REPORT OF THE PROCEEDINGS of the Public Hearing on the Illinois System for Chronic Disease Prevention and Health Promotion, taken at the Municipal Building West, 200 Potomac Boulevard, Mt. Vernon, Illinois, on the 30th day of November, 2010.

DR. ARNOLD: Hello, everyone. For

those of you who don't know, I'm wearing a mustache today for the Movember. "Mo" is slang in Australia for "mustache", and it's for prostate cancer awareness. So I finished with the military back in April, after 26 years, and they are so lucky that they got me this year. Someone found out that I could actually grow a mustache again after high school, so here I am.

So today, first of all, I want to welcome you here. And this is for the Chronic Disease Prevention and Health Promotion Task Force of which I, Dr. 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 rules about just going to the restrooms, they are appropriately marked. If you have any side conversations, please respect the people who are speaking. These are general rules I give out at each of the meetings that we go to.

To begin, the Chronic Disease Task Force has been addressing chronic disease in the State of Illinois, which 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.

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

drug medications, poisons, and even infectious diseases.

In order to address chronic diseases within the State of Illinois, the 95th 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 of Illinois, 20 ILCS 2310/2310-76, to create the Chronic Disease Prevention and Health Promotion Task Force. The charge of the Public Act 096-1073 is to: one, establish a Chronic Disease Prevention and Health Promotion Task Force; two, to hold at least three public hearings throughout the State of Illinois, one being in northern Illinois, one in central Illinois, and one in southern Illinois; and, three, to submit a report of recommendations to the General Assembly and Public Health Director by the 31st of December 2010.

Consistent with Senate Bill 2583 and Public Act 096-1073, the Chronic Disease Prevention and Health Promotion Task Force consists of a total of 19 members. The members

who have been included have been codified by the legislation itself, and the Chronic Disease Prevention and Health Promotion Task Force, hereinafter referred to as CDPHP Task Force for documentation purposes, currently consists of the following members. It consists of, one, Dr. Damon T. Arnold, MD, MPH, Director of the Illinois Department of Public Health and Task Force Chairman; two, Dr. Quentin Young, MD, Public Health Advocate; three, Dr. James M.

Galloway, MD, the Assistant Surgeon General, Regional Health Administrator for Region V, US Department of Health and Human Services, with an alternate of Robert Herskovitz, who is the Deputy Regional Health Administrator, Region V, US Department of Health and Human Services; four, Senator William Delgado; five, State Representative Elizabeth Coulson; six, State Representative Cynthia Soto; seven, Michael Jones, the Illinois Department of Healthcare and Family Services; eight, Dr. Lorri Rickman-Jones, PhD, Director of Mental Health Services for the Illinois Department of Human Services; nine, Janice Cichowlas, The Illinois Department on Aging; ten, Michael Isaacson, the Director of the

Division of Community Health, Kane County Health Department; eleven, Dr. Paul Brandt-Rauf, MD, Doctor of Public Health, Scientific Doctor, Dean of the University of Illinois School of Public Health; twelve, Dr. David Steward, MD, MPH, Professor and Chairman, Department of Internal Medicine, Southern Illinois University School of Medicine; thirteen, Miriam Link-Mullison, Administrator, Jackson County Health Department; fourteen, Mr. Joel Africk, the President and CEO of the Respiratory Health Association of Metropolitan Chicago; fifteen, Dr. Robert A.C. Cohen, MD, Director of Pulmonary and Critical

Care Medicine, Cook County Health and Hospitals System. He is also the Chairman of the Division of Pulmonary Medicine and Critical Care, John H. Stroger, Jr., Hospital of Cook County; sixteen, Dr. James Webster, MD, MPH, Professor and Chairman, Department of Internal Medicine, Northwestern University Feinberg School of Medicine; seventeen, Jaime Delgado, Project Director, Humboldt Park Diabetes Prevention Project; eighteen, Dwayne Mitchell, CEO for East Chicago Community Health Center, Governor State University Lecturer; and, nineteen, we have an

official appointment which is pending at this point in time.

The Chronic Disease Prevention and Health Promotion 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 Chronic Disease Prevention and Health Promotion Task Force was stated. Also, preliminary ideas and suggestions were recorded as notes for structuring the framework of the Chronic Disease Prevention and Health Promotion Task Force. Due to a quorum not being achieved at any one location during this meeting, voting did not occur. Several documents

were provided by IDPH concerning information from the CDC and the Illinois specific information concerning expenditures and the chronic disease burden for the State of Illinois. As chair of the task force, I noted that IDPH would create a website, which has been established and is currently under development for the Chronic Disease Prevention and Health Promotion Task Force. You can go to this website. It's listed

at www.idph.state.il.us. You can go to the A to Z list on that site, and go to C, and then to the Chronic Disease Prevention and Health Promotion Task Force. It's listed there. You can also access that site by going to the IDPH website directly or going through the Governor's website with a link to IDPH's website. We also have links in there to CDC documentation. We're looking at best practices from around the states as well and trying to amass information and to develop a platform in order to address chronic diseases within the state.

I noted that it should include tables also for the collection of information concerning: one, governmental 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 diseases

within the State of Illinois; four, the completed State Health Improvement Plan framework document. Again, although the word "plan" was placed on the document, it is a framework. I reemphasized this with the SHIP group, that any time you have a document, if you say "plan" to me, I have a

military background, it means I'm putting the key in the jeep and we're going so we can implement it. Without having the input from the community partners, which this is actually serving the purpose of, you have no plan. You have a framework that says obesity is a problem. We need to figure out what intervention strategies are working, and to make sure that we have a table of things that are best practices, and we're actually moving in a positive direction. One of the monetarists both at the federal and state level has been no metrics, no money. How can you measure something if you don't know where you're going? So this is also an attempt to establish a basis for metrics, and figure out what do we need, and how do we measure the need of the public health system? Five, also federal and national best practices for chronic disease prevention and health promotion guidelines; six, the existing Illinois state community-based best practice models and any documentation submitted to the task force membership; seven, a listing of

National NGOs and relevant documentation, such as for the Institute of Medicine, The American Public Health Association, The Association of

State and Territorial Health Officials, The National Association of City and County Health Officials, The American College of Emergency Medicine, The American Medical Association, The American Pediatrics Association, The American Dietetic Association as well, and The American College of Emergency Physicians, etc. So other colleges or other sources of information that are a credible source can also be included in the stream in this table. Eight, the federal, state and private sector tools and resources which are available; and, nine, a calendar of events related to the Chronic Disease Prevention and Health Promotion Task Force.

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

During the second meeting on the 14th of October 2010, the CDPHP Task Force was assembled, and with a quorum being present, voted upon and adopted bylaws which govern and guide the functions and operations of the CDPHP Task Force.

A copy of the CDPHP Task Force

meeting, minutes from the first meeting and documents were approved, the second meeting, having a quorum present, and the approved CDPHP Task Force bylaws are attached to this document for inclusion in the testimony stream being presented here today.

In order to accomplish the objectives set forth by Senate Bill 2583 and Public Act 096-1073 regarding public hearings, this task force will seek input from interested parties, and these three locations shall be selected. One was selected for Chicago, one for Springfield, and one for Mt. Vernon, to get input from your communities, and to look at a unified approach across the state in addressing some of these issues.

So, 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. However, this legislation

was subject to appropriation. We move forward with it, and we will make sure that this is actually a force that will develop the platform necessary to address chronic diseases across the state. To do less is waiting for a tidal wave to strike our state.

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 system reform within the State of Illinois; two, ensuring adequate funding for infrastructure and delivery of programs; three, the addressing of health disparities based upon economics, race, ethnicity, or even location; 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 Acts 95-900, effective date 8-25-08, and 96-328, effective date 8-11, 2009. In preparation for this my deputy director, Tom Schafer, has been putting a lot of time into this with his group,

supported for chronic diseases to be addressed throughout the state.

Additionally the Centers For Disease Control and Prevention in Atlanta have noted three priority areas of concern. One of the people that works with Tom Schafer is actually Dr. Schillie. Sarah Schillie is a CDC fellow and has been working with chronic diseases for several years. She actually was under the infectious disease section. And as of July 1st, 2010, the department was successful in having the department, with an executive order by Governor Quinn, to move diabetes from the Department of Human Services back to Public Health, to link it again once again with obesity. This was a sore point for the federal government in funding for the state with these initiatives, as they felt that this was a programmatic fragmentation, and they were giving much more consideration to other states where these were integrated systems. So this will actually put us into a better platform to ask for further coverage.

With that in mind, the CDCs three

priority areas, one being obesity, two being tobacco abuse, and three being injury prevention, they felt that these were the leading causes for loss of funds for states. The major healthcare costs were stemming from these three pools.

However, we know that there are multiple, multiple chronic diseases that are out there, and these are also addressed in the chronic diseases realm from the statement of the SHIP documents.

For an example, obesity may be something that you link to an individual, but you cannot just link it to the individual. In fact, you have to link it to the family, the job place and the community that the person lives within. For an example, if a person has a body mass index which is very high, a 35, let's say that they are in a category where they weigh more than 250 pounds and they have a massive heart attack in the afternoon. Many people will focus on that person who now is laying inside of an intensive care unit in the hospital, and neglect to think about the keys that are in their pocket that open the door for their children at home who don't know where they are. The impact and the ripple effects on one person can be staggering. So

these things we have to address as well as being part of a holistic approach to chronic disease.

This focus was borne in mind when developing the State Health Improvement Plan which recognized five public health system priorities and nine priority health concerns.

The five public health system priorities included: one, improve 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. The local health departments play a critical role in the infrastructure as well as the hospitals and private practices, but the overall view of public health as a population-based dynamic must always be borne in mind as we approach chronic diseases. Also assure a sufficient workforce and human resources. That's the fifth element.

The nine public health concerns identified include, not in rank order: one, alcohol and tobacco; two, use of illicit drugs and misuse of legal drugs; three, mental health; four, natural and built environment; five,

obesity: nutrition and physical activity; six, oral health; seven, patient safety and quality; eight, unintentional injury; and nine, violence.

We can make sure that this is available to you. The SHIP document itself can be found at www.idph.state.il.us/ship. It's also linked to the website I gave you earlier. So you have access to that.

With this I always say that this is one of my favorite quotes, and I hope they put this on my gravestone, but public health covers

everything from particle physics to the food chain. There is not one energy matter relationship that exists around us that public health is not involved in, whether it's asbestos in buildings out there, whether it's the lead in the water for children, whether it's the 11 nuclear plants we have in this state, whether it's the food chain and the biosecurity, whether it's vaccinations against viruses, whether it's treatment of bacterial diseases. We are involved in the entire gamut of things. Even from the neonatal period we do neonatal screening. We give advice on what a child should have before they're even conceived. We give it to their

parents. So from the cradle to the grave and before the cradle we are there. So this is an important thing for people to recognize, the scope of our practice.

We also include the scope of the public health system domain in one of the bills we had passed recently, about a year-and-a-half ago, to show that we have a much wider area of concern than just drugs and bugs. We have a tendency to look at public health as a Pasteurian lens, because that's the thing we were most noted for, smallpox eradication, making sure we have fluoridation in water. But we have done many more things than just that.

The Diabetes Program was moved from Illinois, as I mentioned before, by an executive order of Governor Quinn. Also a Senate Bill, initiated by Senator 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. So we have actually the legislative body supporting this as well. It was in a 116 to a zero vote that it was passed.

This will greatly facilitate the

reintegration of the antiobesity and diabetes objectives, paving the way for better programmatic funding opportunities, efficiencies and outcomes.

So with that, one of the things I want to mention before I go further, there are some things that we really want to emphasize. One of the things that I think is really important to emphasize is that whether you are born in the city, on a farm in rural Illinois, you are an important human being within this state. When people walk into my agency they ask me, Well, what's the first step I should take? And it took me about a few months to develop this one. I'm not the smartest person I guess for that. But I started by listening to people who were saying things in the field. And what I tell

people, the advice I give them, I draw a curve, and I say there are 12.5 million people approximately under this curve. These are the people of the State of Illinois. What I want you to do is pick one person from underneath that curve and hold them in your hand. Then I want you to erase their gender, I want you to erase their race and ethnicity, their age, I want you

to erase their educational level, what their socioeconomic status is, I want you to erase every identifiable feature, what music they like, and then realize you have a human life in your hands. You are supposed to be protecting the general population based on what your scientific knowledge is telling you to eradicate pain and suffering and premature mortality in those people within the State of Illinois and take care of everyone. That's what we're sworn to do as public health people.

So with that I think that this should be something that is for the entire state, not for one particular geographic location. And this platform has to be reaching people who are in communities that are disparately impacted, whether it's an intercity child who is in a very disrupted environment, or whether you are talking about someone who is on a farm in southern Illinois who doesn't have access to dental care.

We need to make sure that we are looking at chronic diseases on the large scale, and make sure we're protecting the citizens of this state. That's what we swore to do.

So with that I'm going to have people

come up to give their talk. We have a special seat sitting over here. So all of the speakers, you can actually -- I think we have seven seats here and seven speakers, according to the list. So if everyone would like, you could come up to the front, and then we can do it one by one coming up to the mic to speak.

We have about five minutes to speak, five to seven minutes, but we can make a little bit of a leeway. Once your passion gets engaged in public health we know that that goes on for hours. So we will take your comments, and we will include that into the testimony stream.

I also want to thank my task force member, Miriam, for setting this up. It's a very, very good location. And she already has been contributing a great deal to our task force, you know, with our conversations and the meetings.

So I am very happy that we are here, and we are open to your comments. Please, if you have any other last-minute thoughts, anything that comes up, we all do that, you know, if

you're driving back home and think, I didn't say this thing, make sure you submit it. It will be

really a benefit to all of us, and we are part of a team.

I always tell people in the military I remember -- and this is my last story, I promise, before my closing story. But when I was in the military an E-5, Enlisted Rank 5, person came up to me one time. And he was yelling, and he threw this book down on the floor, and he said, I can't stand this E-3. He's not following what I'm saying. And at this point in time I was a second lieutenant. And he was saying, Sir, this guy is really terrible, and he's not doing this. And I started smiling a little bit. And he looked at me and he said, Sir, this is not funny. Why are you smiling? This is really a serious matter. And then I told him, I said, Guess what? I said, When you were an E-3 you acted the same way. He was an E-2. He was watching you. And the way that you carried yourself taught him how to be an E-3. Now that you're an E-5 he's watching how you treated your E-5. You did the same thing.

Realize that you're part of a system, and that all the way from the federal government down to knocking on someone's door, we are trying

to create the best tool to make sure this person doesn't die tonight, that child wakes up in the morning alive. That's really what we're here for. So it's really that collaborative spirit that we have to move forward on. No one knows all of the answers. If everyone knew all of the answers we wouldn't be sitting here. But we need to make sure that we're working in the right direction to do the right things, and we are cognizant of things.

I tell the CDC all the time in meetings that we need to know more from what people are saying in the field. Because you can put something in place, and if it doesn't make sense, first of all, it's not going to be complied with, and the second thing, it's going to cause more disruption than it's worth. So why aren't we listening? This is the why from the field. You can have a crucible with this perfect solution, scientifically valid, I come out of my academic institution and say, Here, drink this, and you look at me and say, You're crazy. Even if I'm right it's worthless because I haven't engaged people enough to figure out what really works to get the buy-in, to find out why maybe

it's not a good idea for them or something else

they need for it to work. So for that to be put in place, no one wants to see morbidity and mortality, premature mortality, but that's something that we have to face. And that's the final solution. The final endpoint is trying to reduce those two.

So with that, I'm really happy that all of you have come, that the departments are here, the local health departments, any kind of healthcare facilities that are represented also, you know, from the private sector, also, you know, the nongovernmental organizations, the foundations, they're all critical to the success of this program.

We, as a nation, are facing a tidal wave if those statistics are right about one in three children with diabetes. Can you imagine? What does that mean for the schools? Who's going to take care of them while they're in school? So we have a very, very large problem in front of us, and we have to find some good solutions for it.

So with that we can bring the first person to the microphone. And we would like you

to also spell your name out for the reporter, and make sure that you say your affiliation. If it's a really complicated spelling for the affiliation, to spell it out so that she can get

that as well.

MS. MOEHRING: My name is Patricia Moehring. That's M-O-E-H-R-I-N-G. I'm the Community Health Education Director for Southern Seven Health Department. I've been with the agency for nearly 27 years.

Southern Seven Health Department is a multicounty health department located in the seven southernmost counties of Illinois: Alexander, Hardin, Johnson, Massac, Pope, Pulaski, and Union. The population is approximately 70,000. Southern Seven is the largest health department geographically in the State of Illinois, covering around 2,003 square miles, and is comparable in size to the State of Delaware.

Southern Seven faces significant health disparities compared to other regions in Illinois due to its rural locale and socioeconomic conditions.

Heart disease mortality/morbidity in

the Southern seven area are among the highest in Illinois. Heart disease is the leading cause of death for the seven counties, accounting for nearly 30 percent of total deaths each year. Hardin and Massac Counties have the highest and fourth highest age-adjusted mortality rates in Illinois for heart disease at 890 and 831 per

100,000, compared with 661 per 100,000 overall in Illinois. In five of the seven counties, over 33 percent of adults have been told they have high blood pressure, compared with 26 percent of adults in Illinois overall. In addition, all seven counties' smoking rate is over 25 percent, with three counties over 30 percent, while the State of Illinois is at 18.8.

Alexander County has the highest rate of diabetes in Illinois with a rate of 14 percent, and Pope and Pulaski have the fourth and sixth highest diabetes rates at 11 and 11.1 percent, respectively, compared with 6 percent in Illinois overall. Obesity in Illinois is approximately 25 percent, while the seven counties are greater than 30 percent. Johnson and Union Counties are ranked first and third for the highest obesity rates among adults in

Illinois, with 70 percent of adults classified as overweight or obese to 60 percent of adults in Illinois overall.

Cancer is the second leading cause of death in the Southern Seven counties, accounting for 23 percent of all deaths annually. Three of the seven counties are in the top 10 counties in Illinois for all cancer death rates.

Southern Seven is currently partnering with the Healthy Southern Illinois

Delta Network addressing cardiovascular disease in the lower 17 counties of Illinois. We're partnering with the SIU Center for Rural Health and Social Services, Southern Illinois Healthcare, and Egyptian County Health Department in implementing CATCH in the schools in our area. We partnered with the University of Illinois Center for Research on Women and Gender through ASIST2010. We were recently funded to partner again with them on a planning grant called Coalition for Healthy Communities, funded by the Department of Health and Human Services and Office of Women's Health, to assist our area to further understand and address the factors that contribute to the risk and prevalence of CVD,

obesity, diabetes, and cancer among women. I'm also actively participating with the Illinois Cancer Control Partnership.

In closing, Southern Seven wants to make a difference in the health of our area. We have identified our region's health problems through the IPLAN process. We have an advisory group in place, but with shrinking dollars and fewer people we are facing an uphill battle. What we would propose is a consistent resource or funding stream to help us fight chronic disease and ultimately its toll in our area. We also support action in Illinois and policy change

within the state to help slow down and reverse this trend and assist us in becoming a healthier and fit region and a state.

DR. ARNOLD: Thank you. Do you have any questions, Miriam?

MS. LINK-MULLISON: I don't think so.

DR. ARNOLD: Yeah. One of the questions I had was the major occupations which are in that area. And I'm looking at the smoking rate you said of 25 percent, so I'm trying to figure out if it's linked to anything and any factors that you can pick out.

MS. MOEHRING: Well, one of the things I think we're up against, we're bordering three states that allow smoking, you know, with our nonsmoking rate. But I think the rural community where basically the occupations are a lot of prisons and healthcare, and it's surprising to me that so many nurses actually smoke, but we have a lot of healthcare employees.

DR. ARNOLD: So if the doctors and nurses would stop smoking.

MS. LINK-MULLISON: Well, also the lower socioeconomic status of those counties is a contributing factor for tobacco, I'm sure.

MS. MOEHRING: Yeah. And the rural nature.

DR. ARNOLD: And the rural nature.

Thank you.

MS. BAILEY: Hello. I'm Angie Bailey. I'm the Director of Health Education at Jackson County Health Department, where I've been for the last 11-and-a-half years.

Chronic diseases, such as heart disease, stroke, cancer, diabetes and arthritis, are among the most common, costly and preventable of all health problems. Lack of physical

activity, poor nutrition, tobacco use and excessive alcohol consumption are the modifiable risk factors related to chronic diseases.

To coordinate efforts and increase effectiveness, our focus on chronic disease prevention and health promotion should be at the risk factor and lifestyle level rather than categorically by disease. Funding needs to reflect this approach. For example, we need to adequately fund and support programs in Illinois related to tobacco use, physical inactivity and poor nutrition. Without addressing these issues properly we will not impact chronic disease.

Secondly, a growing body of research reveals a strong relationship between the built environment and these chronic health conditions. Our efforts need to focus on policy, systems and environmental change. We should work with various sectors of our communities; such as

schools, churches, businesses, community-based organizations in order to ensure policies and environmental changes reach all individuals to have the most impact. "The Leadership For Healthy Communities Action Strategies Toolkit" by the Robert Wood Johnson Foundation is a great

tool to get us started. Some specific examples of this include: making CATCH, or the Coordinated Approach to Child Health, curriculum mandated statewide. Working with schools we can address school nutrition, physical education, food service and parents. In southern Illinois over 30 schools are using CATCH with great success. We should also increase the tobacco taxes; add a tax to sugar-sweetened beverages with little or no nutritional value; prohibit the use of the Link card to purchase candy, soda and other food with little or no nutritional value; work with farmers' markets statewide to accept the Link card; we should also facilitate and establish agreements to make schools accessible to allow community residents to use facilities during after-school hours for physical activities; we should also encourage restaurant menu labeling; and regulate the marketing of unhealthy foods in or near schools and other youth facilities.

By creating positive environmental,

policy and systems changes, we are well positioned to create positive community changes that facilitate healthy eating and active living

and reduce tobacco and alcohol abuse, thus improving health for everyone.

Lastly, we need to answer the question, what is already being done in Illinois and throughout the nation that is effective and that can be expanded to improve the health behaviors of Illinois residents? Our focus should be on implementing best practices in chronic disease prevention and health promotion whether they are from the CDC, Institute of Medicine, Robert Wood Johnson Foundation or others. We also need to look at what other states are doing and learn from their successes. There is much we can do if we look at best practices and develop a comprehensive statewide plan for working together to impact chronic disease.

In summary, chronic disease prevention and control in Illinois should be accomplished through three ways: targeting the risk factors, physical inactivity, poor nutrition, alcohol abuse and tobacco use, and supporting this work with adequate funding; also implementing policy, systems and environmental changes; and having a coordinated statewide

vision and approach that implements best practices and proven strategies.

In order to impact chronic disease in Illinois we will need to have a long-term plan with long-term funding.

DR. ARNOLD: Okay. Thank you. Can you spell your name for the reporter?

MS. BAILEY: Oh, sorry. Angie, A-N-G-I-E, Bailey, B-A-I-L-E-Y.

DR. ARNOLD: And one question, you know, that was really why the CDC -- you know, I've been in several meetings with them. But one of their pushes was to make sure that obesity was put in as a category. Because they saw that it was really -- if you're looking at one specific disease, like diabetes, you start separating these things, and it becomes really -- it's chasing many different strings. So, you know, they were looking at trying to make things more of a comprehensive approach. So I think that that was really coming out in some of the things you were saying as well. And I really like the risk factor and lifestyle level focus rather than, you know, specific disease intervention strategy.

MS. BAILEY: One of the things we found was some of the coalitions in our area is people are more interested if it's nutrition and physical activity and tobacco use, because it encompasses all of them. But when you say we're going to form a diabetes coalition or committee, they're like, Oh, well, I don't specifically work on diabetes, so they're saying, oh, they can't be involved. But really they are and should be because of the prevention of it.

DR. ARNOLD: Exactly. Exactly. This is part of some of the ideas of silo walls that we sort of have created around disease states.

MS. LINK-MULLISON: Uh-huh.

DR. ARNOLD: So, you know, I'm dealing with diabetes so do I have to worry about heart disease?

MS. LINK-MULLISON: Well, yeah.

DR. ARNOLD: Maybe. So those things I think are -- you know, I think this is really what this platform is trying to do, is to show the continuum. For any disease state you have things that you are talking about, and they resonate with me on some different levels. My background is internal medicine training, and I

things from a toxicological standpoint, you know, when you're talking about toxicology, you can engineer something out of a system where you're not exposed to this chemical agent, all right? And so that is something like legislation saying that we're going to ban trans fats. So that's really a sweeping statement. We're not going to even put them on the market. You can have a secondary level of administrative control where you control the amount of exposure, and you can say, Well, we're going to put a five-cent soda tax in, and we're going to make it, you know, less likely that people are going to buy or consume those things in higher quantities. And so that's a secondary level, or, you know, what you were saying about restaurant labeling and those kinds of things, those are, you know, sort of like administrative controls.

MS. BAILEY: Uh-huh.

DR. ARNOLD: And if you go down to the prevention side of things, you know, for an example, obesity, you have nutrition and exercise, but those are essentially important for

everything we have for all chronic disease. And then you have education. And then you have the treatment side, where you can cure something, you can maintain a disease, or you can take care of the consequences of it if you wait too long. And

so that's the spectrum that we're looking at.

And, you know, these things are overlapping. So you can actually have prevention in chronic disease management. You can have prevention in the prevention of chronic disease period. So I look at prevention as, you know, going across the entire spectrum. So we want to prevent, you know, the deaths from medication misusage, you know, and hospital safety. We can actually intervene in the chronic disease management in the hospital level, too, or in healthcare settings and say that this is the best practice to minimize the likelihood of that outcome, that poor outcome.

So it really is a very wide spectrum, but I just said that now for the platform so that as we're putting the pieces together, you know, you can find out what your niche is. But you may be crossing all kinds of groups that you never even thought of, you know. Diabetes crosses

ophthalmology. And, you know, there was a time where you just managed diabetes in the office without having a referral to an ophthalmologist. But the technology has caught up where we do, you know, interventions such as, you know, laser therapy to prevent proliferative retinopathy and that kind of thing. So here we are, you know, we need to be keeping in tune with what the best

practices are, what the new interventions are, and trying to put them into a model that can be benefiting everyone in the state.

So I think you put it very well with these categories, so thank you very much.

MS. BAILEY: Thank you.

MR. NEILL: My name is Ed Neill, N-E-I-L-L, and I'm the Vice-President and Chief Operating Officer of the YMCA in Southwest Illinois. I've been in that position for about five years, been with the YMCA as an organization for about 35 years. And I'm here today just to give some brief testimony on behalf of the Illinois State Alliance of YMCAs of which we're a part of that, that organization being YMCA in the State of Illinois.

The core mission of the YMCA is to

put Christian principles into practice through programs that build healthy spirit, mind and body for all. With 51 corporate YMCAs in the State of Illinois, YMCAs serve as a perfect place to cultivate healthy statewide change at the community level.

The two Y programs I'd like to discuss with you during this testimony is the YMCA's Diabetes Prevention Program, and the Pioneering Healthier Communities.

Between 1996 and 2001, the National

Institutes of Health and the Centers for Disease Control and Prevention established a Diabetes Prevention Program, DPP, which found that adults could cut their risk of developing diabetes by 58 percent by losing 7 percent of bodyweight and increasing their physical activity. The original DPP included one-to-one education and support for healthy eating and physical activity with a 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 program. 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 by trained YMCA professionals. The results demonstrated that the Y could deliver the program at a fraction of the cost and achieve similar results to the national program. The program participants were successful in preventing or delaying the onset of Type 2 diabetes by reducing their bodyweight by 6 percent and increasing their physical activity, and continued to maintain this progress 6 and 12 months after the core 16 sessions were done.

In April of 2010 this year, United Health Group, one of the nation's larger health

insurers, teamed up with Y-USA to expand the program. Using the model from the YMCA of Greater Indianapolis, Y-USA has implemented the program in 10 states across the country.

YMCA of the USA worked with Congress to create the Diabetes Prevention Act as a part of healthcare reform which establishes a national community-based diabetes prevention program at the Centers for Disease Control. In September of 2010, the Y announced $50,000 in grants available to introduce a diabetes prevention program at

local YMCAs. Three Illinois YMCAs were approved to start the program in the fall of 2010, but were unfunded. The YMCA is soliciting private funds and advocating for Congress to secure additional startup funding for the approved but still unfunded Y's.

The YMCAs hold a unique advantage in their infrastructure to run community-based prevention programs because of the sheer number of locations and ability to reach low-income and diverse populations who are at the highest risk for developing diabetes.

While Y-USA is looking to fund the three YMCAs mentioned, they are also looking for partners in this work. In 2011, Y's may choose to make a $12,500 investment with the YMCA of the USA to participate in the program.

Now Pioneering Healthier Communities.
In 2010, the Illinois State Alliance of YMCAs was named one of the YMCA of the USA's statewide Pioneering Healthier Communities, PHC. PHC is a statewide collaborative effort that focuses on healthy systems and environmental and policy changes. Three statewide PHCs were started in 2009, in Connecticut, Kentucky and Tennessee.

The 2010 cohort includes Illinois, Michigan and Ohio. The statewide collaboration here in Illinois is supported by a total of 12 local PHCs across the state, of which the YMCA of Southwest Illinois that I represent here today as well is one.

Each local PHC creates a Dream Team that must develop a local roadmap on how they will drive healthy systems, environmental and policy change in their community.

This group starts by doing a Community Healthy Living Index on their community which assesses the following areas: the schools, after-school and child care, work sites, neighborhoods, etc. The index indicates gaps that inhibit healthy choices such as unsafe walking paths, lack of access to fresh fruits and vegetables, or not enough after-school programs that emphasize physical activity on a regular basis.

These local groups support the large statewide team focused on policy change at the state level. The statewide PHC is also charged with the task of building a Statewide Roadmap that will lead to lowering the obesity rate among

Illinois children. We are currently working with five statewide partners at this time.

The YMCA plans to introduce our statewide Pioneering Healthier Communities 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 the people of Illinois to be able to make healthy choices in their daily lives. Thanks.

DR. ARNOLD: Thank you very much.

MS. LINK-MULLISON: I have some questions. Ed, could you tell me a little more about the Pioneering Healthier Communities? Who are the partners in Illinois?

MR. NEILL: There's 12 PHC YMCAs in the state. The four original ones, which were a couple of years ago, the Prairie Valley Family YMCA in Elgin, the Rock River Valley YMCA in Rockford, the YMCA of Southwest Illinois based out of Belleville that represents the Metro-East area across from St. Louis, and the Two Rivers YMCA in Moline and Quad Cities. Those are the original four.

MS. LINK-MULLISON: Okay.
MR. NEILL: Then eight new ones

became PHC YMCAs in 2010. And those are the YMCA of Metro Chicago, the B.R. Ryall YMCA in DuPage County, the Joliet YMCA in Joliet, the Kankakee YMCA, the West Cook YMCA in Oak Park, the YMCA of Greater Peoria, the Quincy Family YMCA, and the Campanelli YMCA in Schaumburg.

MS. LINK-MULLISON: And who are you partnering with in the communities? Like just in your community, like in Southwest, who are the other people that you're reaching out to besides the Y's?

MR. NEILL: Well, in our area we have a Dream Team, just like I referenced in my testimony. And it's members of the Public Health Department. Kevin, who is here today, has a representation on our Dream Team. We have a superintendent of schools. We have educators from the local colleges. SIU-E Edwardsville is on there. The nursing department helps with that.

MS. LINK-MULLISON: Great.

MR. NEILL: There's, I'm going to guess, 10 to 12 on the Dream Team. And they've been an active part of trying to get policy change in the area.

MS. LINK-MULLISON: And then I think I understand how this works at the national level, and I'm not sure, but there are -- I think the Y is collaborating with other national organizations on this, including NACCHO, is that true? NACCHO, National Association of City and County Health Officials.

MR. NEILL: I'm not familiar with that. They may be. Our focus is primarily the State of Illinois, the five partners we have in Illinois.

MS. LINK-MULLISON: Yeah. I think the national initiative with the Y is supporting some of this kind of programming. NACCHO has applicants. And I believe the funding comes from Robert Wood Johnson to these national organizations that then feed it down to the state level, which feeds it down to the community level. So, for example, NACCHO has a grant application process currently out there where they are accepting -- or that they are reviewing to fund this exact same process. So different national organizations are funding this in communities throughout the country.

MR. NEILL: And we've had some

connections with the Robert Wood Foundation as

part of the application process in the state YMCAs, right.

MS. LINK-MULLISON: And a couple of the local health departments in Illinois have applied for the NACCHO funding, that's right.

DR. ARNOLD: Also, the questions I had were really related to, you know, first of all, the YMCA. I think that people have to understand, you know, first of all, the incredible things they've already been doing, but that the Christian doesn't mean that you have to be Christian to go there, for one; that it's open to all faiths; that they service people from all over, various backgrounds, and have an incredible history of servicing the community.

MR. NEILL: Thank you.

DR. ARNOLD: And the second thing is talk more about the collection of data or metrics or whatever deliverables that you are focusing on. Is it body mass index, or are you following children over time, or how are you demonstrating programmatic effectiveness?

MR. NEILL: I think that during the early stages of that would be the CHLI index of

community health, including the index I mentioned earlier. Because that process isn't even going to be rolled out until next year.

DR. ARNOLD: So you need to have the

support for that kind of --

MR. NEILL: That's right. When they put their roadmap together the metrics will be part of that.

DR. ARNOLD: Okay. Thank you very much.

MR. NEILL: Thank you.

MS. LINK-MULLISON: Kevin, do you want to go next?

MR. HUTCHISON: Oh, am I next?

MS. LINK-MULLISON: Yeah.

MR. HUTCHISON: I brought pictures.

DR. ARNOLD: Thank you. And if you have any written documentation you can always hand that in as well for the reporter.

MR. HUTCHISON: My name is Kevin Hutchison, K-E-V-I-N, Hutchison, H-U-T-C-H-I-S-O-N. I serve as Executive Director of St. Clair County Health Department, and also the Convenor, a/k/a Chair, of the St. Clair County Healthcare Commission. Ed and I didn't

strategize ahead of time, but it's going to sound like it, because we are partners in the Healthcare Commission, and we have the privilege of serving as some of our leadership staff serves on the Pioneering Healthier Community's team locally.

This morning I am submitting this

testimony on behalf of the health department and members of our St. Clair County Healthcare Commission. The commission is a membership of about 30 members and affiliate members, and actually it reaches out to probably over 70 organizations countywide that we feel are key partners in part of our local public health system. As a local health department, Dr. Arnold, as you know, one of our -- not just a requirement, but I think it's an opportunity that we have through the community assessment process through IPLAN, it really does engage the local health department and local government involved with reaching out and listening to the key members of the local public health system. And I think your earlier story about developing a medication or a resource that the consumer doesn't understand is a very good point. So I

think the opportunity that we have to really listen locally is what we try to endeavor to do through the local IPLAN process in using data and evidence based for that.

Part of our work in St. Clair County was establishing a shared vision for health and achieving significant health improvements in addressing the physical, financial and social impact of chronic disease. And it's a long-term process. And I think that's one of our talking

points, that these are processes that sustain over time. Clearly when we look at prevention, the focus that we have through our partners, such as Ed, and his organization and others in the community is to get upstream and work with our children, work with our families in primary prevention. And this gets to risk. Risk behaviors I think is what Angie and others have mentioned in terms of, how do we deal with the healthy choices and empowering people to make good choices while they have good health and to maintain that health?

There are some challenges in working in collaborative, in a partnership. You know, all of the folks have -- when you were driving

over you could see the silos. And the silos are there for a reason. They are strong. They're protecting a resource. They're gathering a resource. And some of those resources are different. But also most of the silos have an infrastructure above them of augers and distribution systems that take the resources, blend them, and then create an even better resource that's used to feed livestock in the literal application, but that generates an outcome.

DR. ARNOLD: Yes.

MR. HUTCHISON: And I think that's

one of the -- the idea of a collaborative model is respecting and valuing the individualists of our community system partners, but also having a system that can collect that information, blend it and make it even better to be used by the consumers in our healthcare communities.

Getting multiple organizations to support a common strategy sometimes can be a challenge. Managing the complexity of -- and this is something -- in our county we have a population base of about 260,000 folks, and we're large enough to have lots of challenges but not

so large that we don't know each other. But still within the various systems of private sector business, local governmental services and nonprofit community organizations, faith-based communities each has a perspective and each has a mission to try and carry out. So to look above that to the common shared vision can be a challenge that is not unattainable. It is doable to inspire a shared vision. And I think that's why the opportunities we have today through the task force and through the State Health Improvement Plan, Obesity Task Force are opportunities for us to look up and see what's going on around us with our partners.

A strategy-centered approach in linking objectives and projects is well-suited to

identifying where local programs and resources for chronic disease prevention can be best leveraged. Certainly resources are needed, additional resources are needed, but there are resources in play now. How can we use them the best? You said no money, no metrics, or no metrics, no money, which comes first? If there is not money put into metrics in a data collection system in an infrastructure, then how

do you generate the numbers to, you know -- so it is a little bit of the chicken or the egg. But there is certainly the need for data and evidence-based practice.

Deploying on a statewide basis, effective strategic management systems can improve what we're doing locally, but also support what's going on statewide. And, Doctor, you mentioned the goals of the State Health Improvement Plan. And we see how the work that we're doing here and testimony will fit into that overarching strategy. And I think that's something that's very, very important that we do at the statewide level. You mentioned CDC looking at the fragmentation of how we even structure the funding flow and administrative services. You know, there needs to be this alignment. And there are some strategies that we can look at and think and apply locally, and I

think there are models that can be applied statewide as well.

Some of the things that we have locally through working as a partner under the leadership of the local Y and the Pioneering Healthier Community project, working with the

Healthcare Commission, also a local board of health, area hospitals, who are working with the whole issue of community benefit, which is certainly an opportunity that we have today in today's society to look at as the IRS standards are requiring and challenging nonprofit hospitals to really communicate perhaps better what they're already doing. I think in our local hospitals they are community minded, they are doing services to benefit the community. But they're going to have to demonstrate that clearer, and they're going to have to link that back to the assessment process and the planning process. So in my mind I think that creates great opportunities for us to build relationships. In fact, we have those work relationships already established with our area hospitals and community health centers.

But some of the specific things that have been identified through our IPLAN and our community partnership, I'll just kind of go through the list very quickly because you have

them in front of you, but basically evidence-based prevention strategies and looking at policy change. Sometimes a policy change

doesn't cost more money. It's just a will and having a vision, an idea of how to do this, we're using resources that we have better. Junk food can be very expensive as opposed to just good healthy food. If we leverage the comments that were made earlier about farmers' markets, you know, we live in the breadbasket of American. Just driving over here, the rich bounty of our rural farmland. And thank goodness we have good farming so the people in Chicago and other urban areas can eat. So we all are in this together.

Another recommendation is, establish and support a statewide prevention media campaign, educating, meeting people where they're at. And I have great respect for the need to the role of health educators and understanding and listening to people where they're at to craft educational messages that could reach them. We certainly can build on the experience we just had with H1N1. That was an excellent opportunity to learn what are some of the things that we can do better, and apply those to public health principles for chronic disease prevention.

Transportation and land use policy changes. You know, injury prevention is a big

deal. We live in an urban and suburban area where we're working with area mass transit. And, again, at the policy level of thinking green, green space preservation. You know, one of the partners in our local Pioneering Healthier Communities is the City of Belleville, which is doing a lot in terms of urban and suburban redevelopment. And they're very much public health minded in terms of making walkable communities, having bypass, integrating that with our transit district, trying to engage schools. An interesting antidote is, one of the area schools is right proximate to a MetroLink mass transit light rail system, and building a walkable community creates another public health concern to have about the safety of their children. And I think you have to respect their need to understand the safety of their children proximate to the mass transit. A kid could get on and take a ride and go somewhere else. You know, it's a violence and safety thing. But there are avenues to overcome that if we have a shared vision.

One of the -- I guess the cornerstone of our comments this morning is to establish

strategic alignment. And our recommendation is to deploy a statewide tool for state and local health improvement plan implementation data collection, of course, so that we can define what we want to do, measure what we're wanting to do after we implement it, and then see, did it work? And there are models that are out there. I think we have the IPLAN data system, Version 2.0, that the state has developed that gives us good outcome indicators. But could we not and should we not build a platform to use that as a reservoir for collecting information county wide, community wide, regional wide, and having that feed into a state system, and then push it back down to us locally so it's data that's usable? The Health Information Exchange and some of the work we're doing with meaningful use I think can be leveraged in this effort for chronic disease prevention.

I guess in conclusion, we believe that the goals of chronic disease prevention can best be achieved by fostering a public health system that includes strong emphasis in aligning strategies of key stakeholders at both the local and the state level. Developing strategic

management systems and tools could provide an effective avenue for state and community leaders

to define, implement, measure and evaluate the efforts of multiple system partners and leverage existing resources and hopefully garner some new resources to achieve the desired outcomes in chronic disease prevention. Thank you.

DR. ARNOLD: Thank you.

MR. HUTCHISON: And there are a couple of pictures.

DR. ARNOLD: Yeah. This is incredible.

MR. HUTCHISON: Actually the Figure 1 does depict the partnership that we had with the YMCA and the Pioneering Healthier Communities. Actually that is through the IPLAN. Our MAPP process is garnered and actually fostered a diverging of a new community-based organization. It's not another silo. The Get Up and Go Campaign actually is now incorporated as a vehicle for all of the system partners to try to communicate, take that out to the community, but they are also piloting some tools on community-balance scorecard, those kind of models of aligning, reporting, measuring, feedback, and

then improving through the CQI model. So we're working with that at the ground level, and we've had consultation with some of your staff already and had some dialogue there. So there may be some opportunities to replicate that in other

parts of the state. Because, like I said, public health is everybody. It's not just St. Clair County.

The second figure is just what we know, getting in the same direction in the same way can move us to one outcome.

MS. LINK-MULLISON: Can you maybe elaborate on what resources you think local health departments could use to leverage, to do the things that you're doing, and that we're doing actually in Jackson County, too, in terms of developing that community coalition and leveraging, you know, the partnership to really make things happen? I mean, what kinds of support could the state be providing to encourage that happening?

MR. HUTCHISON: I think on a statewide basis, especially the policy development folks, consultation technical assistance can be a very effective tool that we

can use and have used historically locally. Unfortunately, the policy arm of the state health department has probably been dwindled off, you know, because of the economy in terms of the robustness of technical assistance, current data and current tools. I mean, while we're down in the trenches, so to speak, we need the folks at the state level that have an awareness of best

practices, of current trends, that have expertise that can provide technical assistance to the locals.

A second thing we need is, there are models and tools out there, that some perhaps the cost may be a little pricey, but there may be some other alternatives that are less costly, or if you get the tool and it's used statewide you get the economy of scale going for the strategic alignment where we actually are capturing and gathering data that the community partners have.

You asked, you know, Ed about, Well, what are the metrics of obesity reduction in schools? Well, the person that probably really we need to ask that is our schools and our health educators. And then, are there policies that they can release that information in a way that

protects the individual and you don't have astigmatism of this school district is overweight, and this is the skinny school district, and then you get competing interests there? How can we use these existing -- they're there, the data is there. And I think state policies are things that can help us pull that, and then measure, and then see where we're getting the best return on the investment.

MS. LINK-MULLISON: Yeah. I hadn't realized it, but we recently did a project in

Jackson County where we were looking at the dental health exams. And those are actually available on-line. And I don't know if the physical exam information is available, but the dental exam information is available. And, you know, that's saving us an enormous amount of work locally, because we were going to survey all of our schools and find out what that information was. And we found that we could go on the ISBE website and download all of the information on dental health in our schools.

MR. HUTCHISON: There's abundant examples and opportunities in terms of injury prevention, you know, our local law enforcements

GIS, geographic information, where you can plot out where accidents, where bicycle injuries are. And if we could look at that and look at the proximity, usually it's no surprise there's no sidewalk or a very limited sidewalk. So if that could be integrated with the land use planners and urban development, again, it's a systems thinking and aligning a shared vision. And as we develop our communities -- and this is not just urban issues. You look at injury prevention in the rural areas. And my colleagues are probably more up to speed on the current data, but the last I looked farming was one of the most dangerous occupations in America next to coal

mining, and I think we have a lot of both of those in our area.

DR. ARNOLD: Yes.

MS. LINK-MULLISON: Yes, we do.

MR. HUTCHISON: So injury prevention and extending that out to homes and safety is something that's also data and tools in the infrastructure. Again, how do you collect the data if you don't have a way to collect it?

DR. ARNOLD: That's right.

MR. HUTCHISON: And we need data, we

need technology, and we need local health departments resourced with not only computers and software, but people trained to use the software. And this gets into the human factor. We need people, where I have more computers than I have people. I have an empty desk because of the staffing reductions. So it's a blend.

DR. ARNOLD: Yes. Uh-huh.

MS. LINK-MULLISON: And one other question, do you have any -- just because I know you probably do, do you have any thoughts on funding for chronic disease?

MR. HUTCHISON: Sure.

MS. LINK-MULLISON: Ways in which to do that?

MR. HUTCHISON: I think -- obviously I think we have to be realistic with the economy,

the deficit of our nation and the deficit of what's going on in our communities, the business sector. To not recognize that would be denying evidence. We talk about evidence-based practice. We have evidence of certainly a declining economy and financial needs that are huge. Last year we had an 18 percent increase in demand for services in our health department, coinciding with about a

5 or 6 percent reduction in the budget. If it hadn't been for the H1N1 funding coming in we would have really been reduced across the board. So, yes, we need new resources. I'm not sure if it's going to be new resources or it's using the existing dollars more wisely. And that's prevention and getting funding into prevention.

MS. LINK-MULLISON: Uh-huh.

MR. HUTCHISON: There has to be a core amount of resources that are provided not just to local governments, but I think trying to give opportunities and policies for community-based organizations such as the Y. They do a great job. And I know that they use part of their resources for scholarships for kids. So that may not -- and they have a Reach Out Program. I think those are examples of how can we -- we can't always do more with less, but if we have less we can do the best things.

I don't have a good solution of where

the money would come from. I mean, we've taxed tobacco extensively, which is appropriate. There was a suggestion about a soft drink sugar tax. That may be another avenue. I think at some point in this society and as a policy we have to

allocate more than just one or two cents to local public health systems.

MS. LINK-MULLISON: Uh-huh.

MR. HUTCHISON: If we're going to be the leader and the convenor and the tracker and the monitor, I think our role may change in the future under healthcare reform, but our responsibility won't in terms of assuring that all people have good healthcare. And I think that takes more than the $17 or $18 million that we have, that's for sure. You can double or triple that.

One idea that we fostered about 10 years ago, we called it the one-cent solution. That would be -- this would be at the point of consumption of food products, a one-cent sales tax. It's a consumer-based tax. It would generate over $100 million. That was then. It would probably be twice that now. We're not talking about groceries. We're not talking about food at the farmers' market. We're talking about dining out. And at that point a one cent or some fraction thereof of consumption. So those people

from other states that come in and do tourism, they would help support the infrastructure and

food safety program that we have in Illinois. And this may resonate, I don't know the details, but I know there was federal food safety legislation supported by Senator Durbin that was just passed this morning, or it's being worked on, being entertained by the Senate in terms of food safety. But that point of consumption would generate lots of resources that could be used for food safety and also nutrition education and prevention programs. So it would -- and it's not a new concept. I know I think it's the McCormick -- there are several point of consumption taxes on beverages.

DR. ARNOLD: Yeah.

MR. HUTCHISON: But it's used for other purposes. It's not used for public health. So we need a policy that has a will, that shared vision that this is important to invest in.

DR. ARNOLD: Well, I just want to make a couple of comments. One is, I would be remiss without saying this, but, Kevin, you're always like the consummate professional.

MR. HUTCHISON: Well, thank you, sir. I appreciate that.

DR. ARNOLD: And really a very

positive public health role model for people to follow. And, you know, I love your testimony. I think you are bringing up some very valid points that need to be brought into this structuring. So I think the department will continue but also hopefully become even more involved with yourself and the local health departments in structuring responses.

Again, I was mentioning this idea of the tidal wave, and I think you were touching on it a bit in the tail end of what you were saying, was that in the future, what is the public health field going to look like, and how are we going to structure ourselves to meet this onslaught of the need. We're going to almost double the number of people within the state. We're going to enter into insurance-based systems. And as a provider, you know, I used to see a patient, and you have 15 minutes to see a patient, and that wasn't enough time. So now you have 7.5 minutes if the workforce is not increasing. So part of Title IV is wellness and prevention for the Patient Protection Act, but Title V is workforce development. So we need to be looking at also the future of where we're going.

And as you were mentioning with the

data I sort of put a note on the side while you were talking, we need a data output analysis team prior to this being released, because it can be misinterpreted. I think it was Samuel Clemens/Mark Twain who said there's lies, and then there's damned lies, and then there's statistics. So people can bend numbers the way that they see fit, and that doesn't really help the individual who is walking in because they fractured their hip or they're carrying their deceased child into the emergency room.

So we really have to be very, very cognizant of what's happening at the local level, and make sure that the data is not being used in a negative fashion, but as a mechanism for improvement, and making sure that we address the issues that are underlying the problem with bad outcomes, if we're looking at best practice models or how to modify them or how to make your system better. No one wants to work with a terrible system. So I think that this is one of the viewpoints we should have, that this is more of a proactive positive stance to positive transformation.

MR. HUTCHISON: Thank you very much.

DR. ARNOLD: Thank you.

MS. LINK-MULLISON: Calvin Murphy.

DR. ARNOLD: One other thing is,

Kevin, you know, I thought I was really getting to the point where I was able to do PowerPoint, but you've like blown me away again, so I have to start all over again. This is really great.

MR. HUTCHISON: My staff does good work.

MS. LINK-MULLISON: I was going to say, I bet you anything --

MR. HUTCHISON: Mark Peters.

MS. LINK-MULLISON: Oh, Mark. Oh, well, he used to work for you all, you know.

DR. ARNOLD: Yeah.

MR. MURPHY: My name is Calvin Murphy, C-A-L-V-I-N, M-U-R-P-H-Y, and I am with the Southern Illinois Radon Awareness Task Force. And I would like to just make some very brief comments from a health promotion perspective.

DR. ARNOLD: Okay.

MR. MURPHY: Radon is an odorless colorless radioactive gas that is the leading cause of lung cancer among nonsmokers, claiming

in excess of 20,000 lives annually within the United States, and approximately 1,150 lives annually in the State of Illinois. Data from the Illinois Emergency Management Agency indicates that roughly 45 percent of the housing stock in the State of Illinois has radon in excess of the action level of 4 picocuries per liter of air.

The thing that I would like to see is that radon risk reduction becomes a medical issue. I recently had a procedure performed here in Mt. Vernon, and in the process of being processed through the hospital and surgery, I encountered two registered nurses who had no idea at all what radon was and the health risk associated with radon. And so I think that if we could make this a health promotion issue, and as people have preventative healthcare visits with the doctor, we ask, you know, Have you tested your house? Because if someone tests their house and takes action to reduce elevated radon levels, this is a communal health risk reduction. Everyone in the house, everyone who lives in the house, benefits from not being exposed to elevated radon levels and the associated lung cancer risk. And so we need to make this a very

urgent medical issue that needs to be addressed.

DR. ARNOLD: What is the average cost of addressing the issue per home or household? What are the obstacles that you see for people implementing steps?

MR. MURPHY: That's a real serious issue here in southern Illinois. The cost to mitigate a house, depending on the house, is in the range of $1,200 to $2,000. And so it's in line with other maintenance type items. But when

the issue is making a house payment or mitigating radon, you're going to make the house payment. And so --

DR. ARNOLD: One of the other things I was thinking about also is that -- and I guess it's part of your documents when you purchase a home, but is radon specifically mentioned, about mitigating it or getting it back to acceptable levels, before sale, because we do that for asbestos I'm sure, or some form of addressing of the issue?

MR. MURPHY: Illinois has the Radon Awareness Act which requires the seller provide the buyer with a sheet of paper which says, This house may have radon. You're entitled to test

this house for radon, that the Illinois Emergency Management Agency strongly recommends that you test the house, and buyer, seller and agents sign off. But it's a totally voluntary program. There's no required testing.

DR. ARNOLD: There's no requirement for the seller of the home to have that done prior to selling the home?

MR. MURPHY: No. No.

MR. NEILL: May I speak? It can be if you put it as a condition of the offer, as it did with me. We live in a 1,600 square foot home. The readings were above the 4 that you

mentioned. And we had it tested, and we put in the offer that we would not purchase the home unless the seller did the cost, $1,400, to mitigate the radon system. And then they did, the levels were fine, they came back and retested it, and we bought the house. And we have a mitigation system in our home for radon.

MR. MURPHY: Radon has predominantly been a real estate issue. It needs to be made a health issue.

DR. ARNOLD: Okay. Yeah. It's the second leading cause for lung cancer after

cigarette smoking.

MR. MURPHY: Yeah. And the leading cause among nonsmokers. Thank you.

MS. LINK-MULLISON: Jamie, I'm going to have Cheryl go next. You're just going to be the -- you're going to pull it in at the end. You're going to do a great job, I'm sure. Sorry about that.

MR. BYRD: That's all right. I don't care.

MS. METHENY: Hi. I'm Cheryl Metheny, C-H-E-R-Y-L, M-E-T-H-E-N-Y, and I am a Registered Dietician and Certified Diabetes Educator with the Department of Human Services.

COURT REPORTER: I may have you use the microphone. I'm having a hard time hearing

you.

MS. METHENY: Okay. Is that better?

COURT REPORTER: Yes. Thank you.

MS. METHENY: Okay. I'm with the Department of Human Services with the Bureau of Family Nutrition. And the Illinois Department of Human Services, the Division of Community Health and Prevention Bureau of Family Nutrition, would like to ensure that the task force makes obesity

prevention a priority in its efforts to improve the health of individuals in the State of Illinois. Obesity is one of the biggest public health challenges in the country. Obesity leads to a large number of chronic diseases, including but not limited to diabetes, heart disease and stroke, hypertension and cancer. Environmental factors, socioeconomic status, poor health habits and physical inactivity all contribute to the obesity epidemic, and, therefore, must be addressed by the state. It's critical that the Department of Public Health collaborate with other state agencies and provide financial support, technical assistance and professional expertise through organizations throughout the state who are working to address obesity and food insecurity.

It is essential to create environments within our daycares, schools and

communities that support healthy eating and active living using evidence-based best practices, strategies that are culturally and age appropriate. The US Department of Health and Human Services Healthy People 2010 objectives could be used as a benchmark to guide our

progress. Our Partners in Academia are critical for providing additional education and training to healthcare professionals in health promotion and disease prevention. It is important for the task force to support the State Board of Education's efforts to enhance the National School Lunch Program, the Child Care and Adult Food Care Programs, as well as the School Breakfast Program, as those promote healthy eating and sound nutrition principles and physical activity.

Daycare centers, schools and individual families need education support to develop sound nutrition habits that include the consumption of fresh fruits and vegetables, whole grains and adequate calcium, decreased consumption of sodium and saturated fats.

The Illinois WIC program focuses on providing education in lactation support, recognizing breastfeeding as optimum nutrition for infants, providing nutrition education to pregnant women, infants and children, to foster

the development of healthy health habits preconceptually and through the early childhood period.

Through interagency collaboration the state should continue to identify those making an impact on decreasing obesity in Illinois, and provide examples for others serving in similar populations. We must begin to identify what's working in Illinois and build on that success. Thank you.

DR. ARNOLD: Okay. Thank you. First of all, thank you for giving us your testimony, Cheryl. But the Department of Human Services is one of our sister agencies that actually is represented on the task force, and they are incredible with the coverage and the amount of responsibility that they face every day. They are delivering services throughout the state. They are our partner in blood.

And, you know, one of the things that I made clear in the first couple of hearings is that there is a combined effort, a true effort for people to work and collaborate together. And so we are working with DHS. They are our consummate partners, who are also working with HFS, looking at what the funding issues are, and how can we decrease this overall burden the state has? And it sort of tail ends on something that

Kevin Hutchison was mentioning, is that we have to be cognizant of the area we're operating within. And I can go out and say that this fast food chain, Chicken Fries, whatever, I'm just going to give a name to an organization, that we should close down every one of their chains in this community because these Chicken Fries are terrible. You know, they're using the wrong ingredient that's causing, you know, down the road heart disease. But by closing them down I just put 1,000 people out of work. They're not going to be too happy that there's no other place to go. So how do we change things? Do we have to modify what they're putting in that formulation? Do we have to work with them as an industry to make sure that we are protecting people while we're also making sure they still are employed? So there are multiple, multiple facets that we have to look at as we're addressing things within the industry.

The Department of Human Services is dealing with people on a daily basis where people are in very dire circumstances and very poor communities where it's very difficult for them to always comply with the best made pie-in-the-sky

plan. We have to make sure that this is reality based and that we're working all together. So I'm very happy that you came to give this testimony.

In December, early December of this year, they will be giving out the 2020 guidelines. And I was talking to some people in CDC, so I'm getting a couple of whispers here and there from people about what it's going to contain. But I said, Well, maybe we can finish with the 2010 first. But so as the guidelines are rolling forward, I think we have to look at all of these guidelines and see what's most practical, you know, for us as a group. What can we actually implement? You know, what do we need to use to get to where we want to go? So thank you very much for your testimony.

MS. LINK-MULLISON: Thank you, Cheryl.

DR. ARNOLD: Thank you, Cheryl.

MR. BYRD: Are you sure?

MS. LINK-MULLISON: Yeah.

MR. BYRD: No. I actually appreciate you not making me follow Kevin.

MS. LINK-MULLISON: See, I've got

your best interest at heart always, Jamie. I've got your back, Bud.

MR. HUTCHISON: He's the up-and-comer. I'm the has-been.

MR. BYRD: Okay. My name is Jamie Byrd, B-Y-R-D. I am the Public Health Administrator at the Egyptian Health Department. Egyptian Health, we are a tri-county health department, Saline, White, Gallatin Counties, population less than 50,000. It's ironic you were mentioning occupations earlier, I mean, our No. 1 and 2 occupation: coal miner, farmer. We are a very agricultural area with rich deposits in coal. So we face a lot of the same problems and issues that Patricia mentioned earlier with South Seven. Our overall health is very similar to that. I'm currently President of the Southern Illinois Public Health Consortium for two more days, so I guess I represent them also.

MS. LINK-MULLISON: Until Thursday.

MR. BYRD: But I'm really here today to represent the Southeastern Illinois Community Health Coalition. Our coalition, which is now still less than two years old, we're still pretty infantile, represents now more than 20

taking lead roles in that. And our mission is to take an interest in, and a commitment to, improving the health of the communities of southeastern Illinois.

Chronic disease, I think your average citizen probably hears the words "chronic disease" and they don't really even know what to associate that with. They don't really know a good definition of what a chronic disease is. And part of promoting or educating the public is that we need to put labels with some of these things and make sure that we're promoting -- while we're promoting prevention programs, we're also promoting what we're preventing, the different chronic diseases, and that a chronic disease is associated with a disease that isn't prevented by a vaccine or cured by medication, nor do they just disappear over time. These are long-term and long-lasting conditions that people live with. 88 percent or higher of Americans

over the age of 65 have at least one chronic health condition. Many of them, I think up to 50 percent, actually have two or more health conditions. And we know that health damaging behaviors, particularly tobacco use, lack of physical activity, poor eating habits, things that have already been mentioned here today, are major leading contributors to chronic diseases.

Our health coalition is currently updating our IPLAN. Our latest plan we're working on was developed in 2006, so we're working on our 2011. I'm glad to hear that the Healthy People 2020 is coming out in December, because we're going to need that to use for our goals. And we're also still prioritizing action plans from our 2006 factors. Our current health priorities are substance abuse, heart disease and cancer. And while substance abuse may not be considered a chronic disease itself, it's certainly a leading contributing factor to, you know, liver and heart disease. So while it may not be one, it's certainly tied in with it. And I'd also like to mention that while obesity wasn't listed as one of the factors, we didn't consider that a health priority in 2006. It was

still considered a contributing factor to all of our other health priorities. It's only recently, when we've done our local community health surveys, that we've pulled obesity out and set it as a stand-alone. And I certainly expect it to be either No. 1 and 2 in our health priorities when we set up our 2011 IPLAN. So basically all of our health priorities identified in 2006, and most definitely in 2011, are going to be either chronic diseases or factors that contribute directly to them.

The 2010 county health rankings that were released nationally certainly painted a dire portrait of the overall health of southern Illinoisans. If you look at southern Illinois compared to central and northern Illinois, we fall way below the health conditions. I know Saline County had over a two-and-a-half to one coronary heart disease rate compared to the rest of the State of Illinois. I mean, that's enormous. And according to the most recent Behavioral Risk Factor Surveillance Survey, the coronary heart disease mortality rate in southern Illinois is 38 percent higher than the state average. So I don't know whether it's a lack of

healthy foods, we have a -- certainly we're not at a loss for fast foods around here, but I have a county, Gallatin County, that has absolutely zero grocery stores in the entire county. We have about 6,600 population, and it's a very small rural Shawneetown/Ridgway and no grocery stores. So your healthy food choices are obviously very limited when you don't have any grocery stores.

DR. ARNOLD: But in the same environment do you have fast food establishments?

MR. BYRD: Well, yes.

DR. ARNOLD: Or some kind of --

MR. BYRD: Yes, some sort. And what

they don't have -- now, we have -- as was mentioned with the farmers' markets, I mean, we have a huge agricultural industry here. What we don't have right now is a mechanism to get the fresh vegetables into the hands of the people. There's no grocery store. There's no intermediary.

DR. ARNOLD: Yeah. That was one of the questions I was going to have. I'm not sure if anyone is going to speak here from the farmers' market or farmers' industry. But, you

know, as I was mentioning, the guidelines for the task force are for at least three meetings. So additional meetings can be set up by the chair so that the Chronic Disease Task Force can also call special sessions and talk about specific areas of focus. And one of the areas I really have a specific interest in is the delivery of food services to communities. And I mentioned about a month ago that there are -- you know, when we use the term "food desert", we have to be very careful about how we use terms, because what comes to mind is an intercity environment where you have dilapidated buildings and that kind of thing going on. But a food desert can occur in the middle of a stadium where you have 5 hot dogs and 10 beers, you know. So food deserts are what is your particular access where you are at the

time you are at that point where you are going to eat. So a food desert is a very relative term. And if you don't have access in the community the question is, you know, what can be done to overcome that barrier of fresh fruits and vegetables you know are linked to health?

And we've also started looking at things with maternal child health costs, you

know, with folic acid and neural tube defects and those kinds of things, but also even the effectiveness of chemotherapeutic agents for cancer, and I'm not sure if you have problems with access for cardiovascular health maintenance as well.

MR. BYRD: Lack of access to medical care was actually our fourth identified priority in 2006, so sure.

DR. ARNOLD: Right. So those things are sort of interwoven into that. So I'm just setting the stage for the potential for having additional meetings down the road throughout this year, upcoming year, to talk about specific issues or to develop, you know, the structuring in order to start looking at these things.

I'm also -- for some reason they put me as the chair for the farmers' markets. I started talking about it one day in a couple of meetings, and the next thing I knew something

come out that said farmers' markets. So that's something that, you know, we can start looking at things.

And I hate duplication where everyone is running in different directions. So there may

be linkage here between this and the Health Education Task Force, you know, the Farmers' Market Task Force. And we have to start looking at it to see how those things fit together so we get synergisms between their existence.

So with that, thank you for making that point, because I think that's an extremely important point to make. But, I'm sorry, I want you to continue with your testimony.

MR. BYRD: Okay. Well, and directly correlating to that is, we have a lot of WIC mothers in that county that have to drive 25 miles one way to go use their WIC coupons for healthy food choices for their children, so --

DR. ARNOLD: 25 miles?

MR. BYRD: Uh-huh. That's either to Carmi or Eldorado from Gallatin County. Some actually farther than that, depending on where they're located in the county. Gallatin County is a pretty good sized geographical county.

DR. ARNOLD: And these are WIC moms that may be with economic challenges?

MR. BYRD: The whole county is

very economically challenged.

MS. LINK-MULLISON: I think by

definition you have to be 185 percent of poverty or less.

DR. ARNOLD: Yeah. Where do you buy the gas?

MR. BYRD: Okay. So I'll move on now. One of the strategies already being used, and it's been mentioned twice already today, is the CATCH program. And we're fortunate, we cover six counties with CATCH, and we have a wonderful CATCH coordinator through Egyptian Health Department. And that program combining nutritional education with physical activities, it's been implemented in at least seven of our school districts already, and it's a great program. I could not agree more that to mandate that throughout the state would be a great step towards teaching these children, all children to have the same opportunity to learn about the importance of physical activity alongside of nutrition. Also, you know, health fairs, wellness workshops, summer food programs, just regular school food programs, WIC nutrition, education, these are a lot of the ways that are already currently being done as a form of prevention. We also have in southern Illinois as

part of the Healthy Families is a child care nurse consultant. We house the one that serves the lower 16 counties. And that's a -- I know that that position and that program is one that's probably a little tentative on whether that's going to -- will it continue or not? And it's very important. I mean, you're sending an RN into all of the daycare centers, the licensed daycare facilities, and they're working with the people there on not only safety for the infants and toddlers and pre-K students, but also working with them on healthy food choices. I mean, they're working on diets and everything else with them. We're there for them every day to answer questions and help make sure that the life of a child in those daycare centers is improved. So that's important also.

I'll just say that we feel that it's imperative in Illinois that we, in collaboration with our local communities, local health departments and our partners, invest in future health. Nearly one in two Americans now has a chronic medical condition of one kind or another. And chronic illnesses cause about 70 percent of deaths in the United States and take up about

75 percent of the costs each year.

What other incentive could the state have than to save lives and money at the same time? It's imperative that they address chronic diseases through the policy changes that are designed to promote the importance of proper nutrition, appropriate levels of physical activity, and prevention programs for alcohol, tobacco and drugs. I'm fortunate enough to work in an agency that has a full range of mental health programs that include substance abuse also. And we know that substance abuse treatment has a direct effect on the improvement of health and decrease of potential for chronic diseases. It should be of the highest priority that the dedication of a steady funding stream, which we've talked about numerous times, and a change in attitudes that we can make a difference. And we think local health departments and our partners through coalitions are a prime example of the type of agencies that have the infrastructure to provide these programs. So that's all I have.

DR. ARNOLD: Excellent. That's really an excellent point. And one of the things

that we need to also do is, you know, make available to people the types of programs that are out there. One of the bills that passed about I want to say -- was it two sessions or

two years ago, was this one bill we were helping to push for the people who are providers of care. We cover the EMTs and paramedics for licensure of the state.

So I came back, you know, from the military. I did two tours in Iraq. So I was watching, I was working a combat aid station and a helicopter unit, too. And when I was working I was wondering about people who were returning to the state. And many of the military personnel come back to rural communities. So I really encourage you to engage them. Because what the bill was centered around was the equivalency for training for EMTs and paramedics, and they go back to their community. And who better to train but someone from your community that has a family that is going to stay there. So, you know, really with the workforce development piece coming down and those kinds of things as far as access to care, making sure that people are lining up for opportunities who are going to live

in your community, so they come from the community to train and come back home, and also, you know, maintain and stabilize your infrastructure.

But you also brought up one other point, and it had to do with the farmers' markets and this traveling thing. You know, it's just

that's the first time I've heard that was a 25-mile traveling time period. That is just, you know, a formidable obstacle for someone who's raising a family and also doesn't have an income that's really sustaining them. So those things I think we should be looking at in a much more serious way.

The chronic disease you were mentioning, the 70 percent chronic disease rate for deaths.

MR. BYRD: Right.

DR. ARNOLD: That is really important. Not just from the standpoint of how much it's costing us for their medical care, but what impact is it having on the family and the businesses? Because if I trained you and you have 30 years of experience and you die when you're 52 years old, I've lost money from my

company 13 years before retirement, before 65. And, of course, there's no such word as "retirement" anymore, but, you know, we've lost a great, great investment in someone who was working in this company. And now this company has to retrain someone, and may not even be able to function without them. That may be the only person that turns the widget in the company. So the impact in the company, the loss of the pension and income for the family starts another

spiral, another destabilization process in the family. How does that impact healthcare?

So all of these things are interconnected, and we must make sure that we are paying attention to that particularly. How these programs affect and how effective are they depending on what the person has as resources, basic resources, to be able to gain access? So very good. And Egyptian is incredible. I mean, you know, I've read quite a bit of documents on your program and heard some extremely good comments throughout the state. So thank you.

MR. BYRD: Thank you.

MS. LINK-MULLISON: Dr. Arnold, I just wanted to say a couple of things about

farmers' markets.

DR. ARNOLD: Okay.

MS. LINK-MULLISON: There is a group that had contacted us from Chicago, and I don't remember, do you remember the name of the group? But they are working to try to work with farmers' markets to accept Link cards. And they've set up an infrastructure for doing that. And they've done it in several markets in Chicago and are wanting to now go statewide.

DR. ARNOLD: Yes.

MS. LINK-MULLISON: And to me that's a beautiful opportunity to take an existing

resource and make it more accessible to people on Link cards. We already are very -- the WIC programs are already very active with promoting farmers' markets. We give out coupons for farmers' markets in our web program, and in my county it's very successful. And I think it's just another opportunity of improving access to fruits and vegetables that we could be looking at that really is just a matter of improving the access.

DR. ARNOLD: Absolutely. We have been -- the farmers' markets, some people did

testify at the hearing in Chicago. And, you know, that was something that I think, you know, when we talk about nutrition we have to go with the associations that are intimately involved with the food producers, the suppliers, the Dietetic Association, the local health departments. I mean, this is a continuous chain. And it starts with, you know, in utero management. So I think that that's really the direction we should be going in, that the WIC program, we can sit down with the recommendations from the committee, and as DHS is a part of the task force, that is one thing that we can actually address internally and start talking about that.

MS. LINK-MULLISON: And my

understanding with a WIC reauthorization, with the Child Nutrition Reauthorization Bill nationally, that they are putting more funding into farmers' markets at the national level that will come down through WIC, etc. So it's a good place to go.

DR. ARNOLD: And this is an idea. You know, we want to be a leader as a state, and we have to keep our eyes open for the

opportunities.

MS. LINK-MULLISON: Right.

DR. ARNOLD: And doing it as a collective, you know, so that we can make sure that we get the maximum funding, no piecemeal funding. So --

MR. HUTCHISON: I was just going to comment, Community Gardening has been doing that. And a few weeks ago, again, a good example I think of strategic alignment, it was actually called the Mud to Garden Program.

DR. ARNOLD: Oh, yeah.

MR. HUTCHISON: Where the Department of Natural Resources and the Department of Transportation and the Illinois EPA and Public Health and the local health community, the mud they dredged out of the waterways, after they did appropriate environmental testing for heavy metals and sediments, was redistributed as an

enhancement into the soil, and they're going to use that for Community Gardening, which will help promote healthy vegetables in the community. I mean, those are some excellent examples. And Liz Patton-Whiteside at East Side is providing leadership in that with support of a lot of the

local partners. So there are some good examples of a policy aligning strategically in our thinking. Just like the WIC program with the healthy vegetables with the farmers. Now, it took a little while, but they are now vendors that worked through the machinations of how do you use the WIC card and coupons and redeem it? But if there's a will there's a way to work these things out. I think the Link program would be another good example of that.

MS. LINK-MULLISON: One of the things that he was saying in Chicago is that they had not incorporated WIC very much in their farmers' markets, but they were pushing the Link card. I said, Well, we are pushing the WIC, and we'd love to expand to the Link, and then we'd love you to expand to the WIC. So, I mean, it's just what worked better in which communities. But it's, again, increasing access.

MS. BAILEY: And his name was Dennis Ryan. He's a market manager from Experimental Station is what the company was called.

DR. ARNOLD: Experimental Station, yeah. As I remember, there was one school that they were involved in, and they said they're

going to deliver our mud. But it's really a good program from what I've heard.

But also one thing, you know, I was raised mostly in the city. But I've been throughout Illinois with the military, and I'm not going to even tell you what I've eaten overseas. But here one of the questions I have is, do we have a table of nutritious vegetables that can be grown in the State of Illinois? What kind of table do we have established for what can be produced internally as opposed to bringing it in because of the climate, the soil conditions, those kinds of issues? You know, I don't really know.

MS. LINK-MULLISON: Maybe the Department of Agriculture would have that, or also --

MR. HUTCHISON: Or the University of Illinois Extension.

MS. LINK-MULLISON: Extension service, do you know if they have something like that?

MR. HUTCHISON: Yeah.

DR. ARNOLD: Yeah. If they have a listing or a table of produce that can be

produced within the state that actually is in alignment with nutritious food production.

MS. LINK-MULLISON: I would guess that they would have that.

MS. BAILEY: Actually on the Department of Agriculture site they have a list of all of the growers in Illinois, and then it also lists which fruits and vegetables they grow at each individual grower, so --

DR. ARNOLD: Okay. Because I was trying to figure out what sustainable crops could you grow and that kind of thing. So that would be an interesting point, I mean, from the standpoint of job creation also.

MS. LINK-MULLISON: Do we want to open it up and see if anyone else has anything to say?

DR. ARNOLD: Oh, sure. Yes.

MS. LINK-MULLISON: Does anyone else want to give testimony?

DR. ARNOLD: Any other comments that anyone has? And you can always submit documentation again at any point in time. And you can also, you know, among yourselves talk about the need for or suggest the need for, you

know, other meetings so that we can get them to the department, and, you know, arrange something from that standpoint.

But, you know, I really still feel that these solutions at local -- and I told you I had one more story left also. But this one story, I like to tell this story because it really meant a great deal to me throughout my career. Because one of the things I studied for several years and I was actually an assistant instructor for was martial arts. I don't look like it now because I'm getting older. But this one story came to me, and I thought it was really a very instructive story. And I'm sure Kevin has heard it before. He's probably going to say, Oh.

MR. HUTCHISON: I'll benefit from it again.

DR. ARNOLD: But this story is, one day these two martial arts masters were walking in the woods together, and they were walking down this dirt road, so they were walking down between two rows of pine trees. And they were both dressed in their martial arts regalia with their swords. And they were walking, and there was a full moon that night. And they had

these lightening bugs that were throughout the trees. So they were walking through this arc of

light towards the moon, and the stars were above.

So as they were walking, one of the masters turned his head and said to the other master, he said, Tell me, Master, what is it when two ferocious tigers face each other in a heated battle and conflict? He said, What is the result? And the other master didn't say a word and continued to walk.

So they walked another two miles together. And after walking two miles he turned his head and looked at him, and he said, Master, when two ferocious tigers face each other in a heated battle and conflict one of the tigers is going to be irreparably harmed, is going to be maimed and live out the rest of his days in utter misery and pain. And then he took two more steps and turned, and he looked at him again, and he said, And the other one will die.

So as you're going down the path together, it talks about internal collaboration within yourself and self development. Because we beat ourselves up all the time, I should have done that better. I should have done this. You

have to give yourself some room for growth and development personally, but we also have to do that as a collaborative group, and understand that the ultimate thing is reaching the moon at the end of the path. That's our goal.

And the goal is really something that I've always felt from the beginning. It has nothing to do with me personally. What the goal has to do with is whether someone, based on the word that we've given in the public health system, can stop their child from dying tonight, stop their senior citizen who is in their family from dying on a back porch because no one's there to take care of their hip fracture. That's really where everything lies. Can we stop people from dying from lung cancer from smoking, or children from not doing so well in school because they are lead poisoned, or dying from radon in their homes? That's really what public health is about.

So as we're amassing this information, I really applaud all of you. I know you're out there doing great things already. And that's really why I wanted this to be put into a table format. Because everyone keeps waving

their flags of best practices everywhere, and we need to have our flags up, too. People are doing astounding things in the state, and we have to figure out what are the best practices and support those.

So I commend all of you. Please bring your testimony in, whatever you want to submit. Even a joke once in a while, we could

use those, too. Make sure that -- we want to stay in touch with you. With the website, it's a communication tool. And we really employ you to put things on there.

Again, I want to thank my task force member, Miriam, for setting everything up for us, and also our recorder, who has been feverishly working at the typewriter, and her boss should be really proud of her. But also I want to recognize my regional health officer, Marilyn Green. She's sitting in the background, but she also has been working hard to try to get things focused on southern Illinois, which is great. Tom Schafer, who is my deputy director. And I also want to thank everyone here who is working so hard in the local health departments. But we're in this together, and I really applaud what

you do. And never think for a moment that we don't really care about what's happening in your lives, because you mean everything to us.

So thank you very much. And with that we'll end.

MS. LINK-MULLISON: If you have not signed in there's a sign-in sheet for those just present. I'm not exactly sure where it is, but try to find it. Thanks.

(End of proceedings.)

STATE OF ILLINOIS)
) SS
COUNTY OF FRANKLIN)

I, Leslee A. Copple, a Notary Public in and for the County of Franklin, State of Illinois, do hereby certify:

That the said proceeding was taken before me as a Notary Public at the said time and place and was taken down in shorthand writing by me;

That I am a certified Shorthand Reporter of the State of Illinois, that the said proceeding was thereafter under my direction transcribed into computer-assisted transcription, that the foregoing transcript constitutes a full, true, and correct report of the proceedings which then and there took place;

IN WITNESS WHEREOF, I have hereunto subscribed my hand and affixed my official seal this 10th day of December, 2010.

_____
Leslee A. Copple, CSR#084-004381
Notary Public in and for the
County of Franklin, State of

Illinois
