not only being asked to get our arms around the magnitude of chronic disease, but also to develop some recommendations. So to you and any of the other speakers that we have today, if you would give some thought not only to describing the problems you're addressing and, in some cases, the wonderful ways you're addressing them, but to give some thought to any recommendations that you have for us to incorporate into our recommendations, that would be helpful.

MS. BYRD: I think one thing I would add that with our behavioral health model and with our oral health model as well, the behavioral health model is case manager driven and they manage each patient. There's a wraparound system. We came to have that competency from being involved with the National Healthcare Collaborative. We received the competency in adult health depression. We returned it to get it in adolescent depression and we implement it in one clinic and we spread it to all of our 17 clinics. It is a PHQ driven system and case managers receive those PHQ's after being reviewed

by the doctor and we have a warm handoff system in that our patient that day who is depressed who needs to be referred to therapy or psychiatry, meets the case manager, they see a face so that when they come back they're more likely to come back because they've seen a face and when they get there they're less likely to be anxious about the new encounter.

So we have a warm handoff and a wraparound service regarding that. We run oral health services the same way. We didn't feel as though we needed to reinvent the wheel. We knew we had a great care manager model. So our general services, our oral services, had the same model that is care manager driven.

MR. ARNOLD: Very good.

MR. ISAACSON: Dr. Byrd, good morning. My name is Michael Isaacson. I represent the Northern Illinois Public Health Consortium. I'm just wondering -- I'm going to ask you to generalize a little bit. With all your years of experience in helping so many patients, what is the one greatest need that we have and this can expand into our community and into our

society, but what is the one thing we need to do to help your patients with chronic disease both preventing them and educating them?

MS. BYRD: I would say our one greatest need is to have a way to share information rapidly. Paper slows us down. Paper is inadequate. So our one greatest need is to have a comprehensive, ubiquitous, universal electronic form of communicating about patient care. In my mind, that would help us have better information about the patient. It would also allow us to know if patients are seeing multiple providers. It would also allows us to have safety with medication reconciliation and allow us to know what chronic diseases, early medical conditions, that they either don't remember or don't choose to tell us that we can further their treatment.

MR. ISAACSON: Thank you.

MR. ARNOLD: Okay. Thank you very much for your testimony. Very well done. Next person.

MS. GIBBONS: Good morning. My name is Linda Gibbons. I'm a certified school nurse

and director of the health education and school nurse certification program at National Louis University. I'm representing the Illinois Association of School Nurses.

MR. ARNOLD: One quick question. When you approach the mic, please say your name and spell it and then also -- you've already given your organization.

MS. GIBBONS: Yes. My name is Linda Gibbons, L-I-N-D-A, G-I-B-B-O-N-S. Our children in Illinois spend almost seven hours a day, 188 days a year for 12 to 13 years in our public schools. With all of that time, our graduates should know how to make healthy lifestyle decisions and have learned habits that prevent disease and lead to better health. Research tells us that habits are best formed early in life so it's important to teach nutrition and care for their bodies in the early grades so that they can avoid growing up with conditions that predispose them to chronic disease. Increasing the amount and quality of health education in our public schools is a cost-effective way of starting a whole generation of students on a healthier life

start.

Who will do this health teaching? Consistency is key. Our students need to hear the same message of health from their teachers, lunch supervisors, principals and the school nurse. Currently in Illinois, all schools are required to have a wellness policy. However, there is a lack of enforcement for the implementation of this policy. It sits on a shelf somewhere. With school nurses as leaders of the wellness team, they lead a coordinated effort towards wellness and health promotion across all areas of the school community. Requiring documentation of wellness activities, lessons in the classroom and extra curricular activities for the school and communities will assist our students in making wise choices that lead to higher levels of learning and create good healthy habits.

Illinois is already proactive in requiring Type 73 certification for school nurses that includes developing skills and expertise in education to add to the health and wellness expertise that the school nurse brings. Thus,

certified school nurses have a background in health and education and are prepared to develop and teach a health curriculum as well as when students come to our offices at a rate of 20 to 100 a day depending on the school.

Health teachers are scarce in the lower grades, but the school nurse is available to provide that curriculum and support classroom teachers. We know that the fastest rising public health problem in our nation is obesity. One-third of our children and adolescents are overweight or obese and children from diverse ethnicities and poverty are even more affected by this epidemic. Childhood overweight accelerates the development of various chronic diseases. Most children spend a large portion of their day at school and schools are a key setting in which to implement the strategies to address this issue.

The school nurse has the capacity to reach a large group of youths from diverse groups. They're already there. Obesity must be addressed through this. What did we do to impact that? We respond to physical and emotional

concerns. We connect students with substance abuse treatment and mental, behavioral and reproductive services. We refer families to care providers and insurance programs. We screen for conditions that impair learning such as vision and hearing. We educate our children about healthy lifestyles and we ensure immunization compliance. This is in addition to caring for injuries and illness in managing the care of students with chronic health conditions. With minimal additional spending, appropriate clerical services have allowed a certified school nurse more time to teach and promote wellness. A lack of school nurses due to underfunding in many localities may have long-term health and economic consequences.

According to the CDC, chronic conditions consume 75 cents of every health dollar spent in 2005. When school nurses identify and manage these conditions, they stave off future health problems and help reduce overall healthcare spending. The CDC has also found correlation between lower academic grades and health risk behavior such as smoking, acts of violence and unsafe sex.

This state strongly suggests that school health services that promote healthy behaviors also contribute to educational success. We are well positioned to play a pivotal role in improving students health by ensuring continuity of care, but greater coordination is needed between education and healthcare sectors for us to fully realize this potential.

Every child in Illinois deserves a school nurse so that he/she can become a healthier, well-educated adult who will contribute positively to our society. Thank you for your time.

MR. ARNOLD: Thank you. Thank you very much. One of the things that you are also associated with is -- there are a few bills that are floating out there. One is the Health Education Task Force, which I have illustrated here, and there's also another bill for children and diabetes in schools talking about really having another provider sort of intervening and helping to take care of children so that's under consideration now.

What do you see as an effective

model for schools? What do you think that we can have as a take-home lesson or recommendation as Joel was mentioning before related to how should we intervene with schools?

MS. GIBBONS: Okay. I think, first of all, we need to intervene with the people that are there in place, the school nurses that are there. We need to ensure that all students have access to a school nurse who can manage the health team and the wellness activities that will then filter down through other providers. It takes a mix of a certified school nurse, RN's, LPN, unlicensed providers to provide the realm and the range of healthcare that our students need in school each day, but the case management of that needs to fall to a professional provider such as the school nurse because we're there with the students. We know their families. We see them on a daily basis. The physician may see them once a month, once every six weeks, once every six months. We see our children everyday and are in a position to do a lot of that case management which always includes preventive education and health promotion.

MR. ARNOLD: Some schools don't have a school nurse -- sort of presents a problem in a time period where we're starting to see Type 2 diabetes in children for the first time in history, you know, and we're getting to the point where things like peanut allergies are becoming more common and multiple health complaints in children that we really had not seen or contemplated so what is your experience with that? Do you see an increase or what --

MS. GIBBONS: We see a drastic increase, but it's only based on antidotical evidence because currently the state of Illinois and the State Board of Education do not collect statistics on chronic disease in schools, on number of nurses visits, on number of treatments given. We don't have that data to really say this is what we need and it's really very difficult. We make decisions every day based on the welfare of the children that we see on an individual basis, but making policy decisions and staffing decisions is really difficult with that concrete data and because most schools do not have electronic health records or the nurse has the

castoff computer that two or three other people have already upgraded from, getting that data does present a problem.

MR. ARNOLD: And any other questions from my panel members regarding this?

MR. AFRICK: Just one question. Is there one state or two states that you think do the best job in the US in terms of student health in school nurses?

MS. GIBBONS: Actually, yes. Delaware has a mandate to have a school nurse in every building. Iowa also has a mandate. Delaware has actually met theirs. Iowa is still in the process of doing that. A lot of the difference is the diversity and the geography of the state that makes it more difficult, I think, in Illinois for us to do some of those things. Delaware is a very small state where the schools communicate and they have a limited number of school districts. Illinois has a huge number of school districts to work with who all seem to want to do their own thing.

MR. ARNOLD: Okay. Very good. Thank you very much. For the members -- when you

step up to the mic again, state your name and spell it and for those of us that are part of the Task Force make sure you say your name so the recorder can actually put your name in for your question as well. We're not doing that.

MR. SAMPSON: Good morning. My name is Reverend Dr. Al Sampson. I'm the pastor of Fernwood United Methodist Church, which is located in the Roseland area, 10057 South Wallace if anyone would like to attend. We're the only church in black America that has a Department of Agriculture within our church. I've been there 35 years. Thirty-two out of the 35 years I've took my own time and money and went back into the south, hooked up with black colleges that have departments of agriculture like Florida A & M and Tuskegee, they work with black farmers that are in co-ops and I produced a marriage the last 32 years between the black farmer down south and the black consumer up north. On top of that, we've been working down in the Pembroke area for the last 32 years, a brother named Paul Ivy and Brother John Thurman and other farmers down in that area. I've taken my own time and money and brought them up to

open air farmer market sites. We have been just about all over the city.

On Wednesdays, we had farmer market sites at Covenant Bank on the west side of Chicago, Reverend Bill Winston's bank, and then on Wednesday at Segway we've had farmer market sites. The reason I'm concerned about this particular broker view is because we believe that the seeds in the genetic engineering is what is producing the obesity, the diabetes. Everyone has seen and I assume the panel has seen the Food Desert Report. The tragedy of the report is that it does say that the grocery stores are too far away and the foods that we eat are causing the diseases that we have within the African-American and Latino community. What the proposal does not say, what the report does not say, is that franchises have now inundated our community with bad food and that's not in the report because the franchises have substituted any level of quality of food that our people would eat, especially children.

I'm going to leave, if I may, all of my documentation. We're working -- I see Brother Salim Al-Nuriddin here. We're working

with the health consortium on not only the delivery of the food, but now we're moving towards a nutrition department within our organization, which is called George Washington Carver farms which is Farmer's Agriculture Resource Management Systems. We're collaborating with him and his organization because of the preparation of food. There's nothing wrong with the tomato, but it is what you do with the tomato. So we're talking about healing from the ground, utilizing the various colors of food and what they actually mean. Most of our people get trapped on taste versus what is the nutritional value of food.

Lastly, there are two quick points that frustrate us within our communities. Popeye never gave Olive Oil any spinach, which means he didn't want her to be strong. Popeye is up in our neighborhood with chicken and biscuits and no spinach which means somebody don't want us to be strong.

The black woman went into the kitchen to prepare greens and when she came back she had a jar called a mason jar. Inside the mason jar was the pot liquor, which was the

nutritional and medicinal nutrient value of the juice. The little child asks grandma "Why you keep giving us this juice and not the actual greens?" And she answered with the nutrition. She said "What do you call this, momma?" She said "I call this pot liquor." The problem in our community now, Brother Joel, is that we are getting inundated with pot and liquor. We need grandma to come back with the menu. Thank you.

MR. ARNOLD: Thank you very much. Really astounding. This is really why I'm so happy with this. It's been two and a half years working on this issue and trying to work on alignment. There's so many programs within the community that is outstanding and we don't know that they're there. We need to have these things annotated. This is really what the purpose of this meeting is. One question I have for you is how many people do you service and what is the total size of your operation?

MR. SAMPSON: Because we don't have the grocery stores and because we're the only group -- ethnic group of people in black -- in America, there is no home for the black farmer.

There are 650 black mayors in black America. Nowhere is there a wholesale, retail warehouse. There is no distribution center. So we have to utilize the black church. We only do our program basically through the summer and we have an excellent strategy now as you'll see in my documentation. Cease Fire was one of our folks along with one more time Brother Salim Al-Nuriddin's organization, Chicago State opened up their door two days for us with the Black Farmers Project.

So to quantify numbers our genius was that we have churches within our network that pick up the vegetables on Saturday. They leaf it and we go up on black media, WVON and other radio stations identifying where these sites are and then on Sunday we have a mega church like Bishop Larry Trotter who has Sweet Holy Spirit. So on the 7:00 service, the 9:00 service and the 11:00 service all the farmers from Arkansas, Mississippi, Alabama, from Illinois, all of those that -- all those vegetables that don't get sold on Saturday we bring them to the mega churches and they are able to sell them.

If we had a warehouse, we could utilize that warehouse to provide economic development. There's a thing in the industry that is called added value. Down in Florida A & M, for $60,000 they have a collard green cutting machine where the farmers grow the green, wash them, cut them and put them in the refrigerator and that gives added value for frozen greens. For $3,000 or $4,000, we could get a pea sheller and those of you who know about the crowder bean and the butter beans, you can go on and add value to it. So it's not just Roseland, not just my church. It's several churches in the 20 black wards, which are impacted by our process.

MR. ARNOLD: Excellent. If I remember one statement that Congressman Rush made to me a while ago, it was -- he said "You can find potatoes and tomatoes anywhere on the west side and south side of Chicago" and he said "14 different flavors of potato chips and tomato ketchups in a bottle" and he said that's about as far as it goes.

MR. SAMPSON: Also, Doctor, one of the things on that point, soul food restaurants

are being challenged now. I have soul food restaurants that were paying $28 a bushel for greens, whereas my farmers were able to get it to delivery from Illinois from Pembroke and other little towns like that for less than $10 -- $5 to $10 a bushel for greens.

So we haven't really brought in the economics of this. I'm very much concerned about seeds. So the farmers that I'm working with they grow the food they eat and no farmer in their right mind would grow -- drop the seed and throw a whole lot of pesticides and turn back around and say they're blessing over their dead food. What we're finding, just the other day this summer, there was lettuce, the iceberg lettuce comes in our community, but the romaine lettuce had a recall. Black farmers' vegetables have never had a recall because they grow the food they eat with a limited amount of pesticides because they're all in co-ops. Whether it's five acres of land or a hundred acres of land, they're all in a cooperative. The black community wasn't disturbed about the romaine lettuce because it doesn't come to our community.

Two years ago, it was spinach. There was an e-coli recall on spinach because even the organic people end up getting their manure from the cow and they turn back around and put it on the spinach and then sell it to the consumer. We'd like you to really be sensitive to the role that the black farmer has played inside of our culture so that we can develop a sensible delivery system.

We're the only group of people in this town and other cities around the country where the franchise movement from Kentucky Fried to Popeye, et cetera, are more in our neighborhood coupled with the Food Desert Report which says that the food we eat from the grocery stores is causing us the diseases that we have. This is documented from LaSalle Bank and Marie -- I know you all know about the Food Desert. If not, I have the documentation.

MR. ARNOLD: Yes, that would be great to submit it to the Task Force and also one of the things it also sounds like it's been implied in what you're saying, too, is that there is a potential for job production not just in

growing and being a farmer, but also in transport, the transport business. So that's interesting.

MR. SAMPSON: There's only about two agriculture schools in black America. I believe there's one still in Philadelphia and the one here in Chicago in the 19th Ward. It's interesting most of the black students that come out of that agricultural school go south to black colleges, Tuskegee, Florida A & M, et cetera.

We also see it as another way of bringing our young people back from these land grant schools and let them understand the impact of the preparation of food which is where we are now.

Our food has been inundated with a whole lot of meats to give flavor versus looking at the science of why is the tomato a tomato and why is a lettuce, lettuce? And what is the nutrient value, but what is the value of eating it if you're going to dark it up? That's like taking an ice creme cone and putting a hamburger on the ice creme cone. It doesn't make any sense. So we're moving a switch with our grandparents raising grandchildren to be able to say to them

when you sit at the table now, let's look at the preparation.

MR. ARNOLD: Any quick questions from any of the panel members or Task Force members?

MR. SAMPSON: When you don't get questions, that means you did good or --

MR. ARNOLD: It means you did great. You did a great job. Very impressive.

MR. GREEN: Good morning, everybody. My name is Yihoodah Green. I am a psychiatrist and family practitioner representing Healing Hands Research Center and the Whole Person Project. Our CEO is Dr. Valencia Green. My name is spelled. Y-I-H-O-O-D-A-H. Last name is Green like the color. The Whole Person Project is a Healthy People 2020 focused initiative. It targets North Lawndale, one of 77 neighborhoods in Chicago. North Lawndale is plagued by multiple social stressors including high levels of poverty, poor educational outcomes, crime, criminal justice involvement and health disparity. North Lawndale, like many of the basic health resources, including access to -- places to buy good food as the

Reverend just mentioned.

In comparison to most other Chicago communities in Illinois, national statistics, North Lawndale has higher rates of obesity, diabetes, strokes, cancer, asthma, HIV, STD, mental illness, substance dependance and infant mortality. It is clear that social stressors directly impact health related attitudes, behavior and outcomes. This project recognizes as does Healthy People 2020 that health and health service implementation must be considered in a socioeconomic context.

Thank you. Dr. Fielding, who was the chair of the Secretary Advisory Committee in health promotion and disease objectives for 2020 stated "We can't achieve what we want without looking at education, jobs, public health infrastructure, recognizing that poverty is a poison." It can't just be left to the public health. We need our elected leaders to think about health implementation of what they do, tax policies, mass transit, agriculture subsidies. We need people in all sectors to be thinking about health implementations. One of the things that

you mentioned is what is the best thing that we can do to help prevention. The first thing we have to do is infiltrate the communities we want to present the prevention in. We cannot be perceived as outside entities within the community. If we're perceived as outside entities, the community won't listen to what we're trying to say. No matter how effective, no matter how good it is, the community won't listen because, again, just like your body if it's perceived as an outsider it will reject it.

That being said, the policies that are made in DC, the policies that are made in Springfield are great policies, but what are the real life implementations of those, have those policies be considered in the socioeconomic context of the people that you're talking to, as the Reverend mentioned, if you don't have a grocery store -- and I have a big sign saying eat healthy and I don't have a grocery store to eat healthy at, what is the implementation of that policy?

This project recognizes that community, family and the student body and

willingness to participate in services is the core of effective service strategy. Buy-in requires a service delivery strategy which is culturally and socially competent. Such a strategy requires seven key components which may be best understood in the context of attending a party. First of all, you have to get an invitation, follow the community leads. Community base requests, support and input on services is key to community implementation of services. Two, understand the role of a guest. Healthcare providers should behave as a guest rather than the host of the party. This requires establishing and conducting a service environment in which service recipients receive treatment as a partnership and that ultimately they are in control of their healthcare decisions.

Three, make sure the party is accessible. Providing services in an environment which is accessible, familiar and comfortable to the service participants. Four, don't be a wall flower. Let people know you're at the party. That means aggressive, culturally and socially competent marketing of services. Five, know how

to dance. That means culturally competent provision of services. Six, get the digits. In other words, get the phone numbers. Establish mechanisms to maintain regular contact with service recipients and, seven, stay connected. Establish a tightly woven network of service providers to ensure the integration, continuity and time-sensitive provision of follow-up services. Thank you.

MR. ARNOLD: Thank you very much. You know, that's one of the things that -- some people know my background. I was in the military for 26 years. I did a couple of tours in Iraq, but also Katrina, 9/11 and that kind of thing. One of the things that hit me particularly was when I was in Katrina was the disconnect between two particular issues and there are two different questions. One is how and the other is why. And many times we get stuck on the how part of it. So it's the scientific part that says this is the crucible of the perfect elixir. It's scientifically valid and we did all these studies on it. We know it takes care of the problem, but what people usually ask you when you go into

crisis situations, which many communities are in presently, is the question of why. Why should I listen to you and that's really based on your philosophical viewpoint, your economical background, your geopolitical situation, your socioeconomic status, your education level. Many, many things are implied in that so I'm glad you're bringing this up.

This is the bridge we have to cross in order to get community engagement and without community engagement nothing is successful. That is the person who is actually using the products that you're trying to bring to them, the solution. But if no one takes it, then it's worthless. So we're making worthless answers to problems that people don't want to participate with. So we really need to cross that bridge. I really commend you for that.

Specifically, what would you do to intervene to change that? I see the seven different principles you've listed and outlined, but do you think it's the education that needs to be brought --

MR. GREEN: The first thing we need

to do is we can't be considered a standalone. We have to integrate the community. One of the things this project is proposing just as the school nurse stated, we want to open a school based clinic. Now all the parents know where the school is. These are community based schools so, in other words, they're within three to four blocks of where the parents would be. So access to this place is easy.

It's in a context, not in a hospital, not in a quote, unquote, clinic. It's in the context that people are familiar with to begin with and that helps to lend itself towards feeling more comfortable, feeling more ready to connect with services.

MR. ARNOLD: Okay. Excellent. Very good.

MR. GREEN: Thank you.

MR. ARNOLD: Any other questions? A quick question. Okay. If we can have the group here move down so you don't lose your space and you can come up here. Anyone who wants to come up to the front, these seats are opening up for prevention. Then we're going to move onto our

next grouping. Okay. We can go on.

MR. TINSLEY: My name is Elton Tinsley. First name is E-L-T-O-N, last name T-I-N-S-L-E-Y, M.D. I am Dr. Tinsley, a plastic surgeon and wound care specialist. I represent Solutions in Sync. I'm presenting a program called Healed and Home, wound care recommendations to approve outcomes and reduce costs to the state of Illinois. The three key elements to our wound care recommendations are as follows. First, staff. The bullet point here a, dedicated wound care nurse certified in wound care. Second, physicians, bullet, a relationship with a physician who has a passion and commitment to wound care. Thirdly, treatments. Bullet, cost-effective, evidence based products and protocols.

Illinois has approximately 1,200 long-term care facilities serving more than 100,000 residents. These facilities are licensed, regulated and inspected at least annually by the Illinois Department of Public Health. The state relies on the Center for Medicare and Medicaid Services, also known as CMS, for best practice

recommendations.

CMS relies on the National Pressure Ulcer Advisory Panel, known as NPUAP, for recommendations. According to the NPUAP, the presence of a pressure ulcer increases length of stay, readmission rate and commiserate increases in cost to the state from hospitals from the community and from long-term care facilities. I.e., nursing homes. The total cost of wound care related to pressure sores was estimated in 2008 to be $8.5 billion. The national rate for pressure ulcer development in long-term care facilities is 11.9 percent and the rate for pressure ulcer development in the state of Illinois is slightly higher at 13.1 percent as of 2009.

In fact, 86.9 of the pressure ulcers managed and treated in Illinois nursing homes are community acquired. Nursing home residents with wounds are admitted to nursing homes with wounds. The goal of the Healed and Home program is to expedite wound healing, reduce both the costs and number of pressure ulcers in the Illinois long-term care facilities and return residents to their primary residence.

In the 11 Illinois facilities that have currently implemented the Healed to Home program, the acquired pressure ulcer rates varied from zero percent to three percent. Keep in mind, the national average is 11.9 percent. Healed to Home is divided into prevention and treatment. I will now elaborate on the staff model. As a best practice model, each facility has at least one nurse that is wound care certified. The wound care nurse is responsible for assessing all residents with and without pressure ulcers. They can then identify risk factors and put into place an individualized wound prevention plan based on CMS guidelines already established.

Wound prevention is the most cost-effective measure to the state, the family and the community. According to the published literature, staff education is the key to wound prevention. The wound care nurse would also be responsible for educating the remainder of the staff, the resident and our families on the importance of wound prevention. These findings are to be shared at the regular quality assurance meetings already established.

If a resident has or develops a wound, SWAT is implemented and in our program SWAT means special wound aggressive treatment. The wound care nurse develops a treatment plan in compliance with the established guidelines already established. This nurse monitors the wound and documents at least weekly on the progress.

Oversight is provided by the director of nursing, already established, and further the local physician on an as-needed basis and can report it in the quality insurance meetings that are already established.

The physician model, as a best practice model, a physician with a compassion and commitment to wound care is an integral part of the team. Physician collaboration with the wound care nurse through either on-site rounds or telephone case discussion provide for additional expertise in treating and healing these wounds.

Physician education to both the wound care nurse and facilities staff allow for increased knowledge in the prevention and treatment of wounds. Physician input enhances the use of evidence based wound care modalities in the

treatment and healing of wounds. The treatments model, as a best practice model, appropriate treatments will be applied in the appropriate manner on the appropriate wounds. Best practices are ultimately cost-effective regardless of initial treatment costs. The most expensive wound care dressing may not be the most effective in expediting wound healing. The least expensive wound care dresses may not be the most effective over time in expediting wound healing. Utilizing evidence based practices when deciding on prevention and treatment options mitigates wound development and results in faster healing time and return to home.

In summary, Healed to Home as a best practice model reduces wound care costs to the state at no cost to the state, reduces the incidents of wound development in nursing homes, heals existing wounds faster and finally is cost-effective for nursing homes to implement. Thank you.

MR. ARNOLD: Excellent, Dr. Tinsley. This is really a phenomenal use. This is really one of the leading healthcare costs that we have,

especially with hospitalizations and rehospitalizations to nursing homes. One of the things I wanted to ask you, how many wounds do you see in an average month?

MR. TINSLEY: Me, personally, I see about 60 a week. So about 250 a month, but I only cover three out of the 11 nursing homes.

MR. ARNOLD: Wow. How do you determine which dressing is best for a given wound?

MR. TINSLEY: Actually, that's a very good question. What is more important is not the etiology of the wound, but the cause of the wound. What is more important is the current condition of the wound and I think the greatest impact in terms of cost savings to the state is with progressive education of the staff -- is to minimize the number of nursing home residents that are transported out of the nursing home for wound care when wound care can be delivered in the nursing home. The state's transportation cost just round trip to a wound care facility is $400 to $600. So that's $800 a roundtrip. Multiply that by 13,000 wounds and that's a lot of money.

MR. ARNOLD: How many different types of wounds do you see?

MR. TINSLEY: Typically, we see them all. The most common is the pressure ulcer. There's eight different types of wounds including lacerations, pressure ulcers, burns, every now and then we'll get a surgical patient with a cancer wound in a nursing home, but without question the number one or most common wound is the pressure wound.

MR. ARNOLD: And that's from not rotating the patient and movement and --

MR. TINSLEY: You have to keep in mind regardless of what those 2:00 a.m. illegal commercials are saying about nursing homes, you have to keep in mind almost 90 percent of the wounds in a nursing home actually came from outside into the nursing home.

MR. ARNOLD: Any other questions from the panel members?

MR. AFRICK: Can you submit to the Task Force the calculation of the cost savings that the state would receive by changing its approach to wound care?

MR. TINSLEY: In our three facilities, we've significantly reduced cost and I think we can provide that actual calculation when we're working with the state and actually have the state numbers and we can tell you what the impact would be.

MR. AFRICK: Thank you.

MR. ARNOLD: Fantastic. Do you think there's a need for education also for people at home since these are coming in from the outside?

MR. TINSLEY: There is no downside to education from kindergarten to the nursing home.

MR. ARNOLD: Okay. Next presenter, please. Do you have any records you want to submit? You can hand them to my timekeeper. You can move up to the next level. You can move down one seat to fill this in.

MR. ALSBERRY: Good morning.

MR. ARNOLD: Good morning.

MR. ALSBERRY: My name is Vernard Alsberry, V-E-R-N-A-R-D, Alsberry, A-L-S-B-E-R-R-Y, Junior. There's a third running

around out there.

My organization is the Kid's Health Club. I am the vice president and Diane Alsberry is the president. The Kid's Health Club opened November 19th, 2005. This is the idea of Diane, who is a physical therapist and, myself, who is a physical therapist assistant, Vernard Alsberry. The mission of Kid's Health Club is to be an advocate for healthy lifestyle changes for children and families and to develop products and services that make fitness fun.

On August 27th, 2010, a not-for-profit arm of the Kid's Health Club was developed called the Kid's Health Club Foundation. The mission of the Kid's Health Club Foundation is to prevent and treat childhood obesity through activities, research, education, advocacy and promote healthy lifestyle changes to children and their families.

There is an epidemic of obesity and inactivity in America today. Video games, decrease of physical education in schools, and the fear of letting children out alone have contributed to the fattening of our children and

lead to increased chronic health problems, including cardiovascular diseases and diabetes.

The Kid's Health Club and the Kid's Health Club Foundation look to provide children a place for exercise and have fun doing it. The logo, which portrays a little girl and boy flexing their muscles with a smile says it all. Both organizations will not only provide needed exercise to youth who have spent too much time playing video games, but also assist in prevention of injuries of children who are involved in sports by increasing their strength, flexibility and endurance.

Diane and I have over 50 years of experience in the profession of physical therapy and have worked in all aspects of the profession. We both have a passion for working with children and understand the importance of fitness and health becoming a daily part of our children's life. KidsHealthClub.com and Kid's Health Club Foundation, Incorporated also provide nutritional classes, women workout classes and wellness seminars.

In conjunction with First Lady

Michelle Obama's Let's Move Campaign, designed to eradicate childhood obesity within a generation, Kid's Health Club is proposing collaboration with the state of Illinois to provide a fitness and nutrition program for its youth. Childhood obesity in the Chicagoland and the Southland mirrors national and statewide trends. Illinois has the 14 highest rate of childhood obesity between ages and 10 and 17. Research shows that kids who are overweight often struggle with weight through their entire lives. Overweight during childhood and particularly adolescence is related to increased morbidity and mortality later in life. Some scientists believe the generation of children could be the first generation to have a shorter lifespan than their parents.

The Kid's Health Club is a great way to exercise. We provide entertaining physical activity, a safe social environment with unique exercise equipment, which is targeted towards youth for goal achievement and fun while coaches give encouragement and provide supervision throughout the program. Kid's Health Club is an ideal program for kids who don't have enough

physical activity during the school day because, as I said before, a lot of programs have been decreased. We train kids in sports. We also improve kid's athletic ability and allow them to slim down while having fun doing the activity also. The kid's -- the group of kids that we work with are between 6 and 16 years old. We not only work on their self-esteem -- because a lot of kids who are obese or almost obese have a problem with social problems also, not only chronic illnesses.

When we found that we work with kids, we also take a BMI on the kid when they first come in. That BMI gives us a target line to work towards helping the kid to reduce their body fat. We also have found through our process that kids that are already in this program that have respiratory problems, usually we help assist them with improving their lung capacity. Our program is a circuit work program and the machines are made for children. They're like weight machines you'd see in a regular gym, but they're made for children by HOIST, which is out of California. The kids go through a circuit. They do a minute on the machines. They do a minute on aerobic

activities and the kids are there for approximately one hour. We also have the nutrition program which we mirrored from the We Can program to enhance childhood activity and nutrition. We mirrored this program through our nutrition. It's a six-week program that we have the parents and the kids come through so they can understand what nutrition is, what a good thing to eat is, what is a bad thing to eat and how it affects their bodies. I'll take some questions now.

MR. ARNOLD: Thank you very much. Good presentation. This program it looks like it's housed inside a mall structure, which is really ideal because you have a lot of traffic going through. What is the -- and you probably have security as well --

MR. ALSBERRY: Yes.

MR. ARNOLD: -- in the environment? But how many people do you see and what types of metrics do you use in order to measure the effectiveness of the intervention?

MR. ALSBERRY: Being a physical therapist, we're always looking for outcomes. So

when we start a program, we make up a sheet that initially when they come in what can they really do when they first come in. We take a BMI and then we take a chart and show each machine to see how much resistance they can handle when they first come in. From that, we have coaches. Our coaches usually come from the high school. We train -- they're juniors and seniors in high school. We train them how to work with our kids and to fall into our program. So the first week they come in, they may be doing a one arm machine, it's about twelve pounds and that's about two or three weeks we check them out again and see where they're at, whether they're ready to move up or move down. Diane and I do that and then we'll move the kids up. Usually the machines go up to about 120 pounds and some go to 160 pounds. Most kids get up to maybe about 80 or 90 pounds. The machines are interactive. They're not like adult machines when a child gets on the machine. The machine moves also. It provides them close chain exercises. So that at -- some study shows that if you use machines that aren't close chain exercise machines, it could damage their growth rates, but

the study is not true, but to be on the safe side, because science changes all the time, we're deciding to use these machines because it provides that protection for the youths when they come to the program. We also have our regular treadmills and stair masters also.

MR. ARNOLD: And you're associated also with the tumbling team or gymnastics team?

MR. ALSBERRY: We have the Pink Panthers double dutch team who practices in our facility also and we partner with the township. We ran a summer program. In the summer youth camps, which they have already in the park districts, what we do is instead of going to a baseball game or bowling alley, they come to the Kid's Health Club and they come there maybe three or four times during the summer and we work that program with the park district. We also have a nutrition component, which we ran with Country Club Hills. For the kids in the morning, they were in our nutrition class. In the afternoon, they came over to the Kid's Health Club and exercised. We ran a program through Governor's State University where we took a group of kids, I

think it was 20 youths, we kept them for two months and during that process they had to go through nutrition components. We also took their BMI's and monitored them throughout the program.

We've seen maybe over 800 kids in the five years. That's not counting the nutrition programs we've done. We've done healthcare workshops where we partnered with the Illinois Department of Public Health, Advocate Hospital, St. James Hospital, where they come in and do screenings on the youth and during that screening time we allow them to come into the Kid's Health Club and exercise.

Once they finish their exercises, we do have interactive video games. We have the DVR, we have the Wii games. So once they finish their circuit, which lasts about 45 or 50 minutes then they're free to play their interactive video games, which also helps to keep them active throughout and a lot of times we find out they work harder playing on the games then working the circuit, but they have fun and they're sweaty when they workout.

MR. ARNOLD: Any other questions

from the Task Force? Thank you very much.

MS. COLBORN: Good morning. My name is Erna Colborn, E-R-N-A, C-O-L-B-O-R-N, and I'm president and CEO of the Alzheimer's Association Greater Illinois Chapter and I represent the Illinois Chapter Network, which is our public policy consortium made up of the four chapters that serve the state of Illinois.

I appreciate the opportunity to speak with you today about Alzheimer's disease and health promotion. Alzheimer's disease is the most underrecognized public health crisis of the 21st century. There are as many as 5.3 million persons today living with Alzheimer's, which is the most common form of dementia. Alzheimer's is a disease that destroys brain cells and causes problems with memory, thinking and behavior. It is not a normal part of aging. Today, it is the sixth leading cause of death in the United States. One in eight Americans age 65 and older have Alzheimer's and another American develops Alzheimer's every 70 seconds. Unless something is done by 2050, up to 16 million Americans will have Alzheimer's and a new case will be diagnosed every 33 seconds.

Currently, in Illinois, the number of persons with Alzheimer's is 210,000 and that number is expected to increase by 14 percent over the next 15 years. Although the cause or causes of Alzheimer's disease are not yet known, most experts agree that Alzheimer's, like other common chronic conditions, probably develop as a result of multiple factors rather than a single cause.

An increasing role by public health officials provides a new front in addressing cognitive health in our society. We are well aware that cognitive health is a vital part of healthy aging and quality of life. The lack of cognitive health will not only have a significant impact on a person's well-being and overall health status, but that of our community and our state as well.

The rising incidents of Alzheimer's and related dementia is a public health battle that we in Illinois must be prepared to respond to with services and resources to support the person with the disease, their family and their caregivers. We applaud Illinois

dedication to use of surveillance as a public health tool to develop data on the incidents, problems and risk factors for particular diseases and when risk factors are identified to support the development and strategies to reduce risk.

Surveillance at the state or community level can identify hot spots where resources could be deployed in order to reduce incidents of prevalence and bend the cost curves of diseases. In cooperation with the CDC, Illinois conducts the BRFSS, Behavior Risk Factor Surveillance System. We're very pleased that in 2009 the state included the optional module on caregiving and we're even more pleased the cognitive impairment module be in the survey conducted in 2011.

Effective surveillance on cognitive impairment and caregiving produces the state information about the impact of cognitive impairment, the number of family caregivers, the age, income, living arrangements, health problems, and other characteristics of those with the condition and their caregivers. With this information, we can support and guide campaigns to

increase public awareness of Alzheimer's, help policymakers understand that Alzheimer's disease, cognitive impairment and caregiving are major health problems that require focused planning as new interventions to reduce risks in societal impacts and support collaboration with Illinois public health department to include Alzheimer's and dementia as part of your prevention initiatives and other serious medical conditions.

We soon will have state specific valuable data to identify the impact of Alzheimer's and other conditions on Illinois citizens and to highlight the need for planning interventions, programs and services in Illinois to reduce the risk and impact. With this in mind, the Alzheimer's Association supports the inclusion of these two optional modules in the Illinois Public Health Surveillance Program on a continuing, regular basis.

Let 2009 and 2011 be the start of regular surveillance on these important issues. The incidents of Alzheimer's is rising. We need to know its impact on Illinois in order to provide a sound public health policy response knowing that

a strategic response to the emerging public health crisis of Alzheimer's will be needed to protect all Illinois citizens. Thank you.

MR. ARNOLD: Thank you very much for that testimony. That was phenomenal. This is definitely one of those issues that we must keep in the forefront with an aging population. Also, the interaction of this -- I was mentioning to someone before the meeting started that sometimes we have a tendency to give people a diagnosis and we think that stops everything else from happening and so you have depression then you don't have colon cancer and you don't have other things going on, but we're saying two-thirds of adults are overweight with obesity that's going to intersect with things like Alzheimer's and the person's ability to care for themselves and also with injury prevention.

So all these things are sort of implied when you start talking about complicating any kind of disease state. It's difficult enough to take care of things if you are mentally here and able to focus on everything you're doing, but when that happens and without, you know, the

families having support, without having a support structure or strong family then you have more problems and this is something that we need to keep a very sharp focus on, but any comments from anyone else on the Task Force on this issue? Thank you very much and please include your testimony. Thank you.

MS. WILSON: Good afternoon. Good morning. Janette Wilson, J-A-N-E-T-T-E, W-I-L-S-O-N. I represent -- unlike everyone else, I represent those who give hope and good news as well as those who challenge the system. One concern I have as I look at this panel is the disparity that you represent by your failure to represent a preponderance of the population in the state of Illinois and that is women.

I don't know how you could have a Task Force and not have more women represented in as much as we bring you into the world, we carry you through the world, and then we take you out of the world.

MR. ARNOLD: Thank you.

MS. WILSON: And since you all have been so quiet, I just figured you need a woman to

tell a village about what is going on.

MR. ARNOLD: We have 19 members. We do probably have some women, but we should have 18 of the 19.

MS. WILSON: I'm very disturbed. I'm here representing the faith community incase you didn't know, but when I see no women up there you all need to recruit some from the audience.

MR. ARNOLD: One lady she was here, but she had to leave.

MS. WILSON: I got that.

MR. ARNOLD: Thank you.

MS. WILSON: But we do respect the fact that you're here on the Task Force and I will not read my testimony, but it is printed and I gave it to one of the staff members for distribution to all the panel members. One of the things that I wanted to rise and speak to is an untapped resource within every state within this nation and even around the world and that is the faith community.

We provide the best communication system that you could have to communicate information about chronic diseases,

treatment, prevention, opportunities. We are greater communicators than most media outlets that you tend to use. Our strength was evidenced when the H1N1 flu vaccination program was initiated in Illinois this year. We were able to communicate to our members and to a broader cross section through our broadcast media, through our inserts in our weekly bulletins and communicated across pulpits without regard to faith the value of being inoculated against H1N1. The other thing which the faith community provides that most public health institutions forget or ignore is that we are the largest facility for deploying resources, providing temporary and emergency shelter. We are locations that can provide food on a temporary or even a permanent basis for numbers of people. We can be centers for deploying volunteers, recruiting volunteers and we would be great nutrition sites for communities, particularly in rural and suburban areas, for in those food deserts that Reverend Sampson talked about we need to be connected because we are also the grief counselors.

We are the people that when a

crisis occurs or when a child or a parent is obese or has a chronic disease or has an illness that appears to be terminable, the first person that they reached to is a member of the faith community generally.

We are oftentimes the first responders to a crisis, but the last to get the correct information to communicate. So we provide transportation. We have buses and vans that could be deployed. We have great communication systems. We have shelters. We have food and we have clothing. We can organize people. We can inspire people to act and we can do several things. So we're suggesting that, one, this Task Force should have a faith leader represented and it can rotate so you can cover all of the major faith traditions in Illinois. Secondly, the Illinois Department of Public Health should have a seat at its emergency response table for the faith community.

We're tired of being the last call and not at the table when decisions are being made about our constituents that God has placed in our hands. We know that if you look at childhood obesity and the failure to have good nutrition it

starts in the home. We're the closest to the home. So, oftentimes, faith leaders are not transmitting healthy information to their parishioners. So there needs to be a stronger partnership.

I'm probably the least obese person in the room and it's not by accident. I started out -- in my first 15 years, I ate vegetables from the farms that Reverend Sampson talked about. I didn't know what it was like to eat from a grocery store. My grandparents raised everything I ate, including the meat. So it was not processed food and I did not go home to obese parents. They did not eat potato chips. I didn't have fast food until I was a teenager and it was without the permission of my parents.

These children eat everyday in school and out of school red hots, Pepsi. I did not give my daughter soft drinks until she was old enough to make that decision. So juice and fruits and vegetables are not the common meal in schools, they're not common in the home nor are they common in many of our institutions that our children frequent on a regular basis. You can't change the

behavior without changing the messages that are going forth from every part of the community and that's why the faith community becomes critical in partnership with the Department of Public Health and with this Task Force. Are there any questions?

MR. ARNOLD: Thank you very much. That was very, very insightful. You gave some very strong points, Reverend Wilson. You also -- I know you have the school background, the legal background so I think this is really the trust level that you're talking about within the faith based institution which has born itself out and we have worked on many different programs together.

MS. WILSON: That's right.

MR. ARNOLD: With the H1N1 response and the faith based organizations actually played a critical role with that in saving lives within the state. There were multiple organizations, over 500 faith based institutions that participated. About two months ago, the CDC released some statistics and noted with respect to the ten largest states, most populated states in the country, Illinois actually placed number one

for those over 18 and for those who were less than 18 second. So we have to challenge that second place still, but we actually have great resources within faith based institutions and they have a training program that has been in place started with the pandemic training program. And as far as the seat at the public health emergency operation center, granted. We have one for you. But the state emergency operations center, we have to talk to them about that on the state level because that's part of the IEMA structure.

MS. WILSON: So we have to talk to the governor?

MR. ARNOLD: We'll talk to him and get in touch with him, but definitely because you have been -- not only the H1N1 response, but flood details. It's been very, very progressive, very positive. So I think all those things you were saying with the grief counseling, tradition -- we sometimes wait until the end, you know, even with things like Katrina's response is the most graphic because it was on CNN, but it happens everyday where these disasters occur and the churches are responding and we have a tendency to sort of

downplay and not recognize the contributions being made.

So thank you very much for bringing those forward and any other questions from the panel?

MR. AFRICK: Reverend Wilson, can I ask you about networks for reaching the faith based community in metropolitan Chicago and then expanding that statewide --

MS. WILSON: Well, we have denominational networks within the Christian faith and then there is a Chicago Council of Religious Leaders that represent the major faith organizations in the city of Chicago. You will find in Chicago most of the faith leaders, nationally recognized faith leaders, are domiciled in the city of Chicago. Down the state, there is a network and we have been working with the Department of Public Health to create such a database and it certainly can be expanded upon by contacting the leaders of the Islamic faith, the Greek Orthodox faith and in the African-American tradition, there's the African-American -- African Methodist Episcopal, African Methodist Episcopal

Zion, the 6th Baptist state organization, the 6th Church of God in Christ of state organizations, Before Apostolic Faith Organizations and this not counting the Catholics, the Churches of Christ and Churches of God. So there are just a number that we have that we can help you communicate with, plus the Jewish synagogues as well, and then you have those Native American faith leaders as well.

So it's a broad range that needs to be included because once you include all of us you have included the state and most of the people in it except for those who do not believe in any God. So they should have a rotating vacancy for the agency.

MR. AFRICK: Thank you.

MR. ARNOLD: Thank you very much, Reverend Wilson.

MS. GRIMSHAW: Good morning. My name is Jill Grimshaw, J-I-L-L, last name Grimshaw, G-R-I-M-S-H-A-W. I am the executive director of the High Ridge YMCA in the Rogers Park community, which is part of the YMCA of Metropolitan Chicago. I'm also here representing the Illinois state of YMCAs. With 51 corporate

Y's in the state of Illinois, Y's are the perfect place to cultivate healthy statewide change at the community level. The Y movement has worked hard to address the growing epidemic of obesity, which leads to increased health care costs due to preventable disease.

The two programs discussed in the testimony today will be the YMCA's diabetes prevention program and the pioneering healthy communities program. Between 1996 and 2001, the National Institute of Health and the Center of Disease Control established a Diabetes Prevention Program. The original DPP included one-to-one education in support for healthy eating and physical activity for the healthcare provider. From 2005 to 2008, the authors of this study collaborated with the YMCA of Greater Indianapolis to design, implement and evaluate a group based adaptation of the DPP lifestyle intervention.

Indiana University translated a 16-week course based on the original study which focused on the education and support being delivered in a group setting trained by Y staff. The result of the 92-person pilot demonstrated the

Y could deliver the program at a fraction of the cost and achieve similar results to the national program. Programs such as this were successful in preventing or delaying the onset of Type 2 diabetes by reducing our bodyweight by six percent and increasing our physical activity and continue to maintain progress 6 and 12 months after the core 16 sessions.

In April of 2010, United Health Group teamed with the Y of USA to expand Y and DPP. Rather than simply paying high medical claims to customers, United Heath retained the YMCA's and pharmacists to keep people healthier. Using the model from the YMCA of Greater Indianapolis, Y USA has implemented the Y DPP in Louisville, Cincinnati, Columbus and Dayton, Minneapolis, Phoenix, Jacksonville, Fort Wayne and Bloomington, Indiana, Rochester, New York, Delaware, Seattle and Birmingham. Y of the USA worked with Congress to create the Diabetes Prevention Act as part of the healthcare reform that establishes a national community diabetes prevention program at the Centers of Disease Control.

In September of 2010, the Y announced a $50,000 grant to introduce a diabetes prevention program at their local Y's. YMCA's in Quad Cities, DeKalb and Elgin were approved to start Diabetes Prevention Programs in the fall of 2010, but unfunded. The YMCA is soliciting private funds and advocating for Congress to secure additional start-up funding for the approved, but unfunded Y's.

While Y of the USA is looking to fund the Y's in Quad Cities, DeKalb and Elgin, we are also looking to partners in this work. In 2011, Y's may choose to make a $12,500 investment in Y of USA to participate in the YMCA's Diabetes Prevention Program. The investment will provide access to training, curriculum, tools, resources and support. YMCA holds a unique advantage in their infrastructure from community based prevention programs because of the sheer number of locations and its ability to reach low income and minority populations.

The Y also has a solution to prevent childhood obesity due to primary and healthier communities. In 2010, the Illinois

State Alliance of YMCA's was named one of the state's pioneering healthier communities. PHC, as it's known, is a statewide collaborative effort that focuses on healthy systems, environmental and policy changes that are driven by a community dream team of advocates and ambassadors. The advocates and ambassadors are a diverse group that starts doing the community healthy living index on their community. The CHLI assessment, which it's also called, indicates gaps that inhibit healthy choices such as unsafe walk paths, lack of access to fresh foods and vegetables or not enough after-school programs emphasizing physical activity.

Three statewide PHC's were started in 2009 in Connecticut, Kentucky and Tennessee. In 2010, it includes Illinois, Michigan and Ohio. The 12 YMCA's that are included in the Illinois pioneering healthy communities are located in Elgin, Rockford, Metro East, Moline, Chicagoland, DuPage County, Joliet, Kankakee, Oak Park, Peoria, Quincy and Springfield. Schaumburg not Springfield.

These local groups support the

large statewide team focused on policy change at the state level. Our current statewide partners include Illinois State Alliance of YMCA's, Illinois Department of Public Health, Illinois Alliance to Prevent Obesity, Active Transportation Alliance, the Illinois Chapter of American Academy of Pediatrics.

The Y is planning to introduce our statewide pioneering and healthier community roadmap in September of 2011. 2011 will focus on bringing our diverse group to the table and identifying key areas of state policy that inhibit all of our communities from being able to make healthy choices in our daily lives. Thank you.

MR. ARNOLD: Thank you very much. You have your testimony. You can submit it for inclusion, but very, very stellar work with the YMCA's. I'm not sure of the relationship to, you know, YWCA's because I get asked that question and whether they are involved in the same process as well.

MS. GRIMSHAW: The YWCA's are a separate affiliate. They are not affiliated.

MR. ARNOLD: Any questions from

anyone else on the Task Force?

MR. ISAACSON: Michael Isaacson. Good morning. I'm just wondering in terms of integration across networks for statewide planning you mentioned the statewide group of Y's in Illinois now. What do you think is the most important thing that needs to be done to integrate the Y's into anything that goes on statewide?

MS. GRIMSHAW: If I understand your question, probably a communication network. I know that was just mentioned before. I think that would help. The YMCA tries to sit at every table there is so we're integrated across the board, but communication is probably overall.

MR. ISAACSON: Like establishing a formal communication network of some kind?

MS. GRIMSHAW: Correct.

MR. ISAACSON: Thank you.

MR. ARNOLD: How many students are usually or people are usually involved in the program to --

MS. GRIMSHAW: It depends from community to community.

MR. ARNOLD: Okay. Thank you very

much. We've sort of gone over our time a little bit so if anyone wants a five minute break or keep going? Let's take a two-minute break.

(Whereupon, a break was taken after which the following proceedings were had.)

MR. ARNOLD: Okay. We're going to get ready to start again. We have the next presenter at the podium. If you can state your name and spell your name and also the organization that you're associated with.

MS. GADON: Good morning, members of the Committee. My name is Margaret Gadon, M-A-R-G-A-R-E-T, G-A-D-O-N. I'm a practicing physician in Illinois and the clinical director of IFMC-IL, which is most of what it does in Illinois is it houses the contract for the Illinois quality improvement organization and we are also working on other quality initiatives to improve care across the state of Illinois.

My testimony will largely be general in format, but following my remarks I will be discussing a project, which is in preparation or development that does integrate many aspects of

chronic disease and my remarks span both elements of prevention -- primary prevention and secondary prevention of chronic disease.

As you are all aware, the term chronic disease encompasses any condition that requires care over a period of time and general is one which is not curable. We've heard extensive remarks about the cost of care for chronic disease and I will not elaborate here. However, we do know that chronic diseases caused by degeneration such as arthritis are a natural part of aging and will occur regardless of the type of preventive activities initiated. However, certain diseases are preventable. Those individuals with the genetic predisposition to them alter their environment and lifestyle, specifically diet and the amount of regular physical activity.

I commend the Department of Public Health as well as the US Centers for Disease Control for developing programs at the population level to encourage Illinois residents to make changes in their diet and physical activity to the extent that it is within their personal control, that they have the sufficient

income to purchase healthy foods and live in an environment in which there is access to affordable and safe physical activity. It is difficult for me to speak with any credibility today to the issue at hand which is how the state can best coordinate and integrate its efforts to health promotion and reduce chronic disease disparities without knowing the specifics of the various initiatives.

I am, however, aware of the 2010 State Health Improvement Plan which lays out a clear pathway to health promotion and chronic disease prevention using well accepted strategies. What struck me in reading over this document particularly in relation to those I hadn't seen when I was a public health physician working for the State Health Department of New York several years ago was the degree to which health reform, community engagement and interdisciplinary approaches to socioeconomic determinants of health were recommended. From my perspective, these three approaches are the essential elements to integration of health promotion programs. Regardless of the degree of integration at the

state level through planning, it is at the community level as Dr. Arnold so eloquently mentioned previously where these activities are implemented and where the integration is most essential. Specifically then through health reform, funds for prevention should be funneled as much as possible to the local level where they are planned and implemented with the input of community members, including the children of that community. The medical societies and hospitals should be elemental to this and encouraging their physicians or physician office teams to participate. This would not only help with the planning process, but also better link medical and public health services leading to reenforcement of prevention messaging to community residents.

Secondly, through community engagement activities, if activities can be culturally and linguistically tailored, thereby increasing their likelihood of being understood, heard and eventually adopted, volunteers can be engaged thereby filling the needs of underresourced local health departments.

Community ownership is more

likely to reenforce these activities and lead to creative applications across the social spectrum of resident lives, and, finally, through interdisciplinary approaches to address socioeconomic determinants of health the environment which facilitates behavior change can be developed. The challenges to achieving a healthy lifestyle such as media messaging, unsafe neighborhoods, lack of park space, lack of access to nutritious food and lack of solid family structures in with children can prosper loom large in many of our communities particularly in urban areas.

Innovative solutions for these problems are likely to occur in small community settings with strong leadership, private public partnerships and a strong commitment from the business community and perhaps that's one of our greatest challenges, how to make better health for the public a win for business. This is a tougher road ahead for the state with its budgetary constraints, but this time also represents a great opportunity with increased funding for prevention coming from the federal government and a public

increasingly aware of the issues.

Now, just quickly, I wanted to mention -- I won't mention it. Primary Care Extension Program --

MR. ARNOLD: You can make one very quick question about it. You can put that into the testimony, but if you want to make a one or two sentence summary sort of what it is that would be fine.

MS. GADON: Yes. The Primary Care Extension Program is part of the Federal Healthcare Reform Act. The funds have not yet been appropriated, but there is $120 million intended for this program. We're not sure how many states are in this program. It's modelled after the Agricultural Extension Program. Funds go to the state level and then are sent to the local level where a hub of medical services, public health services and the community members are working to integrate care and this is run by a community focused health extension agent who links and coordinates care between these different groups and specifically provides coaching for the community residents, helps -- practices transform

to teen based care and the medical home and most importantly actually creates an opportunity for those small community projects which you're talking about being linked to physician practice and incorporated into medical care to prevent both primary and secondary disease.

MR. ARNOLD: Thank you very much. Very great summary. I do have time for one very quick question. Anyone right now?

MR. ISAACSON: I have one question. Doctor, Michael Isaacson. I'm wondering -- I agree with you whole heartily on the local -- the grass roots effort is really where the rubber meets the road and I think people need to know the importance of community and working from the inside. What advice do you have to this panel in terms of a statewide approach where we can really foster those efforts?

MS. GADON: As I said, I think the most important thing you need is integration on these things and you need representatives from each of the communities feeding information up to the statewide level in a format that is easily -- that is standardized and easily analyzed to

provide best practices, but unless that money is channelled to a coalition at the multiple community levels, you're not going to have an opportunity to really represent the voice of the people and my neighbor, who is markedly overweight, I've seen her little girl, she comes in with chocolates and stuff, I'm sure she knows she is overweight.

I'm sure she has heard the messaging. She is not incentivized. It just hasn't rung home and she hasn't decided to get on board. Until her -- whatever makes her tic and that's going to be her peer relationships and her community incentivize her, she's going to be keep buying Oreo's, chips and feeding the little girl chicken tenders.

MR. ARNOLD: That's a very, very important point. The one thing about the State Health Improvement Plan and you sort of reiterate this point is that the State Health Improvement Plan is -- I have a bit of a military background so when someone tells me a plan, it means I can put the key in and drive so we're operational wise. So although it's stated as a plan, it's a

framework and you have a mechanism now in order to extend the community with the best practice model, those kinds of things, but the community engagement piece still has to be there to utilize those tracks. So a very, very astute observation.

MS. GADON: Thank you. I've been in community health my whole life and it's wonderful that somebody is actually recognizing this is the way to go.

MS. ROBBINS: Good morning. Pamela Robbins, R-O-B-B-I-N-S, representing the Illinois Nurses Association. Thank you for allowing the Illinois Nurses Association to speak today. Professional nursing is a vital component to any healthcare system. Illinois has over 164,000 licensed nurses to serve the public. As the soaring costs of healthcare increase, efforts to improve the efficiency and effectiveness of our Illinois healthcare system must take into account the nurses contribution to ensuring cost-effective, high-quality care. Numerous studies denote the impact of higher nursing staffing levels have on reduced hospital related mortality, hospital acquired pneumonia, mitigating

complications by more rapid intervention to name a few.

In today's healthcare arena, we see increasing pressure to control costs. Patient volume and level of illness are still at an all-time high. There is a growing demand to improve safety and quality. Quality is important. The question becomes who is best to make it happen. Nurses already know they're a part of that answer. Recent studies are documenting that from an economic standpoint, it is no longer acceptable to look at just the cost of nursing service, but rather the cost savings and value of quality patient outcomes that the nurse provides.

In light of October's Institute of Medicines Report, healthcare reform is not just an idea. It must be made into an action plan. Such reform will take a departure from what is and move it to what it should be. Any plan will take cooperation of the state holders which will include a redesigning of the nursing workforce, reworking financial health initiatives, expansion of health insurance coverage, investing integration of health technology, changes in

education of nurses, consideration of the workforce skill-mix and broadening the scope of practice to Illinois nurses in many profound ways.

To truly reform healthcare from the historical model of treating illness in an episodic manner, we must move to a method of providing care across the studies of all providers allowing the public to fully recover from the illness or manage exacerbations of a chronic illness. These methods would include emphasis on prevention, wellness programs, chronic illness management, home base primary care, nurse home visits, nurse managed health centers and community health teams.

A study by Jencks, et al, from the New England Journal of Medicine reported that 20 percent of Medicare beneficiaries hospitalized between '03 and September '04 readmitted within 30 days of discharge. The percentage increase went to 56 at one year. The cost of Medicare to taxpayers was estimated at over $17 billion. Mary Naylor has studied the use of advanced practice nurses, APN's, to coordinate and manage healthcare for hospitalized older adults with multiple

comorbidities and chronic illness. The APRN, advance practice nurse, begins working with the patient upon admission to the hospital, coordinates care during hospitalization, makes home visits within the first 24 hours of discharge and, most importantly, continue to manage until the patient is stable and the caregivers are able to manage on their own.

Naylor's transitional model has reduced hospital readmission rates, improved patient's physical health, functional status and quality of life and reduced by about half the cost of patient's total healthcare costs.

We must focus on how to close the gap on chronic illness. Nurses working in the community play a crucial role in healthcare promotion and disease prevention today. Various states have had programs sharing successful, care management strategies directed by nurses who were integral to a provider's practice who coordinate care and communication between patients and all members of the interdisciplinary team serving that patient and who directly provided healthcare services via in person, telephone or electronic

methods.

Increasing evidence is showing an enhanced, integral involvement of nurses in both the coordination and delivery of care particularly for patients and during multiple chronic illnesses and complex care regimes. Care management is critical to achieving the cost in quality targets. Several programs and initiatives include the health reform legislation involving intra-disciplinary and cross-setting care coordination as well as care management services by RN's. I'm sure you're following my fundamental direction of care from costly acute hospital based care to prevention, wellness and chronic management delivery systems where the public lives and costs are diminished by keeping the public in a state of health.

Many states have embraced changes in such deliveries of care. The question is when will Illinois. As state holders, policymakers, funders, educators, practitioners, we must look beyond the medical model as the sole solution to community health and recognize the contribution nursing and nurse practitioners are

making to primary care and health. Thank you for allowing me to speak to the panel.

MR. ARNOLD: Thank you very much. Very insightful and very well said. One of the questions -- you had mentioned -- you were mentioning a couple of issues that I was really interested. One is the view of what is the person of the future. I have gone through this before with the school of public health. What is the public health work of the future? What do they look like? So what do you envision the person of future for nursing to look like and how do you coordinate things between different institutions where nurses are practicing a myriad of different settings? Is there a way of connecting that?

MS. GIBBONS: I think the first thing one in every 48 adults in Illinois is a nurse. There are nurses that volunteer in parishes, at schools, in all sorts of communities. I would love to have a study of how nurses' families are managed with their care to keep them out of hospitals and take care of them on a wellness path and then disadvantage to those that don't have that nurse to manage.

You have to educate. Being in the schools is vital. That is a community. That is where nurses need to be to coordinate healthcare for these children. I'm married to a farmer who is in a family farming operation. His 90 year-old mother and father still full-time farm. They are healthy, they are engaged, and they also have managed care by a nurse.

I really think that you've got to educate the young. You've got to allow for access and I think advanced practice nursing and disallowing those barriers that we face today to be able to get the care to the community whether it's the school or the home because it's essentially -- nurses were public health nurses. They went out. School nurses were established to keep sick kids out of school, out of the community to keep the community well.

The public nurse went in and took care of a brand new baby, made sure the mother knew about how to feed, how to care for that infant. Education is important. When you prevent the problem, it's much more cost-effective than waiting for them to come to you to the

hospital where you have as one doctor called it expensive care than intensive care. And location, location, location.

We've got to go out to the communities. I've heard this wonderful group of people who know how important it is. My community, my family community, my church community, the school community, how do you keep people from going episodically to the doctor when they are so sick and they have gangrene because they had untreated diabetes and we wind up cutting off a leg in the operating room. I'm a recovery nurse for the last 32 years. It is just much easier to take care of by preventing than to do episodic, putting the fire out. So that is why it's the education axis and location, location, location.

MR. ARNOLD: And in the Naylor transitional model, do you have any cost benefit analyses on that or documents?

MS. GIBBONS: Actually, the document study that has been done and they tried to introduce federal legislation so I can get that information to you.

MR. ARNOLD: Great. Thank you.

MS. GIBBONS: Thank you.

MS. NAUSS: Good morning. My name is Mary Rose, M-A-R-Y, R-O-S-E, N-A-U-S-S, and I represent the National Kidney Foundation. I am a volunteer. I'm under the supervision of Kate O'Connor and Marla Solomon. I am here today impromptu to -- so much has been said that I would love to echo all of it, but as a volunteer I want to say it's not unique to what people say, but as far as I am concerned I represent courage, faith and enthusiasm. I'm part of Advocacy Day where people meet at the kidney foundation and we go to Springfield on a bus. We're educated on what to say to the legislators and how to say it and do like the three minute elevator speech type of thing with them to let them know how important it is for prevention with diabetes kidney disease. Something many of you are probably familiar with is the Kidney Mobile, which is once you've looked at how much salt is in a rib, it will probably be spoiled for you and that kind of thing.

I have experienced somebody who I love dearly and been with for 15 years

experience a kidney transplant and that's what inspired me to become involved with this group. Seeing what he went through with dialysis and all that and it was because of that kidney disease, but just to have someone give so much love to donate an organ and have him be able to live a normal, happy life. With all the challenges that go along with a transplant, I felt it in my heart to go out there and work with them. I have probably lots more things to say, but --

MR. ARNOLD: Thank you for your participation today. One of the things that underlies a lot of the programs that we speak of now and also has been part of President Obama's push from the beginning is volunteerism. We know he started in that track before becoming the president. So that is really a central focal point that we have to keep in mind that volunteers -- you know, volunteerism is a way that I learned when I was in high school.

You know, I donated 2,000 hours to hospitalized patients just at the school running in and running home and that was over a four year period, but I got a lot more out of what

I gave than what, you know, what I actually put in I think. So thank you for your time and putting that on the record, but volunteers should be noted as being a central component and extremely important in this process. Thank you.

MR. AFRICK: If I could just add a comment. You have a wonderful leader in Kate O'Connor and I think it really does underscore that as we're looking at all of the influencers on chronic disease, there is a role for nongovernmental organizations to interact with the patient communities.

MR. PATTERSON: Good morning. My name is Bill Patterson. I'd like to speak to martial arts programs as agents for chronic disease prevention and health promotion. I represent K.S. Hyun's Hapkido Schools in Chicago and with me is Dr. Shorty Mills representing 3 Cities Pagoda Martial Arts Schools in Hazel Crest. I'll present an abbreviated version of the testimony and an expanded version I've provided to the staff. I'd like to thank the Task Force for this opportunity to express our concerns for the public health of our communities and recommend the

utilization of community martial arts program as agents for chronic disease prevention and health promotion.

During this time, I'd like to establish a context with a brief overview of chronic diseases and existing guidance to deliver chronic disease prevention and health promotion and then describe the use of martial arts programs as agents of chronic disease prevention and health promotion. I've provided a program logic model as a handout for the Task Force and it does correspond with this written report. Obesity and violence have become major public health concerns both national and local community educations. While the two concerns may appear to be unrelated, they both pose a major negative impact on the present future health of the population and the safety of our country.

In January 2010, the surgeon general issued a report that identified obesity as a national epidemic draining billions of dollars from our economy. Further, two-thirds of the US adults and nearly one-third -- one in three children are overweight or obese. Conditions that

increases their risk of diabetes, heart disease and other chronic diseases. Obesity has become a national security concern. Over 9 million young adults, 27 percent of all Americans age 17 to 24 weigh too much to join the military according to Mission Readiness, a nonprofit organization promoting health and education.

The group of young adults is also a source in which we draw our emergency responders, police, firefighters and paramedics. The health of this population decreases, the defense of our country and its ability to respond in time of crisis during a national emergency is also diminished. The Justice Department study in October 2009 found that more than 60 percent of children surveyed were directly or indirectly exposed to violence in the last year. Victims of robbery, vandalism, theft or sexual assault. Nearly half the children or adolescents were assaulted at least once and more than one in ten were injured as a result, nearly one quarter of victims of robbery vandalism or theft.

Project Oneness is a IDPH initiative for a more comprehensive approach to

community health specifically targeting health risk behaviors that are leading causes of obesity, diabetes and various chronic diseases including violence. Unaddressed, these behaviors will result in increased death, disability, hospitalizations and illness among young people and adults in the United States. Communities experiencing high levels of these behaviors are identified as, quote, environmentally at risk, end quote. In a concept paper, IDPH martial arts initiative dated 15 November 2007 the director of IDPH proposed utilizing existing martial arts academies to deliver positive health interventions and in environmentally at-risk communities.

Further, that martial arts schools share similar objectives of public health and are to provide health education and promote safe environment where individuals can obtain their best possible state of physical and mental health and spiritual well-being; body, mind and spirit.

It's estimated there are over 200 martial arts programs in the Cook County area, approximately 800 to 900 throughout the state of

Illinois. These include independent schools or programs located within park districts, community youth serving organizations such as Boys and Girls Clubs, YMCA's, YWCA's, churches, et cetera. These programs are able to provide youths between the ages of 6 and 17 with professional martial arts instruction from established community martial arts schools.

The program of traditional martial arts instruction is a holistic approach to improving public health by emphasizing physical health and safety, mental health, education, positive care to development and good citizenship. Beginning in January 2008, Dr. Mills and I began a collaborative effort with the IDPH staff to design and implement a demonstration project for the martial arts programs to deliver public health interventions in the community. The program is entitled Youth Martial Arts for Total Health, the M.A.T.H. Project. The project, while still a work in progress, has integrated the expanded public health education into the martial arts curriculum. A major effort has been in the development of an evaluation design that records and tracks the

progress of students.

Currently, there are four martial arts schools that are participating in the project and collaborating on the -- collecting performance data that is forwarded to IDPH for analysis.

The program logic that I'm going to provide to the Task Force provides and identifies the basic framework for the evaluation of this particular project. It illustrates the relationships and the activities to the results or outcomes of the martial arts training. The basic components of the model are inputs, outputs and outcomes that measure initial, immediate and long-term impacts.

The quantitative data may be derived from attendance, fitness testing, promotional records, school report cards for academic progress, behaviors, attendance and police reports. Once again, I would like to thank the Task Force for this opportunity to express our concerns for the public health of our communities and recommend the utilization of community martial arts programs as agents for chronic disease

prevention and health promotions. We strongly believe that the need is urgent for our state to address chronic disease prevention health promotion specifically targeting obesity and youth violence. Every resource we can identify must be used. Community based martial arts programs share the goals of the Department of Public Health and are uniquely equipped to deliver positive public health interventions.

Dr. Mills and I would like to take what time is left to answer any questions that the Task Force might have. Thank you.

MR. ARNOLD: Thank you very much. I have martial arts experience in my background over the years, but I would never challenge these two. That would be my demise. The two of them have been working with this project and the one thing I say from this is that many projects are out there where you have these sports endeavors people can participate in such as volleyball, football, basketball, but many times -- and even baseball. They're looking for the star athlete and everyone else sits on the bench. So many of our programs that are actually being instituted across the

state are very, very slanted towards the higher achiever, the person who is going to be on CNN accepting the Heisman trophy, but this program actually focuses on each individual student. It talks about nutrition, cardiovascular fitness, anti-drugs, anti-alcohol, anti -- it's really across the board. Self-esteem building, focus in school. It has many of the components that we talk about within public health which really attracts me to it. There are basically ten components that I thought were very, very strong within these programs.

So this is really a pilot program that has been underway and we're looking at the potential for the integration of the principals within the school system as well. Both have a law enforcement background and a military background as well and surely you can stand up, Dr. Mills. And as you can see, he's not really short. So if you ever see his name on a platform and you're supposed to be sparring with him, back off, but I will leave it open to the panel if anyone has any questions about what they're doing and how this is influencing children's lives. I

have all kinds of letters from parents. Just remarkable instructors, the teachers, the schools they're seeing transformations in these children. It's always my belief that if you give a child -- if you have a child under your auspices that you're taking care of, you can make a Hitler out of them or an Einstein. It depends on how you treat them and this is actually training them how to respect themselves, especially for young women as well, making sure they focus and develop their self-esteem component, but, with that, I'm going to leave it open. Any questions or -- okay. Very good. Thank you very much for your testimony.

MR. PATTERSON: Thank you very much.

MS. VAVIGLUS: Good morning, ladies and gentlemen. My name is Martha Vaviglus, V-A-V-I-G-L-U-S. I am a professor of preventive medicine and medicine at Northwestern University Feinberg Medical School. Well, this is the first public hearing I attended. So you have to bear with me because I didn't know what is a public hearing at this state level. I have been invited years ago to the White House to give a public hearing on health cause, but it was different.

What they wanted me to talk about in public was exactly what I knew as a scientist as a researcher. Also, I wanted to tell you that I am the principal investigator of the Hispanic community health study, study of Latinos. It's the longest study to date on the conditions that effect several ethnic groups of the Latino population because when we think about Latino we believe that they are all Mexicans and maybe they are different -- different between of all these ethnic groups in the Hispanic community.

Therefore, we are collecting data on 16,000 individuals ages 18 through 74 with the purpose of seeing the true prevalence of conditions and this is including diabetes because, among Latino's, obesity and diabetes has the highest prevalence compared to African-Americans and whites. So you have -- this gave us an idea of perhaps seeing so much diabetes among this population it would be important -- I think I just wanted to say before saying that what we are going to learn from this historical study among Latinos we can apply to other bases. It can go to other communities, of course. So having a registry of

diabetes in the state of Illinois, we believe it's timely not only because we want it to count how many number of people with diabetes we are going to have in the state of Illinois or what are the best practices and treatments that work better than the others, but also this register has to have a public health service program for prevention because we already know that these people are going to go to hospitals where admissions -- and I just wanted to say as a note 40 percent of admissions to the hospital has a diagnosis -- underlying diagnosis of diabetes.

So to prevent those admissions and to prevent the awful consequences of diabetes -- because I don't have to tell you. We all know what happens with obesity and what happens with obesity and ask a cardiovascular person and with my background I can tell you prevention of diabetes is important, but now we are talking about secondary prevention where we cardiologists believe that diabetes is equal to myocardial infarction. So that is how terrible this disease is.

So we would like with this

registry of diabetes, having the service of public health, help diabetic patients to, perhaps, eat better and exercise more and quit smoking and the emphasis as I mentioned previously should be always on the less educated, the low income, the people who have English as a second language because maybe they go to see physicians, maybe they are -- they know that they have to be treated, but, unfortunately, they cannot go to do it or they cannot register on the Internet. They don't know how they are going to register on this wonderful program of exercise, nutrition that we are talking about.

So efforts on these great organizations that aren't doing such an important work it is imperative. We would like to continue and, of course, talking about probably hundreds and millions of dollars that we never have for health, however, this is going to prevent a cost in the future because if we are letting the population grow frail, we are not only making a disservice to the people why people would like to live longer with this awful condition.

So we would then like -- because

it is important for us, for Northwestern University, to help in this program. For example, Northwestern was very involved in the control of diabetes, in the control of hypertension and work together with the state and with the national. So I do believe that this is an important problem registry that the state of Illinois should consider because it is timely due to the accessibility of medical records. Thank you very much.

MR. ARNOLD: Thank you very much, Doctor. I can see your passion coming through as well. That's very, very good, but registry is definitely a concept that we have been entertaining because actually part of this diagram which I have not gone into because actually it will be rolling out, we're developing pieces of it, but the idea of a community based kiosk model is already developed, but also the fusion center concept about using public health information and having data being more accessible to people on a general basis, on a statewide basis, but that most definitely is really one of the things that we are really seriously considering the issues of so

thank you for bringing it to the forefront and thank you for your passion and it looks like --

MR. AL-NURIDDIN: Good afternoon.

MR. ARNOLD: Good afternoon.

MR. AL-NURIDDIN: Salim Al-Nuriddin, S-A-L-I-M, A-L-N-U-R-I-D-D-I-N, the Healthcare Consortium of Illinois and the Roseland Community Hospital. I'm wearing both hats this morning. First of all, I really am glad to be here in front of this Task Force and really I'm glad mainly because all my advocacy friends have been here this morning so I don't have to say everything that they said, but I will say something to them with this opportunity.

Advocacy has to get focused on one or two things that we can all get done because if we don't do that we're going to keep on for the last fours -- we keep missing everything because we can't get together on a couple of things and I really hope we can find that and hopefully that's another discussion.

Meanwhile, we have the Department of Public Health and its leader here and I want to, first of all, frame this last

little comments on one, the need for leadership and vision in government. Since the election is over and we look like we have four more years of Governor Quinn, I want to know if you're going to stay for four years because if you're not, then we need to know about the consistency of the leadership. Fortunately with Dr. Whitaker leaving, you came in and took over and even gave us a whole sense of breath as we talked about this whole sense of public health and understand what public health is and the importance of it. I ain't laughing because to me this is serious.

I know my friends in advocacy understand this and maybe don't want to talk about it, but we got no money in the state. So we got no money. We need to be certain about leadership and because we don't have any money we better focus on things that don't cost no money because there is no guarantee no money is going to show up unless somebody has some to put in the state's coffers and it ain't me.

What I see is we're going to look at losing programs and losing things and I'm not going to spend time trying to argue the

financial benefit of prevention. That's a waste of time. That's already been done. The question is does anybody got the courage enough to start reforming the system.

We have a great healthcare reform platform in law. We have a Healthcare Reform Implementation Task Force and Committee. Where is the plan for implementation? If prevention doesn't give the incentives, then it ain't going to happen. If it ain't dollars on the front end for prevention, then we going to keep on having this conversation because nobody is ready to give up feeding their families in order to do the right thing. That takes too much courage and there ain't that much courage out here unless somebody knows something I don't know and I'm willing to listen.

We need to be able to as advocates impact the governor and our legislators around policy issues that we think someone needs to say raise the water so all boats have an opportunity to rise. I'm so sick of the disease of the month, the flavor of the month. I can't get enough attention on one disease. My wife is a

diabetic. My mother and my father are diabetics. They want to know how come everybody talks about cancer and nobody talks about diabetes. Well, we talk about diabetes now. We got about 15 more days before we have to talk about something else. A month before that it was sickle cell. So what is it? Disease of the month, every flavor you can get and it keeps on competing over the same issue where everybody is dying because of what they eating or what they ain't doing.

So when we get to this whole issue, what are the whole issues and they've been spoken of already before so I don't need to go over there, but what I'd like to talk about is this. One, please stop letting the folks take money out of outreach and public education and calling itself doing something. The Department of Family Health Services, the Department of Public Health, it's hard and harder to get a dollar to get people who can go and knock on doors and do this peer kind of education and information. If you don't have that, you are putting planes in the air, you are putting missiles in the air, but you ain't got no troops on the ground to fight this

war for poor health. We have to have boots on the ground. There's a lot of Democrats almost lost the dog gone election in Illinois. No troops on the ground. You all get that. Somebody better know something.

All right. Community health workers -- this whole healthcare reform there is more need than their capacity. I love my nurses. Some of them are gone already. There's a shortage of nurses. There's a shortage of doctors. There's a shortage of technicians. There's a shortage in every profession. So what the heck are we sitting here talking about putting together programs when we ain't got nobody to do them. We need to talk about how we're going to clear the pipeline. Two things I hope we do. One, address the issue of certification for community health workers. That doesn't take a fight. Everybody seems to be in agreement. So why don't we just get some certification, get the public education system to start doing the training so we can put people out in the public education doing patient advocacy, doing system navigation and doing all the things that community health workers are doing

from dealing with the whole issue of food deserts to everything else.

You tell me my time is up so let me finish with this. We need to focus on the strategies to increase -- this is one of the areas where I think everybody can get a rise. I would like to see the Department of Public Health and the State Board of Education come up with a Task Force to work on these pipeline opportunities the healthcare reform provides and let's get people on the bottom rung for healthcare workers and let's talk about getting the pediments out of the dog gone nursing program where they trying to tell my daughter she is going to get an online nursing program and I know damn well you can't because you ain't got enough nurses to do the training and every school got backup lines that is three years long. So let's get the mess. Either let's talk a way to get something other than master's degree level nurses or let's take it on computer lines that supposed to be able to get more advantage of the nurses that are available, but otherwise than that I really know we just don't want to make this a wasted day and a wasted night and I know you

guys are going to do a lot of good, hard work, and I hope we can get to a few of these policy issues that don't cost no money, but I think we're ready for a little fight. If you say so, we'll be down there with the buses.

MR. ARNOLD: Thank you. One of the things that is really important to what he was saying is -- that was an interesting point is, one, that when we start talking about the issue of the Patient Protection Act, Title 4 is for wellness and prevention and I believe it's somewhere in the area of $150 billion that they're talking about putting into that. Title 5 is workforce development, but as one of the things that many of my deputy directors go through when they walk up to me and ask for different money and more staff and I always give them the analogy I have a thousands pieces of a car in front of my house and I want to join the Indy 500 in a couple of months and all these pieces are scattered all over the lawn.

So they come forward -- and I don't have the lawn in reality. So all these pieces are in front of my house and I ask them to

bring in gasoline. I say "Why don't you bring a hundred gallons or a thousand gallons of gasoline and pour it on top of the parts" and he looks at me like what are you talking about? And then I say "Why don't you bring in some strobe lights and metrics so we can measure how fast this thing is going and flags" and it's like what are you talking about? That's crazy. You have parts all over the ground. Then I say "Why are you asking me for more staff and more money when you don't have a plan?" You don't have something functional. You don't have something put together."

And that, you know, really astounded me about two months ago. I realized that Ray Batra and the -- for the CDC's position and for HHS when they came forward and said you have seven days to bring me a plan in order to get funded and then 14 days is the maximum and I'm looking at it like how can you get something together in that period of time and the point is that you should already have it together. They're looking for projects where people have been thinking over time and putting something together

that makes sense and they don't want people throwing things together in the last seven days and saying "Here. Take this."

So the planning and the development stage is something you don't need money for. All you need is a cup of coffee or a cup of tea, sit down and plan and make sure that this thing is making sense and once you implement this model that it is actually going to have some metrics in place and makes sense once it's implemented, but until this point we're just spinning our wheels and throwing gasoline on broken parts.

So that's really why it's important to really focus and to make sure that we're looking at best practice models and developing the right mechanisms. Next.

MR. WILLIAMSON: Good afternoon. My name is Eli H. Williamson, E-L-I, Williamson, W-I-L-L-I-A-M-S-O-N. All right. Today, I'm here representing an organization I cofounded. I'm a veteran of both Iraq and Afghanistan, had the pleasure of serving with Dr. Arnold in Iraq in 2004.

I cofounded an organization called Leave No Veteran Behind. Leave No Veteran Behind was cofounded by two veterans of Iraq and Afghanistan to provide educational and employment opportunities to veterans and they return to civilian life. These two pillars of our organization, education and employment constitute the backbone of any successful veteran integration and support services. Our unique programing seeks to provide innovated strategies that create synergy between government agencies, industry, veteran support service providers and the community at large.

The first component of our services provide educational debt relief to veterans who are facing economic hardship, are not covered by existing educational programs and have completed some form of higher education. This retroactive scholarship relieves veterans by applying privately donated money to the veteran's student loan account. Once the veteran's educational debt has been paid in full, the veteran is required to give back by performing 100 hours of community service. Since our program has

been founded, we have paid off the student loans of four veterans and these veterans have already completed over 400 hours of community service.

While the primary mission is to keep the promise of equal access to educational benefits to all of our veterans, the secondary focus of our program is the benefit of volunteerism on veteran integration. The veterans of this program are highly motivated and have a successful demographic. They have all shown the drive to complete some form of higher education and, of course, serve in the United States military. Coincidentally, 98 percent of the veterans who are enrolled in our educational debt relief program are already performing some form of community service. The other two percent would be if they weren't inundated with educational debt.

PTSD and other mental health related problems routinely keep veterans from attending and/or finishing school. We hypothesize that community service and engagement is another key component to help veterans readjust to civilian society. We hope to use the data from our program to ascertain the positive effects of

volunteerism and veterans integration. We are also looking for an established mental health medical partner to work with our organization to research potential mental health opportunities that community service provides.

The second component provides workforce development and employment services to over 50 personnel on the south side of Chicago. Our innovative program provides transitional jobs to veterans who are unemployed or underemployed. Leave No Veteran Behind was one of the community organizations that was awarded a contract with the Chicago Public Schools for Safe Passage. Our veterans provide Safe Passage to Chicago public school students as they walk to and from school for this school year.

Veterans hired by this program get paid $10 an hour, six hours a day every school day for the school year. We currently serve the Hyde Park, Wood Lawn and Bronzeville areas. These services reach over 3,000 students every day. This contract was an extension of our community service initiative that was started by one of our veterans who has helped with our educational debt

relief program. His name was Haki Gurkin. He is also a Chicago police officer, served ten years in the United States Navy in military intelligence personnel and he is also a ten year veteran of the Chicago Police Department. He was integral in creating our strategies for Safe Passage. Ingrained in this transitional employment opportunity are multiple opportunities that facilitate our primary goal, transitioning veterans into long-term, sustainable employment. All employed veterans receive 20 hours of free unarmed security training, which allows them to get their PERC card. This card will allow them to work security or work security related jobs anywhere in the state of Illinois.

Our organization did not seek to pigeon hold any veteran to a specific field, but this qualification fits the training regime that all our veterans received in the military and provides a solid, fallback opportunity if their other plans are not successful. Veterans are also provided with our youth engagement training that is specifically designed for the Safe Passage contract. This training focuses on violence

mitigation techniques, positive adult interaction and governments who use service referrals. Our holistic approach to mitigating youth violence has literally saved the lives of at-risk youths this year.

Finally, we hope to provide first aid and CPR training to all of our veterans associated with our program. This training will not only be important if they see an old lady who falls down getting on the bus or a kid who was attacked at school because of violence, but it's also important because they have this training in their own household as well.

At every stage of our workforce development program, we put an emphasis on providing our veterans tangible skills, income and most importantly a connection to the community that they live. It is our hope to have employed and trained over 150 veterans by the end of the school year and have placed 100 of those veterans in long-term employment. We also hope to provide interested veterans exposure to opportunities for employment with at-risk youths. We feel that veterans offer at-risk youths several attributes

that will positively impact their lives. They understand standards. They are taught mentorship and leadership. They know how to teach skills and tasks. They are our nation's heros. Leave No Veteran Behind has been servicing veterans for just over a year and a half. We have leveraged our education, business and knowledge of veteran's issues to provide the best services to our veterans and also within our community. We hope to continue this success with your support.

MR. ARNOLD: First of all, I want to applaud you for what you've done, but, you know, it's not just because I happen to be a veteran, an old one, so I hope it's old men, too, if they fall you help them as well, too.

MR. WILLIAMSON: We have a Korean War veteran that is going to be signed onto our program next week. He is 80 years old.

MR. ARNOLD: But the thing about the program that it really is helping people who are coming into -- back home from oversea's deployments. Many of them have challenges, you know, mental and physical, because of what they were exposed to and the reason why I joined the

service actually was because with the Vietnam veterans the way they were being treated in hospital systems when I first was going through my training in medical school and it was deplorable and there were some circumstances that led me to within a week to go and sign up and to join the military. So it was for a six-month period. It turned out to be 26 years. The best thing I ever did in my life. So I applaud you for what you're doing and I think this is an ingenious program. One of the bills that we actually helped to support and pass was this bill to extend the bridge between academic institutions and people who are returning from service who actually have some background and training in emergency response and paramedic training and EMT training.

So that's in effect as well, but many community are without paramedics and EMT's so we sort of suggested that would be a great idea for the people who are returning to especially rural communications to be involved in this program so that they can actually get gainful employment and we can keep veterans off the street. They don't deserve to be there. So thank

you again, but any questions from anybody else on the Task Force? Thank you.

MS. LIU: Good afternoon. My name is Hong Liu, L-I-U, and I'm the executive director of the Midwest Asian Health Association, MAHA. First, I'd like to thank Dr. Arnold for inviting me to this hearing and this is very educational. Asians -- I'm here to testify a few key health issues in the Asian community and on behalf of the Asian community. Asians are considered more of a minority, but we do share some of the health issues and the health concerns as other minority communities.

Illinois is among the five states with the largest number of Asians. Approximately 79 percent of Asians are foreign born. In Cook County, 30 percent of Asian households are increasingly isolated indicating that no household member age 14 and over speaks English well. More than 26 percent of Asian households have an income less than $20,000 and 20 percent of Asians do not have a regular source of healthcare.

Since over 65 percent of all

Asian Americans are foreign born speaking over 100 different languages, access to healthcare in the Asian community is, therefore, not limited to socioeconomic status. Linguistic isolation, the lack of culturally appropriate care providers, low socioeconomic status and many other issues contribute into the great health disparities among Asian populations.

For example, Asian Americans in the US have the lowest cancer screening rates of all ethnic groups and are more likely to be diagnosed at a later stage in the cancer progression when cure is less likely and the treatment is less effective. Although it is rare in women living in Asia, within a few years of immigrating into the US, breast cancer in Asian women increased by 35 percent in Illinois. Among Vietnamese and Filipina women, cervical cancer rates are five times higher than for white women living in the US -- in Illinois.

Hepatitis B and liver cancer rate is much, much higher in Asian population. Eight to 15 percent of Asians is Hepatitis B positive as opposed to one to two percent of the

general US population. According to our study, in three Asian communities, diabetes is very high in the Asian population. You feel we eat healthy food, but for some reason diabetes is high, very high. Recent studies have uncovered an increasing prevalence of mental health among minority communities and among Asian population. According to the recent press release issued by the Substance Abuse and Mental Health Services Administration, SAMHSA, one in six Chinese American young adults experience serious psychological distress in the past year. Despite the high prevalence among this group, only one in nine, 11.2 percent Asian American young adults with serious psychological distress received care within the past 12 months.

Overall, the rates are seeking care for mental health among racial ethnic minority young adults are much lower than they are Caucasian counterparts. In addition, Asian American females have had the second highest rate of suicide in every age group in Illinois and there have been more than 160 suicides in the Asian American community in the past 15 years.

Also, the US Department of Health and Human Services reported in 2005 Asian American women between the age of 15 and 24 had the highest number of suicides among all US women in that age group. Asian American children and adolescents are considered by mental health providers to be highly prone to depression. And even if mental health problems is prevalent in the Asian population, mental health programs targeting the Asian population are scare.

In the atmosphere in the Bridgeport community, which is most of the Chinatown area, 60 percent of residents are Asians, but there's no community based mental health intervention program targeting the issue. So I'm here -- I don't have much time so I'm here basically to advocate for a wellness and a program in the four key health areas for the Asian population which is low cancer screening rates, high rate of Hepatitis B and cervical cancer, high rate of diabetes and the fourth is the mental health prevalent issues.

In summary, I believe we need resources, programs, to address those issues which

have highly impacted our community. Thank you for allowing me to have this opportunity to speak on behalf of the Asian communities.

MR. ARNOLD: Thank you, Hong Liu. And for people that don't know you, she does a phenomenal job with the community outreach and providing services within her community and actually reaches beyond the community with many of the things that she does. And that's -- these four priority areas we have talked about them previously and this Hepatitis B is something that is totally preventable through vaccination programs and with the issues that you brought up about mental health as well, you know, suicide is becoming a big issue among teens throughout the nation and we need to really start addressing many of the concerns that are surrounding that.

I think these four areas of intervention really need to be looked at. Are there any -- I know there are some clinics that are in the area that you have been working with and developing, but what is the thing you feel is needed the most? Is it the community education or is it the actual access point or funding stream to

build a model?

MS. LIU: I think access issue is a big issue among the Asian community because of the language issue and there are some community based clinics surrounding the Chinatown area -- not right in the Chinatown area. So that's a problem in terms of access issue, lack of language assistance. If we have a community based clinic serving low income uninsured clients right in the community, then the community can help with a lot of language assistance help.

So it's hard to find an area -- going out of this opportunity, but if you have a center there then we can provide free volunteer services to solve that language problem so the bilingual staff is right in the community, but if you go out then that becomes a challenge. So I'm trying to advocate for a community health center that provides comprehensive community services right in the Chinatown which has 60 percent of Asians which would reduce a lot of costs for providing language services and we can get mobilize communities to provide that, but the location is not there for us to provide the

health.

MR. MITCHELL: Dwayne Mitchell, CEO for East Chicago Community Health Center which is a federally funded 330 community health center in Indiana, but I'm also with Governors State University and I can give you help and guidance. Between now and December 10th, the federal government has initiated new access points and the new access point applications, about $650,000 for new starts. I would encourage you and I can help you if you have a couple of community health centers in that area that would probably be in preparation to do this, a Mercy access and you also have the Near North Health Service Corporation which is right near in the Grand Boulevard community 47th and Greenwood.

You can get my information after this meeting and I will put you in contact, but also the Illinois Primary Healthcare Association would be able to guide you with Bruce Johnson who is the president and CEO. So I think that you have a good opportunity to get federal dollars to actually bring access to care in that community and begin to look at some of the enabling services

that the state would be able to provide in terms of prevention processes.

MS. LIU: Wonderful. Thank you so much.

MR. ARNOLD: And with the issue about -- it's sort of borderline on the issue of the cultural and linguistic competency. You know, one of the things that is a provision within the document and I asked them to make sure it was explicitly stated is that we brought up the issue as one of the co-chairs of the SHIP document, but one of the things that was stated was there needs to be cultural and linguistic competency and I said "There's one way to save money directly" and they said "What's that?" And I said "You have linguistic and cultural competency training, but you also have people within the community who are already linguistically and culturally competent that can be trained." So their needs to be brought forward, too, with the workforce development under Title 5 and with what Dwayne is saying about making sure that you gain access to resources that can actually support you. That actually is written as part of the SHIP document

to make sure that people within the community have ownership and some responsibility in the actual treatment care course and prevention course. So that's really a good platform for you.

MS. LIU: Thank you so much.

MR. ARNOLD: Thank you for your testimony. Any other documents or supporting documents that you would like to give us, please provide them to us and we will also make ourselves available to anyone who needs that kind of assistance.

MS. LIU: Thank you.

MR. BONGNER: Gentleman, good afternoon. My name is Brian Bongner, last name B-O-N-G-N-E-R. I am actually with the Lake County Health Department and Community Health Center. Today, I'm actually here representing the Illinois Public Health Association and the AIDS Foundation of Chicago Service Providers Council, the topic I'm sure you're very familiar with already.

As you are aware, we do have many medications right now that are used for the treatment of HIV. People are able to live a much healthier, longer life because of these life

saving medications as long as they are able to access the medications early during the diagnosis and are able to continue that without interruption. For those people that have HIV disease, it is becoming a chronic disease in our community. People are living longer, which is a wonderful thing, but we are also starting to see that longevity of life is creating some other obstacles that we now have to face.

Today, we look at what is happening in our community. We know that we have approximately 45,000 individuals in the state of Illinois that have been diagnosed with HIV. Unfortunately, we estimate that there's about another 10,000 that have not yet been diagnosed or are completely unaware of their diagnosis at this point. We've seen some estimates from the Department of Public Health that approximately seven to eight individuals are being diagnosed with HIV in Illinois everyday, 56 people every week, just slightly more than 3,000 people every year in this state are being diagnosed with HIV. The cost for HIV care just the medical components is approximately $350,000. We are going to spend

close to $1 billion this year on the total for healthcare for people living with HIV. Staggering health disparities also exist within the realm of HIV and AIDS. A study conducted in Chicago found that HIV positive rates among African-American men identifying as men who have sex with men were as high as eight times that of the counterparts of white men in the same area. We also have found that the same disparity exists within the Latino population. Latinos have a higher prevalence or three times higher rate of incidents compared to their white counterparts in that same area.

We are asking that the Chronic Disease Prevention and Health Promotion Task Force take into consideration three things as you're moving forward with your process. First is to prioritize the core of public health functions. A strong, skilled and adequately resourced public health sector is instrumental for the state's efforts to continue to prevent chronic disease and promote health. However, local health departments have been challenged, crippled and even put out of business because of some of the funding cuts that we have, some of the reduction in services and

some of the efforts that have continued to put the agencies under the gun.

Public health departments are the first responders in the fight against chronic disease, but cannot respond adequately if the resources are not there. To use the first responder analogy, you have an ambulance that has very bad tires. You have just barely enough medical supplies to prepare for the patient and enough gas to get the ambulance to that patient, but you don't have the gas to get them to the hospital. Much like your scenario, Dr. Arnold.

We are also looking at what this Commission can do is be able to sustain the local health protection grants that are able to be used in local communities. Secondly, we are asking that you look at the opportunity to implement a Section 1115 Medicaid waiver. The many provisions of the healthcare reform will not begin until 2014. Illinois will spend close to $20 million this year alone on the AIDS drug assistance program and although the federal red and white funds will meet some of the basic healthcare needs of people living with HIV in our community,

current funding is insufficient to address a more complex condition which are directly related to HIV infection, including bone density loss, cancers, renal disease and the list goes on.

Illinois could gain a lot of -- keeping millions of dollars or even more from federal Medicaid funding by implementing the 1115 Medicaid waiver to expand Medicare coverage to people with HIV who are not currently eligible. We expect the federal government to soon release a template to state that they wish to adopt the Medicare waiver and expand that HIV care as well.

The last point I'd like to bring forward to this Commission is the opportunity to stress and work with the Department of Public Health to reassess all Illinois HIV prevention activities. The state has a massive budget deficit. To reduce future spending on HIV medical care, Illinois must ensure that every dollar spent on HIV prevention programming is getting the maximum return. In the era of fiscal disparity, we must get more prevention services out of every dollar that we spend. We urge the state to ensure that every dollar spent goes to prevention and

testing of the population at greatest risk and is spent on the activities that will yield the greatest benefit to our state.

Gentlemen, all of our goals is very simple. We want to reduce the number of new infections of HIV in the state every year until we are no longer seeing infections happen. This is achieved through prevention efforts. This is one area we really must focus on. Maintaining the funding to be able to do that is important, but keeping in mind these three core elements are also things that we'd like you to take into consideration. I'll offer any opportunity for questions.

MR. ARNOLD: Okay. A couple of comments embedded in all of the things that you said which are really some great points to be made that can actually be a benefit to the state, the Section 1115 we'll look at as well. I know my staff is already starting to --

MR. BONGNER: I've been working with Dr. Williams on that.

MR. ARNOLD: But also that, you know, HIV now has led to development of AIDS. Of

course, back in the 1980s is when we first encountered those things, but people are living a much longer life now and one of the things we have to get away from is looking at diseases and saying that once you have a diagnosis that's the only diagnosis you're going to ever get. So we become labeled as that thing. So you're a diabetic or you're hypertensive so you're put into this category and it seems as though you have a shield around you that you can't get anything else, but with living a longer life you are still going to be running towards the same kinds of things, colon cancer, heart disease, those same kinds of things and we have to keep a focal point on that as well because the overall health of a person is very, very important.

I'm glad you brought that up and it needs to really be recognized as a chronic disease in full and also on the idea that there are other coexisting conditions that need to be addressed as well for medical coverage, but thank you very much for your presentation and thank you for your documentation and your work in the field and a great organization.

MR. BONGNER: Thank you, gentlemen.
MR. ARNOLD: We're getting close. I know we're going overtime by about ten minutes after 1:00 right now and I've been on many task forces in the past -- they've gone usually two hours in the past. So we're not going too badly, but I'm trying to make sure that we're respectful of people.
MS. SCIAMMARELLA: Good afternoon. Thank you, Doctor, for this opportunity to testify for the concerns that we have in our community.
MR. ARNOLD: State your name, please.
MS. SCIAMMARELLA: I'm sorry. My name is Esther Sciammarella. I spell it for you. S-C-I-A-M-M-A-R-E-L-L-A. The Chicago Hispanic Health Coalition is who I represent and I'm the director. The Chicago Hispanic Health Coalition has been having meetings since 2005 not only with agencies in the community, with hospital agencies in different institutions, with the state, with the city of Chicago, with Cook County and with this group we have made a list -- has been making recommendations and what I'm planning to do today

is list to you the different recommendations that provide to the Chicago Hispanic Health Coalition for improving diabetes -- I mean, in general, I think I would be specific in diabetes, but this could be with chronic disease. I want to acknowledge you on the effort. We work together in the Task Force to promote with the state's -- the current Task Force and I see the effort that has been done so one thing I want to emphasize is the importance to have a registry. We know that currently Minnesota and all different states has been very strong and I think it's time and it's important that Illinois have a registry condition. I think if we talking to each other knowing that many people are doing things and we need to have a directory of service and programs, websites in the community to the activities and address diabetes and other health conditions as well, collection of the best practice on diabetes healthcare. I think the coalition did an inventory of the different providers in the city of Chicago and I want to go back a little bit about my history of being in the health department for 19 -- to 2006, I believe. That we need to know who is doing what. Not only

for us providers, but for the consumers and be sure that we know who is doing what. We need to have good problems in diabetes because it's very comprehensive. It's necessary to -- like an experience in breast cancer, we need to do this same thing with diabetes so people know where to go and where to get good service and for Illinois communities we need good programs. We need assistance in order to change disparity. I challenge myself in other communities that the disparaging continue and we need to figure out why we are not succeeding and improving the condition of the minority community.

So we need to -- really bring best practice on diabetes that are culturally appropriate, increased health fairs effectiveness and I want to mention what Mr. Salim was mentioning about the community health workers. Health Department, Incorporated and the community health workers in 1990, we funding different communities now, Chinese community, Asian communities, the Hispanic community, I can name Korea, but we need funding to navigate patients to the services they need. We need to have community

health workers. We are trying to work on funding, the navigator to connect everything and we don't have that. Money comes into organization to pay for health promoters, but it's not code to be implemented and you're competing with no nurse and no doctor. So not just statewide -- and we need to work with the Cook County Department of Public Health, we need to work with the city and I think with -- I mean, different organizations who are going to improve hospital discharge planning.

I mean, we need to work with the emergency room. Many people have mentioned that people go to the emergency room. They are not planning to discharge and we need to have continuation of care. I think that example way back to mental health is when we discharge people from nursing home, we need to have a way to connect those people with services. So -- and I think we need to make diabetes an important thing. Thank you very much for your time.

MR. ARNOLD: Thank you very much because I know that you have done a lot in that field in bringing together a big group with the support for the diabetes registry so I think it's

an excellent idea that we need to move towards the establishment and we can start looking at that. If you have any particular models that you are looking -- you mentioned Minnesota and --

MS. SCIAMMARELLA: I think currently Minnesota I have -- I don't know if it's the Mayo Clinic or what, but they have good, modern -- I think the governor mentioned that the Department of Public Health is working with the family service so there is money there. I think this is the opportunity. When I start, nobody want to touch the issue of registry because there is no money to implement the system, but now with the medical record I think it's the opportunity to use and I think the Department of Family Service -- no. I think it's family service?

MR. ARNOLD: No. That's why I think it's so fundamentally important for --

MS. SCIAMMARELLA: So it's a matter of bringing everybody who is at different levels together and figure out how we really want to maximize the resources. My concern is when I see the inventory nobody knows who is doing what and one time the Cook County and the city funding just

bring people together. It's no matter a convenience for family -- it's to be sure the community health is serving their needs and that's the collaboration.

MR. ARNOLD: Yeah.

MS. SCIAMMARELLA: Thank you.

MR. ARNOLD: Thank you. That's why I thought it was so fundamentally important to reintegrate diabetes and obesity. It just has to happen so --

MS. BURNS: Hello. Thank you very much. I'm very glad to be here. I'm here to talk about secondary prevention at the community. My name is Anne Burns, A-N-N-E, B-U-R-N-S, and I'm a nurse also. Like one of our early speakers, I want to speak about secondary prevention at the community clinic level and I represent underserved populations with chronic disease.

I have been working for seven years in a free clinic for uninsured working people with volunteer doctors in a nurse run clinic. It has been challenging and in response to that I have reached out and communicated with many different areas. And in relation to the

subject we just were on about registries, in case I forgot, I want to mention the West Virginia Office of Services Research -- or what are they exactly? I always get that mixed up. The Office of Health Services Research, West Virginia University School of Medicine has done phenomenal work. It's all free.

They built on the University of Washington's C-desk program which incorporated all of the HRSA health disparities, collaboratives, benchmarks and, again, it's done, it's free and it's available and they give backup service and I recommend we build on that. So, anyway, what I want to advocate for is support for chronic disease management. Currently at the federally qualified healthcare community centers, there are no nurses. That means that you can't do chronic disease management. Chronic disease management is not just data reporting. It's an extension of postop nursing. It catches early decomposition, coordinates treatment, it increases activity and mobility and slows progress of chronic diseases. All chronic diseases. We don't need to split them up. We know perfectly well comorbidities is the

rule. You just don't get one and you're done. It doesn't really matter. I'm in cardiovascular in particular by happenstance, but they're all involved. You have to be in touch with them all, but the risk factors for most are related to each other. So in keeping with Dr. Lorig's work at Stanford with self management support often you don't really need to split hairs on that.

Why do you deal with chronic disease management -- self management support? It improves outcomes for morbidity and mortality. There has been frustration with getting evidence for chronic disease management because so much of the work has been done on trivial outcomes of behavior. The Office of Accredited -- Congregation in 2003 complained. There's just -- it's not that we're not saying you don't need it, but there's no evidence. All the data is on trivial outcomes. The recent heart researchers in the Journal of American Medicine Association, however, has finally -- a huge very, very rigorous study, documented results regarding self management support. It is sort of paradoxical. They're saying it does not support it. However,

in their further discussions, you'll see they did say except for underserved populations. I think we should build on that. At last we have data on actual mortality and morbidity to commend chronic disease management. Again, registries. Registries are huge. That's why I've worked with West Virginia to such an extent. I've been able to improvise with a retired Lucent programmer and develop the database for my population.

What I want to really advocate for is in chronic disease management, that clinicians do their own -- use the databases. Don't just be passive reporters, but use them with the populations to identify cohorts and also follow up with individuals. Once people use their data themselves instead of just being reports they become a lot more sensitive to the data quality issues. We're seeing terrible problems with electronic medical records, sloppy scanning, sloppy recording. So we've got a quivering bowl of jelly underneath the electronic medical records and medical homes and what is a meaningful use. Meaningful use is based on a bowl of jelly. If that data is all -- as bad as some of what I've

seen.

So, finally, I'll give an example of this kind of use that I advocate. We -- with my cardiovascular population, 600 patients I manage with two volunteer cardiologists, the DuPage County Health Department was wanting to partner for some smoking cessation so I went to my database and I asked how many of my hypertensive's have not been at goal in the past year, are overweight and smoke. With that, I pulled down a core group and I only had 15 capacity -- whoops. Times up. Fifteen capacity in each group so I pulled out a first set of 25, called them personally and said "I've reserved you a spot. You are at high risk. I want you to have this opportunity." The health department was very pleased. We had 17 enrolled, 11 actually completed the program and they said they have not seen that kind of response.

This was based on being able to study your population, both in aggregate and individually and I have a risk managed -- risk matrix that I use that will show you your population aggregate in different levels of risk,

but then with a pivot chart pull out who's the list and where is your actual source data for this.

MR. ARNOLD: Can you submit your documentation for that and some of the models?

MS. BURNS: I actually spoke at the Illinois Public Health Institute --

MR. ARNOLD: Yes.

MS. BURNS: -- on this and I'm very happy to share it. It's freeware and I just -- for underserved patients with chronic diseases, I think we should make use of what we have for free.

MR. ARNOLD: Right. Thank you.

MS. BURNS: Anything else?

MR. ARNOLD: I'm one of those believers of not reinventing the wheel.

MS. BURNS: Thank you very much.

MS. WEBB: All right. Good afternoon. Good afternoon, member of the Chronic Disease Prevention and Health Promotion Task Force. I'm Valerie Webb, W-E-B-B. I'm the current president of the Illinois Public Health Association, IPHA. We're a 7,000 member organization devoted exclusively to the matters of

public health in Illinois. As the largest affiliate of the American Public Health Association, IPHA represents individuals and organizations from local and state agencies, hospitals, communities, clinics and voluntary agencies, all whom have supported a healthy Illinois. Over IPHA's 70 year history, we've worked to fulfill the mission to lead an advanced public health practice. In response to the Task Force hearings, IPHA identified several aspects of the state's chronic disease prevention and health promotion infrastructure that should be addressed including leadership epidemiology and surveillance, partnership, planning, interventions, program management and administration. But in the interest of time, I'd like to focus on just two of those performance improvements, epidemiology and surveillance, the cornerstone of public health and partnerships.

However, we will submit complete documentation and explanation on all the components to the Task Force within the required time period as well as we will have other speakers at other hearings provide additional testimony.

So starting with the cornerstone of public health, epidemiology and surveillance. IPHA recommends that IDPH, the Illinois Department of Public Health, should expand its commitment of resources to the behavioral risk factor surveillance system. The survey collects information on the behavioral risk factors associated with the development of chronic disease and will be an important strategy in measuring short-term progress.

IDPH should have sufficient resources to collect a statistically reliable and valid sample on an annual basis for all of the 102 counties, the city of Chicago and the suburban Cook County area which I work in my full-time job.

IDPH should also have the resources for analysis, interpretation and publication of the survey findings. The management of the survey can be done most efficiently at the state level. Number two, IPHA recommends that IDPH should also expand its commitment of resources to analysis of the hospital discharge database and the vital records system. These two data sets provide important information on the longer term impacts of

prevention efforts and the burden of chronic disease and morbidity and mortality. Due to the current lack of resources to invest in this information infrastructure, IDPH is often two years late in publishing annual vital statistic reports and has only limited ability to analyze and interpret the results.

It is difficult to plan tactics or evaluate strategies when the best information to you that is available is two years old.

Okay. Partnerships. No sector of the healthcare system can address the burden of chronic disease and isolation. There are many partners who have a stake in the prevention. Therefore, all of these partners should have a hand in designing, implementing, monitoring and evaluating the systems overall performance as well as their contribution.

Some of these partners includes the medical community, voluntary organizations, colleges and universities, faith based organizations, schools and families, state and local governments as well are essential to the effort.

Now, to my point on partnerships. Coordination of policy and innovation strategies at the state level is essential for success. IDPH should work with the Illinois State Board of Education and with the Illinois Department of Human Services to ensure efforts to prevent tobacco and alcohol abuse in and out of the classroom are consistent.

IDPH should work with the Department on Aging to ensure support for community preventive health services. IDPH and IDHFS, Healthcare and Family Services, should ensure that preventive health services including self care education and other services required by the Patient Protection and Affordable Care Act, are available to Medicaid recipients. IDHFS should continue its efforts to provide intensive health education and support to persons who consume excess amounts of healthcare services to treat their chronic health conditions. They should also take full advantage of the grants authorized by the Patient Protection and Affordable Care Act to develop programs for tobacco cessation, weight loss, reduce in

cholesterol, blood pressure -- control of blood pressure and the prevention of management of diabetes among Medicaid beneficiaries.

Through the Task Force, IDPH and IDHFS should collaborate on a media campaign required by the Patient Protection and Affordable Care Act to inform Medicare recipients of the availability and coverage of obesity related services.

All these partners have a role and should be a part of the Task Force's ongoing membership to work closely with IDPH at the state level and should be partners with local health departments in every community.

In conclusion, these are recommendations and the others that I wasn't able to describe to you, but will present later and will have documentation on are developed to assist the Task Force to reform the delivery system for chronic disease prevention and to ensure adequate funding of the infrastructure so that the burden of chronic disease and disparities in the health status and the state's healthcare expenditures may be reduced. IDPH stands ready to assist the Task

Force in any way.

MS. ARNOLD: Thank you very much. Valerie has done a wonderful job with IDPH as the president there. I always read the viewpoint you put out which is really phenomenal. A lot of great information on there. But, also, you know, one of the things that you were talking about is an interface which was making me think of this interface which is one between the hospital -- between hospital systems and practices in the private sector versus a public health approach which is really a global approach to the population base dynamics and it seems like there's a bridge that needs to be crossed at that point because many conversations that were made were being directed at the data and local utilization of data and that would potentially increase the quality of it which is great, but the data sharing is another issue as well and how to bring those things into one kind of formulized system is another bridge to cross. It's formidable, but something we need to. So thank you very much.

MS. QUADRI: Good afternoon -- good afternoon, Honorable Dr. Arnold and respected

team. I'm happy and honored to be here. My name is Zehra Quadri, Z-E-H-R-A, last name is Quadri, Q-U-A-D-R-I, and I am the advocate and volunteer from ZAM's Hope Community Resource Center located in Rogers Park in West Rogers Park. We have been a part of the community for the past last 10 years -- successful years. We serve lower income individuals from all walks of life. We are very thankful to the Department of Public Health for being there for us throughout these years helping us to educate our clients and community members.

I would like to thank Dr. Masud Ali and Dr. Wansia Ali. They are here always for -- always lending a hand and helping us to become more aware of -- helping us to become more aware of body and mind. We are serving seven different countries and we have after-school programs, senior services, ESL classes and health education.

MS. KASI: Good afternoon. My name is Deenuka Kasi. D-E-E-N-U-K-A, last name Kasi, K-A-S-I, and I am currently a volunteer at ZAM's Hope and also a medical student. So, personally, as a medical student we come across various

subjects that are vital to our knowledge. Pathology being the most important because it helps us understand the abnormalities and the diseases. The most important are chronic disease that mostly occur because we do not take care of the problem head on or take notice of it first.

This may be because of the lack of knowledge the community members have about healthy living. So chronic diseases such as heart diseases, cancer, stroke and diabetes are the leading causes of death in the United States. Seven of every ten deaths in the US are caused by chronic conditions. Heart disease is the leading cause of death among both men and women followed by cancer and stroke and diabetes is the sixth.

What we need to do is promote health wellness programs at schools to excite healthcare and community based settings so people can have more of an understanding of the diseases that occur.

MR. ARNOLD: She must be brilliant because I never had time when I was a medical student for a public hearing.

MS. QUADRI: My name is Aisha

Quadri. A-I-S-H-A, last name Quadri, Q-U-A-D-R-I. I'm also a volunteer to the executive director and a medical school student as well. The two projects that we are currently working on are the free health centers and providing Kosher soup kitchens. The free health center is because we want to provide equipment and, you know, lectures and stuff to make people understand and become more aware of what there is and what you can do. I know we all love fried food. I don't know if you guys have been to Devon, but our community is mainly made up of south Asians and our food has so much oil and all the other good stuff, but it's so bad for us and our community is unaware of that and I know that I was unaware of it and I'm not sure if it's appropriate to name documentaries and stuff, but when I was in high school I watched a documentary which made me completely forget about fast food. It gave me a better understanding of what is out there and unfortunately our low income families they don't have time to prepare something. They don't even have money to, you know, give a proper meal at home. So we want to provide classes to help them, you know, realize

alternatives and to cooking.

I love cooking. When I'm not studying, all I do is cook and she can vouch for me, but it's always -- I'm trying to find alternative ways just to be healthy and providing a free health center it will allow people -- especially seniors because if you think about it the youth today are learning so much about trying to live healthy and people are trying so much to give all these children opportunities to exercise more and be more active, but the seniors who have been -- who have been here for a really long time -- I mean, especially mother's home cooking. People don't always, you know, give importance to exercising. I know that my grandparents because they have a facility in their area they're allowed to workout, but think about how many other people there are who don't have those facilities. So we're trying to provide facilities to those people who, you know, cannot maintain those because it does take a lot of money to go into workout places and stuff and then the soup kitchen there are so many students who cannot get hot lunch because of their religious requirements and nutrition

requirements and then their families cannot afford to give them a proper meal to take to school. It's always fast food because it's so affordable. So we want to provide a soup kitchen so we can make food for people and then give it to the children and have these parents come and take classes so we can teach them different ways of cooking.

MR. ARNOLD: So when you mention soup kitchen, we normally think of people who are really homeless or low income. This is a different type of soup kitchen?

MS. QUADRI: I mean, it is available to the community, but it's also a healthier soup kitchen.

MR. ARNOLD: That's also the thing.

MS. QUADRI: It's really vital to the community to be able to eat properly.

MR. ARNOLD: Okay. Excellent. Very good.

MS. QUADRI: I'm really sorry. Just one more quick thing. We are working -- we are receiving grants from your department for educating the community for STD and HIV issues.

This is really a very touchy subject for our community and we are doing a phenomenal job in the community and the big thing I thought was people were going to throw rocks on me, but to be honest, they appreciate it. They are coming. They are more open. We are talking to kids. We are talking to the community. We are having free testing even though we are not receiving any funding and I'm working more than full-time as executive director and I'm the founder for ZAM's Hope Community Resource Center and I would like you to visit our website and also a center if you can, please, www.zamshope.net. Thank you so much.

MR. ARNOLD: And make sure you give the information so we can include that into the record as well and it's very, very good work. I'm very proud of you.

MS. CAGAN: Good afternoon. My name is Elizabeth Cagan, E-L-I-Z-A-B-E-T-H, C-A-G-A-N. I'm the executive director of White Crane Wellness Center, but, first, I would just like to thank the Task Force for the opportunity to engage the community to work together to promote health across Illinois. So we still value the message

that you're sending here today. I'm here today as part of my testimony to really highlight and emphasize the importance of chronic disease self management. So chronic disease self management why is it important? Why now?

In 2007, approximately 38 million people in America were age 65 and older. Thirteen percent of the population. At least 80 percent of older Americans are living with at least one chronic condition. Fifty percent have at least two chronic conditions. Healthcare expenditures increase as people age and their health deteriorates.

US Department of Health and Human Services projects that the cost of healthcare will reach $3.6 trillion in 2014 up from $2.2 trillion in 2007. Medicare spending is projected to be nearly $935 billion by 2018. So why take care of your health and what does that mean?

Again, as part of my testimony, I'd like to really emphasize the value, ethicacy and importance of disease self management programs and options of care. Self management programs

such as at Stanford University as our colleagues are concerned here. The Stanford program developed by Kate Lorig addressed chronic health conditions, have demonstrated reduction in hospital days and physician visits, reveal the paradigm shifts, enhance disease management strategies, and they focus on health promotion and disease prevention. They successively implement a diverse -- in diverse populations and language groups and in a variety of locations.

For the first time ever here in Illinois, we've been able to implement them in Chinese, Korean, Filipino and south Asian communities. And with respect to national research outcomes of these disease self management programs, they've demonstrated to include communication with family members and physicians, fewer hospitalizations and visits to physicians and emergency rooms, no further increase in disability two years after the program, improvement in health status such as self reported health, fatigue, social activities and energy and finally improvement in health behaviors such as exercise.

Vulnerable populations such as underserved, isolated, frail older adults have great difficulty in accessing health, wellness and social services. Barriers to access include physical, emotional and mental health problems, language, as well as cultural barriers, lack of financial resources, lack of insurance, lack of linguistically and culturally competent programs and services. Examples of chronic disease, however, that can be mitigated and effected by such disease management programs include arthritis.

With regard to arthritis, 46 million American adults or one in five have some form of doctor diagnosed arthritis. In fact, arthritis is the most common cause of disability is the US rendering $128 billion to be spent on arthritis annually. Falls, according to CDC, more than 33 percent of adults age 65 and older fall each year in the United States. In 2000, the CDC estimated that the total medical cost of all fall injuries for people 65 and older to be $19.5 billion. Among older adults, falls are the leading cause of injury deaths, nonfatal injuries

and hospital admission for trauma. Depression and mental health, major depression can be highly disabling. Beyond symptomatic sadness, inactivity, cognitive deficits and attention problems, it often accompanies other serious age associated medical conditions such as heart disease, stroke cancer and diabetes. And like these other diseases, it robs older adults of their quality of life, reducing physical, mental and social functioning and increasing healthcare.

Finally, Alzheimer's disease and related dementia. Very sad. An estimated 5.3 million Americans of all ages have Alzheimer's disease. This figure includes 5.1 million people age 65 and older and 200,000 individuals under the age 65 have younger onset Alzheimer's disease. One in eight people age 65 and older, 13 percent, have Alzheimer's disease.

To conclude, with respect to how do we address these problems, programs that can help include evidence based intervention such as the chronic disease self management developed Stanford University. They should be cost-effective. They should be community based.

There should be alternative for institutionalization and they should provide choices for care that address physical and mental health issues such as adult day programs, in-home support, congregate meals, early disease detection prevention programs, health education support and caregiver support.

Here today as executive director of White Crane Wellness Center, but also I am chair of a regional subset of the Illinois Adult Day Services Association as well and I just want to give the panel ideas of ways we work together and alternatives to institutionalizations. Adult day programs in the state of Illinois and nationally are just extraordinary alternatives in nursing home placement and costs approximately one third of what we pay for nursing home placement, nursing home placement, which is often avoidable, premature and unnecessary for that older adult and for their families.

Other alternative approaches to disease prevention includes fall prevention programs such as the evidence based matter of balance. Again, the chronic disease self

management program developed by Stanford, the Arthritis Foundation exercise program and healthy ideas of depression screening and case management for older adults. Our next steps could and I hope to be continued to engage are partner agencies in the discussion of these issues, additional needs prior characterization of needs and types of services we can offer to address these needs and, of course, our capacity to meet these needs with quantifiable measure and I would just like in closing like to thank the Illinois Department of Public Health for sending this message and we've been watching the progress and passing of this state legislation and are very proud to be part Illinois at this time, but also wanted to thank Illinois Department of Public Health for your leadership in developing a very strong relationship between your department and the Illinois department on aging and the Illinois Aging Network overall. So -- and thank you for your patience today.

MR. ARNOLD: Thank you very much. Your testimony was very, very well received. I want to make sure your submit those documents as

well, but one question about the cost analysis and, you know, you were talking about metrics. I guess you have some documentation of the programs and how --

MS. CAGAN: Yes. We can -- we'd be more than happy to forward on the state data with respect to comparing community based adult day services with nursing home placement and some of the Stanford data as well.

MR. ARNOLD: Thank you very much. Okay. Anyone else that wants to make a comment other than we want to go home. No?

I just thank everyone for all of their attention and especially the panel. The Task Force was being pulled forward. They are doing this sort of pro bono, but their interest and their passion for this particular issue is really a paramount importance and success of the whole program. So all of the IPHA, all of the organizations that came forward today I really want to thank you for your time and dedication to this process.

We will take the testimony into advisement as we start to create this document,

but, again, I think it was stated several times and I know Valerie restated it as well is this intervention occurs at the person's home. It really occurs where the person actually opens a gym door or a clinic door or participates in a screening test or, you know, takes this carrot and says I'm going to replace my hot cakes with this carrot. So, you know, it really is at the level of the person who actually takes advantage of the issues or takes advantage of the resources that are out there and we have to really keep a focus on education and prevention throughout the spectrum.

Right now, we were talking about this statistics and one of the statistics that really alarmed me the other day was the idea that the CDC put a projection out that one in three children born in the year 2000 or after will develop diabetes in their lifetime. That is absolutely staggering. I don't know how we cannot look at that and say that we have to do a gargantuan effort, mega gargantuan effort to address that issue alone, but there are many, many chronic disease issues that we have to keep in

mind. Again, nothing happens in isolation and comorbidities are quite common.

So as we go forward we are going to try to take this information, distill it down into a document, but, again, the timeframe is at the end of December to submit this document and move it forward. However, the involvement of the groups who are here this is also a time period where you're coming onto a record and you have to become part of a process that is ongoing. It must occur in every community in the state and it must be available to every citizen in the state. One of the comments I make when -- I'll tell you two very quick stories and let you go and -- you know, with any follow-up comments from people on the Task Force.

One of the stories is that when people walk into the Agency they ask me what is the first step I should take, you know, coming into the agency. I haven't been in public health. And I always draw a little curve and say that there's 12.5 million people under this curve and that's about the number of people within the state of Illinois. I want you to take one point off of

that and hold it in your hand and then I want you to erase their gender, their race, their ethnicity, whether they're rural or city, I want you to erase their religious beliefs, what kind of clothing they are wearing, what kind of music they like, everything that's identifiable, the age, and then I want you to realize you have a human life in your hand. They are entrusting themselves to you to find the solution to really end the pain and suffering and premature death that is occurring in itself and family members and the community members.

So as we're moving forward, we will talk about many of the different disparities and these resources should follow a disparaged impact curve to make sure we're giving everyone access and doing a proportion to what their -- what the consequences of these diseases they have for them. So as we're developing this matrix and we're looking at how to implement processes that actually are working, we are looking to you to actually give us guidance on what is working because you are at the ground level working with the person in the clinic.

And I always say that miracles don't happen with the stroke of a pen in policy, but in the clinic when someone touches someone else's hand. So, going forward, one of the -- the second story is one about two martial arts masters and I'm glad the other two have left. There were these two martial arts masters that were walking down this dirt road together and as they were walking down the road there were two rows of pine trees and they had lightening bugs in the trees and it was a full moon that night. So as they walking, one of the masters turned and looked at the other one and said, "Master, tell me what is it when two ferocious tigers face each other in a heated battle and conflict? What is the result?" And the other master looked at him and didn't say a word and continued to walk for another two miles and after walking the two miles the master stopped, turned and looked at the other and said, "Master, when two ferocious tigers face each other in a heated battle and conflict, one of the tigers is going to be irreputably harmed. He's going to be maimed and live out the rest of his days in utter misery and pain" and then he took two more

steps, turned around and looked at the master and said, "The other one will die."

That's what happens when you're going for a goal, but you have a problem with either getting involved with a level of coercion where you're forcing things to happen or litigation or you're going to a level of arbitration or mediation. The best place to be is in a negotiation when you're negotiating a collaborative effort to make sure you've reached the goal you want and that's to save the lives of the people in this state and to prevent pain and suffering and premature death.

So, with that, I commend you all for being involved in the field, but I'm opening it to the other members because they are phenomenal. This chart is really the beginning of a framework that I really am looking at the most important part of any healthcare chart is the person receiving the intervention, always. And we have to make sure we keep focusing on that. So, with that, thank you for your time.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

I, Steven Brickey, Certified Shorthand Reporter, do hereby certify that I reported in shorthand the proceedings had at the trial aforesaid, and that the foregoing is a true, complete and correct transcript of the proceedings of said trial as appears from my stenographic notes so taken and transcribed under my personal direction.

Witness my official signature in and for Cook County, Illinois, on this _____ day of _____, A.D., 2010.

_____
STEVEN BRICKEY, CSR
8 West Monroe Street
Suite 2007
Chicago, Illinois 60603
Phone: (312) 419-9292
CSR No. 084-004675