CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION TASK FORCE

PUBLIC HEARING

November 22, 2010

Southern Illinois University School of Medicine

Springfield, Illinois

Present:

TASK FORCE

Damon T. Arnold, M.D., Chair
David Steward, M.D.
Dwayne Mitchell
Mike Jones

SPEAKERS

James Nelson
Monica Vest Wheeler
Brian Tun
Karen Little
JoAnn LaMaster
Wiley Jenkins

DR. ARNOLD: Good morning, everyone. Sorry for the delay. We had to actually -- We had a lot of headwind coming in I believe which was pushing our helicopter back a bit.

The state plane was being repaired, and we were trying to get them to land on top of this building but they said no. Taking us to the airport.

What I would like to do is first of all thank everyone for coming here today. I have some prepared remarks so I'm going to read this because I wanted to emphasize the point that what we are saying actually is something that should be viewed as being something that we're applying throughout the state, whether it's a child who is on a farm in the southern tip of Illinois or whether it's a child who is within the city. These are human beings that we are charged with taking care of within the state.

So with that I want to first of all tell you good morning and welcome to 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. Of course we didn't start on time.

Before beginning the hearing I would like to present some housekeeping rules for the hearing. Please place all cell phones and pagers onto silent or vibratory mode. Also take all side conversations outside of the room during all phases of this hearing and during presentations as this will disrupt the progress of the public hearing.

If you have any specific or special need for assistance, please let one of my staff members know. Additionally, the bathrooms are located in the hallways as indicated on the posted signage and are to the right. Please also note the safety signs located in the hallways should an emergency arise requiring an emergency response or building evacuation.

I would like to thank the SIU School of Medicine and Dr. Steward for allowing this meeting to take place within the SIU facilities.

To begin, chronic disease in the state of Illinois has resulted in a heavy economic and medical resources burden. It resulted in the loss of about $12.5 billion in Illinois during the study period leading to Public Act 096-1073.

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

Further, projections for both the short and long-term medical facility -- fiscal situation are dire at best. For example, currently two-thirds of adults and one-third of children in the United States are overweight. Fifty percent of the adults have a body mass index of 31 or greater with an index of 30

being indicative of obesity.

In fact, it is projected that one out of three children born in the year 2000 or after will develop diabetes within their lifetime. They will also average a shorter life span for the first time in history with respect to the

life span of 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 excessive amounts, tobacco in all of its forms, illegal drugs, misapplied prescription 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 public -- 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, one in northern Illinois, one in central Illinois, and one in southern Illinois; and, three, submit a report of recommendations to the General Assembly and the 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. This includes the Director of Public Health, the Public Health Advocate appointed by the Governor, the Secretary of the Department of Human Services or his or her designee, the Director of Aging or his or her designee, the Director of Healthcare and Family Services or his or her designee, and four members appointed by the General Assembly as well as ten members appointed by the Director of Public Health and who shall serve as -- and be representative of State associations and advocacy organizations with the primary focus that includes chronic disease prevention, public health delivery,

medicine, health care and disease management, or community health.

The Chronic Disease Prevention and Health Promotion Task Force hereinafter is referred to as the CDPHP Task Force for documentation

purposes.

Currently the task force includes the following members: Myself serving as chair; Dr. Quentin Young, M.D., who is a Public Health Advocate; Dr. James M. Galloway, M.D., Assistant Surgeon General for the Regional Health Administrator for Region V, U.S. Department Health and Human Services, his alternate being Robert Herskovitz who is the Deputy Regional Health Administrator, Region V, U.S. Department of Health and Human Services.

Also Senator William Delgado; State Representative Elizabeth Coulson; State Representative Cynthia Soto; Michael Jones, the Illinois Department of Healthcare and Family Services; Dr. Lorrie Rickman-Jones, Ph.D., who is the Director of Mental Health Services in the Illinois Department of Human Services.

Janice Cichowlas who is the Illinois Department of Aging's representative; Michael Isaacson, the Director of Division of Community Health, Kane County Health Department; Dr. Paul Brandt-Rauf, M.D., M.P.H. and doctor of Public Health, scientific doctor, Dean of the University of the Illinois School of Public Health.

Dr. David Steward, M.D., M.P.H., Professor and Chairman, Department of Internal Medicine, Southern Illinois University School of Medicine; Miriam Link-Mullison,

Administrator, Jackson County Health Department; Mr. Joel Africk who is the President and CEO of the Respiratory Health Association of Metropolitan Chicago.

Dr. Robert A.C. Cohen, M.D., who is the Director of the Pulmonary and Critical Care Medicine, Cook County Health System and Hospitals. He's also the Chairman of the Division of Pulmonary Medicine and Critical Care at the John H. Stroger, Jr. Hospital of Cook County.

Also Dr. James Webster, M.D., M.P.H., Professor and Chairman, Department of Internal Medicine, Northwestern University Feinberg School of Medicine. Also Jaime Delgado who is the Project Director, Humboldt Park Diabetes Prevention Project.

We also have Dwayne Mitchell who is the CEO for East Chicago Community Health Center and is a lecturer for Governor State University, and the last appointed -- the 19th one, the official appointment is still pending.

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, 2010. During this meeting Senate Bill 2583 and Public Act 096-1073 were reviewed and the charge to the Task Force was

stated. Also preliminary ideas and suggestions were recorded as notes for structuring the framework of the Task Force.

Due to a quorum not being achieved at any one location during this initial meeting,

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voting did not occur. Several documents were provided by IDPH concerning information from the CDC and Illinois specific information concerning expenditures and the chronic disease burden for the state of Illinois.

As Chair I noted that we would -- needed to create a website as well and IDPH would put this in place which has been established and is currently under development for the Task Force.

I noted that it should include tables for the collection of information concerning governmental (sic) organizational charts; a Chronic Disease Prevention and Health Promotion Task Force organizational chart and general member information; General Assembly legislative House and Senate Bills, Rules and Laws impacting chronic diseases within the state of Illinois; the completed State Health Improvement Plan framework document.

And I noted that the State Health Improvement Plan although we use the term plan is actually a framework planning document. In order for a plan to be actually implemented you

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must have the input of the people you are actually implementing the plan with.

Also Federal and National best practices for chronic disease prevention and health promotion guidelines; the existing Illinois State community-based best practice models and any documentation submitted to the Task Force membership.

A listing of National NGOs and relevant documentation such as for the Institute of Medicine, ASTHO, NACCHO, the American College of Occupational Environmental Medicine, the American College of Emergency Physicians, AMA, APA, ADA, and extensive lists.

Federal, State and private sector tools and resources should also be tabled and a calendar of events related to the Chronic Disease Promotion -- Prevention and Health Promotion Task Force.

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

During the second meeting on October 14th, 2010, we did achieve a quorum once assembled and did vote upon and adopt bylaws which govern and guide the functions and operations of the Task Force.

A copy of the Task Force first meeting

documents and approved minutes, second -- second meeting notes and the approved Task Force bylaws are attached to a document for inclusion for the testimony stream being presented.

In order to accomplish the objectives set forward by Senate Bill 2583 and Public Act 096-1073 regarding public hearings, this Task Force will seek input from interested parties. The Task Force shall hold a minimum of three public hearings across the state including one in northern Illinois, one in central Illinois, and one in southern Illinois.

The first hearing took place in Chicago on the 15th of November. Today we are now here at SIU in Springfield for the second meeting on the 22nd of November, 2010. The third meeting

will take place in Mt. Vernon on the 30th of November.

Therefore the CDPHP Task Force is assembled here today in Springfield to listen and record the first -- the second of these public testimonies. This testimony will in part serve as the basis for the establishment of a document containing Task Force recommendations that will be submitted to the Governor's office, IDPH Director, and the State Legislature on or before December 31st, 2010.

Consistent with the intent of the legislative Act the content of this report at a

minimum will contain recommendations concerning the following issues which I encourage you to testify on today.

One is the 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 any other factor which can cause a

disparity. The role of the health promotion and chronic disease prevention in support of state spending on health care.

The source for the General Assembly's focus on the above issues for Task Force recommendations is contained in Public Act 95-900 and also Public Act 96-328.

Additionally the Centers for Disease Control and Prevention in Atlanta have noted three priority areas of concern. One is obesity; two, tobacco abuse; and three, injury prevention. This is by no mistake. These have probably the largest impacts on our communities and our nation as a whole.

This focus was borne in mind when developing the State Health Improvement Plan which recognized five basic health system priorities and nine priority health concerns. We removed the sticky notes from the wall and

focused on what was important, what the CDC was actually telling us to look at.

The five public health system priorities included improved access to health care

services; enhanced data and health information technology; address social determinants of health and health disparities; measure, manage, improve and sustain the public health system; and finally assure a sufficient workforce and human resources.

The nine public health concerns identified by the SHIP document include but are not listed in rank order: One, alcohol and tobacco; two, use of illicit drugs and misuse of legal drugs; three, mental health; four, natural and built environments; five, obesity including nutrition and physical activity; six, oral health; seven, patient safety and quality; eight, unintentional injury; and nine, violence.

The SHIP document can be found at www.idph.state.il.us/ship.

The Diabetes Program was moved from the Illinois Department of Human Services back to the Illinois Department of Public Health as of the 1st of July, 2010, by an Executive Order of the Office of Governor Quinn.

A Senate Bill initiated by Senator Mattie

Hunter supported this which was unanimously passed and adopted by the legislature also strongly supported the position of the restoration of the Diabetes Program back into the Department of Public Health.

This will greatly facilitate the re-integration of the anti-obesity and diabetes objectives paving the way for better programatic funding opportunities, efficiencies and outcomes. We will proceed with the hearing according to the following format with this format structured in order to afford time for all those wishing to provide testimony to have an opportunity to do so.

One, each speaker will be allowed five minutes for the provision of their testimony. A timekeeper will indicate your time remaining. Please begin your testimony by stating your full name and spell it for the testimony recorder. Also provide the name of your organizational affiliation and who you represent if this applies.

Also any supporting documentation that the speaker wishes to submit for further Task Force review can be handed to the testimony recorder. Additional time not to exceed three minutes will be provided for any questions the Task Force members have for the testimony presenters.

If we have more time allotted we can actually answer some more questions. If we feel that we have sufficiently met the needs of this hearing, we actually may adjourn a little bit earlier if necessary. Please adhere to the following -- these following rules and timeline guidelines in order to respect those waiting to testify.

The order of the presentations will be organized into areas generally with prevention and then with treatment being the two major areas. With any chronic disease we basically have a balance between prevention and treatment.

For an example with obesity you may have a form of prevention which involves nutrition,

education, and exercise and also legislative acts that bar things from happening within the communities. But you also have a treatment side so cure, maintain and to palliate the consequences of the disease.

So, for example, diabetes is a leading cause of blindness, nontraumatic amputations. Also it's a leading cause for renal dialysis machine usage. It has untoward consequences socially for family structures, for our community and for the workplace. So these both must be borne in mind, prevention and treatment as well as a safety net may not be able to filter everything out.

So if you are doing prevention focusing, if people -- We cannot afford the luxury of having 90 percent of people actually being preventatively -- you know, being helped by preventative efforts and ten percent not or missing that net and not having a safety net for them in treatment. We must be cognizant that both are required, the entire spectrum.

And actually within treatment itself is

embodied the concept of prevention, stopping the further -- the further progression of disease and making sure that people have a better life. What we are here for is for human life. Every person in the state of Illinois. And what we're trying to do is stop pain and suffering and premature death in everyone.

So with that if time lapses without sufficient time for those in attendance to present their information, we will also consider future meetings that we can actually establish so that we can actually get more information.

What we're trying to attempt to do is to get a feel for what is it you think as the people who are actually interacting with the communities, who are actually providing services are important. Where do you fit on this scale. How can we develop a model where people are actually working collaboratively as

part of a network as opposed to disjointed reinventions of wheels.

I've seen the wheels go around for the

last 30 years in practice, and sometimes you get almost nauseated at the cogs coming back around and every time it comes up it's -- it's a new idea.

But we've worked with many different organizations. Faith-based organizations, schools. In fact, the H1N1 response within the state of Illinois we were number one with those over 18 and we were number two with those less than 18 as far as vaccination rates go in the ten most populated states in the country.

That had a -- in large part had to do with organizations coming together, school systems, faith-based organizations, the agencies, the media. Every one was important in this. The non-governmental organizations, IPHA, all these organizations were essential to make sure that we were meeting the needs of the people within the state.

So I think this can be done with our systems in general and hopefully we will move forward with this. I'm also one of those people -- I use that word plan because I just

retired from the military, 26 years, and when people tell me they have a plan, it means that

they actually are able to put a key in the car and go. Do it. And so plan has a different connotation for me.

So framework is the more appropriate term in the stage we're in. We're trying to figure out what pieces need to be in the plan and what pieces are already out there working. There are some people who have incredible accomplishments who are out there. Where should we be putting our resources especially in a fiscally challenged time period.

So with that I would like to turn it over to any of my panel members. These people were chosen because of their high level of expertise, their insight, their ability to collaborate and to accomplish tasks. They have accomplished incredible things in their own fields.

This is a task force, not an IDPH task force. This Task Force is for everyone coming together to make sure things happen to help

people. That's why we're here. If we forget that and we miss that issue and we start putting our own priorities as being number one, we're doing everyone a disservice. So with that I turn it over to Dr. Steward for any comments.

DR. STEWARD: Just a quick comment. On behalf of the SIU School of Medicine I welcome

Dr. Arnold, Task Force members, IDPH staff, and all of you who are going to testify today. This is an important -- critically important area of interest and of need as you've already heard. I'm looking forward to the best thinking people can apply to the problem today. So thanks for coming and we look forward to your participation today.

MR. MITCHELL: Good morning. Dwayne Mitchell from the Chicago Community Health Center and Governor State University. I just wanted to share with you my appreciation to Dr. Arnold for giving me the opportunity to be a part of this initiative.

And again as you begin to testify today

be open, be direct, but also be global and think about how can you encourage the climate of your particular proposal to be included as a part of the system wide initiative that impacts provisions within the state of Illinois.

MR. JONES: Good morning. I'm Mike Jones. I represent the Department of Healthcare Family Services and on behalf of my director, Julie Hammus (phonetic), I'd like to bid you welcome to the hearing.

Dr. Arnold, thank you very much for your introduction. I'm delighted to be here with you and with our attendees and fellow panel members. As you all very well know, the agency I represent pays claims for the youngest, the

oldest, the sickest and the poorest persons in our state and we're at a transformative moment in health care history.

We have opportunities to really expand the coverage options for people who haven't had options before and we need to use the resources available wisely and to invest them in better, higher quality, more effective treatments. So

we're looking forward to hearing your remarks today that will help educate us and move us farther along the path that Dr. Arnold described. Thank you very much.

DR. ARNOLD: Okay. I'm going to have the people who wish to testify come forward. You can actually sit in the front row. We're going to use the microphone at the podium. Take a seat in the front and the first person to come down, Jim Nelson, you can go to the podium.

MR. NELSON: James Nelson. That's J-a-m-e-s, N-e-l-s-o-n. And I'm Executive Director of the Illinois Public Health Association. Good morning, Dr. Arnold. Thank you for the opportunity on behalf of the membership of the Illinois Public Health Association. We really appreciate the opportunity to come before you and testify.

My remarks this morning are going to be brief and I won't read the testimony of the Association. Actually our official testimony

is being -- will be mailed to you. Our president, Valerie Webb, did testify in Chicago

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last week and I think we'll have other partners and members who will be from organizations which are either partnership or affiliate members of IPHA who will speak also.

I just want to give a very brief sort of background for our association interest -- our association's interest in this. As most of you know the IPHA is the state affiliate of the American Public Health Association.

We are the organization that represents front line workers from all across the spectrum of local health departments, community health centers, hospitals, outpatient clinics and so on. Our membership has had a long interest in chronic disease prevention. Obviously it is the core of local public health.

And about four years ago -- it seems like forever but times were a lot better and we were coming forward with a proposal then, the Chronic Disease Prevention and Health Promotion Act, which was a vision of our membership and our leadership that we would actually be able to create an organizational system that

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adequately supported comprehensive local public health prevention.

What that means is the ability to have

systems in place at the local level where health educators work with the community, work across all lines in the community to create systems that promote health and wellness and healthy lifestyles.

I actually met with Senator Delgado in December of 2006 and -- up in his Humboldt Park office and his concern with diabetes in his neighborhood created a situation where he decided to sponsor this legislation.

Our concern was that Illinois had been going down a path of piecemeal or looking at each issue separately, silos, the disease of the day if you want to call it that or the disease of the year, and this legislation was really designed and proposed to bring that system together in a comprehensive way and for this task force actually to look at the dilemma that we have.

And it's partly our own doing. We would

go as individual organizations to the legislature and say we're concerned about asthma or we're concerned about diabetes or we're concerned about a particular condition that was a -- represented our organizational system. All of the cancers and so on.

And then we would be given an appropriation of maybe $200,000.00 or a hundred thousand or sometimes really lucky a million

dollars and those individual programs that would function as silos. And so our leadership really in coming up with the idea behind the Chronic Disease Prevention and Health Promotion Act was really using five drivers and I'll just mention a couple of them.

One that's been mentioned by Dr. Arnold, the Health State Improvement Plan. That was a key driver for us to say this plan has already had a lot of people behind it and it really recommends some very specific things. But the other driver and I think the key one was that our local public health departments were falling further and further behind in their

ability to address the broad-based prevention systems.

They would get a grant from the state for $5,000.00 to address cardiovascular disease and that would be called a mini-grant and it would be not enough to hire a staff or not enough to do anything. So they would do some community awareness or something like that.

So the leadership of IPHA really came then to the table and worked very hard with all of the organizations across the state and with the assistance of, of course, Senator Delgado we were successful in seeing this legislation come to the point that it is today.

And we appreciate your serious look at this as a task force. We know this is only the

beginning. We think that -- We're optimistic that in a decade we'll have a strong, well-built, well-designed public health prevention system. Thank you and I'll be happy to answer questions. Is that now or -- Okay. Thank you.

DR. ARNOLD: Do you have questions?

Thank you. Please spell and state your name for the record and affiliation.

MS. WHEELER: My name's Monica Vest Wheeler. M-o-n-i-c-a, Vest, V-e-s-t, Wheeler, W-h-e-e-l-e-r, and I'm representing the Alzheimer's Association. I'm also an author and a caregiver, and I've been working with the Alzheimer's Association as a leading advocate voice for public policy at the state level on behalf of more than half a million Illinois families including 210,000 people with Alzheimer's, their families and their caregivers.

An estimated 5.3 million Americans of all ages have Alzheimer's disease which is the most common form of dementia. This figure includes ten -- excuse me -- 5.1 million aged 65 and older and 200,000 to 500,000 individuals under 65 who have early onset. And this rate is growing faster.

Every 70 seconds someone in this country develops Alzheimer's and that's supposed to

23 increase down to every 33 seconds by

mid-century. Illinois must tackle Alzheimer's not only as an aging issue but also as a public health crisis. Alzheimer's is a disease that destroys brain cells and causes problems with memory, thinking and behavior. It's not a normal part of aging.

Today it's the sixth leading cause of death in the United States and that's up from eighth place just two years ago. The disease robs a person's memories, judgment, and independence and it robs spouses of lifetime companions and parent -- and children and grandchildren of their parents.

There's a case for the increasing role by public health officials to provide a new front in addressing cognitive health in our society. For those experiencing cognitive impairment and for those who are their caregivers. The lack of cognitive health will not only have a significant impact on a person's well-being and overall health status but that of our community and our state and our nation.

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Alzheimer's individuals and other dementias are living at home and most of these people receive unpaid help from family members and friends. Over 300,000 caregivers in Illinois provide

nearly half a million hours of unpaid care, and the state must work to quantify the problem of Alzheimer's disease and the burden on caregivers.

I witness the strain of caregiving every week as I meet more and more Illinois families confronting the tragedy of this devastating brain disease. I've watched robust healthy people deteriorate physically and emotionally from their caregiving role.

I grieved the death this year of one of my dearest friends, a caregiver who helped other caregivers and educated emergency responders in our community of Peoria. Only she didn't put those lessons to work for herself. Caregiving killed her.

Alzheimer's and other forms of dementia destroy brain cells and cognitive reasoning. Caregivers are on the clock continuously to

protect their loved ones from harm and from harming others. I was suddenly thrust into a caregiving role for my father-in-law this spring, bringing him here from Florida to care for him.

His rapid descent into Alzheimer's late this summer forced us to place him in a more secure locked facility out of fear for his safety and ours after he began to set fires in his room by smoking, in preaching to God to

destroy the state of Illinois, he had stole a license plate to plot his getaway, and he nearly seriously injured a nurse as he attempted to punch her in his rage.

No, not all patients are violent but unfortunately in our case it is. It isn't in his mind or a mental illness. It's this tragic brain disease that is stealing every part of him. I lost sleep for weeks as I had him on the waiting list of five facilities. Yet I didn't endure a fraction of what hundreds of thousands of Illinois caregivers deal with every day.

Our caregivers do not wish to be a burden on society, but they are forced to deal with a disease that will destroy the heart of many families and plummet this nation into financial ruin if we do not find a cure soon.

Our family alone spends $4,800.00 a month out of pocket for my father-in-law's care. Illinois surveys for all kinds of diseases to the point of knowing how many people are diagnosed or impacted with a particular condition. We applaud Illinois' dedication to the use of surveillance as a public health tool to develop data on the incidence, prevalence, and risk factors for particular diseases.

Surveillance at the state or community level can identify targets of concern where resources can be deployed. Obtaining a more

definite picture of Alzheimer's is essential to any successful, responsible state strategy to respond to this emerging epidemic.

We're pleased that Illinois implemented in 2009 an optional module on caregiving in the Behavioral Risk Factor Surveillance System and

we're pleased that the cognitive impairment module will be included in the survey conducted in 2011. This is why we reiterate a recommendation stated in a previous hearing to continue an ongoing focus on Alzheimer's and the toll it's taking on our caregivers.

DR. ARNOLD: Any questions?

DR. STEWARD: Thanks for your testimony and you've presented a compelling argument I think for improving caregiving -- caregiver services. I wonder if you have any thoughts about the prevention side of this and what things can be done to prevent this problem before it starts, if you have thoughts about that.

MS. WHEELER: Well, there's a couple areas of prevention. They're trying to prevent the disease but they still haven't figured out that yet. That's still very allusive to us much to our frustration.

But the caregiving too is -- it's involved with respite opportunities, education opportunities because -- I tell you an hour

break for a caregiver can carry him for a whole week. And so we need to keep reminding our folks because they're neglecting their eating habits contributing to obesity, sleeping habits which is contributing to faulty judgment for caregivers if they are not alert enough to that. And we've had -- I mean, we've had caregivers who are dying before the patient.

DR. ARNOLD: That's exactly -- You know, I was just thinking about that when you were mentioning that. You know, we need to have some form of prevention strategy for the caregivers as well. Their -- Their health is at risk as well in that situation.

What Dr. Steward was alluding to also made me think of the need to have prevention as part of an understanding of what people face in general. Not just direct medical care to a person but prevention of things like starting fires in homes, those kind of things.

How can we combat that particular issue and ease the burden on the provider. Also we have a tendency to start thinking about the

provision of services to a patient based on a diagnosis. So once you get a diagnosis such as depression or HIV positive, everyone thinks everything else goes away and that you're -- this is what you have.

You're classified as this one particular entity, but you're still susceptible to colon cancer. You're still susceptible to breast cancer. Those things still happen. Prostate cancer.

So what would you say as far as the care -- the level of care that's being provided to people who have Alzheimer's? They're really not able to express themselves as a general person would where I have pain in my chest or I have pain in my stomach.

MS. WHEELER: Yes. That's -- with my father-in-law just last week. He was saying something's not right with me, something's not right. Well, what hurts? And he couldn't describe and so we went to the doctor.

He just had a sinus infection luckily, but that is so painful for and that's why

caregivers struggle with do I take him to the doctor. That's increasing health costs too because they can't communicate what's wrong with them so a lot of them end up at the emergency room.

MR. JONES: I'd like to tag on your comments about the Behavioral Risk Factor Surveillance survey module on caregiving. I recently just became aware of the fact that that module was put in place and that some of the results are coming in.

So I think one of our problems as we build policy is to try to address the fact that the lack of data is not the lack of a problem, and the first step in recognizing and trying to figure out what our options are is to have some data.

So I think -- I would recommend that everybody in the room who may not be familiar with the Behavioral Risk Factor Surveillance survey take a look at it on the DPH website and we can anticipate in the next year or so, hopefully the next few months we'll get more

results from this caregiving survey and figure out how we can use that data to drive some good policies so thank you for bringing that up.

DR. ARNOLD: And this is one of the bridges that -- you know, I always talk about this bridge and that we have a bridge between two questions. And when I had responded to Hurricane Katrina with a group on the military one of the things that hit me like a lightening bolt was the fact that we were asking -- I was trying to answer two different questions.

One was how -- The question of how is really a scientific question. You know, how do you treat diabetes. How do you treat or prevent Alzheimer's from occurring. Those kinds of things. Those are scientific questions. How does the plane fly.

But the question that people always ask

is why. Why should I listen to what you're saying. You don't understand my geopolitical situation, my socioeconomic status. You don't understand my educational level, where I am in school, whether I'm a laborer.

You don't understand my ecumenical or religious background. You don't -- You don't understand this is my culture I'm living in and that's what we're trying to say. It's not just the person or individual. It's a culture.

And so it's very important to go into these homes and to talk to people. These are the hidden subpopulations that we haven't been paying attention to.

MS. WHEELER: Yeah. A lot of Alzheimer's caregivers won't ask for help.

DR. STEWARD: Thank you.

MS. WHEELER: Thank you very much.

MR. TUN: My name is Brian Tun. Last name T-u-n. I'm representing Peoria City/County Health Department.

Prevention and control of chronic diseases such as heart disease, stroke, cancer, diabetes, arthritis, obesity and respiratory diseases are the major public health challenges of the 21st century. As you all are aware, chronic diseases are the leading causes of death and disability in the United States.

Seven out of ten deaths among Americans each year are due to chronic diseases. Heart disease, cancer and stroke account for more than 50 percent of all deaths each year. Almost one out of every two adults has at least one chronic illness.

More than 75 percent of our health care spending is on people with chronic diseases that could have been prevented. Health disparities in chronic diseases are seen widespread among member of the racial and ethnic minority population.

Illnesses caused by chronic diseases have a significant impact on our healthcare delivery system. More than two-third of Americans believe that the U.S. healthcare delivery system should focus more on chronic disease preventive care.

More than four out of five Americans favor public funding for prevention programs. Majority of chronic diseases are known to be associated with risky health behaviors such as lack of physical activity, poor nutrition,

tobacco use, and excessive alcohol consumption.

Furthermore, lack of access to regular medical care, preventive health screenings and early detection services play a major role in the illness and prevention -- premature death related to chronic diseases.

Evidence-based health promotion and education programs along with policy, environmental and system change approaches at national, state and local levels for chronic disease prevention and control have been proven to be effective at very little cost.

Trust for America's Health estimates that an investment of $10.00 per person per year in community-based programs tackling physical inactivity, poor nutrition, and smoking could yield more than 16 billion dollars in medical cost savings annually within five years.

This saving represent a remarkable return of $5.60 for every dollar spent without considering additional saving in work productivity, reduced absenteeism at work and school and enhanced quality of life.

In order to reduce chronic disease burdens in Illinois, it is crucial to have state coordinated prevention program with sustainable funding for local communities to promote health behaviors, expand early detection and diagnosis of disease and increase access to prevention services.

Effective community-based health promotion programs focusing on prevention, early detection and public education should be a public health priority.

We must promote policy and system change

approaches that support healthy eating, daily physical activity, and tobacco cessation for school children and adults.

It is important to have a skilled public health workforce and system partners who can deliver preventive health services at the national, state, and local levels. Better training and education of public health professional is the key to succeed in the delivery of preventive health services.

We must work together to have a strong,

adequately funded chronic disease prevention programs. More population-based chronic disease management system such as diabetes management, hypertension management and tobacco cessation counseling should be promoted.

More involvement of healthcare providers in the routine delivery of health risk assessment and referral to chronic disease management services should be sought.

We must also focus health promotion strategies targeting underserved communities in an effort to increase access to affordable healthy food options through the development of community gardens, farmer's markets or full-service grocery store within neighborhoods.

Those living in underserved community must have an equitable access to screening and early detection services for chronic illnesses

such as cancer, diabetes, high blood pressure, and high cholesterol.

On behalf of the Peoria City/County Health Department I appreciate the opportunity

to comment on the prevention of chronic disease. Thank you.

DR. ARNOLD: What interventions do you think need to be done now, any new directions, any major focal points that you think should be addressed?

MR. TUN: Well, presently we have done a lot of health promotion. Like areas for hypertension management and blood pressure screening and also diabetes screening, thing like that. But these has to be sustained.

Sometimes we do that because we have funding from the state so once the funding run out we don't have any mobility to provide that staff services so I think it should be important to get the funding use proven in order to get the sustainable services to the community.

DR. ARNOLD: And what types of things do you use to measure how successful you are? What's your, you know, return on investment? So what kind of metric do you use to gauge the effectiveness of the community interventions?

MR. TUN: We do -- normally we do a number of screenings that we provided and also -- we also do patient satisfaction and also follow-up and referral so -- but these are the things that we can do in the community but there's no like, you know, evidence-based type of evaluation done in place. It's very minimum that we try to conduct these programs.

MR. MITCHELL: Mr. Tun, Dwayne Mitchell from Chicago. Your presentation was outstanding. My question to you is more the coordination processes from the promotion perspective primarily, that is actually the initial impact in terms of the disease.

What about the treatment component -- and I know we're not there yet in terms of our presentation -- but utilization of the primary care networks, whether they are look-alikes or community health centers. Are you looking at that as a part of your collaborative model?

MR. TUN: Yes. Fortunately we have FUHC (phonetic) in Peoria. We work with them very closely. We provide the screening and we

provide the referral to them so they can follow-up with these patient who cannot have a regular physician. So these are people that -- who don't have insurance or any type of services so we work with the FUHC to provide that type of treatment and also follow-up treatment.

MR. MITCHELL: As a suggestion, they may have some data for you that actually articulates what I believe Dr. Arnold was saying in terms of what evidence do you have to show success in the program and that's the coordination process that I think is a positive piece.

DR. ARNOLD: Any other questions from anyone?

DR. STEWARD: I agree also, nice presentation, thank you very much. I'm interested in one of the things you said about developing policy approaches to these things since -- and I suppose I'm interested in hearing your thoughts going beyond just policy that relates to how well funded local programs

are.

I'm talking about other kinds of policy. You mentioned one policy related to healthy eating. It seems like this is always sort of an emotionally charged area. I wondered what your thoughts were about what kinds of policies could be implemented to promote healthy eating?

MR. TUN: My main priority is in school, our lunch program policy. That's one of things that we should be doing, a statewide policy in place. And also physical activity in the school and after school program.

These are the things that -- because I

talked to one of the school and they said they don't have the funding or other -- like they have a lot of programs during the school section (sic) and they cannot do any extracurricular activities during that school section.

So only thing we can -- like we can focus after school programs so -- because of the -- There's some lack of policy statewide to promote the physical activity like during the

PE and PE times. So I think that need to be enforced.

DR. STEWARD: In follow-up. You mentioned a lot of sources of healthy food being available, whether it's farmers' markets or just having markets available in communities where they might not be otherwise. Any thoughts about policy to encourage those sorts of things?

MR. TUN: In terms of farmers' markets my thought is we can set-up some type of -- try to get the vegetable/fruit at the school buildings, that's another thing, and try to encourage student to eat more healthy food like fruit and vegetables and that's one of the things that I would encourage to do that. Thank you.

MS. LITTLE: All right. My name is Karen Little. K-a-r-e-n, L-i-t-t-l-e. I represent the Illinois Dietetic Association. We are a

professional healthcare organization of over 3,000 practicing licensed dietitian nutritionists which is our license title in Illinois, and I appreciate the opportunity to be here and we applaud the formation of the Task Force on Chronic Disease Prevention and Health Promotion and appreciate the opportunity to submit testimony.

Speaking of fruits and vegetables... Thank you, Dr. Steward. Registered dietitians are part of the healthcare community providing firsthand knowledge of the impact of multiple factors that influence nutritional status and lifestyle choices.

The convergence of inadequate nutrition and physical activity, poor lifestyle choices, environmental influences, and many other factors has resulted in astronomical costs to individuals, families, and to the state of Illinois which have been mentioned already.

As a group we believe that the three essentials of optimizing the health of Illinois' citizens and preventing chronic disease are health care, food and nutrition, and physical activity. And I'm going to forgo all of the statistics which we are all too aware of and get tired of reading and hearing I

think.

The members of the Illinois Dietetic Association actively recommend, promote and teach behavioral lifestyle intervention strategies using evidence-based science to help individuals adopt healthy lifestyles.

As part of the health community dietitians are already working to provide expert guidance that is personalized, doable, practical and affordable. As an example. Compare the cost of nutrition counseling to the cost of cardiac bypass surgery. Case in point.

We also recommend community prevention services focused on population-based intervention such as -- and some of these have been mentioned already. School-based nutrition education and intervention programs. There are a number of these out there right now that are doing very well.

I've seen everything from a diabetes screening of children in a school who are at risk for developing diabetes and then

intervening in both the school and the home. This was a program in southern Illinois and even -- I believe south of Carbondale and over in the Belleville area that was very successful.

Also school-based interventions to increase physical education and length of time for physical activity. Ensuring adequate food

marketplaces that address both the socioeconomic and cultural needs of the citizens of Illinois.

Implementing changes in restaurant food and beverage availability, pricing, portion sizes and labeling. Along with this given the recent report of the Dietary Guidelines Advisory Committee we need to work with manufacturers very closely to improve the food processing industry.

Worksite interventions to promote healthy eating information, availability of healthy food selections, and support for increasing exercise and activity in the workplace environment.

Providing more access in communities to places and opportunities for engaging in physical activity. You don't have to go to an expensive gym to get adequate amounts of activity.

In the community and at worksites and in schools promote policies and environmental supports that increase preparation of and access to more healthful foods and beverages in vending machines, restaurants, cafeterias, including more fruits and vegetables, reasonably priced, good-tasting, heart-healthy items with lower fat, sugar and sodium content and making changes in food and beverage

advertising to children.

These are just a few of our ideas. Specific guidelines for lifestyle changes are already available. The Dietary Guidelines for Americans 2005 which is an updated policy document every five years, and soon to be released the 2010 guidelines, provide the basis for all federal government administered food and nutrition programs.

So we have policy tied to reimbursement in other words. These guidelines are derived from the latest science-based evidence and detail the changes needed in the American and thus the Illinois diet.

The overarching messages of the Dietary Guidelines for Americans are increase intake of fruits, vegetables, including legumes, whole grains, low fat dairy foods and fish; decrease the intake of solid fats, saturated fats, refined starches and sugars, salt and sodium, including refined, processed grains, sweets, and sugar-sweetened carbonated beverages.

These have all been formally identified as the most pressing problems in our American and Illinois diet. And third from the Dietary Guidelines is increase physical activity with specific amounts of time tied to each recommendation and each population group.

Funding for these interventions requires an up-front investment, but within a few years

the cost avoidance of treating chronic diseases will save several times the amount invested.

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Primary prevention is the most logical and effective approach and it reduces the burden on our citizens. We can't afford to postpone action and argue about who's going to do it. We've just got to get going.

By prioritizing chronic disease prevention and treatment and coordinating the efforts of policymakers, insurers, government agencies, professional healthcare organizations, business and community organizations, we can make progress in improving the health of Illinois citizens.

As a group the members of the Illinois Dietetic Association offer their expertise in addressing these issues. They provide a link to nutrition and health with an emphasis on science and evidence.

Addressing chronic diseases and health maintenance through evidence-based science will provide a foundation for getting well and staying well. We ask that dietitians be included in addressing this critical component of health care in Illinois. And thank you.

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DR. ARNOLD: Further back-up to that comment that they must be. One of the issues

that I was thinking about when -- as you were talking is the issue of things such as -- on in utero care because we start eating and our nutrition begins in utero.

MS. LITTLE: Exactly.

DR. ARNOLD: And so folic acid with the prevention of neural tube defects. You know, many of the things that we talk about. Also with the issue of breast feeding and the occurrence of obesity further on and even vitamin D deficiency, a link to potentially prostate cancer and other forms of cancer.

MS. LITTLE: Absolutely.

DR. ARNOLD: So there -- there are multiple things that are in the nutritional field and so it looks almost like -- as though we need to have a unified field of nutrition going from in utero to death basically.

MS. LITTLE: Absolutely. That's an excellent observation, Dr. Arnold. And, in fact, the 2010 Dietary Guidelines Advisory

Committee has touched upon every one of those suggestions and points that you've made.

Good nutrition, healthy lifestyle starts in utero. When moms are overweight tremendously and then gain excessively, not to mention they eat foods that are deficient in nutrients, then that poor child doesn't -- he or she starts out in a chronic disease mode.

So you're right. The recommendation is

no longer that the Dietary Guidelines serve as a basis for ages two and up. It is for in utero and up.

DR. ARNOLD: Yes. And one other quick question is do you see any other state models with respect to nutrition that are standing out because I know you're with the Illinois Association, but on the national level are there other practices that are being done within the country or globally in other countries that you're aware of that we need to be cognizant of as we approach modeling in Illinois?

MS. LITTLE: That's a really good

question. I think that is the question. There are a number of models out there that are going on right now. I know some also that don't work very well unfortunately. But we really need people who are -- we need dietitians that are at the state level to help coordinate these programs.

The schools are an excellent example. There has been more focus on legislation and policy directed at schools rightfully so -- that's where we need to focus -- where food and nutrition professionals are involved and those -- there's better coordination and better communication and there are unbelievable things happening in schools.

If you feed fruits and vegetables to children in elementary school, they just go on eating them. It's real interesting. And I hate to tell my age but, you know, 40 years ago -- 30 years ago -- I won't go back that far -- I took my little tray of vegetables and fresh fruit with a little bit of yogurt dip into my kids' kindergarten class. That tray

got devoured.

They were even eating pickled okra which I took some down. One of the few of my favorites. But when you make it fun, when you make it interesting and don't have all this other junk in vending machines and passed around in classrooms, they don't know.

DR. ARNOLD: Yeah, that's one of the things -- one of my favorite quotes that I use is, you know, all models are wrong but some are useful.

And so even with models that have failed, maybe we can learn from some of those to make sure we don't make the same mistakes or understand why they didn't work but to also look at successful models so as we implement them we have pieces to put together that make sense. But with that I'm going to turn it over because I know we probably...

MR. JONES: No questions. Thank you.

DR. ARNOLD: But it was an excellent, brilliant presentation.

MS. LITTLE: The other thing is I've

mentioned in the past though, you know, we have an excellent chance in medical homes and other ideas that are coming up with the Affordable Healthcare Act and implementation of that in states to get a strong referral network built around a healthcare team approach.

You know, I've worked for the medical school in the past and we had a really neat situation where I worked in the clinic and the resident -- the medical resident brought the family to me where we could begin talking and made the referral.

If we could focus more that direction, then we become -- even as far as screening those who do not get regular medical care and we could somehow get the referral and help either in group situations or on an individual level. That works very well and is not expensive.

DR. ARNOLD: Are you represented on any of the school councils now or on hospital systems or medical systems?

MS. LITTLE: Oh, yes. We are part --

many of our members are part of the school wellness councils and there are a number of organizations in Chicago. Clock (phonetic) is

one of them. The Building a Healthier Chicago is the name of another one.

Round in Springfield we have a program called Gen H, Generation Healthy. Dietitians are working with all of those. Unfortunately right now mostly in a volunteer capacity which, you know, you can't spend a lot of time but we can show results.

DR. ARNOLD: Thank you.

MS. LAMASTER: Good morning. Thank you, Dr. Arnold, for the opportunity to testify and to the panel as well. My name is JoAnn LaMaster (phonetic). I'm the outreach coordinator for the Simmons Cancer Institute at SIU School of Medicine and today I represent two entities. One would be SIU School of Medicine and the other is the Regional Cancer Partnership and I'd also like to touch on a separate area as well at the end.

The Regional Cancer Partnership began in

2001 and reorganized in 2006. The mission of the Regional Cancer Partnership is to provide cancer control, prevention and education in central Illinois. The RCP represents approximately 30 active members and over 16 organizations in central-west Illinois. It is also the largest working cancer coalition in the state.

Currently the RCP covers west central Illinois and has recently expanded to include

east central Illinois. All the way to the area of Danville. Collectively the Regional Cancer Partnership has worked to develop, plan, implement, and evaluate successful cancer screening and awareness programs.

Some of those include prostate cancer screening, colorectal cancer screening and skin cancer screening. We mobilize resources to meet the needs of the population in our area.

Our membership is strong and is growing, and we welcome any and all new members and organizations to help communities lessen this burden of cancer. We come today with a little

bit different prospective than the other presenters but just wanted to make you aware of this coalition that exists and is striving hard to meet those needs of our communities.

The other area that I wanted to talk on was to allude to the previous speakers in the area of fitness and physical exercise and nutrition in the fact that SIU School of Medicine has several medical student electives that I'm currently working with family and community medicine on to help medical students learn and understand the importance of nutrition and physical fitness and how to talk to patients and bring that into the communities.

Last year we had over 50 students take

part in our nutrition elective. We've recently launched our physical fitness elective and this has been attributed to several grants that have been awarded to SIU School of Medicine. So with that education the student goes out to a week-long process in which they go out into the communities and to the schools and really learn

how people shop, how people eat, and will be able to take that knowledge and skill back into their practice. Thank you very much.

DR. ARNOLD: Thank you.

MS. LAMASTER: Any questions?

DR. ARNOLD: Do you think there's a need to -- What you're talking about is sort of borderlining on a particular topic that would be kind of interesting to me. It's the reengineering or the redefinition of what the role of a health care provider is and, you know, how we should be trained in order to prevent disease as well as treat it.

So is there something -- Do you feel that there's a need to have some kind of platform established for curriculum development around that issue? Do you think there are other community members that should be part of that initiative, volunteers, those kind of things?

MS. LAMASTER: Yes. Absolutely. And to your points earlier this morning at your opening remarks with respect to understanding where the patient's coming from, their cultural

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background, their socioeconomic background, I think that's a big part of how we teach in our communities in terms of nutrition and physical fitness to have that cultural confidence. That's a foundation that really needs to be -- provided more education and insight to health care professionals.

DR. ARNOLD: Thank you very much. Thank you for your testimony. Any other comments anyone would like to make or any issues or viewpoints?

MR. JENKINS: Just a quick question for actually the Task Force as a whole. I had a question -- When the Task Force makes recommendations I'm wondering if consideration is given to how the recommendations may or may not be prioritized.

For example, some things may have proven effectiveness but may not be terribly attractive. For example, it's proven if we increase cigarette tax by a dollar we're going to stop people from smoking. Proven. However, that's going to be a part of a person's life.

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Banning soft drinks and candy from school vending machines will reduce the calorie intake by children by three to five hundred calories a day. However, schools would likely need to be

reimbursed for that loss of income. That's reasonable to --

But on the other hand -- So those are reasonable, proven effective methods to make a substantial impact, but on the other hand we're not supporting programs, we're not necessarily supporting an association.

And so I'm wondering how -- It looks a lot better to say we're going to fund 80 exercise augmentation programs in 80 counties. I mean, look what we're doing in the community and we're employing a number of people and we're creating, we're sustaining a bureaucracy to support those programs and those grants.

And I'm not saying those are bad things at all, but I was wondering given the financial realities that the state is facing, will we really look at what is proven effective, how much bang can we get for the buck.

DR. ARNOLD: Most definitely, most definitely. I think that that's one of the things that was underlined -- a couple of comments I think about the metrics and, you know, whether you can actually show a return on investment for what you're actually putting into -- into fruition in the form of an intervention strategy.

But the thing that's underlying this is that many people approach me and they'll ask me within the agency, you know, I need more staff,

I need more money, I need -- those things and I give them the analogy. I say imagine having a thousand pieces for a car in front of my house and I'm wanting to enter the Indy 500 next week.

What I want you to do is come over and poor gasoline on these parts, a thousand gallons, maybe a million gallons. Why don't you just come over and bring some flags and strobe lights so we can see how fast this thing will run. And they'll look at me like I'm just totally crazy.

And the point in that is that unless you have a system, unless you've put something together that makes sense, then why are you asking for more staff and more money when you don't have a model that's really truly operational that's going to give you a return on investment.

So with this -- This framework is really looking at what is actually working out here first of all -- because we have some successful models within the state. But we have some terrible models too and maybe those models are terrible because they don't have the support they need or they need to look at things differently but -- We can always learn from every model but especially the models that are working.

I was going to save this till the end to introduce my staff and other people who are present but Dr. Shilly (phonetic) is our CDC Fellow and she actually is looking at a lot of models for the diabetes program and looking at what are the best practices that are out there.

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But to get back to the point that was made about that "why" part about going into a community and intervening, I could have a perfect solution and it's crucible, it's a perfect solution, scientifically valid, will cure everything you have.

And I walk up to you and I say drink this and you look at me like you're crazy. I might as well throw it away. So even if I have the perfect solution, if a person's unwilling to accept it or to use it, it's worthless. It's something I'm making that's in isolation of the reality of this person actually wanting to drink this thing.

So I think that we have to really look at both sides and when we say best practice model, best practice on Mars, New Guinea, Australia, where. And how the people react to it. Is it flexible enough to accommodate and learn from the people who are actually participating in the system.

So I think you're absolutely right on point that we actually have to look at what are

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the best practice models, what has already shown us that success. How can we strengthen it. Now to get to the point about the legislative side of things and people saying, well, you know, there's a cigarette tax increase and, you know, ban on soda pop, but I don't think the public understands -- really, really understands what the impact of chronic disease is on themselves and their families in the community.

They may see it but they don't really cognitively -- they don't understand what the implications are. So if I were two -- 350 pounds and I had a massive heart attack this afternoon and I ended up in an intensive care unit -- and what happens if I'm the single parent of my kids and the key to open the door at home is in my pocket and now the son is sitting at home and the kids don't know where I am. No one knows where I am.

The implications if I don't get my pension, I lose the home, my family's on the street. Those implications are staggering and

people go through that every day. There are people who are living on the streets right now who because they could not pay their medical bills or because they found themselves with chronic disease or extricated from family life

are now homeless. Dramatic impact on them, their families, their whole social structure.

So once people understand that this is why this is so important for me, they'll be the ones asking for the tax. They're the ones who are going to say ban this thing from our society. It's causing too much devastation.

But I think people have to understand that first in a real sense, and we have to understand why they say, well, it's not so important to me right now. It's more important to me to get to work and to smoke five cigarettes to get to work because I have to stay up for 16 hours to feed my family.

So we have to really get into a real partnership with people and not this thing we're going in to treat you. No, no, no. We are going down the path together to figure out

what treatment works.

MR. SCHAFER: Director, could -- Wiley, could you give your name and spell it for the court reporter?

MR. JENKINS: Wiley Jenkins, W-i-l-e-y, J-e-n-k-i-n-s.

MR. SCHAFER: And who you represent.

MR. JENKINS: Technically myself but I'm here at the school of medicine.

DR. ARNOLD: But brilliant question.

MR. JENKINS: And that actually -- kind of just wanted to second point out -- and I'll

finish with this. Public health really approaches policies and interventions in almost two mindsets. One, we're going to provide or force you to do something like a cigarette tax. We're forcing you to pay more for cigarettes.

And the other one is if you provide it they will come. And I'm wondering if the panel or the Task Force would also consider when they look at recommendations to make what type of paradigm will predominate in that.

For example, those people who smoke will

tell you they have tried to smoke (sic) at one point. So it's not that they don't know that cigarettes are bad or that they don't even want to keep smoking but it's difficult. So it's not always a lack of knowledge.

Myself for example. I had a double Whopper with cheese and fries -- large order of fries the other day. I know that's not particularly good for me. I want to have it anyway and no matter how much you educate me, I'm still going to have that double Whopper with cheese until such time it becomes important for me personally to change my habits.

So I'm wondering, you know, when we look at how -- what types of interventions we want to do are we going to look at it from how do we make an importance that someone wants the

service, that they want the intervention, or is it going to be something more punitive in the sense that we're going to force you to do this.

I state as an example the City of New York banning trans fats from their food and I

think -- my personal opinion is not -- is that I think that's a lot. It sounds great. I think the long-term effects from this remains to be seen and I view that personally as almost a punitive.

You don't know what's good for you so I'm going to force you to do what's right, and I think a lot of people backlashed against that option. But I'm just curious what the thoughts of the Task Force might be on those two types of ways to approach it.

DR. ARNOLD: I want to say something very brief and then I'll pass it over. My background is -- I was trained in internal medicine and then a second residency in occupational medicine and public health. I went for a Master's in that.

The occupational health arena, the way we approach problems in occupational health is through a series of different interventions. So the first one you're talking about is engineering something out. So you say that we're not going to have trans fats. Done with.

We can't do it.

However, sometimes in the process it becomes very difficult to find a substitute so then you move to a second level. Administrative control. So I say that this substance X that you're exposed to -- and we have all the biological exposure indices and threshold limit values, NIOSH, you know, all them sort of go back and forth, the Department of Labor with OSHA.

So they determine that with substance X you have a certain level that you can be exposed to and for a certain amount of time. So that would be something like putting a tax on soda and saying that you can't have -- you can drink soda but you're going to be paying if you try to excessively drink soda.

So it's still in the system. And then we go to another level where we start looking at the person. We use personal protective equipment. And that would be something where we try to minimize the harm. So we look at milk containers for, you know, expiration

dates. We want to make sure that you have some kind of protection. That we take this thing out of the system.

And if it breaks through the barrier and you are exposed to it, then we have surveillance and we start looking at how's

this -- what level do you have in your body. Do we take blood tests. Do we do different tests for your hearing for hearing conservation.

So those things are really looking and watching the different forms of disease as it develops. Primary, secondary, tertiary, prevention strategies. So there's a whole array of things, but I think it depends on what the particular topic is that the balance may be more on one side or the other but in essence you may have to have all -- all these levels involved at the same time.

So I think -- I think you are hitting on a very critical point because then -- I think you're thinking more from economic modeling and where are you going to put your bang for the

buck. But I think we have to look at all of these levels and figure out for what we're dealing with what's the best strategy at this time.

MR. MITCHELL: Let me just kind of give you an overview from a direct service provider prospective. Back in the eighties I did my residency at Cook County Hospital in health administration coming out of graduate school and County Hospital at that time had about 5,000 deliveries.

The infant mortality rate throughout the near north side where -- the Windfield Moody

(phonetic) Health Center was astronomical. It was about 26 percent. Higher than some third world countries.

But you had programs to change behaviors. Family with a Future. Helping Moms Help the Kids. And you also had the economic impact that was impacting the neonatology unit at some of these hospitals. So the two married and what you had is more of an awareness.

A case management program that actually

gave you the awareness to the community about prenatal care, first trimester, educating that behavior. Making sure that individuals understand the risk that was associated to the individual but also to the unborn fetus.

So what you have now, you have a demise in the infant mortality rate in that community. And that could be attributed based on justification (phonetic) but there's other factors.

So I think the two has to be more of a behavior process that goes over time -- and I love what the dietitian stated in terms of education over a period of time. But also the economic engine that actually put more of that savings back into the positive evidence that was -- actually came out of some of these implementation of these programs.

DR. STEWARD: I have just a comment.

First of all, Wiley, you're my hero for eating a double Whopper. That's really something so I need to take notes from that.

But the other question I have about -- We

hear a lot about -- and it's a flash point -- about what you do with school vending machines and school activities. And I'd like to think about that as what do we do about public spaces. Public -- Public facilities, not just schools, and apply the principles across larger venues.

Because schools are clearly a flash point for this but look around the vending machines here for example and ask the question among us who are interested in this -- and I count you and I as people like that.

Are we doing anything to make a difference even for our own work environment and what kind of effort should we be making even on our own if we want to change policy for many other people whose lives we aren't necessarily directly related to or responsible for.

So I think expanding the concept you're talking about to me is -- It gets to be a bigger and bigger problem as you expand the range of places and people you're trying to

affect. I also think we ought to be all

thinking about all those things. I hope the Task Force does as we're working on this.

DR. ARNOLD: Yeah, Dr. Steward sort of brought another concept into my head that I was thinking about previously. When we start looking at food deserts -- About three weeks ago I was speaking to someone and they were saying a food desert, and what we automatically think of is this desert with sand and, you know, dilapidated buildings and everything is torn to pieces and that kind of thing.

You can have a food desert in the middle of Cardinal stadium. See, I know where I am. So Cardinal stadium. And you can have a food desert there where five hot dogs, three beers and, you know, all the nachos you can get predominates and if you ask for something healthy they'll say you mean here?

So this happens in a lot of our venues where we don't have the access to it, but I think it begins with, you know, looking at that. And what Dwayne was saying also about

the reinvestment. Making sure that we don't take money away from a fairly healthy intervention strategy.

Once people start asking for those things, I'm very cognizant -- I spoke to Dr. Freedon (phonetic) about that whole situation with trans fat in New York City, and

one of the things that he said that he was astonished by was that there were over a million tankers that go in and out -- literally over a million tankers that go in and out of New York City every year delivering and pulling out oil from McDonald's establishments.

But, see, what that translates into is jobs. So the question is, you know, if you stop that without thinking about a transitional model, without going into a better practice or transforming the way things are done.

Luckily they were able to transfer things to a different type of oil that was being transported, but it's going to take a lot on the level of industry. It's going to take a lot from association with the Dietetic

Association, the healthcare associations to sit down and say, you know, how can we engineer this stuff out or, you know, or make it more attractive to people.

Because if you tell me you're taking away my Pepsi, you know, it would be -- well, this is something I use but if you tell me there's a better flavor out, new improved but it's healthy -- but they don't tell me it's healthy, they don't even have to say -- Say it's new and improved, try this one.

If you have things that are being engineered so that we are doing it with the consciousness of health of the people in the

country, we can still maintain jobs but transform the way that we're delivering products to people and what we're giving people to eat.

I think that's something that we have to keep in our mind is that people still need jobs, but we have to transform things so that it's healthier in outcome.

And so at this point I'll re-introduce

Dr. Shilly from the CDC, my CDC Fellow, my assistant director Terry Girardy (phonetic), and also my Deputy Director who is over the chronic disease section but health promotion, the Office of Health Promotion, Tom Schafer, and we also have other people who are in here.

They don't want to be recognized but they're here. My staff members in the back. They all are involved. Our finance department, our department of legislative appears, our public information officer and people who are actually in the Department of Health Promotion.

I think this is something that is really in a critical time period. We're going to be taking advisement from you. If you have other documents, other things that you come up with, other thoughts, please send them in and we can have them entered into the record.

But it's going to take everyone to have a solution to this. I am very fearful of some of

the things that I've been seeing recently and those statistics I was mentioning, the CDC released that about six weeks ago or so. One

out of three children born in the year 2000 and after can develop diabetes. I mean, this is just astounding to me.

We are facing a tidal wave. As I mentioned before I was in the military back in 1984. There was a three to five percent rejection rate on conduction physicals. There is now a 27 percent rejection rate. Some places -- There were four centers that only had a 30 percent pass rate. That's national and domestic security.

So we can't raise a military force, international security, but many of those are guard members who you see in your communities with flood responses, tornado responses, hurricane responses down in the gulf coast, ice storms. There are state troopers, our police officers who are also there.

If you can't pass a military physical, what about police, fire, EMTs, paramedics and laborers. That's the domestic security threat. With two-thirds of adults, one-third of children overweight where are we going to get

the work force. We'll be taking care of everyone. Whoever is healthy is going to be

taking care of two or three other people.

So unless we really address this now as a very, very serious issue, we stand to have a heck of a time down the road dealing with the consequences of inaction now. So with that I want to thank you for your time and your presence here and we look forward to working with all of you in the future. This is just the beginning point. Thank you.

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C E R T I F I C A T E

I, SUE A. PHELPS, a Certified Shorthand Reporter of the State of Illinois, do hereby certify that the above public hearing was recorded stenographically by me and reduced to typewriting by me and that the foregoing transcript of the said public hearing is a true and correct transcript of the testimony given

at the time and place specified.

IN WITNESS WHEREOF, I have hereunto set my hand this 8th day of December, 2010.

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SUE A. PHELPS, C.S.R.

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