SHIP Vision

Optimal physical, mental and social well-being for all people in Illinois through a high-functioning public health system comprised of active public, private and voluntary partners.

Illinois
State Health Improvement Plan
Public Comment and Testimony

Illinois State Board of Health

May 2007

Prepared by Illinois Public Health Institute

All public comment and submitted testimony have been included in this document. The first three sections include the transcripts from all public hearings. The last section presents the unduplicated written testimony submitted to the State Health Improvement Planning Team for review and consideration. Several participants read their written testimony at the public hearing. In such cases, their testimony is included in the transcript, rather than the written testimony section.

State Health Improvement Plan
Public Testimony Transcripts & Written Comments

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STATE HEALTH IMPROVEMENT PLAN

PUBLIC HEARING

MT. VERNON, ILLINOIS

AUGUST 4, 2006

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24 REPORTER: STARLA D. JAY, R.P.R., C.S.R. No. 084-003993

1 BE IT REMEMBERED, a public hearing was held on
2 the 4th day of August 2006, at 2 p.m., at the Holiday Inn,
3 Mt. Vernon, Illinois.
4 Transcript of proceedings were taken down in
5 stenotype by Starla D. Jay, a Certified Shorthand Reporter
6 and Notary Public within and for the State of Illinois, and
7 afterwards transcribed into written form.

8

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14

MR. KEVIN HUTCHISON: Good afternoon, everyone. We're gonna go ahead and get started. On behalf of the State Board of Health, I'd like to welcome you for this public hearing on the State Health Improvement Plan. My name is Kevin Hutchison, K-e-v-i-n-H-u-t-c-h-i-s-o-n. And I've just modeled what we'd like you to do when you come and testify, which is to give your name and your organization and spell it on behalf of the court reporter. In addition to serving on the State Board of Health, it's my pleasure to serve as the health officer for St. Clair

County. And I sit on the health board as a representative of local health departments.

This afternoon, the purpose of this hearing, in August of 2004, governor signed a House Bill 4612, which calls for the State Board of Health to deliver a State Health Improvement Plan using the acronym SHIP to the governor and to the General Assembly in 2006. This legislation provided for the establishment of a planning team appointed by the director of the state health

department and developd a plan that would include priorities and strategies to improve the health of the citizens of the state of Illinois. One of the elements of this plan is to link to national strategies. Additionally, the focus really is on prevention. What can we do to not only maintain health but to improve health through prevention?

The State Board of Health is holding three hearings on this draft plan, which I hope all of you have had an opportunity to review. Once the input is -- public input will be incorporated into the plan, and then it will be delivered to the governor and the General Assembly. This process will be repeated approximately every four years during every succeeding gubernatorial administration.

To begin our process today, I'd like my colleagues

on the State Board of Health, colleague, to introduce themselves.

MR. HERBERT WHITELEY: Herb Whiteley representing the State Board of Health, representing veterinary medicine

on the State Board of Health. And I'm dean of the College of Veterinary Medicine, University of Illinois.

MR. KEVIN HUTCHISON: Also, sitting at the -- the head table is several members of the State Health Improvement Planning Team. As I mentioned, these were individuals, representives, a variety of different organizations, providers, business, consumers, that have been meeting to serve in developing this plan. And I'll let them introduce themselves at this time.

MS. SHELLY EBBERT: Good afternoon, everyone. My name is Shelly Ebbert. I'm the immediate past president of the Illinois Public Health Association, and I work at the Illinois Department on Aging.

MS. MIRIAM LINK MULLISON: My name is Miriam Link Mullison. And I'm representing -- on the planning team, I represent the Southern Illinois Public Health Consortium and local health departments, and I am the administrator for Jackson County Health Department.

MS. KATHLEEN WELSHIMER: Hello. I'm Kathleen Welshimer. I'm an associate professor in the Department of

Health Education and Recreation at Southern Illinois University, Carbondale, and the coordinator of the Master's of Public Health Program there. I suppose I represent the workforce and academic public health.

MR. KEVIN HUTCHISON: Thank you very much. The next thing we'd like to do on our agenda is -- many of you may be aware. But, again, we do not want to presume anything. So what we are going to do is ask Miriam to come and to give an overview of the SHIP plan, the process that was went through, as well as highlighting the strategic issues that are recommended in this plan. So Miriam?

MS. MIRIAM LINK MULLISON: Thanks, Kevin. So we are here to talk about the State Health Improvement Plan, and this will be just a brief overview. Kevin's already gone through the background on the plan. And he briefly mentioned the team, which was a broad range of public, private, and nonprofit stakeholders, including state agencies, business, laborer, insurers, local public health agencies, health providers, universities, et cetera.

The team started to meet last October. We've met about monthly as a team, and then there were also a variety

of different subcommittees as a part of the team as well. What we have been doing is engaging in a process that's referred to as Mobilizing for Action Through Planning and

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Partnerships. It's a MAPP community-assessment and planning process. And one of the first -- one of the parts of the MAPP process is to determine a vision, to do four assessments, identify strategic issues, and then develop a plan. So that's really the steps that we've been engaged in in the last year.

The vision that we set for ourselves is optimal physical, mental, and social well-being for all people in Illinois to high functioning public health system comprised of active, public, private, and voluntary partners. The emphasis here is on total well-being, on providing a good public health system for all people, a system that includes not only our governmental public health but also our private and voluntary partners. As -- we identified our vision, and then we started to work on our four assessments that are included in the MAPP process. Those include a

state health profile, which is looking at all the health data for the state, looking at it as much as we could for different minority populations, as well as overall, and looking at it for different age groups in some situations. So we did a state health profile looking at the data. We identified or looked at data from a public health system assessment that had been done previously, which examined the performance of again the public health system, not just

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governmental public health, but the entire system based on some national standards.

We also did an assessment of statewide themes and strengths, which included some focus groups to obtain perceptions about what the health issues are in Illinois. We looked at what local communities have been doing, in terms of identifying health priorities in those communities, as a part of their IPLAN. IPLAN is the Illinois Project for Local Assessment of Needs, which has been going on since the early 1990s. And we looked at what the priorities have been set in each of the local

communities throughout Illinois over the last ten to fifteen years.

And, lastly, we looked -- as a part of the themes and strengths, we looked at the state-level strategic plans, which there are a number of strategic plans that have been developed around individual health issues or -- or individual strategic issues. So we looked at those as well.

The fourth assessment that we did was forces of change. And, actually, that was the first one we conducted. And what we did there is we looked at what are the trends and the issues that are impacting the public health system in Illinois? And things -- that would be,

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like, the -- the -- the movement towards looking at preparedness more in public health as a force of change. Changes in demographics are force of change. Those are examples of what we looked at and brainstormed around for that assessment.

So those were our four -- four assessments. And

what we did from those assessments was we looked for issues that appeared in all or most of those different assessments. What were the crosscutting issues? What were the strategic issues facing the public health system in Illinois? And these are -- these are the issues that we came up with: health disparities, data and information technology, access to healthcare, work -- the workforce, both the adequacy, numbers of workforce and also the competency of our workforce, the public health system, how we measure, manage, and improve our public health system. And then, finally, we did identify some priority health problems that were crosscutting -- crosscutting in nature. And there were lots of different public health conditions, priority health problems, that we could have looked at. We chose these four because they are crosscutting, because impacting these four are going to impact a whole variety of other health conditions. For example, obesity and physical activity are going to impact diabetes, cardiovascular

disease, cancer, and mental health issues. And each of

those is very crosscutting and impacts many, many other things. So those are -- those are widely chose, those particular health conditions.

So we have -- now I want to go through each of the strategic issues in just a little bit more detail, and that's what I'll do next. So on health disparities, the question that we asked ourselves was how can the Illinois Public Health System monitor health disparities and identify and implement effective strategies to eliminate health disparities? So what we want as a long-term outcome here is a public health system actively engaged in addressing health disparities and the social determinants of health disparities that affect health outcomes. And that's what we're looking for. Long term and the immediate -- intermediate, what we would like to do is have healthcare accessible to all residents. We would like to have our public health system partners work to address social determinants of health like poverty, like access and those kinds of things. We would like our public health and our healthcare workers trained in health disparities so they can recognize what some of the target audience should

be and how they might work with those target audiences that have more health disparities more effectively. And we

would like public health and healthcare workers who are more diverse and culturally and linguistically competent.

So that's what we're working for in health disparities. And what the plan then does once it's set up the long-term and intermediate outcomes is it's identified what do the different components of the public health system do to help us reach those outcomes? For example -- I went to the wrong page. Wait a second. Have too many papers. I had it all set up exactly right. For example, under access, we've identified some strategic actions for each sector of the public health system. For business, one of the things business could do to impact these outcomes would be to implement workplace wellness programs that focus on disease prevention. Education institutions could be evaluating prevention elements used in healthcare interactions. Healthcare providers could be incorporating prevention into client interactions. Health

insurers could include prevention as a part of routine healthcare interaction. And it goes on. What could the legislature do, local health departments, other sectors, state agencies? There's a role for everyone in making a difference in impacting these intermediate and long-term outcomes, and that -- and the plan outlines what those roles are for the different entities and what the

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strategies that could have a long -- long-standing impact are. So it does that for each of the issues. So we have health disparities, these are the intermediate outcomes, and then the plan proceeds to give strategies for each of the sectors.

The next strategic issue is data and information technology. The question, how can the system assure current health status data and public health systems data? What we want is good data that will run the decisions that we're making around public policy. If you have good data, you will have hopefully better public health policy decisions. And so we're wanting to make sure that we

identify a system, a well-understood linked data system that measures, analyzes, and reports on health status of residents, including those impacted by disparity. It was very frustrating to us in our process because the data is sort of there, sort of not there. There are big gaps. It became very apparent in our assessment process that data is needed in order to drive better public policy.

Intermediate outcomes that we see regarding this is where the state health department to -- or some other new data agency to lead the state design and implementation of publicly accessible data system, that the workforce needs to have an increased capacity to collect and use health

data, and that state agencies need to have streamlined data reporting processes so that data's being collected, turned around, and able to be used for public policy decisions. And, again, there are strategies in the plan that link to each of those -- to that overall outcome and the intermediate outcomes, and there's strategies for the variety of sectors of the system.

The next strategic issue is access to healthcare. So what can we do to ensure that the people of Illinois are getting access to quality prevention programs in middle -- prevention programs, mental health, medical, and long-term care when they need it? So the long-term goal is to have a system that's responsive to the needs of the community. Intermediate outcomes would be to have diversity among health providers, culturally and linguistically competent workforce, more multilingual providers, immigrants with access, elimination of biases, and promotion of community health priorities. And, again, there are matching strategies for each of the sectors.

Okay. Individuals have information and prevention skills. Those are other intermediate outcomes. Financial systems support prevention and access, and public health infrastructure is financed to ensure prevention and health promotion, comprehensive approach to access. And then,

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again, we have the strategies for access to care. One of our issues around access to care is there is currently

another planning group in the state around Healthcare Justice Act, and they are focusing all of their attention on access to care. And this is one of our strategic issues. So one of the -- one of the challenges will be to keep those to our access to care in connection with what they're coming up with. And I think that that is a very doable thing, but there is a lot of work right now being done on access to care in Illinois.

Having a competent workforce is another strategic issue. We want not only an adequate number of -- an optimal number of different people in the public health workforce, but we want them of -- diverse in nature and competent. So the long-term outcome relates to the preparation and numbers and distribution of the workforce. The intermediate outcomes illustrate a system that analyzes and addresses workforce issues, increasing the competency of the workforce and making sure that the workforce is being expanded to meet our needs, increasing the proportion of minorities entering health and healthcare as careers, and, again, training on cultural and linguistic competency skills, more multilingual workers.

The next strategic issue, measure, manage, and

improve the public health system. This is the strategic issue that comes primarily from that assessment around the public health system. The question here is how can the State Health Improvement Plan be implemented in a way that ensures accountability, ongoing improvement, and performance management? We have our -- our long-term outcomes. Our intermediate outcomes would be to hold biannual summits with stakeholders. Again, we have to share this plan because it's not a plan for governmental public health. It's a plan for the entire public health system, and we need to engage lots of stakeholders in making sure that this plan is being implemented. Other intermediate outcomes are action plans revised and updated as needed and the state health department producing annual, interactive State Health Profile.

And our next strategic issue is our issue around priority health conditions. And, again, there are lots of priority health issues looked at as a part of this process. We identified four conditions that have overarching,

crosscutting impact. So we have alcohol, tobacco, and other drugs. And what we're trying to accomplish there is to decrease the use of alcohol, tobacco, and other drugs. With obesity, we want to reduce the number -- the proportion of children and adolescents who are overweight

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and the proportion of adults who are -- who are obese. And with obesity, what we're primarily wanting to do is increase physical activity and increase consumption of fruits and vegetables and decrease fat. Physical activity is another one of our conditions. We want to improve the physical activity of all Illinois residents. And, finally, violence is our fourth priority, to reduce violence and exposure of violence. And that's -- and that -- those are our strategic issues.

I want to -- I had something I know I want to say, if I can find it. Oh, can't find it. I want to encourage you to really look at not only the outcomes that we've identified but, also, specifically, the strategies that we've identified. And with your input, we can strengthen

this plan further and have it really be a plan that -- that helps us meet the vision of total well-being for all residents in the state and working with all of our partners in the state. So I thank you, and we look forward to your input in strengthening this plan.

MR. KEVIN HUTCHISON: Thank you, Miriam.

MS. MIRIAM LINK MULLISON: It occurred to me that I would be willing to answer questions or, actually, any of us would be willing to answer questions before we get into the public testimony, if anyone had questions.

MR. KEVIN HUTCHISON: Thank you. Before we get started with the testimony, there's several items that we need to procedurally just advise you of. This thing is cutting out. I'll try to hold this up better. First, if you haven't already done so, please sign in at the registration table in the back. There are two sign-in sheets. One is for individuals who want to give oral testimony, and other is just to simply register that you're here. So we would like a -- it's not me. It's the mike

that's cutting in and out. We would like to have a record of your attendance. And, also, for those who wish -- are not wishing to give oral testimony but have written testimony, we certainly would welcome that as well. All of this information will be assimilated not only from today's hearing but the other two hearings and then forwarded up to the full State Health Improvement Planning Team for their review and then ultimately to the State Board of Health. And as I mentioned earlier, that plan will be finalized and submitted to the governor and the General Assembly.

If you are giving oral testimony today, we ask that you be as brief as possible. But given the size of our group, we certainly want to give you adequate time to express the thoughts and ideas that you have. We would invite your comments to be no more than five minutes. We

will have a timer up here. Should we need to give you the hi sign the time is about up, if you still have additional remarks after your time has expired, the board members or staff will be here. We certainly do want to listen to your

comments, and we can do that after -- at the conclusion of the proceedings today.

At this time then, I would like to invite our first speaker to the center microphone. Again, as you come, please indicate your name, spell your name for our court reporter, and identify what organization you're with. So, Angie Bailey, if you'd come forward, please.

MS. ANGIE BAILEY: Okay. Good afternoon. My name is Angie Bailey, and it's A-n-g-i-e-B-a-i-l-e-y. I'm the director of health education at Jackson County Health Department. And I first want to say, "Thank you" to all of you at the Illinois Public Health Institute and the State Health Improvement Planning Team for all your work on this plan and all your work on the assessments. I know it's tedious and time-consuming but very important.

Being the person that coordinates IPLAN for our county, I am very glad you have used the information from IPLAN in both the statewide themes and the strength assessments. In reviewing the plan, I would like to share some of my thoughts. In the strategic issue access on

page 14, I think we need to beef this up. For example, under businesses, add information such as establish an environment which supports healthy choices. We also need to add that we will include cultural competency in educational institutions' training programs.

Under state agencies, we need to look at providing funding for locally identified priority problems through IPLAN, and we need to provide support for local community needs and planning. Local health departments struggle to obtain funding to do these assessments and to fund applicable programming.

Moving onto page 15, the health data and IT needs of Illinois should continue to be coordinated by IDPH. We should also be training our public health and healthcare workforce on not only technology but, also, on data collection and analysis.

On the strategic issue measure, manage, and improve the health system on pages 19 and 20, this section is a little confusing, and there's not much detail under strategic action. We could go back to -- earlier in the

document to the public health systems assessment and incorporate that information in those priorities. Other ideas for this section include garnering and leveraging resources for our public health system, managing continuous

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improvement, and integrating state and local action.

As a health educator, I am especially interested in the priority health conditions. Overall, I think we could look at these and make sure we are including all sectors of the community, if applicable. For example, in some sections we do not list schools and businesses. We need to make sure to cover all of the following sectors of the community in each outcome section, including businesses, healthcare providers, insurers, schools, educational institutions, such as colleges and universities, community-based and faith-based organizations, voluntary health organizations, local health departments, the state health department, other state departments, legislature and our local government, philanthropic organizations, and the media. We must all work together to address our state's

priority health problems.

Also, regarding the priority health problems, we should also be sure to list the Healthy People 2010 objectives throughout. For example, the violence section lists the Healthy People 2010 objectives, the objective number, and the objective. However, the physical activity, obesity, and alcohol, tobacco, and other drug sections do not.

We also use educational institutions and schools

sometimes interchangeably. I see educational institutions as things like the colleges and universities and the schools as being K-12 settings. I think this needs to be clarified because they can have different roles in addressing our priority health problems. We should also look at a variety of research-based resources for programming that has been proven effective, such as the Guide to Community Preventive Services and other such publications.

In going into more detail about the sections, I

have also made some notes and listed some additional ideas. I will share these as time allows, but I will submit all of my written notes. In looking at Outcome One, alcohol, tobacco, and other drugs on page 21, we should add the following: decrease use and misuse of alcohol, tobacco, and illegal -- other illegal drugs. Under business, we should also add advocate for smoke-free workplaces. We need to advocate for making Illinois a smoke-free-workplace state. Fourteen other states are already smoke free, and Illinois should join them. This is one thing that we can do that has proven to decrease youth from starting and decrease -- or I'm sorry, and increase sensation rates, as well as increase sales revenue in other parts of the country. We should also add information regarding training

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for employees on proper sales procedures, such as carding and cutting people off. Employers should be trained in what to do if they suspect an employee is misusing substances.

Under schools, we should add alcohol, tobacco, and

other --

MR. KEVIN HUTCHISON: If I could interrupt for just a second. Time is about up, but we'd certainly be interested if you have written testimony, we will have that handed in to all the folks who will see the details of what you're referring to. And I advise you as you wrap up, if there are any other major key points you'd like to summarize.

MS. ANGIE BAILEY: I can do that. Thank you.

Under schools, one thing we really need to focus on that is not included is the eight components of coordinated school health education programs throughout the entire document. For state health departments, we should also add collecting data. And these are for all the priorities, collect data, determine model programs, provide funding for model programs, and provide funding for local health departments to engage in programming. Also, under the legislature and local government to assist in funding community-based organization, health departments, and

others, we could also work with the philanthropic organizations by assisting with programming and funding. And another key piece that we do not have is media. We really need to engage them in assisting with our educational programs.

And then my last little bit that I think's important to share is under obesity. Currently, all schools in Illinois are required to have a wellness policy. That's not something we currently mention. And I think as public health, we could be working with schools on their wellness policies and on their wellness committees that they are required to have by the State. We could also work with students to increase personalized physical activity and making sure that all food served at schools meet minimal nutritional contents standards.

So I have lots more comments, so I have submitted those written comments. And I want to thank you for your time.

MR. KEVIN HUTCHISON: Thank you very much. Any members of the panel have any questions of Ms. Bailey?

(No response.)

MR. KEVIN HUTCHISON: Okay. Thank you very much

then. Our next person we'd like to call to the stand to testify is Deborah Wolf.

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MS. DEBORAH WOLF: Thank you very much for having me. My name is Deborah Wolf, D-e-b-o-r-a-h-W-o-l-f.

MR. KEVIN HUTCHISON: And if you'd like to identify the organization you're with.

MS. DEBORAH WOLF: I represent the past president of the Illinois Association of Health, Physical Education, Recreation, and Dance. We use IAHPERD to make it short. I also -- try again. I also am a professor at Eastern Illinois University at Charleston.

MR. KEVIN HUTCHISON: It's not you. It's the PA system. It's cutting in and out.

MS. DEBORAH WOLF: I'll use my gym voice. Does that sound good? Okay. The -- we represent -- IAHPERD represents over 7,000 health and physical educators in the state of Illinois. And we are absolutely delighted that the physical activity is one of the four major outcomes of SHIP, and I appreciate being here this afternoon.

Research confirms that physical activity can reduce obesity, drug and alcohol abuse, and violence in schools, so it has a very important relationship to the other three outcomes. We also know that children born today have a shorter life expectancy than their parents -- research has shown this -- due to lack of physical activity and to obesity. I would point out that physical education in

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schools is the place where children and adolescents learn to develop healthy physical-activity habits. This document states physical activity over and over again. Physical activity is great, but children need to learn how to develop healthy activity habits. Phil Waller is a good friend of mine. He was a pioneer in developing the new physical education. He says that if PE was a pill, it would be the miracle drug for lots of the problems that face children today, lots of the health problems.

I would also like to say that on page 22, when the SHIP document addresses physical activity, under educational institutions, if it could be added, an outcome

could be added, increase the opportunities for daily physical education, which trains children in health-related fitness. So increase opportunities for daily physical education, which will train children in health-related fitness. I add -- I add this health-related-fitness part because there is a new delivery system in physical education, and every school within the state should jump on that bandwagon and incorporate that new delivery system.

IAHPERD will be happy to help in support the efforts of the Illinois Department of Public Health to implement SHIP, and we will be -- we hope that SHIP will help to increase and promote daily physical education in

the schools. Thank you so much for this opportunity.

MR. KEVIN HUTCHISON: Thank you. Before you go, could you -- I have another question, but I'll defer if you have one first.

MS. SHELLY EBBERT: Is it about the new delivery system?

MR. KEVIN HUTCHISON: Could you elaborate what you

mean by "the new delivery system"?

MS. DEBORAH WOLF: Absolutely. I would be most happy to. The new delivery system focuses on health-related fitness. Children learn about monitoring their heart rates, about all of the components of physical fitness, muscular strength, muscular endurance, the body composition, flexibility, et cetera. They do -- they have activities. Many, many schools now have climbing walls. They do -- they don't just run and walk, but they'll have roller-blading. They have adventure education, in which the kids learn how to -- orienteering, actual climbing, you know, on rocks and so forth, bicycling, lots and lots of activities that incorporate the things that adults do. We don't have the chance to be -- be on a football team, basketball team, that sort of thing, once school is out. So kids learn how to do things that can keep them healthy and active when they become adults.

MR. KEVIN HUTCHISON: Thank you. Are there any other questions?

MS. MIRIAM LINK MULLISON: I guess the other question that I would have is if you -- if you see any other roles for the school, other than in, like, PE classes, for increasing physical activity.

MS. DEBORAH WOLF: Recess is a good opportunity. We don't want to see any recess eliminated at all. However, that is not the place where the kids learn the healthy habits. So -- and research has already shown that by eliminating opportunities for recess and -- and physical education, it doesn't help those test scores that administrators are so concerned about. It helps -- actually, kids do better if they have the opportunity to be active. So there can be -- we can do physical education in classrooms. We can teach classroom teachers how to offer opportunities. I just did a workshop about that not too far from here. So we can help classroom teachers implement opportunities when they see kids, you know, zoning out. So there are lots of places that can be done, even things in between classes and so forth. So before school, after school. But we want to see it happen in school as well.

MS. MIRIAM LINK MULLISON: I have one other

question. And as someone from Eastern Illinois, what do

you see the -- the university and college role being in physical activity? Do you want to expand on that any?

MS. DEBORAH WOLF: I will be happy to because -- because I preach this to my students all of the time. We no longer address very much team games. We have coaching classes for that. We teach our students how to implement this health-related-fitness approach to physical education. In every class that I teach, I -- I do that so that our students come away with knowledge about how to get kids active and understand what they're doing. It's really important to tell kids why they are doing this and the benefits that it has. So it's important, I think, for all universities to do away with some of the old-school type physical education and incorporate health-related fitness as a primary objective for their students as well.

MS. MIRIAM LINK MULLISON: One other question. In -- in -- at Eastern Illinois, when they are teaching teachers, elementary and secondary teachers, not PE

teachers, but other teachers, is there any kind of physical components being incorporated in that? And do you think there should be?

MS. DEBORAH WOLF: I absolutely, definitely think there should be. And it is -- at Eastern -- I can't speak for other universities. But some of my colleagues who

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teach those classes and elementary PE for classroom teachers definitely include the health-related aspects and the heart-rate monitor and what -- what happens to your muscles and what happens to your circulatory system as a result of activity. And the other part of it is the -- all of these -- the activity is related to reduction in some of the diseases, you know, diabetes and high blood pressure, et cetera.

MR. KEVIN HUTCHISON: Thank you very much, Ms. Wolf.

MS. DEBORAH WOLF: Thank you so much for having me.

MR. KEVIN HUTCHISON: Next, we invite Mr. Hardy Ware to come to the microphone that works 72.3 percent of

the time.

MR. HARDY WARE: All of the time. I'm 24/7.

MS. MIRIAM LINK MULLISON: We know that, Hardy.

MR. HARDY WARE: I'd like to thank the --

MR. KEVIN HUTCHISON: Please identify -- spell your name and identify your organization, please.

MR. HARDY WARE: Sorry. My name is Hardy Ware. I'm a system administrator at the East Side Health District. And I'm also a member of IFLOSS, which is a oral health component, and that's what I'm gonna speak about today.

SHIP appears to have overlooked all our health needs of the average person and how it affects them in their day-to-day life. Even though oral health is integral part of the overall health and has links to all of the four priority areas in the state plan, it is not highlighted in the plan. Even a vision statement of the plan should include oral health with mental health in order to bring oral health to the forefront.

Oral health is being discussed and recognized nationally by other states. The surgeon general published the first-ever report on oral health in America in 2000. Healthy People 2010 has a chapter on oral health. Perhaps they perceive lack of oral health data or proven strategic intervention predicated the oversight. This perception should lead to a larger focus on oral health by the State Board of Health to assist the Illinois communities in coping with oral health needs.

There's a gross underfunding of dental Medicaid services and no Medicaid funding for adult preventive oral healthcare, the lack of dentists and dental hygienists employed in public health settings, few safety net facilities, especially in Rural Illinois, and even fewer dental providers offering specialized care for young children and complex oral surgery and an ambiguous lack of

value of oral health for all sectors throughout the state. These are significant health problems that require significant attention in the State Health Improvement Plan.

Oral health impacts all four priority areas addressed in the plan, not just alcohol, tobacco and other drugs, and violence. Physical activity is linked to orofacial injuries and the need for preventive mouth care use, mouth guard use. I'm sorry.

Poor nutrition is a risk factor for both obesity and oral health. And how can we expect people to eat a rich -- a diet rich in fresh fruits and vegetables if they have poor oral health? Good oral health should be considered a protective factor against obesity. Consider this as a ponderable. If the field of dentistry was truly an integral part of the medical field, a physician who specializes in dentistry rather than cardiology would have had profound impact on oral health. Rather than having a field of dentistry as a separate entity, as we search for answers in a quest to improve the overall health of all the people throughout the state of Illinois, we must consider and include oral health as a crucial component that will create healthier people within each respective community throughout the state of Illinois. Thank you.

MR. KEVIN HUTCHISON: Thank you very much,

Mr. Ware. Are there any questions from any of the members? Yes.

MS. SHELLY EBBERT: In terms of incorporating oral health into the plan, are you suggesting that it should primarily be in the -- the priority health concerns and the vision statement? Or do you also think it should be included in places like access?

MR. HARDY WARE: Places like access. We have an IFLOSS coalition. We should probably provide you with a detailed synopsis of -- of our plan. But, basically, what we discovered is that there are transportation access issues. And if we find somebody with a problem, there's no dentist that will accept them and one or two that do them on a gratis basis; in particularly, the universities that help out. We still -- it's a major problem. And whether you're talking about rural or urban, I think we ought to really put it out on -- on the plate a little further because if you have good oral health, you know, you're gonna be okay. I always give the analogy of the children in school, and this maybe even can relate to test scores

and all the other physical problems that the children are having now with obesity. But if you can keep a child in school -- you get so many dollars a day for a kid that stays in school. But if these kids are out so many days

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for tooth problems, they're not gonna be able to comprehend because they've missed the classes and they had -- you know, it just creates a mushrooming effect of a kid that can come out being attorney or doctor, lawyer or dentist ends up doing nothing because he can't, you know, study. So I think we need to move this -- you know, put it in more spots in the plan, and funding is a major problem.

MS. MIRIAM LINK MULLISON: I really am glad you brought this to our attention. We did not totally -- I mean, we looked at -- the state oral health plan is one of the things we looked at. And I'm kind of surprised that you're not finding it because I'm surprised I'm not finding it either. So I'm really glad that you brought that to our attention, and I absolutely agree that it should have been in the vision statement. And where were our heads when we

were putting that together? because you're right. It's a critical issue.

MR. HARDY WARE: Any other questions?

MS. SHELLY EBBERT: Thank you very much.

MR. HARDY WARE: Thank you.

MR. KEVIN HUTCHISON: Thanks very much, Hardy. Next, we'd like to invite Carol Schlitt to the microphone. I hope I'm getting that pronounced right.

Please restate your name and spell it and identify

your organization, if you would, please.

MS. CAROL SCHLITT: Good afternoon. My name is Carol Schlitt, C-a-r-o-l. Last name is S-c-h-l-i-t-t. The L is the very important letter in that last name. I'm nutrition and wellness educator with the University of Illinois Extension out of the Edwardsville Extension Center. I cover ten counties in nutrition, wellness, and food-safety education.

Today, I'd like to respond to one line in this particular document found on page 9. It's a bullet that

says, There is a fairly strong planning culture in Illinois, but resources for community implementation are insufficient. And I think that says it all. I really think that we have lots and lots of in-depth planning, but a little bit comes down to the people that are at the road, at the asphalt level that are meeting people.

There's other things in here about developing programs. We don't need to develop more programs. There's more information than ever before. We need to help those existing programs with the passionate people that are there that are meeting people face-to-face and helping them with that nutrition education. I speak specifically for our food stamp education program and the EFNEP program, Expanded Food and Nutrition Education Program, which are

excellent programs that meet people one-on-one, changing people that way. That's how you change people, is by that passion and that -- from within. We don't need more plans. We don't need more information. We just need more assistance for those programs that are already on the

ground and doing more like that.

I'd like to say, too, after reading through this, I kind of see an obvious lack of coordination with some existing programming. And I really want to say I don't know about the buy-in you're going to get when you've kind of ignored some of that existing programming because it just feels like top down again instead of bottom up, where that's where the changes are made in people's lives. Thank you.

MR. HERBERT WHITELEY: How much interaction is there between extension and local Departments of Public Health?

MS. CAROL SCHLITT: There's quite a bit. If you're aware of the University of Illinois Extension, we have approximately 12 nutrition and wellness educators across the state. I'm located in Edwardsville, and I'm very, very involved with the Madison County Health Department; in fact, was the key player on the development of their IPLAN. And so I know the whole planning process. Unfortunately,

since I cover ten counties, I cannot do that for each county that I'm involved with. However, I know that the individual extension services in each of those counties work very closely with the health department in the delivery of programs. We're all on very, very limited budgets. And the only way we're gonna make a difference is collaboration, putting everybody together with those parts that they can bring to the table. And I do this quite a bit with hospitals, amazingly, because hospital dietitians do not have enough time for doing education. And I do a lot of collaboration with hospitals to do that, so --

MR. KEVIN HUTCHISON: Yes. You have questions?

MS. MIRIAM LINK MULLISON: I just wondered, Carol, if you wanted to give us more information on some of the existing programs that you think are missing from the plan, more specifics on that.

MS. CAROL SCHLITT: I can talk about several programs. One is pertaining to Dining With Diabetes. Diabetes is such a huge issue in the state of Illinois, and University of Illinois Extension has a three-part state program called Dining With Diabetes. And we can't -- I

could do that program every day, you know, in Southern Illinois and have a full class. There is such a need for this type of personal education, and the constant thing I

get from people are, you know, they just don't get the information from their physicians or from other dietitians. So it's very important for that type of program.

We have a two-part Cancer Smart Program. We also have a two-part Heart Healthy Program. And, like I said, I could be just teaching these day and night because there's such a need for this basic education for how to put into action what their physicians are telling them they need to do.

MS. MIRIAM LINK MULLISON: I totally agree with your comments about the extension service working with local health departments. We consider our extension service a primary partner. The plan does not specifically say anything about extension service. Do you think we should be listing them as a separate partner, linking it as a subset of what we do under educational institutions? To

me, it seems like maybe something we missed as well.

MS. CAROL SCHLITT: My answer would be yes.

MS. MIRIAM LINK MULLISON: Okay. So under educational institutions, a separate section, extension service.

MS. CAROL SCHLITT: Absolutely. And I think we should be at the table because we are the people that are there to help you deliver research-based education. We're

on the street doing this.

MR. KEVIN HUTCHISON: I had a question relative to the -- the amount of programs that are currently in place. One of the issues that I think will be important when we talk about the inadequacy of resources for existing programs is the issue of data and the issue of evaluation. Specifically, for example, the Dining With Diabetes Program sounds very important. And I'm wondering if there are information, in terms of the program evaluation, how effective this is in helping keeping these participants from having adverse health episodes associated with their

disease. The State of Illinois is also looking at intensive disease management, case management approach for chronic diseases. So it seems like it would be an opportunity as they're moving forward with that avenue to use some of these existing programs and, particularly, if they have good information showing how well they work or identify which ones don't work and how that could be perhaps plugged into this overarching plan the State is developing. So any comments you have relative to that would be welcome.

MS. CAROL SCHLITT: Yes. Thank you very much. I can direct that. The Dining With Diabetes Program is a program that is very well-evaluated. It's only three

parts. So how much change can you make in a person's life in approximately six hours of education? But it is evaluated. It's a master's-degree-level evaluation that's being done at the University of Illinois for all data to that, so we do have that information that can be pulled out for any one of our classes. And we do make a change on

education, our perceptions of education.

What I'd like to address, one thing that I've done personally is that one of my partners with the Madison County Coordinated Youth has CDC grant, the Illinois Diabetes Control grant. And I've been working with her since the very beginning of the -- as she got the grant. And she in her wisdom and her partners is able to come out to every one of the ten counties that I go to as a collaborative effort. She's able to use garnered funds from that particular grant, match it with University of Illinois grant, and we're able to maximize something that was designed to only go for Madison County, to now touch ten counties. And when you've got that kind of passion between two people that see that we need to do this, it's possible with limited funds. So when the CDC evaluator came, he said, I've never seen anything where a person took money from one county and made it go spread out for ten counties.

MR. KEVIN HUTCHISON: Thank you for that example,

and I think it really captures the spirit of what we hope will be the outcome of the State Health Improvement Plan, is leveraging resources but, also, empowering different communities working together for the overall --

MS. CAROL SCHLITT: I think extension is a great example of that because we have that as our passion, our motto, to be able to bring agencies and everyone together for the common good.

MR. KEVIN HUTCHISON: Thank you very much.

MS. CAROL SCHLITT: Thank you.

MR. KEVIN HUTCHISON: At this time I do not have any further names of individuals that have registered to give oral testimony. But, nevertheless, recognizing several folks in the room, we would like to open this up. If there are any other individuals that would like to make oral comments relative to the plan or reactions to the testimony you've heard thus far this afternoon, we would invite you to come to the microphone at this time, one at a time.

We have Mr. Stevens. Please state your name and spell it for the record and your organization.

MR. MARK STEVENS: Okay. My name is Mark Stevens,

M-a-r-k-S-t-e-v-e-n-s, and I'm the director of the local

health department of Jefferson County and have been involved in a lot of the plans referenced in the summary and work with a lot of people you see at the table. And when I look at the plan, I have a quick question. It's a summary, so I'm guessing that there are more elaborate details listed in the plans because I think there needs to be, you know, some more specific details. While I agree with -- wholeheartedly with priorities in the plan and -- and with some of the interventions, I think there's some that I question, but it's because I don't have the documents to review.

Just gonna hit the identified areas that I -- that I reviewed in the plan like access. I think in access what we have to do is -- is change the attitudes of the general public, as far as their attitudes on the value of prevention. It's hard to tell somebody that when -- when they're a child and weigh well within the ranges that they weigh that physical activity and healthy nutrition is

something they need to worry about. You know, as a young person, I heard a lot of people tell me You need to start thinking of this. I thought, Well, I'm young, I have many years to -- to implement that. And then, sooner or later, it catches up with you. I think we need to work with social marketing groups. And I've had the privilege of

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hearing presentations from several over my years of public health. And I think that's very important, getting -- getting geared marketing out to the people that we want to touch.

I think we have to be aware of the special populations needs. I mean, for instance, WIC program for your average citizen, that information might not reach somebody in another ethnic background, and we might need to use other things. I remember hearing if you're trying to reach a certain segment, you put information in Red Book, but if you're trying to reach the African-American population, you put it in Ebony and because we don't share some of the same interests. I think that we need -- for

access, we need access to information technology at a local level within any agency that -- that takes part in this. There are many partners here in this, and that's something I think needs to be brought out in the plan.

We talked about IPLAN a lot. IPLAN was a local health department initiative through the State of Public Health Department. But a lot of times, what we found in IPLAN was that once the plan was done, every partner that helps on that plan said, Well, that's a health department plan, I don't have any role in it. Health departments are not the end-all and catch-all for public health services in

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Illinois and in your community. We've seen things ranging from alcohol and substance abuse. Some health departments have alcohol and substance abuse programs because they do mental health; some do not. We play roles in levels. But how can we be judged on a plan that we really have little access or resources to provide?

A lot of health departments have opened medical clinics because of access issues. Funding for these

programs are very difficult to secure. And a lot of them simply have gone by the wayside because of lack of funding, or they don't operate on a steady enough basis to have -- show that continuity of care. So I think we need to look at funding aspects, and funding's gonna be a reoccurring issue in most anything that I say today. We need staff and resources to increase access. You know, we have shrinking and stacked-up grant funding and tax bases now in Illinois. And we could increase some of this through grant writing, but you have to have dedicated staff to do the grant writing.

I move onto data. You know, I full -- fullheartedly agree that data is spread out. In a lot of instances, it's old. Data that I would do my IPLAN or -- or not even just IPLAN. I don't want to pick on IPLAN. But we'll refer to 2001 data. You know, when you write a

grant and you give old data, they're thinking, Well, they're not up to date. And then when you use old data in your outcomes, how can you prove that you made an outcome?

And I think we can increase that data by having -- dealing with the closed systems that we have, where one system won't talk to the other system. Health departments face that every day. We'll make an entry into one system and then have to turn around and put the same entry back into another system. I think we need all our partners, not just the Illinois Department of Public Health -- I'm talking VHS and the federal government -- to combine those systems.

About time, Kevin. Can I go on?

MR. KEVIN HUTCHISON: You can finish up.

MR. MARK STEVENS: Okay. And then we talked about disparities, and I think that again goes to social marketing to the groups. And, finally, the funding for special programs. We need staff and training to carry out these specific programs, so that means we need to train our workforce in the techniques needed to carry out specific intervention programs.

I've already touched on measure and manage with the IPLAN and the community health plan, and I think -- we'll skip that in essence of time. But in our workforce, what we are finding in our workforce -- I did a walk-through

today talking about some issues, trying to show that local health departments -- we have three or four less staff than we had five years ago, yet we have more duties today than we did years ago. Our funding has been stagnant. We have not had cost-of-living increases. So we're doing more with less, and we're about to a meltdown here in what we're doing. You know, we participate in things listed in the plan like internships. What we show those people is that there's nobody in health departments working at a health department that aren't overworked. And we have so much competition because we don't pay near the wages that a hospital would. And I think that's been a forefront of many plans, showing that local public health can't pay the wages, and what we get are people really dedicated to public health. What we need, a bigger workforce, and we need the ability to be competitive. When you live in a city with two hospitals, the health department, RNs are hard to find. And we need to educate them with the special population skills to deal with the individual programs that

we -- that we see.

In summary, you know, the plan identifies a lot of things that have been evident and talked about in a lot of different plans. I don't think this plan is any different than a lot of plans that I've seen. The issues are the

same. The issues are the same around the table with any associations. Here are our problems. You've identified them. What's great about this plan is that it was legislatively mandated. Hopefully, that means that they're going to take action on the plan that you give them. We need to provide a basic working plan of everything you've put in here. And that's why I asked the questions, Are there more details in the plan? And then we need to make sure we adequately -- adequately fund the initiative spawned out of the plan because if we don't, there's very little success -- there's very little chance of success if we don't fund it.

Go onto my last page.

MS. MIRIAM LINK MULLISON: You're on a roll, Mark.

MR. MARK STEVENS: I really wasn't gonna give testimony.

MS. MIRIAM LINK MULLISON: You're doing great.

MR. MARK STEVENS: But I did have some note cards. You know, public health's been at the forefront, not just local health departments, but public health in general, especially since 9-11. Now's our ten minutes in the sunshine to ask for the funding of our projects. You know, we piecemeal, and that seems to be the case in Illinois. It's been piecemealed together. You know, we might throw a

little money here. But when you fund a lot of little projects, you have little success -- little bit of success here and there. But they usually fold. It's like working with your community partners. If you have five people out running little businesses that are the same, eventually, they'll all fold because none of them can make a go of it. And public health's so much the same way. We do need a partner, and local health departments partner very well with community resources. That's not out of mandate.

That's out of survival. We have to survive, especially rural health departments, because we don't have access to so many services. We work with a cooperative extension. We work with other local health departments and agencies. We tend to serve on lot of the different committees to get information. I know that I had served on Illinois Public Health Association, Illinois Rural Health Association, and then served in lots -- many committees with you on the -- at the table. So I agree with the plan, but I think the legislature needs to take into consideration -- they authorize this through legislature. They need to back up their words when they get the plan, and that will be my supporting comment.

MR. KEVIN HUTCHISON: Thank you very much, Mr. Stevens. For members of the SHIP Planning Team, if you

could, perhaps respond to Mr. Stevens' question regarding the background information, the reports, the -- I think there was a myriad of other plans and data that were reviewed that were summarized in the document that was

distributed. My understanding is there are some source information that will be put forward either as dependencies and/or electronically as this plan moves through finalization. So any comments on that that you'd have we'd welcome.

MS. MIRIAM LINK MULLISON: I -- just to highlight what you were just saying, there is for each of the assessments -- I mean, there's probably a binder of information. I mean, it's not -- these are very, very brief summaries. And there's much more data there, much more information there. These are the summaries of that. In terms of the detail on the plan, itself, there will be more detail. But right now, this is the level of detail the plan's currently at.

MS. ELISSA BASSLER: And I don't know that it will get very much more detailed. I think the -- the vision is then you -- those sectors come together and say, Okay, now how do we accomplish those roles that are discussed in there for us? that that's the next phase, is the implementation. And you need to engage those groups in

thinking about how to do that implementation. But there will be some additional work with this SHIP plan.

MS. MIRIAM LINK MULLISON: We're gonna take the comments we get from the hearings and flush this out some more. But if you look in that section on managing, improving the system, it talks about convening summits and reporting out and those kinds of things.

MS. ELISSA BASSLER: And all of those source documents, the assessment documents, are up on the Web site. They are all there.

MR. KEVIN HUTCHISON: In case you did not hear, the source documents are on the Web site. So if anyone wants to see the information the planning team looked at to come forward with the summary, it's there.

Mr. Stevens is still in the room. I didn't know if any of the other panelists had any questions that you wanted to ask Mr. Stevens. I'm sure he'd come back to answer them if you twisted his arm.

MS. KATHLEEN WELSHIMER: I would -- I would be interested in hearing more about your thoughts with regard to the strategic issue of, particularly, managing and

improving the public health system.

MR. MARK STEVENS: Okay. Let me go back and get my paper so I can refer to it.

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MS. KATHLEEN WELSHIMER: Because I suspect you have notes.

MR. MARK STEVENS: All I need to do is look at that page.

MR. KEVIN HUTCHISON: As he's looking, we'll certainly invite other members of the attendees today, if you wish to make any oral comments, please be thinking. And we'll invite you to do so in a moment.

MR. MARK STEVENS: Okay. For local health department, that would be the one that concerns me the most. The two things under strategic things here are align organizational plans with SHIP objectives. Now, I'm gonna tell you our objectives are basically dependents of everything you have in here. Is that what you're asking, what I think about the comments that are directed at health departments?

MS. KATHLEEN WELSHIMER: Uh-huh, in particular, but --

MR. MARK STEVENS: Conduct local public health systems assessment. We do conduct assessments called the IPLAN. And, again, like I said, we go through a planning process every five years. And what we find is we identify areas that need to be worked on but not necessarily areas that the health department has resources to do. Like I

said, a lot of departments around the state implemented some sort of rural health clinic or wellness clinic because of access needs. What we found and what I found here is that they didn't have the resources to implement it. Or when they did find the resources, they are very short-term, and then you might operate one day a week. Now, tell me what the continuity of care on a clinic that's one day a week. Do I wait till Wednesday to be sick and go to my doctor and follow up because I can go to a clinic where Medicaid will pick up the charge? That would be another thing, payment practice and funding. We all know that. I

do bring that back.

But -- so I think the health departments have tried to take responsibility for what's in their IPLAN, but I don't think we can. I think the MAPP process is a process that probably shows more ownership to the system as a whole. And the system, there's local elected officials, health department, business partners. And I think that's a tainted plan. We have to have a buy-in from them that they are a vital part because if we -- if we implement preventative strategies, their healthcare costs go down, their operating costs go down. I think they have a vested interest, but we have to sell that to them.

And I think another thing, we are held in our

IPLAN. What are you doing to hit this strategy? And in some cases we have just led the discussion and not really determined -- you know, because if I had to write a health plan for my health department to follow, I'd write things that I think I can achieve. So I don't need the community to say what I think I can achieve. So when we use

them -- when we use a group made up of business, private sector, government officials, they need to think, We're part of this, and we have to help the whole group achieve. And I hope that answered your question.

MS. KATHLEEN WELSHIMER: Thank you.

MR. KEVIN HUTCHISON: Thank you. Thanks again.

MR. MARK STEVENS: You're easy.

MR. KEVIN HUTCHISON: Thank you. As you're thinking of any other persons that wish to make comment, we would invite Ms. Bailey back up because we kind of cut you off in view of time. But since we have time available and you -- you're welcome to make any additional remarks.

Following her comments and any responses from the panel, if there are no other persons that at this time are interested in providing testimony, we will go into a recess for a few moments until either the appointed time ends of the hearing or in the event that someone else wishes to make testimony, in which case we'll reconvene and listen.

MS. ANGIE BAILEY: Mine are going back more

specifically again to the prior health problems and strategies we could implement. And many of them touches on what she had said about individualized health when we get physical activity and the nutrition and those things. I think some of it is that we need to educate parents about the importance of serving their children healthy foods, importance of physical activity. Many of our plan again is looking at what -- agencies and organizations in groups. But, again, we need to get that social marketing back in and put some of the ownership on the individuals.

Also, vending machines in schools and not just at the high school level or the elementary school level only, but throughout the schools, making sure that all foods meet those nutritional standards, decreasing the use of school waivers. In our community that's a really big thing that schools offer. At one of our local high schools, who is a high school who has a lot of programming, you can get out of PE for eight different waivers. So trying to work on the systems with regards to that in the schools, around that issue, working with the schools to develop personalized physical activity programs that increase

students' heart rate and focusing again, as she mentioned, on lifelong sports in cooperation with the school wellness

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committees.

Some things that we can do around physical activity with insurers is encourage insurance companies and the like to help adults by paying a part of the membership fee or reducing the membership fee and work some system of accountability into that. Also, encouraging healthcare providers to do education with their patients on all of these issues with physical activity, discussing the importance of physical activity with their patients. Many times, I know I have never been talked to from my physician about physical activity level. Also, as far as legislature and local government, helping the local governments build environments that support lifelong exercise, such as sidewalks, parks, those types of things. Again, the media, working with them to develop educational and social marketing campaigns. And then on violence, for that outcome, one of the things we can do is work with schools

to train staff on mandated reporting of child abuse, train them on offering peer mediation and bullying prevention programs, which in many communities like ours, we're doing a lot of those programs with agencies like University of Illinois Extension. So groups like that don't only work on nutrition but, also, many other components.

Within violence as well, we can train healthcare

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providers on screening and referring for domestic violence, elder abuse, child abuse, and all of these things, making screening and referral part of the curriculum for all healthcare providers. So when students are in training or people are in nursing school or the PAs are going to school, make sure that they are trained in order to do all of these things with their patients and screen and refer and comfortably talk with them.

Mainly, those are some ideas. It's not a all-inclusive list. There are many resources out there that we could help beef up this section with. But I think all of these sectors should have a role in addressing all

of these priorities so we can all work together with all the different organizations.

MR. KEVIN HUTCHISON: Thank you so much for those very thoughtful comments. Any questions or reactions from the panels?

(No response.)

MR. KEVIN HUTCHISON: If not, we will -- yes, ma'am.

MS. VICKI VAUGHN: My name is Vicki, V-i-c-k-i, Vaughn, V-a-u-g-h-n. I'm the director of community health at St. Mary's Good Samaritan, two hospitals. I was sitting back there and absorbing all this, and it finally -- I had

to stand up because I wondered if anybody on the panel had considered in asking hospitals to appoint a liaison, point person, point of primary contact or anything like that for all of the Office of Public Health to be able to get ahold of.

When you think about the hospital perspective, when you deal with administrators, they see you as oversight

people. When you deal with somebody like myself, who's an RN, who's been on the fringes of public health for years -- I've worked with Miriam in the HIV program. I've been a school nurse. I've done a gazillion things on the fringes of public health. So in anything relating to public health, what you're doing comes along, it usually filters to me, but I'm not empowered to do anything about it. When I am empowered, because I get the message across to somebody that, hey, this is a good idea, our hospital can do great things. We have money, we have resources, we have smart people, but you have to ask us because we don't know what's going on out there.

We have an effective Breast and Cervical Cancer Center at my hospital. I get millions of dollars from public health. But if you don't tell us what you need, we don't know you need it. So I would ask you to consider that. It might be something very simple that can be done

very quickly. Ask the hospitals to appoint a person that can be the point of contact to deal with any public health

office.

Any questions?

MR. KEVIN HUTCHISON: Thank you very much for that suggestion. Any questions or reactions from the panel?

MS. MIRIAM LINK MULLISON: Good suggestion, Vicki. I know -- I mean, I know you have worked right there with public health for many, many years.

MS. VICKI VAUGHN: Yeah. We don't know what your needs are. I guarantee you that.

MS. MIRIAM LINK MULLISON: And I think some hospitals -- I know the hospital in our community has worked really closely with us, but I don't think that that is necessarily throughout the entire state. And if we can leverage those resources, that's a simple and wonderful suggestion.

MS. VICKI VAUGHN: My hospital had a meeting just last week to talk about the amount of money we provide to various charities like the Boy Scouts, and we found out that we provided 20,000 per year for little things that maybe they could have done without or -- just think what we could do with 20,000 if we gave it to a public health program. So I think we need to encourage the public health

departments to work closer with us. We need to encourage our hospital administrators to appoint somebody to work closer with you guys so we can all get the job done because we're all working on the same thing.

MS. MIRIAM LINK MULLISON: Absolutely.

MS. VICKI VAUGHN: We have dietitians that are doing programs that work with university extension. We're all in the same boat. And I'm here to tell you our hospital is here to help you, but you've got to tell us what you need.

MR. KEVIN HUTCHISON: Thank you very much.

MS. MIRIAM LINK MULLISON: Thanks, Vicki.

MR. KEVIN HUTCHISON: Anyone else wish to make any comments at this time?

(No response.)

MR. KEVIN HUTCHISON: If not, we will take a recess. Thank you.

(Whereupon a short recess took place.)

MR. KEVIN HUTCHISON: Can I have your attention?

At this time we are going to reconvene the hearing. For those remaining, are there any other interested persons that would wish to provide testimony on the proposed SHIP plan?

(No response.)

MR. KEVIN HUTCHISON: Hearing none, I would like to thank my colleagues on the State Board of Health and SHIP Planning Team for joining us to hear these important comments but, most of all, would like to thank all of those who have participated and testified this afternoon. I hope that all those persons that submitted written testimony have done so, but there is -- if you see the staff, they do have a mailing address or e-mail address if you have any additional comments that you wish to make.

At this time I will consider our hearing adjourned. Thank you.

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1 STATE OF ILLINOIS)
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2 COUNTY OF WILLIAMSON)

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4 The undersigned, Starla D. Jay, a Notary Public
5 in and for the County of Williamson and State of Illinois,
6 DOES HEREBY CERTIFY:
7 That I was personally present at the time and
8 place set forth in the caption sheet hereof, that I took
9 down in stenotype the proceedings, and that the foregoing

is a correct transcript of such stenotype notes so made at such time and place.

IN WITNESS WHEREOF, I have subscribed my name and affixed my Notarial Seal on the day of , 2006.

STARLA D. JAY, C.S.R., R.P.R.
NOTARY PUBLIC

PUBLIC HEARING
FOR STATE LEGISLATION PLANS

HELD ON
TUESDAY, AUGUST 8, 2006

HELD AT
ILLINOIS STATE UNIVERSITY
BONE STUDENT CENTER
OLD MAIN ROOM
BLOOMINGTON, ILLINOIS

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APPEARANCES

PANEL: Ann O'Sullivan
Jack Herrmann
Jane Jackman
Karen Phelan

ALSO PRESENT:
Elissa Bassler, IPHI

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(WHEREIN, presentation of Illinois State Health Improvement Plan - Overview was presented by Mr. J.A. Herrmann, MPH, DVM.)

MS. O'SULLIVAN: So before we get started with the testimony, there are several items that I need to address with you.

First of all, if you haven't already done so, please sign in at the registration table at the back. And there's two different sign-up lists, one to provide oral testimony today and the other for people who are just registering that they are attending today.

Those of you who came prepared with text for your presentation may choose to submit that text without giving testimony. If you are providing written testimony only today, please leave your submission at the registration table and sign the attendance book. If you are giving oral testimony today, please be as brief as possible.

Individuals will be called to testify in the order in which they have signed up. We're asking that your oral

testimony be limited to three minutes. Our kind gentleman here will give you timelines. What do they look like?

MR. GIANGRECO: I've got one minute. I've got a make shift, 30 seconds, and then out of time.

MS. O'SULLIVAN: Additional written testimony, of course, may be submitted. But for purposes of this afternoon, we ask that you keep your oral testimony to three minutes. Should anyone want to speak for more than three minutes, you may do so after everyone else has had the opportunity to speak. And depending where we are in time, we'll offer the opportunity to provide testimony after all the people signed in have done so, because sometimes that kind of makes you think of things or trigger thoughts in your mind that you want to share with us.

We'll begin the hearing by calling out the first five speakers and ask them to sit in the front row, right here. We ask that you sit in the order in which you are called.

When you come up to testify, please state your name, state your first name and your last name and spell them for the Court Reporter. And if you forget to do that, she'll remind you. She's really good at that, I'm sure.

These proceedings will be transcribed so the

entire membership of the SHIP planning team will have access to the verbal testimony. And, of course, any written testimony you provide will be distributed to all members of the team. The Illinois Public Health Institute

will also provide a summary of the public hearings.

So the first five people, first early birds who were here early; Tom Barr, Bill Halliman, Mary Johnson, Matt Huntsaker and Linda Jeehart. I'm so sorry if I really massacred your names. So, Tom.

MR. BARR: Hi. I'm Tom Barr; T-O-M, B-A-R-R. I'm here for the Center for Human Services and the executive director, Center for Mental Health Center for McClain County. And as probably many of you know, one out of every five people will at some point in their life experience a problem so severe it will warrant the need for mental health treatment, one out of five. And the interesting thing about mental health is it is an equal opportunity disorder. It will not discriminate based upon age, sex, race, socioeconomic status.

In your old report on Page 12, you identified mental health as 1 of 3 out of 17 items where all 4 of the major health conditions were influencing. It's clearly important that we look at studying and look at strategic

20 strategies for both short and long-term solutions. Equally

21 important, I feel, is the need that we don't lose the

22 progress that we've made so far in the strides that we have

23 taken in serving the population.

For the past three years, the Department of Human Services has been changing the way that you're funding us, and the state implemented the changes that they proposed that resulted in reduction in mental health services to the community. For example, the Center for Human Services receives about 3.9 million dollars of a 5 million dollar budget from the Department of Human Services. If the changes the state were proposing were implemented today, we would lose funding of over 450 thousand dollars. This will result in a reduction in the services to the mentally ill to this community.

As a private not-for-profit community mental health center, we prioritize serving those people with the greatest needs and the fewest resources. We view it being critically important to look at short and long-term solutions. But we also don't want to lose the strides and progress that we have made so far in this community.

And joining me today are two individuals who receive services from us. I don't know how you want to go

about introductions at this point, but I'll turn things over to Bill Halliman. Thank you.

MS. O'SULLIVAN: Thank you.

MR. HALLIMAN: My name is Bill Halliman. My last

name is H-A-L-L-I-M-A-N.

I came to the center when I was 26. I signed up for intake. I went to their orientation and then was assigned a therapist. That is not so easy to do anymore. They made it more complex and harder to save money.

I used to get rides to the day programs they had, and you can't do that anymore unless the weather is really extreme, to save money. Now they are talking about cutting back the number of classes at PSR to save money. And this would be -- the fact is, good things cost money. And if we keep cutting programs and efforts to save the state money, we're going to have people out on the street who otherwise could have been -- had programming and could have been -- had their needs sought to and kept them out of jail, which is -- jail is a lot more expensive than the programs that are being run in the City of Bloomington.

Our bottom -- the state's bottom line may be to save money, but our bottom line is, what more can you take?

That's all I have.

MS. O'SULLIVAN: Thank you, Bill.

MS. JOHNSON: Good afternoon. My name is Mary Johnson; M-A-R-Y, J-O-H-N-S-O-N. I always tell people, think baby powder.

I wanted to start with a laugh, because my story is extremely serious. I am a survivor of a tortuous family. I grew up in Southern Illinois. By the simple grace of God, I arrived in Bloomington on August 31, 2003.

Now, for the first, I would say from age 11 through 36, I did not have much childhood memories. I did not remember. And I remember having this impending sadness, and I would go to my mom and say things like, mom, I'm acting the way that people on TV say people act when that happens; did that happen to me? And, of course, I always received a no.

After a car crash in 2001, they weren't memories, they were mind bombs. And they kept coming. December 3rd in the evening, of 2002, I faced my father, and I said, how come you didn't stop it; how come you didn't stop granddad from doing what he did to me; how come you made me go to all of those meetings?

And his face -- it was just so evil that there wasn't any doubt in my mind. The next day I 911'd. And I

was so depressed and pressured I couldn't even talk. They called me back and said, do you want us to come? And I said, yes. When they came, I was then -- I then told them, I'll go anywhere; I'll live any place, but please don't

make me live here; I don't care where it is; I don't know even care if it's jail, but please, please just get me out of here.

At that point in time -- anyway, I got to Bloomington, got to the Salvation Army, and they referred me to CHS, because I was just so upset most of the time. And there they listened to me. They gave me so much support, just in the fact that they listened without trying to judge what was going on.

In December of 2003, I was referred to PSR, which is Psychological and Social Rehab. That's at 530 North Main Street. And PSR is beautiful. Growing up the way I did, I did not develop decision-making skills. I didn't really -- there was a lot of things that normal people kind of knew that I always felt outside, didn't quite catch -- and the support is so awesome. I mean, it's not just -- I mean, people ask, how are you? And they want to know. Or they will say, what are you doing; why don't you come hang out at my time management class?

20 And things are always helpful that are going on,

21 whether it's just a funny movie to lighten the day or we do

22 crafts. And they have cooking, and they have a pantry so

23 that I don't have to walk, because I have problems with the

heat, so I don't have to walk all the way up and down the street to get my lunch. I adore PSR. And I just really wanted to let you know and give you my complete and total applause for what you do for Illinois, because people like me -- I mean, I have a chance now. I have a life now. I don't know that I would have had it otherwise.

Thank you.

MS. O'SULLIVAN: Thank you, Mary.

MR. HUNTSAKER: Matt Huntsaker; H-U-N-T-S-A-K-E-R. My name is Matt Huntsaker. I'm a family physician by training. I was in practice in Southern Illinois until a couple of years ago when I went to take a leadership role at the University of Illinois College of Medicine at Rockford with the rural medicine program. As I reflected on the SHIP proposal, the draft, I think that there are a couple of things that would certainly strengthen the draft.

One of them is an attention to geography, particularly rural geography throughout the state. About two thirds of the state is composed of rural communities.

They are certainly different in their structure and certainly different in their public health needs and the way that healthcare service are delivered.

At Rockford, we have been involved in rural

medicine for about 15 years, first through the ARMD program and then with the expansion of the National Center for Rural Health Professions. Although budgets have been tight in Illinois, we continue to strive to make training programs that are enrolling students from rural communities, engagement of a unique participatory action model as part of their training, so when they return to the rural communities, they are able to in effect, not only deliver care, but to effect change.

I've given you both a copy -- or given you each a copy of the charting or the workforce proposal that is in response to your charting healthcare agenda, which is at the Paul Simmon Institue at Southern a few years ago with specific recommendations much like the SHIP program is. We've made four really what I believe to be the important recommendations as it pertains to workforce, specifically to rural communities.

They include successful recruiting methods for all disciplines as it pertains to rural communities, extending

rural health profession's education using the ARMD model

that is community based and requires students to be

involved in these projects to increase aftershow and

enhance the rural work force retention efforts and

establish and maintain a consistent database measuring the Illinois rural health workforce.

As was mentioned earlier when Jack was presenting his slides, Illinois has a huge paucity of accurate data. We know that licensure data doesn't work because it doesn't capture who is actually delivering the service. We know that there is some shortcomings in each of the professional registries and association databases.

As we look at what we do for planning, we used to talk about 2010 as being far, far away; it was healthy people, 2010, a decade from now. As we look at Illinois, we've got some pretty distinct shortages throughout the state, as well as specific ones in Illinois. In Illinois, although nine percent of the nation's doctors' practice in rural communities or if 90 percent of the population live in rural communities, our doctors cannot keep pace with the citizens living there in terms of retirement. With the expected baby boomer retirees, we are going to shrink the overall healthcare class in the Illinois system in just a

few short years. For example, as I mentioned, it was a decade ago, now it's four years.

Using a generous retirement age of 75 for physicians, we'll be 485 physicians short in 2010. 2010

we'll be 4,265 nurses short. Over half of those are required by small community hospitals that are the safety catch for Illinois.

I see I'm out of time. I've submitted some written remarks, as well as a copy of the vote. I would hope and encourage you to define rural as a distributor and consider it as you make your recommendations as far as strengthening the workforce as it pertains to both educational pathways and the length of time required for training professionals.

Thanks.

MS. O'SULLIVAN: Thank you, Matt.

MS. JEEHART: Linda; L-I-N-D-A, J-E-E-H-A-R-T. I am on the staff at Macon County Community Health Foundation, which is part of the Macon County Health Department. Thank you very much for the work that you've done. We appreciate it and it follows much of the work that we are doing. So we appreciate that.

Three comments. One, I serve on a state board for

abused and others. Everything that you have in the plan have other state agencies besides public health involved. And we would hope that there is some coordination of activity and strategic plans so that there is not a

repetitive situation. Also, as you work on action, which is where I am -- I'm at the grass roots level -- we would hope that there would be some consistent evaluation and accountability.

I don't have the funds to hire Dr. Peter Malchoff at the University of Illinois, which I would love to do on every case. So we need some consistent data gathering procedures so that we are all working from the same page.

Lastly, we would hope that as you present this to the legislature, that funding follows the work that needs to be done.

Thank you.

MS. O'SULLIVAN: Thank you, Linda. Thank you all. Our next group; Sara Wilham, Jan Morris, times two Pat Sthou and Jeff Sunderlin.

MS. O'SULLIVAN: Sara.

MS. WILHAM: Thank you for this opportunity. Sara, S-A-R-A; Wilham, W-I-L-H-A-M.

Good afternoon. I am a planning and program

specialist from the East Central Illinois Area Agency on Aging. Our agency is responsible for planning and supporting a continuum of supportive services for the older adult and family caregivers. Last year our agency and our

network of 31 community-based programs provided services to over 26,000 seniors and 1,800 caregivers. We appreciate the work of the planning committee in developing the State Health Improvement Plan. Thank you for the opportunity to provide the following comments.

First, we support the vision of the plan. We concur with the 11 key findings of the assessment and the priority health conditions addressed in the plan. We particularly agree with no need to address the needs -- with a particular need to address the cultural diversity population in Illinois. To do this, we would recommend adding a statement about the need for a life span approach to the planning and delivery of healthcare across the generations and the elimination of ageism which restricts access to healthcare options for older people.

Second, we support the long-term and intermediate outcome proposed for the strategy, strategic issues of access. We recommend the addition of a long-term outcome for healthcare and public health systems, which promotes

the inspiration of prevention, healthcare, supportive services and housing to enable older adults and persons with disabilities to live independently in the least restrictive setting.

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Our agency currently collaborates with the Federal Administration on Aging, the Center for Medicare and Medicaid, the Illinois Department on Aging, and the Macon County Health Department in implementing a starting point, the Aging and Disability Resource Center for Macon County.

Starting point is coordinated point of entry that makes it easier for older adults and persons with disabilities to access home and community-based services for independent living and effective management of chronic disease and disability. Starting point can serve as a model community in the state.

I'm sorry. I have a little more, but I see I'm out of time.

MS. O'SULLIVAN: A little more.

MS. WILHAM: Just a little more?

MS. O'SULLIVAN: Sure.

MS. WILHAM: Served as an advocate in the field of mental health and aging. We support the plans called for providing mental health parity and benefits in planning for

the Medicare program and private health insurance as Illinois moves towards fee for service as a mechanism for paying providers of mental health centers to ensure continuum of care for individuals who do not qualify for

Medicaid and have limited ability to pay for private treatment.

Lastly, we support proposed strategy to address priority health concerns. We support outcome one, to reduce the use of alcohol as the backbone and drugs. We support the development of programs which are designed to help older people in the treatment of alcohol and other substance abuse issues. We pledge our support for outcome goal to promote collaboration among state and local health departments, elder abuse providers, family violence prevention programs, to reduce the incidence of violation affecting children, women and older adults.

Thank you.

MS. O'SULLIVAN: Thank you, Sara. Jan.

MS. MORRIS: My name is Jan Morris; J-A-N, M-O-R-R-I-S. I'm with McClean County Health Department. But I have also been asked to read a statement from the lieutenant governor's office.

While the State Health Improvement Plan identifies

four priority areas; obesity, violence, physical activity and substance abuse, it is silent on an epidemic plaguing Illinois children, poor oral health. Tooth decay is the number one cause of chronic illness in children. And

toothaches are the leading cause of school absenteeism. In fact, in 2003, the U.S. Surgeon General estimated a staggering 51 million school hours are missed each year due to the effects of dental disease.

Additionally, poor oral health can lead to the very problems the plan seeks to address. For example, dental decay can lead to problems with eating, speaking, concentrating and learning in school. Once these problems occur, students inevitably fall behind. This leads to poor self-esteem, which can result in disruptive, violent behavior and substance abuse. That's why I made access to quality oral healthcare for all people a top priority.

With the help of Illinois legislature's only dentist, Republican David Miller, we helped pass the Health Smiles initiative requiring dental exams for every Illinois child entering kindergarten, second and sixth grade.

Dental disease is an education issue, a public health issue, an economic issue facing every Illinoisan. And we need to continue to battle this growing epidemic by

20 making it a priority of the Illinois State Health Plan.

21 MS. O'SULLIVAN: Thank you, Jan. Now the next

22 Jan.

23 MS. MORRIS: Now I will be speaking for the

McClean County Health Department. And we are pleased to see that must emphasis has been placed on prevention and evidence-based programs in the State Health Improvement Plan. However, the needed resources are not available for the suggested prevention programs addressing tobacco, obesity and cardiovascular programs. In fact, resources have been constant at best and many cases have dwindled.

An example of decreased funding for local health departments would be the reduced amount of money allotted by the Master's Backbone Settlement Fund for prevention messages and tobacco programs. McClean County Health Department first received $153,000 for fiscal year 2000. And then the money was slashed to $53,859, forcing us to reduce staff and cut programs.

The message from the Surgeon General's report is so powerful in stating that smoking is the single greatest avoidable cause of disease and death. In fact, scientific evidence indicates there is no risk-free level of tobacco exposure. There is so much work to do to educate the

public and so little funding to accomplish that task.

Health professionals must deliver the prevention message to a variety of audiences, to the kids before they begin using tobacco.

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Evidence shows that if adolescents and teens do not begin tobacco use prior to age 18, most likely they will never take up that habit. To parents and future parents, that tobacco use is hazardous to the health of children in their homes, as well as to their unborn children. And we must help the many people wanting to quit smoking.

All these programs are necessary to reduce the morbidity and mortality rates in McClean County, in Illinois and in the United States. Due to cardiovascular disease, lung and other cancers, SIDS, asthma and other respiratory conditions, we at McClean County Health Department ask the State of Illinois to reinvest in the health of your citizens by allocating more money for the needed tobacco programs in all local health departments.

Thank you.

MS. O'SULLIVAN: Pat.

MS. STHOU: Thank you. My name is Pat Sthou, S-T-H-O-U. And I'm the executive director of the Illinois

Critical Access Network. And it's about 51 hospitals covering across the State of Illinois from Metropolis to Molina and in the smallest of small hospitals.

I'm here to share a few comments. I want to first

commend you on a great report that you put together. It's very difficult to be comprehensive. I come from a public health background, and I really applaud all the efforts and thank you for the opportunity to speak today. I just had a couple of remarks.

Because of my background and work with rural health, I encourage you to put more into it about rural health. Dr. Huntsaker spoke about the importance of rural health and to include something with geographic sensitivity to rural. Because of the challenge of transportation access and EMS, I really encourage you to speak to that a little more in the report, as well as with EMS, because living in these small communities, that infrastructure could easily crumble. And working with the local health department, we need all to work together.

Just another comment was regarding -- it's great to have the focus around patient diseases and chronic diseases and so forth. And I commend that. I would just like to add that maybe you might include something about

patient safety, you know, the importance of that in the delivery of care and the delivery of services. That's a big focus. And really just thank you for the opportunity and continue to keep rural in mind.

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MS. O'SULLIVAN: Thanks, Pat. Jeff.

MR. SUNDERLIN: Thank you. Jeff Sunderlin, S-U-N-D-E-R-L-I-N. I currently serve as the program manager for the Department of Public Health State Nutrition and Physical Activity Program on obesity and other chronic diseases. It's not to criticize as much as it is to ensure that we have a bridge construction that occurs as it relates to collaboration.

I can only imagine my surprise on July 17th when for the first time I see a document that includes obesity and physical activity. And given the fact that there is staff shortages everywhere and I understand all of that, but the point is that that work that has gone on for three years prior to this partnership statewide with the variety of various medical teams groups to assign people that we had across the state, to get them buying it when they would call me and say, what is this about, and I haven't an answer.

So this notion of how this collaboration -- how do

we improve this and issues that we look toward, specifically the things that are -- I think that are missed in this particular document have to do with the notion of where obesity fits in as driven by nutrition issues as

opposed by the combination of the balance between PA and nutrition. And then the outgrowth of that imbalance results not only in obesity but other issues as it relates to chronic disease processes. So it needs to be more comprehensible, inclusive of diabetes, the cardio/metabolic issues, the cancers, the asthmas and how these all play in. And that's the direction that we are headed.

Second point, I want to make sure there is some -- the understanding that the reliance on the strategies, our own work, in terms of survey work with health departments and with focus groups -- follow-up focus groups, in showing us readiness levels as it relates to PA and nutrition is very weak at best. And given the fact that these units of public service are so maxed and stretched to the point to what they can possibly do, it is on us that we have to create more support education systems just for our own local health departments, which we as a department have gotten away from over the last five or six years.

So this notion of how do we get back into the

basic education and get as many players on the same page as possible as it relates to this issue of physical activity and obesity -- and I think the third thing that I want to make sure we are clear, as well, is the notion that the

State -- the shift plannery looks to the state agencies to align with their programming efforts with the SHIP plan where I would contend and submit it that it should be potentially the other way around given the fact that we are three years into a planning process for the C.D.C. Funding Cooperative Agreement and the notion of us having to rebuild back into a different plan that we didn't necessarily have a part of doesn't make sense to me.

So I think this notion of making sure that we have some build back as it relates to our state plan and where we are headed in the final production of that probably within the next few months so that there is a coordinated effort between where the SHIP plan is headed and what we have in our particular document, as well.

But I congratulate you on at least getting obesity and PA on the radar. So we are extremely pleased with that issue because we know the problems that exist with that.

So thank you for your time.

MS. O'SULLIVAN: Thank you very much, Jeff. And

Deb O'Connell.

MS. O'CONNELL: My name is Debra, D-E-B-R-A; O'Connell, O-C-O-N-N-E-L-L. And I'm here on behalf of I Floss and Oral Task Force, a state-wide task force, and

Heartland Headstart, a comprehensive family and childcare program for McClean and Livingston Counties.

The SHIP plan seems to miss the oral health needs of the average person. Oral health affects people every day. Even though oral health is an integral component of overall health and has links to all the four priority areas in the state plan, it is not highlighted in the plan. Even the vision statement of the plan should include oral health with mental health in order to bring oral health to the forefront.

Oral health is being talked about, recognized nationally by other states. The Surgeon General published the first ever report on oral health in America in 2000. Healthy People 2010 has a chapter on oral health. Perhaps the foreseen lack of oral health data or proven strategic intervention predicates oversight. This perception should lead to a larger focus on oral health by the State Board of Health to assist Illinois communities in coping with oral health needs.

There is a growth underfunding of dental Medicaid services and no Medicaid funding for adult preventive oral healthcare, lack of dentists and hygienists employed in public health setting, few safety net clinics, especially

in rural Illinois, and even fewer dental providers authorizing specialized care for the very young children and complex oral surgery needs. And the generalized lack of value of oral health promotes that throughout the state. These are significant health problems that require significant attention and a State Health Improvement Plan.

I would like to point out that last year Heartland Headstart had 100 children with follow-up treatment and we spent over $100,000. We are reaching that goal almost this year.

Thank you.

MS. O'SULLIVAN: Thank you, Deb.

I would like to remind everyone who presented testimony, if you do have written testimony, to please hand it in at the registration table so that we have that.

Is there anyone else who wishes to testify who hasn't had the opportunity to yet?

Come on down.

MS. SMITH: My name a Cynthia Smith. I'm a

Director of Nursing at a developmentally disabled residential facility for children in our state. I'm here to agree with the two previous ladies who have talked about dental and the problems that we face in dental. Medicaid

is grossly underfunded in the amount of reimbursement that they pay. We struggle on a constant basis to provide just the very basic services for our children.

We have children with fractured teeth; we have children with abscesses that we are keeping on antibiotics, long-term amounts because we don't have providers in our community that will accept Medicaid. To get a child in to a physician, we have to send children to oral dentists in Chicago from Springfield or we have to send them to SIU School of Medicine, or if they have behavorial problems and issues, we many times have to wait six to nine months to get a child in with a local provider. Hope School also has to offer up additional funding to get those kids in, and they don't have the money.

So I would advocate for better dental care, increased funding to DHS, increased funding for Medicaid for those procedures.

Thank you.

MS. O'SULLIVAN: Thank you.

Would anyone else like to testify? It's pretty painless sitting here, anyway.

Come on down.

MR. LOVE: I don't have a prepared list, but as

people have been speaking, I jotted down some notes.

My name is Greg Love; G-R-E-G, L-O-V-E, and I have been a paramedic for 25 years in the State of Illinois. And over that time, I have seen EMS change. And as we heard a number of individuals speak earlier, EMS is the catch-all for a lot of those individuals who can't get healthcare and other means. And it's ultimately EMS that falls when they don't follow the preventive health or they don't get the healthcare that they need.

We have seen an increase in acuity of the patients as patients stay shorter periods of time and are sent home with conditions which would have had patients in the hospital for weeks previously. At that same time, we have seen a decrease in the workforce as the smaller communities.

And we had an individual who spoke earlier about the rural issues. In rural parts of Illinois, EMS is delivered by volunteers. These small communities where these individuals live have become bedroom communities and

those individuals are often driving out of town to go to work. There are not enough in the community to provide EMS.

We are seeing where both adults in the family are

both working. We have seen an increase in single parent families, and there's fewer individuals to volunteer in these rural communities. This has caused a huge problem with the number of volunteers in the rural areas. At the same time, in our urban areas, we are seeing a decrease in the workforce because EMS is just not a flashy career. It doesn't have a high enough pay scale and in fire departments where maybe the pay scale is a little higher.

Often it is the new guy coming into the program that is pushed out of the ambulance because they go out on twice as many calls as they do otherwise and they spend their whole career trying to get off the ambulance so they can sleep at night. And nobody can blame them. But this is all creating a problem.

At the same time, we are seeing some real problems within Illinois, specifically in getting these individuals trained and getting these individuals licensed. The Department of Public Health does not have currently a state test for EMT basics. They have a state EMT intermediate

test which from February through May, every individual who took it failed.

There are some real problems with testing at the department. There are some real problems with turnover at

the department. They have had an expedious of individuals from the last two years from the division of EMS, Illinois Department of Public Health. These issues need to be addressed because they are only going to further aggravate the issues that we have already seen.

What I would like to suggest -- in your plan on Page 6, it addresses this issue of emergency services as a problem, and yet, I don't see it addressed elsewhere in the plan. And what I would like to suggest is that you look to a number of things.

Historically, support for EMS has come through the EMS systems and through hospitals which have stepped up and have provided the support to their EMS system and the providers in their area. These hospitals need to get some benefit from that because they're not getting reimbursed for putting on classes and providing the training and providing the oversight for these systems.

Additionally, because they don't get that support, we have seen a shift of the training out of the hospital to

the local community colleges. And while that sounds great academically, it doubles the cost of the courses to most of these students and means that many of these students have to travel to community college, whereas in the past, the

courses were taken out to them.

I would also like to see the possibility of support given to community colleges which offer these courses at a decreased rate to the students, particularly to volunteers. And this will help address the workforce issue for EMS.

Thank you for your time.

MS. O'SULLIVAN: Thank you. Anyone else?

Does anyone that has already testified want to have more comments or have more testimony?

MS. O'CONNELL: I just had a question. Debra O'Connell.

The governor had a transition team for healthcare that met a month before his inauguration and there were some recommendations. Were any of those taken into account with the SHIP plan?

MS. BASSLER: Those transition documents were not shared back out with the public, as far as I know. I was on the public health team, and I don't think those became

public documents.

MS. O'CONNELL: It would be interesting to look at that, because we had fore priority to see how they paralleled with the state plan.

MS. O'SULLIVAN: Anyone else?

You can certainly submit written testimony after this time. I have an address here that you can submit the testimony to, if you would like to. We need it in by August 10th. So that is coming right up, Thursday or Friday.

MS. BASSLER: We are going to add a week to it.

MS. O'SULLIVAN: I want to make sure that everybody has met Lisa Bassler and Mark Edgar. They are both with IPHI, who have done tremendous work pulling all of this together. Do you remember when Jack said, keeping us to the time schedule? He is really good at that. And Patty Timmel is over there from the Department of Public Health. She has been very active in our work and deliberations.

And am I missing somebody else? I didn't catch your name. And you did such a good job with those.

MR. GIANGRECO: I'm Chris. I am with public health. But I do more than keep time.

MS. O'SULLIVAN: I figured you probably did. But you did that really well.

So anyway, thank you. You all have done a phenomenal job to help all of us to get the work done,

Because, you know, when you're sitting around the table with 24 people, with 24 different ideas and then they come out with these documents that look like this after about eight or nine months work, it has just been incredible. So thank you, very much.

If you want to submit more testimony a week later, which would be August 17th, you may certainly do that and you can send it via e-mail to DPH.SHIP@Illinois.GOV.

Does anybody actually send anything in the mail? I can give you the mail address to anybody who wants it.

MS. BASSLER: It's all on the website.

MS. O'SULLIVAN: DPH is upper case, SHIP is upper case. Is it case sensitive?

MS. BASSLER: It doesn't matter. All of this is on the website. But they can actually click on the website and put in the e-mail.

MS. O'SULLIVAN: And there you go. It's all set. We'll take a break now.

The members of the State Board of Health and SHIP

plan will be here until 6:00 because that's what the posted hearing times are. You are free to talk to each other, talk to us, go home and eat dinner, whatever you do when you actually leave work.

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I really want to thank all of you for coming and your very thoughtful testimony and input. It has been a pleasure to have you all here. We'll be here if you need anything or if you know of anybody else who is coming later on to take anymore testimony, other people come for testimony. We'll have the gavel person here call us back to order.

Thank you very much.

(WHEREIN, the hearing concluded at 5:15 p.m.)

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CERTIFIED SHORTHAND REPORTER'S CERTIFICATION

I, Daphne G. Killam, Certified Shorthand Reporter and Notary Public of the State of Illinois, do hereby certify that the Public Hearing took place before me on the 8th day of August, A.D., 2006, and that I did take stenographic notes of the hearing and that said notes were reduced to typewritten form under my direction and supervision.

I do further certify that the attached and foregoing is a true, correct and complete copy of my notes and that said testimony is now herewith returned.

Dated this 14th day of August, A.D., 2006, and given under my hand and seal.

_____

Daphne G. Killam, CSR

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STATE OF ILLINOIS

DEPARTMENT OF PUBLIC HEALTH

ILLINOIS STATE BOARD OF HEALTH

STATE HEALTH IMPROVEMENT PLAN

HELD August 9, 2006

4:00 P.M.

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CHICAGO, ILLINOIS

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A-P-P-E-A-R-A-N-C-E-S:

CO-CHAIR:

Robert Kieckhefer, Blue Cross/Blue Shield of Illinois

TEAM MEMBERS:

Caswell Evans, University of Illinois, School of Public Health

Michael O'Donnell, East Central Area on Aging

Patricia Canessa, Salud Latina/Latino Health

David Mc Curdy, State Board of Health

Jorge Girotti, State Board of Health

Karen Phelan, State Board of Health

Peter Orris, State Board of Health

Barbara Shaw, Illinois Violence Prevention Authority

Richard Sewell, University of Illinois Chicago, School of Public Health

ALSO PRESENT:

Elissa Bassler

P-R-O-C-E-E-D-I-N-G-S

DR. EVANS: Welcome, everyone on behalf of the State Board of Public Health. I'd like to welcome you and call this public hearing to order.

This afternoon we'll be discussing the State Health Improvement Plan. Our scheduled time is to initiate our discussions at 4:00 p.m. to terminate at 6:00 p.m.

I am Dr. Caswell Evans, and I am an Associate Dean for Preventive and Public Health Sciences at the School of -- College of Dentistry at the University of Illinois-Chicago. I'm also a professor of public health at the School Public Health University of Illinois at Chicago. And I'm a member of the State Board of Health.

In August 2004 Governor Blagojevich signed House Bill 4612, which calls for the State Board of Health to deliver a State Health Improvement Plan, or SHIP, to the Governor and the

Assembly in 2006.

The legislation calls for the planning team appointed by the Director of the Illinois Department of Public Health to develop the plan recommending priorities and strategies to

improve the Illinois public health system and Illinois residents' health status.

The plan to use national objectives and standards as frameworks, and it considers community and regional priorities and strategies and public and private sector contributions address, racial, ethnic, gender, age, socioeconomic and geographic health disparities and focus on prevention.

The State Board of Health has held -- this is the third hearing. The first was in Mt. Vernon on August the 4th; the second in Bloomington/Normal yesterday, August the 8th, and today, August the 9th, in Chicago. The three public hearings are to address the draft of the State Health Improvement Plan that has been prepared by the planning team.

Once public input is incorporated, the plan will be finalized and delivered to the

Governor for presentation to the General Assembly.

This process will be repeated approximately every four years during every proceeding gubernatorial administration.

To begin our process today, I would

like to ask my colleagues on the State Board of Health and State Health Improvement Planning team to introduce themselves. And why don't we start from my right.

MR. GIROTTI: Jorge Gerotti, State Board of Health.

MS. SHAW: Barbara Shaw, Illinois Violence Prevention Authority and a member of the SHIP planning team.

MR. KIECKHEFER: Bob Kieckhefer, Blue Cross and Blue Shield, and also a member of the SHIP planning team.

MS. CANESSA: Good afternoon, Patricia Canessa. Salud Latina/Latina Health; (indecipherable) --

COURT REPORTER: I'm sorry. I don't understand.

MS. CANESSA: You could listen.

-- (indecipherable) improvement plan

as well as the state improvement plan.

MR. O'DONNELL: Good afternoon. Mike O'Donnell representing the Illinois Association of Area Agencies on Aging.

MS. PHELAN: Hi. Karen Phelan, State Board of Health.

DR. ORRIS: Peter Orris, State Board of Health. I am a physician doing occupational environmental medicine, and chief of service at the University of Illinois Medical Center.

DR. EVANS: Are there any other members of the State Health Improvement Planning team that have not introduced themselves, or Board members?

MR. MC CURDY: David Mc Curdy from the State Board of Health.

MS. SHAW: David, do you want to come up?

DR. EVANS: Thank you for joining us, and thank you all who -- the people who are here to both listen and to make comment.

Next I would like to ask Bob Kieckhefer, the president of public affairs for Health Care Services Incorporation, which operates Blue Cross and Blue Shield of Illinois -- and he

will share some additional information regarding the process that has led to development of the State Health Improvement Plan.

Bob.

MR. KIECKHEFER: I'm going to go through

this fairly quickly because I see as you all know what's in the draft, you wouldn't be here, and we are here to listen to you, not you to listen to us. I will go through this very quickly. Besides, our draft is all we talk about the first couple of slides.

As Dr. Evans mentioned, the SHIP Act does require a State Health Improvement Plan approximately every four years. It requires a multi-sector planning team which was appointed by the Director of the Illinois Department of Public Health. And it requires us to come up with strategies for improving the health of all Illinoisians and the public health system itself. It requires addressing health disparities, and the report is to be delivered to the Governor, who will take it to the General Assembly.

The team is, believe me, a broad range of public, private and non-profit

stakeholders. Those of us who have been to the hearings you can testify to the broad nature of it.

The team convened last October, and we've had meetings here and in Springfield for the time in between. The primary tool that we've used

is the MAPP process, including -- and it came out with a vision, four assessments, strategic issues, and an action plan.

The SHIP vision. And you can read this. I will read it too, because it's important: Optimal physical, mental, and social well-being for all people of Illinois through a high functioning public health system comprised of active public, private and voluntary partners. That's the vision.

And the four assessments that were used along the way with the state Public Health Profile framed by the Healthy People 2010 national health objectives of the state public health system assessment which is framed by the national public health performance standards; statewide themes and strengths which look into perceptions and local health priorities state-level plans; and forces of change: Examining external challenges that are facing our system and the public health system in

Illinois.

Six strategic issues are identified during the course of our deliberations: Health disparities and implementing effective strategies to reduce health disparities; using data and

information technology to plan its implemented policy and programs; improving access to health care for prevention, mental health, medical and long-term care; assuring an optimal diverse and competent workforce; measuring, managing and improving the public health system. And they identified several priority health conditions: Obesity, physical activity, violence, and alcohol, tobacco and other drugs.

In each of these we drill down to long-term objectives and intermediate objectives.

The health disparities issue we address: How can the Illinois Public Health system monitor disparities and identify and implement strategies to eliminate them. A long-term outcome is: Public health system actively engaged in addressing health disparities and the social determinants to affect health outcomes.

Intermediate outcomes. Accessible

public health systems partners working to address the social determinants; public health care workers trained in health disparities; public health and health care workers more diverse, culturally and linguistically competent.

Data and information technology. We asked: How can the Illinois Public Health System assure that the current health status data and public health system data are used to plan and implement policy and programs? In other words, how can we plan programs using data that give us some basis? The long-term outcome is a well-understood and linked data system that will measure and analyze these things, and reports, including residents impacted by disparities.

Intermediate outcomes. And these are real challenges: The Department of Public Health, or a new data agency, to lead in the design and implementation of a publicly accessible data system; a workforce that has increased ability to use data, to collect data, to train and to build capacity for that; and for state agencies having rational and streamlined data reporting; and could report back data in a timely way for use.

Access to health care. How can the people of Illinois gain access to quality prevention programs, mental health, medical and long-term care when they need it? Long-term outcome we identified as a system that's responsive

to cultural, linguistic, and other needs of the population; integration of prevention with care, and universal availability of services.

Intermediate outcomes: Diversity of health providers; the cultural and linguistic competency; more multi-lingual providers; access for immigrants; elimination of biases; promotion of community health priorities; individuals with information and prevention skills. That means the people who are accessing health care have those skills.

Financing systems that support prevention; a public health infrastructure that's financed to ensure prevention and health promotion; and a comprehensive approach to access to care.

Terms of the workforce: How can the Illinois Public Health System assure an optimal, diverse and competent workforce? Long-term outcome: A workforce that is optimal in terms of

preparation, numbers, and distribution. And intermediately: A system that analyzes and addresses workforce issues, more competent workforce, expanded workforce to meet the existing and future needs.

And long-term outcomes: A workforce reflecting diversity of the state, culturally and linguistically competent. And intermediately: Increased proportion of minorities entering health care and health education careers; more training in, and utilizing of, cultural and linguistic competency skills, and more bi and multi-lingual workers.

Going beyond this draft, we ask the public comments that you will provide into a final report to the Governor and General Assembly: How can the State Health Improvement Plan be implemented in a way that ensures accountability, ongoing improvement, and performance management? We didn't do this just to have it sit on a shelf, we want it to actually do some good. The long-term outcome is -- is a system that will monitor the SHIP implementation. And ongoing health status and risk factor monitoring.

Intermediate outcomes: A bi-annual summit for stakeholders to report on and be informed of progress toward the SHIP, so that we can track where we are going, if we are actually making progress towards these goals. Revision of

the action plans updating them as needed, based on what we find there. And an annual, interactive state health profile that's produced by the IDPH.

Priority health conditions and risk factors and implement effective strategies to reduce them; drug use to decrease the use of alcohol, tobacco, misuse of other drugs.

Reduce the proportion of children and adolescents who are overweight or obese, and the proportion of adults, by increasing physical activity, consumption of good foods, and reduce fat and sodium.

To improve the physical activity level of Illinois residents and to reduce violence and exposure to violence.

As I said, this is a very high level of what we have done and what we have come up with some drafts. And we are here today not to talk to you, but to listen to you.

Dr. Evans.

DR. EVANS: Bob, thank you for that review. Before we get started, just a couple of housekeeping matters.

I think our trap at the door was a

submission to capture everyone signing in. There is an attendance roster and there is a roster for those who are willing or are wishing to speak. If you are intending to speak, but have not signed the sign-in roster for speakers, please do so.

Now, those of you who came with prepared testimony for your presentations, and you may choose to submit it without providing testimony, if you wish, if you are going to provide written testimony only today, please leave your submission at the registration table, and of course, sign the attendance log.

If you are going to give oral testimony, please be as brief as possible. You see we have a great deal of interest understandably in the State Health Improvement Plan. We have a full room.

Individuals will be called to testify in the order in which they have signed up.

We are asking that your oral testimony be limited to three minutes.

Mark Edgar of the Illinois Department of Public Health will be sitting in the front. Mark has got a sign there for "one minute"

and another sign for -- and that's the bad one, because when that happens, we have a trap here -- don't be fooled by this carpet. We have a trap. When that "no time remaining" sign comes up, the trap door opens and you disappear.

In respect to all those who have come to testify, we do understand that people may have more than three minutes' worth of commentary. We'd like to go through our entire list of speakers; and if there is time remaining, then invite those persons back, if they have to be cut short.

We will begin the hearing by calling out the first five speakers, and ask them to sit in the front row. And we ask that you sit in the order in which you were called. And perhaps you can do that from my left to the right.

When you come to testify, please state your first and last names, and spell them for

the court reporter. These proceedings will all be transcribed so the entire membership of the SHIP planning team will have access to the verbal and oral testimony. And of course, any written testimony you provide will also be distributed to

all members of the team. The Illinois -- the IPHI will also provide a summary of the public hearings.

Let's see. I have a list of other five people. I saw Professor Sewell in the back. Do you wish to join us up here?

PROFESSOR SEWELL: No, this is fine.

DR. EVANS: Any members of the State Board Of health who have just arrived?

MS. BASSLER: There's lots of people here, but not many people have signed up for testimony. So I think you don't have to worry too much -- I mean you should keep people to time, but you don't have to worry too much about running out of time. If you have questions and things of people, that will be fine.

DR. EVANS: We have Bill Mays, Janet Holden, Kathleen Monahan, is it, J. Thomas Willis, and Bruce Blehart.

Mr. Mays.

MR. MAYS: Good afternoon. I'm Bill Mays M-A-Y-S, Director of Community Health at the Lake County Health Department and Community Health Center. I'm testifying on behalf of our health department and its executive director, Dale

Galassie, that's G-A-L-A-S-S-I-E.

This State Health Improvement Plan articulates strategic issues of compelling importance that were identified in the four assessment modules.

The planning team representing public, private, and voluntary sectors, with the assistance of the Illinois Public Health Institute, should be commended for its comprehensive assessment. The findings articulated in the strategic issues are of compelling interest and importance to public health in Illinois.

Outcomes and strategies, when implemented, will improve the health of the Illinois population and the effectiveness of the public health system; and we collectively will move closer to our vision of a healthy state.

The Lake County Health Department would also urge modification to the "Strategic

Issue: Priority health conditions"; outcome: Alcohol, tobacco and other drugs, which I believe is on page 21 of the report. The suggested modification would be to promote a comprehensive smoke-free law covering all public places in

Illinois. I'll repeat that: To promote the comprehensive smoke-free law covering all public places in Illinois.

In light of the current momentum, wide public support, and the latest Surgeon General's report, it is appropriate for Illinois to go smoke-free. The Surgeon General's report finds that secondhand smoke is even more dangerous than previously thought. It clearly demonstrates that the scientific evidence linking secondhand smoke to lung cancer, heart disease, and respiratory illness, is indisputable, and shows that there are no safe levels of exposure to secondhand smoke and no ventilation systems that can effectively eliminate secondhand smoke exposure. It's the right thing to do for public health in Illinois.

Thank you for your time and attention.

DR. EVANS: Jane Holden.

MS. HOLDEN: Janet Holden, H-O-L-D-E-N.

I am the co-chair of the Illinois Injury Prevention Coalition, a group of dedicated injury-prevention specialists from federal, state and local agencies, NGO's and academia.

We are working closely with the

Illinois Department of Public Health to prevent injury in Illinois. Injury is the leading cause of hospitalization and death for all Illinois persons between the ages of 1 to 44.

In Illinois motor vehicle traffic deaths are still the leading cause of injury, death, followed by suicide, poisoning, homicide and falls.

According to the State and Territorial Injury Prevention Directors' Association, no matter how they are measured, in terms of deaths, temporary and permanent disability, years of life lost, or health care costs, injuries take a tremendous toll on our society. Each injury-related death and disability is even more tragic, because so many are preventable with already existing tools. Unlike other fields that await new scientific and technical breakthroughs, injury prevention has

proven strategies ready to be applied.

The IIPC, or Injury Prevention Coalition, is one of our statewide strengths. We are currently writing a strategic plan, a little too late to get into your first plan, but we are

currently writing a strategy plan that, when completed at the end of 2006, will serve as a blueprint for local health departments to prioritize their injury prevention efforts, facilitate the development of secure and infrastructure for injury at the State Department of Public Health, which does not exist at the moment, and be a resource for all injury-prevention specialists within Illinois.

While we applaud the efforts of the SHIP planning team, we have concerns about the findings. In the SHIP plan summary, under "key health status findings," injury and violence are ranked most important.

We are concerned that subsequent to this finding, the word "injury" has been dropped, and "violence" not "injury and violence" is the thread that continues through the rest of the plan.

We are also concerned that the term

"accidents" is used throughout most of the supporting documentation, while we in public health use the terms "unintentional injury" as "intentional injury or violence," and have more many years. The reason this is important to this

is that the word "accident" implied that there is nothing can be done, whereas injuries are preventable, utilizing public health tools.

We ask the Board to consider the importance of injury both in their own research findings in developing the report and as a public health issue, and to "injury" along with "violence" as a priority health condition. We ask the Board to maintain the use of the term "injury" and "violence," when addressing this first-ranked issue throughout the plan.

By incorporating this change, the State Health Improvement Plan will become a much more useful tool in addressing the health of our residents. Thank you.

MS. MONAHAN: Kathleen Monahan, M-O-N-A-H-A-N. I'm speaking on behalf of Jenifer Cartland. That's Jenifer with one N, C-A-R-T-L-A-N-D, at Children's Memorial Hospital.

I will restrict my comments to the section of the draft State Health Improvement Plan focusing on data and IT issues.

In my capacity as the director of the Child Health Data Lab at Children's Memorial

Hospital in Chicago, I have had the opportunity to work hands-on with a number of Illinois Department of Public Health data systems during the last seven years. We have also worked with data from a wide range of non-IDPH data systems, such as data from the Medicaid, food stamp and child protection programs in Illinois. We use these data to help community leaders, policymakers, clinicians, and researchers identify ways to improve the well-being of children and adolescents in Illinois.

The Child Health Data Lab has also worked hard to improve public health data in the State of Illinois.

By gaining philanthropic support on behalf of IDPH, we are building the Illinois Violence Death Reporting System, which combines vital statistics, Medical Examiner and crime lab and police data. And we continue to distribute our analysis of youth injury, the SCRIPTS report, state

and community reports on injury-prevalent and targeted solutions.

Every day I witness the power of public health data when they are put properly into action. And every day the Child Health Data Lab

shares the costs of developing usable data for the State of Illinois.

Hence, it is with great appreciation for both the need for these data and the hard work of many agency data experts that I present my abbreviated remarks.

The Illinois State General Assembly passed legislation in 2006 to establish the Illinois Health Survey Task Force. The task force is charged with examining the feasibility of performing a survey similar to the California Health Interview Survey, in Illinois.

The Child Health Data Lab is assisting the task force in its efforts to examine the costs and benefits of such a data system for Illinois.

I ask the Board to expand its data and IT goals in three ways. First, I ask the Board to consider other means besides data linkage, to

cost effectively provide data to policymakers, community leaders and agency staff.

An Illinois Health Survey would be one additional tool to investigate. I am confident that there are others.

Second, I ask the Board to adopt standards, such as reliability, timeliness, and flexibility, that would help determine whether data systems warrant public investment. Employing such standards I believe will assure that the data that results from the Board's efforts will confidently drive public health policy for the State of Illinois.

Third, I ask the Board to develop a means for public officials, agency staff, philanthropy organizations, and university faculty to collaborate in developing the best possible data system for the health needs of Illinoisians. In my experience, the combined efforts of these individuals can lead to powerful and exciting possibilities.

Thank you very much. And expanded written comments will be submitted.

MR. WILLIS: My name is J. Thomas Willis,

first initial J., as in John, middle name Thomas, last name Willis, W-I-L-L-I-S. I am a 22-year full-time firefighter and paramedic with the Lombard Fire Department. I'm also the 4th District vice president of the Associated Firefighters of

Illinois representing full-time union firefighters, fire officers and EMT's at all levels in Kane, Kendall, DeKalb, Will, Grundy and DuPage counties. I also chair the EMS committee for the same association. I sit on the International Association of Firefighters, the EMS committee representing the 8th District, which is comprised of Illinois, Indiana, Michigan, Ohio and Kentucky. I also am a member of the State of Illinois Advisory Council for EMS, and the EMS for Children Advisory Council.

In my 22 years I have seen numerous changes in prehospital fire-based EMS from new innovations in medication therapy by a vasic defibrillation and the use of latex gloves, all these changes for betterment of citizens we are sworn to protect and those that serve them.

Unfortunately, as many beneficial advancements that have been introduced, there have

been as many changes to the detriment of those we protect and those that protect them. Even if not a detrimental change, no change or stagnation can be just as harmful. The state of prehospital, fire-based EMS in the State of Illinois is sound,

but can always be improved.

Fire-based EMS on average provide 70 percent of the fire department or district's total annual calls, oftentimes, with minimal personnel or skill (inaudible) from other apparatus to provide the immediate response needed.

Full-time fire-based EMS is always on the job and ready to respond within two to three minimums of dispatch. This provides all our patients the best chance for a positive outcome, providing there are enough ambulances and proper coverage areas and enough personnel to man those ambulances.

Municipalities that provide these services have to be willing to fund the departments that provide the services to those citizens.

Volunteers and paid-on-call accommodation departments are not the answer, due to the delayed response, the continued change of

personnel, and the lack of a true command system which -- with a means of progression and advancement in employees career.

The full-time fire-based EMS and firefighting personnel have stability in their

department and the citizens has stability in their response network.

The average firefighter/paramedic is employed by the same municipality for 25 to 30 years. The knowledge gained and passed on to those that are hired to replace those that are retired is invaluable to those they work with as well as those they work for. The ability to have an employee for that amount of time versus one that is at will or at whim provides a more cohesive unit. In addition, these career fire-based EMS personnel have the advantage of knowing the community that they serve both in understanding the physical streets and the people that live there.

Because of unique variances and respective EMS systems, SOG's, or standard operating guidelines, it is even more vital to maintain continuity in the EMS personnel.

Prehospital, fire-based EMS

personnel are not doing the same job we did 20, or even 10 years ago.

When you call for the ambulance, or the foam owner (phonetic) as it was called so many times in different locales, it was because of a

traffic accident, a motor vehicle crash, or someone that was living alone and truly had no one to check up or care for them or to get them to the hospital, so their own primary care physician can continue care in the hospital following a short evaluation in the emergency room.

Today the role of prehospital fire-based EMT has changed as much as it is -- has for the emergency room in the hospital.

Due to the rising costs of health care in our state and the nation, and the subsequent rise in the cost of health care insurance, a larger majority of people that used to have health insurance either through their plan employment or on their own, can't afford it anymore. This has become burdensome on many levels.

The insurance industry is burdened by attempting to provide the same coverage we have

come to expect at the same cost over the decreases in revenue for fewer insurees. The hospitals are burdened with a larger number of patients utilizing the emergency room as their primary care physicians.

The prehospital, fire-based EMS system is burdened with the increase in calls that the average citizen used to drive themselves to the hospital, or talk to their primary physician and get advice to treat themselves at home, or be advised to come into their office.

Since the growing trend of less and less people being able to afford health care --

DR. EVANS: Can you quickly get to your recommendation? Or we can come back to you to testify at the end of the testimony.

MR. WILLIS: My recommendation would be on the workforce issue.

Recruitment and retention issues statewide are more in the forefront than ever. Rural areas, as well as high school graduates, or graduates with an associate's degree in fire science are looking at this career as burdensome, especially with the lack of a statewide

certification and licensing test that we've had to deal with over the last three years.

DR. EVANS: Thank you, sir.

MS. SHAW: Interesting.

MR. BLEHART: Good afternoon. My name is

Bruce Blehart. And that's spelled B-L-E-H-A-R-T. I'm a member of the Board of directors of the Chicago End of Life Care Coalition, the CECC. We are a membership group that works to advance the conviction that people should expect excellent care at the end of life and that health care institutions should be able to meet this expectation.

Now, one week ago I was sitting at a local ICU, at a friend's bedside, when equipment came rolling in to be used in performing a flexible sigmoidoscopy. Now, the patient was a frail, elderly woman, barely alert, who clearly was in the last week of her life. Aside from being a patient, she was one of the first female attorneys in Illinois, one of the founders of the ABA's health law section, and one of the smartest people I have ever known. I asked my friend if she wanted them to perform this invasive test, and she clearly said

"no."

I explained this to the physician, who wanted to know what authority I had to refuse the test for the patient. Rather than answer that question, I suggested he ask the patient, who

clearly understood what this test entailed, and was totally capable of self-management. Needless to say, the equipment left the room unused.

I tell you this as a prelude to three important points relating to self-management that are missing or in need of greater clarification in the proposed plan. First, the importance of self-management should be expressed more strongly; second, palliative care needs should be included in the discussion on access; and third, the role of the public as the beneficiaries and partners in advancing public health needs should be incorporated into the final plan.

In addressing the potential roles for, quote, each sector of the public health system, end quote, the proposed plan identifies ten sectors, without identifying any role for a public sector.

We can go forward and forget the

public. Each of us, as well as our family members and everyone else, constitutes those who need and receive health care services, including palliative and end-of-life-care services.

The CECC believes that the public

must be included as an added sector of the public health system. This will be an invaluable tool in recognizing and identifying the role of individual, effective self-management, and this will help address the one essential identified in the plan as "not met," the development of policies and plans to support individual and statewide efforts.

Advancing the health of the public is a very broad subject. From birth to death, the range and quantity of health care experiences and services and individual encounters are voluminous.

Our concerns, that the document fails to address the reality that patient needs often shift from cure to care, and that self-management includes the decision to seek palliative care.

Palliative care is a very different concept from even long-term care, and it must be included in the identification of services for

necessary access.

In conclusion, and in support of these points, we have submitted testimony proposing specific language for nine potential changes for incorporation of the final version of the State

Health Improvement Plan.

The CECC appreciates your attention to our views and recommendations. Thank you.

DR. EVANS: Thank you, sir. I'd like to thank the last five speakers. Our next three speakers in order are Patricia Canessa -- Linda Kaste and Joe Hollendoner.

I also recognize that there are perhaps some individuals who are intending to speak who have perhaps not signed in as yet.

Are there any such individuals who are planning to speak but have not yet signed in?

(NO RESPONSE.)

DR. KASTE: Hello. I am Dr. Linda Kaste from the University of Illinois College of Dentistry. I am an epidemiologist, and a dental public health specialist. I just would like to raise concern about the capturing of health priorities as appear in the report and in the plan

especially concerning oral health.

As a contrast to the report, I'd like to point out the World Healthy People 2010 report for oral health, because in the top five priorities by organizations and specifically in the

midwest region.

Paraphrasing from the report, oral health is increasingly recognized as a serious rural health problem.

National rural areas record higher rates of people 65 and older with total loss than do their urban counterparts.

Shortages of dentists are more common in rural areas. Dental care as measured by dental visits within the past year tend to be lower among adults in rural areas than in urban areas. And dental shortages are identified as a major rural health concern among the state offices of rural health.

Oral health is named by over 50 percent of national and state experts as a rural health priority, just behind access to care and mental health.

Thank you. And I will provide a

more expanded written comment.

COURT REPORTER: Excuse me, Doctor. Will you spell your name?

DR. KASTE: K-A-S-T-E.

MR. HOLLENDONER: Hello, my name is Joe

Hollendoner, H-O-L-L-E-N-D-O-N-E-R. And I'm the director of youth services at Howard Brown Health Center, and will be representing the Coalition for Education on Sexual Orientation.

The Coalition for Education on Sexual Orientation, CESO, is a 48-member statewide coalition in Illinois working to ensure the safety and well-being of lesbian, gay, bisexual, and transgender youth in Illinois schools through education, public policy, research and youth involvement.

CESO fully supports the State of Illinois in its assessment and planning for state health improvement, and is providing this oral commentary with the hopes of further improving the current plan.

The goal of the assessment to develop a set of measures that broadly communicate the health profile of Illinois' population remains

unmet, due to the lack of inclusion of sexual orientation.

Page 10 of this summary plan indicates that many other factors were included in the attempts to collect data, with sexual

orientation being glaringly left out.

The Healthy People 2010 with leading health indicators and objectives used to guide -- used to guide this Illinois work include sexual orientation in 33 objectives.

Local and national data consistently show that the correlation between identifying as lesbian, gay or bisexual and increased adverse health outcomes, including, but not limited to, depression, suicide attempts, being a victim of sexual assault, HIV infection, and substance abuse.

While further data collection such as further state health improvement plan is always needed to further clarify the correlation, the data that is available right now makes clear how important it is to consider sexual orientation as a factor in health status in individuals and populations.

Because sexual orientation is left

out of the assessment process, it is absent from any of the outcomes defined in the plan.

CESO is pleased to provide a list of specific areas of the plan where sexual orientation is clearly missing. However, sexual orientation

needs to be included as an important category throughout all phases of assessment, planning, and evaluation, in order to be fully represented.

Strategic issue of access are -- our recommendations are the intermediate outcome needs to also guarantee that cultural competency is inclusive of sexual orientation.

Strategic issue of data and IT. The intermediate outcome needed to guarantee that any and all data collection systems are inclusive of sexual orientation. This will ensure that any evidence supported programs in Illinois is inclusive of sexual orientation as a factor in health status and will thus impact all of the outcomes and actions in this issue.

Strategic issue disparities. The description of this issues does not include sexual orientation, even though it is well-known as a factor of health status. The list needs to be

expanded to include sexual orientation so that all outcomes and actions within this issue will include sexual orientation.

Priority health conditions. There are 33 Healthy People 2010 objectives that

reference sexual orientation needs to be consulted in order to understand the unique connection between identifying as lesbian, gay or bisexual and adverse health outcomes in these areas. For example, the Chicago Youth Risk Behavior survey results from 2003 indicate that youth who identified as being lesbian, gay or bisexual, when compared with a non-gay peers, were ten times more likely to have used heroin, seven times more likely to have used meth; six times more likely to use cocaine regularly; nine times more likely to have used needles to inject drugs; three times more likely to have carried a weapon to school; almost four times more likely to have been requiring medical attention; and more than three times more likely to have been victims of sexual assault.

Finally, strategic issue workforce. The plan must also ensure that the definition of cultural competency is inclusive of sexual

orientation.

And finally, just on gender identity, gender identify to one's understanding about whether one is female, or male, or both, or neither, regardless of one's biological sex.

Transgender is an umbrella inclusive of transsexual that refers to people whose gender identity is different from their biological sex at birth.

This idea of the population that identifies as transgender is understudied, and, thus, left out of the most health-related assessments and planning.

CESO highly recommends that gender identify is added to the list of categories for which Illinois will collect health-related data. And I'll also be submitting a written document with more detail.

MS. SHAW: Thank you.

DR. EVANS: Thank you. Next we have William Baldyga and Matt Maloney.

MR. BALDYGA: I am William Baldyga, B-A-L-D-Y-G-A. I'm the associate director for the Institute for Health Research and Policy at the

University of Illinois at Chicago.

I would like to commend the State Board on their fine work, and thank them for their efforts to improve the public health systems and priorities in Illinois. And I would like to ask

that, among the considerations that are included in future work, the effort to communicate more clearly about the power of prevention in public health to achieve these objectives, either by making that a priority in future iterations of the report, or by incorporating that, perhaps, within each of the priority areas.

I think we have a long way to go to build a constituency for public health. And you have an opportunity to greatly assist in that function.

My second impromptu comment is with regard to your efforts to make this a live document, and to review this report regularly, and provide updates to us about its progress.

And I implore you to also think about including in those future reports the responsibilities and the duties of public and private bodies and agencies to achieving these

objectives and clearly demarcating who is responsible for the improvements that we all hope to see. And I think that perhaps, with that kind of inclusion, we can monitor what we have achieved and what we still need to achieve.

I think Steve Whitman has clearly shown that Healthy People 2010 only goes so far in identifying health disparities. And we need a much more targeted effort, if we are going to actually improve those disparities. Thank you.

DR. EVANS: Thank you.

MR. MALONEY: Good afternoon. I am Matt Maloney. I'm the director of health policy at the American Lung Association Metropolitan Chicago. M-A-L-O-N-E-Y. I want to make two brief points today --

Well, first of all, I want to applaud the planning team and the Board for coming up with this wonderful plan.

The two points on the data and IT, I want to emphasize the need for the legislature to allocate necessary resources for proper (sic) as serving Illinois statewide. And the second point I'm echoing what was earlier, on the priority

health condition, to support a 100 percent comprehensive smoke-free law statewide. Thank you.

DR. EVANS: The speakers' list that I have has been exhausted.

Is there anyone who wishes to

testify who has not had an opportunity to do so?

Okay. Then I would like to take the names in this order. I see three hands. And if you'd just come up in that order?

MR. GRAHAM: Thank you. I am Bruce Graham, G-R-A-H-A-M. I'm dean of the College of Dentistry at the University of Illinois at Chicago.

My message today, apart from commending the Board and Dr. Whitaker and the Governor on having the insight and providing the leadership for initiating this important planning process, apart from that message, my central message is that, of course, that oral health is inseparable from general health and well-being of citizens of Illinois. And I am pleased to see that SHIP recognize this fact appropriately.

The State has the benefit of an existing oral health plan that was released in the spring of 2002. And recently there have been

several well-attended public meetings around the state regarding the development of a follow-up oral health plan. And this oral health plan, as it exists now, and as it will be in its second iteration, I'm sure, fits well into the planning

structure and platform that's provided by the SHIP.

I just want to comment that the development of the oral health plan and much of its subsequent success is attributable to having an excellent state dental health officer. And, as you may know, that position is now vacant. And I would just plead that that position should be filled as soon as possible by a highly-qualified applicant.

I would like to comment that the most recently available data indicate that 56 percent of school-age children in the State of Illinois have experienced dental decay, or caries. Thirty percent of those carious lesions in those children's teeth were untreated. These data place Illinois off the mark, when compared to Healthy People 2010 goals for carious experience in children.

Also, oral cancer rates should be a serious concern in Illinois. The age-adjusted

rates for both genders and all races is 9.3 per 100,000 population, but 23.2 per 100,000 for African-American males. In Cook County it bears a disproportionate share of this oral cancer burden.

Recent research has indicated --

suggested linkages between periodontal or gum disease and diabetes, premature births and cardiovascular disease. And there's a lot of research ongoing across this country and around the world to confirm these correlations, or disconfirm them in.

In the context of the SHIP's objective to improve access to care and to strengthen the public health care system in the state, the UIC's call to dentistry is placing its senior dental students into community clinic sites for 60 days of their education for service-learning experiences in those clinics. These community clinics are located in the greater Chicago area and as far as away as Rockford.

In this way, we project that nearly 20,000 distinct dental services will be provided to nearly 8,000 Illinois patients this year, who would not otherwise have been able to access dental

health care.

It is our expectation that these experiences will help our dental students better understand the issue of access to oral health care, and prompt them to devote time in their careers to

provide care to underserved citizens of Illinois, and to their communities.

In keeping with SHIP's workforce strategies, we are also tracking our graduates in order to assess their career choices and their modes of practice.

Please consider our college of dentistry as a partner in strategies to improve health in Illinois. Thank you very much.

DR. LEE: Good afternoon, everyone. My name is Howard Lee. I'm a pediatrician -- I have been a pediatrician for the past 40-plus years. I try to make as many of these forums as I can. My main topic has always been for years and years: What are we going to do about our lead poison children?

Now, in the --

You can't even get the people to talk about it. Every time I make some kind of

presentation, I get teachers, psychologists and other folks who should know. And I believe they know, they just won't say.

Now, Chicago, as you probably know, has one of the highest lead levels in the United

States. You got Cleveland running second, and Detroit, and Philadelphia, and Pittsburgh. These are just the big ones. So, one thing we can easily say is that in cities with a large minority population you are going to have school problems and you are going to have a bunch of kids going to school loaded.

Now, what I try to do is get people interested enough to look up some of this stuff themselves, so they won't think I am making it all up.

It has been estimated that up to 70 percent of inner-city kids go to school leaded. What we are trying to --

The funny thing about it is that lead poisoning is 100 percent preventable. And yet and still, we don't take the time; we don't take the interest to get rid of it. You only have to get rid of it once. It's not going to die. And

you can't make it.

The next thing I would like to introduce is the fact that we grownups seem to think that once the children have had their bout with it, it's all over. It isn't.

Research is coming out now to implicate the kneecap, your kidneys, your heart, and a bunch of other things, which I don't have time to go into right now.

So, we will be doing ourselves a favor; we will be doing our children a favor; and we will also be doing the City a favor.

As far as the School Board is concerned, they won't even discuss it. But yet and still, up to 70 percent of their students are leaded.

And you will find a large amount of lead in areas where they have reading, math behavior and all this stuff. And they just: Well, you know, behavior you put them on Librium -- not Librium -- oh, boy -- anyway, you put them on the famous drug that I can't think of right now. But it doesn't do anything for them.

It has been determined, by all kinds

of research, that there is no cure for lead poisoning. We have to know that the only option left to us is prevention. And that hasn't been done.

I know I am getting close to my

three minutes, and I'll shut up in a few minutes.

Anyway, I attend these meetings because I would like to stimulate some of the movers and shakers into talking about it. You don't have to do anything, just talk about it. And at least people will know that I am not the only one running around here with my big mouth.

So, hopefully --

Oh yeah. There's one more thing I want to say. When I go to these health fairs, picnics, stuff like that, one of the first things I want to find out is: What are you doing with the kids?

Well, we are doing -- We are immunizing.

I say, what else?

Nothing.

They do not take lead levels on children that will be going to school in a few

20 months. And then the ones that get there,

21 especially from the inner city, this has happened

22 many, many times, the child comes in for a school

23 physical that should have been due last week.

24 So I don't have time to wait around

for Librium (sic) because some of the teachers will put them out. So we have to deal with that too.

I hope you folks take this under consideration as you proceed with your, shall we say, essays on what's happening in the health care system. Thank you very much.

MS. ALCOTTA: Good afternoon. My name is Luna Alcotta (phonetic). I'm a genetic counselor, and I am a coordinator of a chronic disease (inaudible) and genetics prevention program of Illinois Department of Public Health.

It wasn't my intention to testify today, but I did see that in your local health priorities, access to care, cancer and cardiovascular disease have been noted. Reading that, it became obvious to me that it's very important that the value and the importance of family history, for purposes of early detection be recognized in your document. The Surgeon General,

CDC and the NIA have many programs and online accessible family history tools.

The other thing that I think it's important that the availability of presystemic genetic diagnoses be known to Illinoisians. And as

a corollary to that, the importance of LCD, ethical, legal and social implications, such testing also be addressed in the document. Thank you.

DR. EVANS: Thank you. Again, I would ask, is there anyone who would like to testify who has not had an opportunity and who has not yet signed up?

(NO RESPONSE.)

DR. EVANS: I believe that everyone who spoke had an opportunity to exhaust their comment.

Is there anyone who would like to come back again to complete any comment that they didn't have a chance to fully complete?

(NO RESPONSE.)

DR. EVANS: I'd like to remind you then to submit your written comments to the staff at the registration so that we have this information for the record. You can also submit written

testimony --

Can we give them the address, or do

I need to read it in --

MS. BASSLER: Sure. It's all on the

Website. And we've extended the deadline for that

to the 17th.

DR. EVANS: All right. You got the e-mail address. Since our meeting is public, and the time for adjournment is 6:00 p.m., and there may be others who come late and wish to testify, I am asking that our SHIP planning team and State Board of Health members stay on.

If there are members of the audience that would like to talk with any of us, that's quite possible as well.

And we will adjourn at our appointed hour at 6:00 p.m. I appreciate everyone's attendance, everyone's comments. Thank you very much.

WHICH WERE ALL THE PROCEEDINGS
HELD ON THE ABOVE-MENTIONED DATE
IN THE ABOVE-ENTITLED MATTER.

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I, Tonja R. Jennings Bowman, a Certified Shorthand Reporter, doing business in the County of Cook and State of Illinois, do hereby certify that I reported in machine shorthand the proceedings in the above-entitled cause.

I further certify that the foregoing is a true and correct transcript of said proceedings as appeared from the stenographic notes so taken and transcribed by me, this 15TH day of AUGUST, 2006.

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Tonja R. Jennings Bowman, CSR.

C.S.R. Number 084-00299

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August 10, 2006

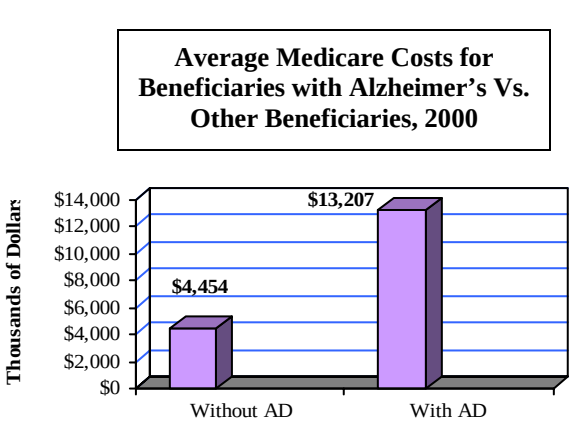
SHIP Public Comment
c/o Zoe Zhang
Illinois Public Health Institute
100 W. Randolph St., Suite 6-600
Chicago, IL 60601

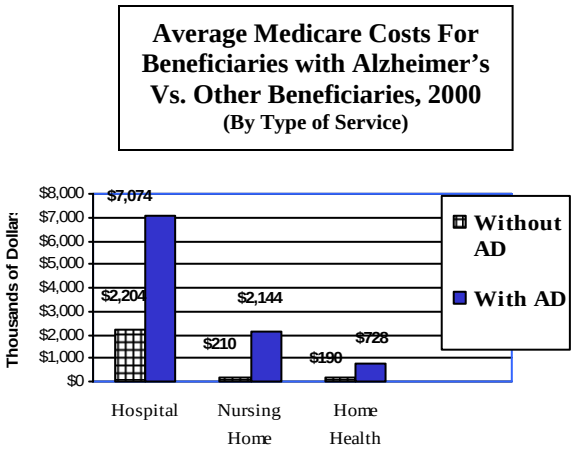
TO: Zoe Zhang

The recently submitted draft State Health Improvement Plan has a focus on many disease states and health conditions and does an admirable job of attempting to set priorities and action steps. However, it has not a word about another health crisis—the crisis of Alzheimer's disease and related dementias. In our opinion, there are four important reasons that Alzheimer's disease must be considered in long term state health planning.

1) **The shear numbers**: At present it is estimated that there are 210,000 citizens of Illinois with Alzheimer's disease, which will grow by 14% in 2025 to 239,000 assuming no cure effective treatment or prevention method is found. That many people would fill Wrigley field nearly 6 times! ("State Specific Projections Through 2025 of Alzheimer Disease Prevalence", Evans et al, Neurology, May 2004)

2) The impact of dementing illness on **health care costs is huge**. For example, Medicare beneficiaries with a dementing illness cost nearly three times more than those without because of their severe cognitive impairment, persons with Alzheimer's disease with other chronic and co morbid conditions are more expensive to the overall health care system.





Source: Centers for Medicare & Medicaid Services, FY 2000 Medicare claims data for a 5% random sample of Medicare beneficiaries

Finding new and better ways to factor in the hidden extra cost of dementia in health care would be an important health care goal.

3) The hope for effective dementia prevention strategies that very closely align with other primary prevention strategies detailed in this report **is real**.

It is estimated that 85% of what is known about Alzheimer's disease has been discovered in the last 15 years. Though primary prevention research is in its infancy, there is a growing body of evidence to suggest that **heart health, diet and exercise, and mental and social activities play important roles in preventing dementia and Alzheimer's disease.** (See http://www.alz.org/maintainyourbrain/science/overview.asp) for a detailed scientific review of the evidence on all three.

The federal Center for Disease Control has initiated an Alzheimer's Prevention program in the last 15 months; it might be time for Illinois to consider the same.

4) Many persons with Alzheimer's disease need access to **high quality skilled nursing** home care. It is estimated that as many as two thirds of nursing home patients have Alzheimer's disease or some other untreatable dementia. (See attached fact sheet) The department has a major role in enforcing laws and regulations that protect health and ensure safety (Essential Public Health Service – EPHS-- #6) for this vulnerable population.

Further, as **health care workforce issues** (EPHS 8) are considered a vital strategic issue in this report, it would also be desirable to think about the long term care workforce on whom institutionalized persons with dementia rely.

In conclusion, given the lead responsibility of the Illinois Department of Public Health and the Illinois State Board of Health to develop state public health system policies and plans that support individual and statewide health efforts (EPHS #5), the Alzheimer's Association would like to recommend that an appropriate task force be established to create a linked state Alzheimer's plan. The Association stands ready to work with the Department, Board and Institute to investigate and work toward resolution of the major health problem of Alzheimer's disease in Illinois. We are anxious to continue our work on behalf of responsive, accessible, safe and available services and treatment of Illinois citizens with Alzheimer's.

Thank you for the opportunity to offer comments.

Sincerely,

Judy Buchanan *G. Kent Barnheiser*

Judy Buchanan
Chair, Alzheimer's Association
Illinois Chapter Network

G. Kent Barnheiser
President/CEO
Greater Illinois Chapter

JB/eec
enc

Prevalence of AD – Nursing Homes
Special Care Units

alzheimer's association

PEOPLE WITH ALZHEIMER'S DISEASE AND DEMENTIA IN NURSING HOMES

It is generally acknowledged that at least half of all nursing home residents have cognitive impairment consistent with dementia, but many of these residents do not have a documented diagnosis of Alzheimer's disease or another dementing illness. In 1999, only 12% of all nursing home residents had a primary diagnosis of Alzheimer's disease or dementia.[1]

The latest figures from the required Minimum Data Set (MDS) assessment show that in 2001, 46% of nursing home residents had moderate to severe cognitive impairment, and 26% had mild cognitive impairment.[2] Given these figures, one could estimate that on any single day in 2001, there were 750,000 nursing home residents with moderate to severe cognitive impairment and 420,000 additional residents with mild cognitive impairment.

ALZHEIMER'S/DEMENTIA SPECIAL CARE UNITS IN NURSING HOMES

Rapid growth in the number of Alzheimer's/dementia special care units began in the early 1980s. By 1996, 13–19% of nursing homes had one or more special care units, and these units contained a total of 73,000–100,000 beds.[3,4] Combining 1996 figures showing that 48% of all 1.6 million nursing home residents had dementia[5] and the figures above for the number of beds in special care units, one could estimate that in 1996, only 10-13% of all residents with dementia were in a special care unit. The remaining 87-90% of residents with dementia would have been in traditional nursing home units.

Government data indicate that in 2001, there were 90,300 beds in Alzheimer's/dementia special care units, and this number increased to 92,400 in 2003.[6] Thus, growth in Alzheimer's/dementia special care unit beds has slowed or stopped.

Combining the figure above for the number of special care unit beds in 2003 (92,400 beds) and the number of residents with dementia from the same data source (about 700,000 residents), one could estimate that in 2003, only 13% of all residents with dementia were in a special care unit. The remaining 87% of residents with dementia were in traditional nursing home units. These figures are not exact but do make the point that most nursing home residents with Alzheimer's disease and other dementias are not in Alzheimer's/dementia special care units.

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[1] Jones A, *The National Nursing Home Survey: 1999 Summary*, National Center for Health Statistics, 13(152), 2002.
[2] Centers for Medicare and Medicaid Services (CMS), unpublished data provided by CMS, Feb. 4, 2003.
[3] Krauss NA, Freiman MP, Rhoades JA, et al, "Nursing Home Update—1996: Characteristics of Nursing Home Facilities and Residents," *MEPS Highlights*, No. 2, Agency for Health Care Policy and Research, Rockville, MD, July 1997.
[4] Leon J, Cheng CK, Alvarez RJ, "Trends in Special Care: Changes in DSCU from 1991 to 1995 ('95/95 TSC)," *Journal of Mental Health and Aging*, 3(2):149-168, 1997
[5] Krauss NA, and Altman BM, Characteristics of Nursing Home Residents—1996, *Research Findings*, No. 5, Agency for Health Care Policy and Research, Rockville, MD, December 1998.
[6] Nursing Facility Special Care Beds: CMS OSCAR Data Current Surveys: December 2003, accessed 4/9/04 at http://ahcaweb.org/research/oscar/rpt_special_care_beds_200312.pdf.

August 17, 2006

Illinois State Board of Health
SHIP Public Comment
c/o Zoe Zhang
Illinois Public Health Institute
100 W. Randolph St., Suite 6-600
Chicago, IL 60601

Members of the Illinois State Board of Health:

I am writing to submit comments on the Illinois State Health Improvement Plan. While we appreciate the thorough research that went into the development of this plan, the Ounce of Prevention Fund is concerned about the lack of focus on outcomes and strategies addressing the maternal and child health population within the six strategic issue areas and the four strategic health priorities.

Given the mandate by P.A. 93-0975 to develop a "prevention-focused" State Health Improvement Plan (SHIP), a more prominent focus should be placed on those interventions that target Illinois' citizens in the earliest months and years of life – pregnant women and young children.

Additionally, given that the planning committee ranked maternal, infant and child health to be one of the three most important categories to address (State Health Improvement Plan summary p. 11), it is surprising that this category was not among the final list of four priority health conditions.

Within the context of the draft plan, we submit the following specific additions to the existing outcomes and strategic actions to enhance the focus on maternal and child health and mental health issues.

Strategic Issue: Access

- Add to intermediate outcomes:
    - An increased number of providers are trained in providing mental health services to children age birth to five and their families.

Strategic Issue: Data and IT

- No comments

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Strategic Issue: Disparities

- Add the following intermediate outcomes:
    - The public health system and partners are engaged in strategies to decrease disparities in birth outcomes (i.e. prematurity and low birth weight).

Strategic Issue: Measure, Manage, and Improve the Public Health System

- No comments

Strategic Issue: Priority Health Conditions

Outcome 1: Alcohol, Tobacco, and Other Drugs (ATOD)

- Add an intermediate outcome as follows:
    - Reduce cigarette smoking by pregnant women
    - Reduce the proportion of pregnant women using elicit drugs
    - Reduce the proportion of pregnant women engaging in binge drinking of alcoholic beverages

Rationale: Pregnant women require different types of interventions than other populations. Successful interventions with this population provide benefits for women and their infants.

Outcome 2: Obesity

- Add an intermediate outcome as follows:
    - Increase rates of breastfeeding initiation and breastfeeding rates 6 months post-partum.

Rationale: Research has shown that breastfed babies are less likely to be overweight or obese.

- Add strategic actions in "Health Care Providers" and Local health Departments" as follows:
    - Provide comprehensive nutrition counseling to pregnant women.
    - Provide education on benefits of breastfeeding and supportive services for breastfeeding mothers including increasing access to lactation counseling.

- Add strategic actions in "Business" as follows:
    - Implement policies and procedures to support breastfeeding mothers when they return to work (i.e. lactation rooms, breaks for breast pumping).

Outcome 3: Physical Activity

- No comments

Outcome 4: Violence

- Add the intermediate outcomes:
    - Increase the availability of trauma-informed intervention and treatment services for children who have been exposed to violence
    - Increase the availability of supportive services for pregnant women experiencing domestic violence.

Outcome 4: Violence continued

- Add to strategic actions in "Multiple Sectors" and "State Agencies":
    - Fund and implement a range of mental health intervention and treatment services that are trauma informed for children and women who have been the victims of violence.

Rationale: The focus in this section of the State Health Plan is on the reduction of violence, but not on the response and recovery of children who have been exposed to violence. Research shows that children who have been exposed to violence are significantly at risk for developing the following: major mental illness, substance abuse, AIDS and sexually transmitted diseases, impaired physical health, and developmental disabilities (Felitti, Anda, et. Al, 1998). This study showed that exposure to trauma as a child has an increased correlation with smoking, adult alcoholism, chronic depression, obesity, and the likelihood of dropping out of high school. Specifically, it showed that the odds for major depression increased nearly two-fold and is associated with poor response to antidepressant medication and poor overall treatment outcomes. It also showed that exposure to trauma increases the risk for alcohol and drug abuse in adolescents and is the best predictor of drug and alcohol abuse in women, as well as being associated with poor treatment outcomes and increased treatment drop out.

In addition, violence can severely impact pregnant women. Research shows that violence not only puts pregnant women and their unborn children at risk of serious physical injury or death, but it also has serious psychological impacts, such as increased depression and addiction to tobacco, alcohol and drugs, which will also have negative outcomes on their children. A 2001 study published in the Journal of the American Medical Association found that homicide was the leading cause of death for pregnant women; while a CDC household survey (1998) found that pregnant women are 60 percent more likely to be beaten than women who are not pregnant. Violence is cited as a pregnancy complication more often than diabetes, hypertension or any other serious complication. A study specifically in Cook County found that 26 percent of the deaths of pregnant women recorded between 1986 and 1989 were due to homicide.

Strategic Issue: Workforce

- No comments

Thank you for consideration of these comments and suggestions. I look forward to seeing the next version of the State Health Improvement Plan. If you have questions please feel free to contact Karen Yarbrough of the Ounce of Prevention at 312.922.3863 x505.

Sincerely,

Harriet Meyer
President
Ounce of Prevention Fund

COMMENTS ON THE STATE HEALTH IMPROVEMENT PLAN
Illinois State Board of Health
August 9, 2006

Jenifer Cartland, PhD
Director
Child Health Data Lab
Children's Memorial Hospital
Chicago, IL 60614

Thank you for the opportunity to provide comments on the Illinois State Board of Health's important effort to establish goals and procedures for improving the health of Illinois residents. I will restrict my comments to the section of the draft State Heath Improvement Plan focusing on Data and IT issues.

In my capacity as the Director of the Child Health Data Lab at Children's Memorial Hospital in Chicago, I have had the opportunity to work hands on with a number of Illinois Department of Public Health data systems during the last seven years; we have also worked with data from a wide range of non-IDPH data systems, such as data from the Medicaid, Food Stamp, and child protection programs in Illinois. We use these data to help community leaders, policy makers, clinicians and researchers identify ways to improve the wellbeing of children and adolescents in Illinois.

The Child Health Data Lab has also worked hard to improve public health data in the State of Illinois. By gaining philanthropic support on behalf of IDPH, we are building the Illinois Violent Death Reporting System (which combines vital statistics, medical examiner, crime lab and police data), and we continue to distribute our analyses of youth injury (State and Community Reports on Injury Prevalence and Targeted Solutions, or SCRIPTS). Finally, we have recently received a seed grant to explore the feasibility of developing an Illinois Health Survey, which would collect data on a wide range of health challenges for Illinoisans every two years.

Everyday, I witness the power of public health data when they are put properly into action, and everyday, the Child Health Data Lab shares the costs of developing useable data for the State of Illinois. Hence, it is with great appreciation for both the need for these data and the hard work of many agency data experts that I present my remarks.

While I applaud the suggestion to create an inter-agency linked data system that would be widely accessible across the State of Illinois, I have several concerns about this approach. These concerns relate to Reliability, Timeliness, and Flexibility of the resulting data.

Reliability: In linking data in our office among two hospital-based data systems, we find a reliable linkage very difficult to achieve. This is because name, address, birth date and other information used to link data are often entered into the system incorrectly. If reliability is hard to achieve with data that are gathered in the *same hospital* for the *same patient* at the *same time*, how much more difficult is it to link data gathered by multiple agencies for different events at different times? Pilot studies to examine error rates in the linkages are

needed to gauge the extent to which data linkage can be a reliable means of optimizing the use of currently collected data.

Timeliness: There is generally a four to five-year lag from the time data are gathered by the agency, made available to us, cleaned and presented to policy makers. This is the case when the data are uncomplicated from a linkage or an analytic point of view. For many public health issues, this lag time means that data are no longer relevant by the time they are put to use. A successful data system must address the lag time between the collection of the data and the release of findings, with the goal of releasing findings within one or two years of collection.

Flexibility: Many of the data systems we rely on in our work were originally created for wholly different functions; changing them to meet current needs, we are told, is not feasible. Thus, we have many data systems that provide very little information that policy makers currently need and not many that can be adapted to changing needs. A successful data system must be able to be flexible enough to monitor emerging health challenges, as well as shouldering the burden of sunsetting data systems with low public utility.

Illinois is not the only state facing these challenges. Many states find themselves wondering how to optimize the data they have on hand, and how to efficiently and cost-effectively provide policy makers, community leaders and agency staff with the information they need to move forward. What can we learn from other states' experiences?

I would like to take this opportunity to give an example of a data system that was created in response to these very issues, the California Health Interview Survey. The California Health Interview Survey is a population-based survey of Californians that permits county-level estimates of a very wide range of health conditions and health needs. It is now in its third wave of data collection and is considered a model for other states. What does the California Health Interview Survey do right?

- *Timeliness* of data is assured by two means – conducting the survey every two years and committing 25% of the funding for the survey to data analysis and dissemination
- The survey contains sections that are repeated with each wave to reveal long-term trends; and it contains sections that change each wave to respond to emerging challenges – thus assuring that it is *flexible*
- It is conducted in such a way to provide *locally relevant* data, so that policy makers at all levels of government have data at their disposal
- It is the result of a partnership between the state health department, a leading university, and funders from the public and private realms, building on the strengths of each partner
- It has been integrated into other data systems in the state so that it does double-duty and is cost-effective by reducing redundancy among agencies

The Illinois State General Assembly passed legislation in 2006 to establish the Illinois Health Survey Task Force. The Task Force is charged with examining the feasibility of performing a similar type of survey in Illinois. The Child Health Data Lab is assisting the Task Force in its efforts to examine the costs and benefits of such a data system for Illinois.

I ask the Board to expand its Data and IT goals in three ways. First, I ask the Board to consider other means, besides data linkage, to cost-effectively provide data to policy makers, community leaders and agency staff. An Illinois Health Survey would be one additional tool to investigate. I am confident that there are others.

Second, I ask the Board to adopt standards – such as reliability, timeliness and flexibility – that would help determine whether data systems warrant public investment. Employing such standards, I believe, will assure that the data that results from the Board's efforts will confidently drive public health policy for the State of Illinois.

Third, I ask the Board to develop a means for public officials, agency staff, philanthropy organizations, and university faculty to collaborate in developing the best possible data system for the health needs of Illinoisans. In my experience, the combined efforts of these individuals can lead to powerful and exciting possibilities.

By incorporating these changes, the State Health Improvement Plan will become a powerful and enduring tool to face emerging health challenges.

Thank you very much for your time today and for your continued efforts to improve the health and wellbeing of youth and adults in Illinois. Should the Board decide to develop an interdisciplinary group to collaborate on data issues, I will be happy to assist with developing a list of prospective participants.

Contact Info:

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Council for Jewish Elderly (CJE) appreciates the opportunity to provide input on the State Health Improvement Plan.
Established in 1971, CJE today provides a continuum of care to over 12,000 individuals throughout metropolitan Chicago area annually, in an effort to achieve its mission of promoting the dignity and independence of older adults and enhance their quality of life. At CJE, we fulfill this mission and realize our vision by striving for excellence through respect, advocacy, compassion, intention, and accountability. A broad range of in-home and community services designed to help older adults maintain their independence in the community for as long as possible are carried out by 878 highly skilled employees, from medical professionals to researchers, administrators, activity personnel, in-home workers, bus drivers, and many others. CJE also offers a variety of residential care options, including subsidized housing, assisted living, and skilled nursing care. In addition, CJE has a geriatric psychiatry program affiliated with Northwestern University, as well as a full array of social work staff and counselors. Services are provided to Jewish and non-Jewish older adults from all income levels. The broad range of high demand services provided by the agency is a distinguishing characteristic of CJE. The core philosophy of CJE is its dedication to quality programs and services for older adults, their families and caregivers, which are based on respect for the individuality, dignity and independence of each person served.

CJE supports the Plan's vision of optimal physical, mental and social well-being for all people in Illinois. We are pleased to note the Plan's recognition of the role of community based/faith based organizations and encourage the State to include organizations such as CJE in partnership arrangements as public health initiatives are developed. CJE has a depth of experience in prevention based programming for older adults as well as helping individuals deal with chronic illness. While we are pleased at the prevention focus of the plan we are very concerned about the lack of funding to support this type of an effort. We strongly encourage the State to facilitate the availability of funding to sponsor these programs throughout Illinois through senior centers, independent apartments and assisted living facilities. We also suggest that prevention become a part of the IDOA chore housekeeping and IDPH home health care agencies for to meet the needs of the homebound elderly. The plan does not address the issue of undiagnosed dementia in older adults. Initiatives are needed to assist internists and family practitioners to recognize and address this issue.

Again, CJE appreciates the opportunity to comment on the State Health Improvement Plan.

Contact:
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August 22, 2006

To Whom It May Concern

Dear Sir or Madam:

Thank you for the opportunity to comment publicly on the proposed State Health Improvement Plan. My comments are as follows:

Grammer Issues

Page 9 under *Eleven key findings…* third dot point
Actions are not nouns. Reducing risk factors cannot be a tool.

- Page 11 under *Choosing Priority Health Conditions,* first dot point
  Should read: Have a large impact/affect on a number of other conditions

- Page 13 under *The intermediate outcomes…* eighth dot point, *Financing systems…*
  This statement is incomplete

- Page 21 under *Local Governments*
  This dot point should read: Encourage/pass smoking bans in places of public accommodation

- Page 25 under *The intermediate outcomes…*third dot point, *More bilingual and multi-lingual*…
  This statement is redundant. Multi-lingual would suffice.

Content Issues

- Page 13 under *Strategic issue: Access*
  The difference between health care, public health, access to health care, access, and access to prevention seems to be blurred. Suggest that "health system(s)" be substituted or that access to health care and public health services be addressed separately.

- Page 23 under *Violence*
  Why reference Healthy People 2010 objectives, only in this section?

Sincerely,

Mark J. Hilliard, MPH, CHES
Administrator
Logan County Health Department
109 Third Street, P.O. Box 508
Lincoln, Illinois 62656

Response to draft SHIP Plan Summary

David McCurdy

8/16/06

I have several "key issue" comments and a number of smaller-issue, narrower-focus, or editorial comments. I'll begin with the larger-issue comments. For the sake of time, I am addressing the issues I see, rather than the strengths. There is *much* to appreciate in the document, not least the way the 4 "priority health conditions" connect with so much else, as was intended.

Key Issues

P. 2 (and throughout)

"Long-term care services" and aging: Strategic issue #3 addresses access to key areas, including "*long-term care services*." By extension this would seem to encompass at least some health issues related to *aging and aging populations*. The remainder of the document does not, so far as I can see, directly address this set of issues or give much attention to the more specific question of "long-term care." Home care ("personal care") is mentioned in passing with regard to workforce issues in the public health assessment (p. 5). An "aging population" is mentioned as a changing demographic (p. 6). Disparities related to age are mentioned, i.e., at least listed as a potential factor to consider in assessing disparities. Elder abuse is mentioned as a problem of violence (p. 23). But I don't see much else that explicitly or directly takes on population issues related to aging or the narrower question of long-term care.

P. 6 (and beyond)

Poverty and health: The "forces of change assessment" mentions but does not zero in on *economic* issues in *populations* in the "demographic" and "environmental/social" areas. Poverty is mentioned some in the document, but (in my opinion) rather sparingly as a health factor. Lack of insurance and finances appears as an access issue (p. 9). "Socioeconomic status" receives passing mention (p. 10). "Economic factors" are recognized as a determinant of health outcomes, and (I am guessing) may be an ingredient in the oft-mentioned "social determinants" of health in the discussion of disparities (p. 17). An intermediate outcome under the disparities heading does explicitly (and commendably) aim at reducing poverty. But no subsequent item in the discussion of disparities addresses poverty directly.

If poverty is generally agreed to be a key determinant of health for individuals, the economic health of communities/populations would seem to be a prime factor to lift up—especially since the vision of "health" in the document encompasses "social" well-being. I wonder if somewhat more could be said about how a state plan might take into account and address a community's economic status. For example, in the list of things that

"public health partners" might do to help address disparities, might businesses be urged to pay a living wage, or—perhaps more important—to provide adequate healthcare benefits?

P. 23

Violence and mental illness: This concern is narrower, but still a significant one. The next-to-last intermediate outcome under the "violence" heading seems to view growing up with a mentally ill household member as a risk for violence, alongside growing up with substance abuse in the household. It is as if the very presence of mental illness creates a risk of violence in the home or perhaps creates the risk that the young person will become violent later on. Either way, I fear that this way of incorporating mental illness runs the risk of inadvertently stigmatizing it (*an outcome to be avoided*, according to an "Access" action item on p. 14). This association with violence may contribute to a stereotype that mentally ill persons *are*, almost by definition, violent or prone to violence. I am sure that's not the intent here; but I wonder if some or many readers might infer it nonetheless.

Moreover, the association with substance abuse appears to equate mental illness with substance abuse and may further stigmatize mental illness as a result. (Off the top of my head, I'd guess that the connection with violence may be stronger in the case of growing up with substance abuse. There may in fact be data suggesting that the presence of mental illness is somehow associated with violence, statistically speaking; if so, I'd like to see some sort of qualifying language indicating that this association is statistical but that mental illness and persons living with it are not thereby automatically violent or prone to violence.)

Other Concerns and Editorial Suggestions

P. 2

Data strategic issue: The way this issue is stated seems to me a bit oblique and may rob an important issue of its force. I don't know that I have an improvement, but how about something like this:

"Ensuring that policies and programs are grounded in current, adequate data"

(The corresponding question at the top of p. 15 could be reworded in similar fashion, perhaps: *"How can the Illinois Public Health System ensure that policy and program planning and implementation are grounded in current, adequate data?"*)

P. 7

The "interdependent" nature of the medical and public health systems: A great insight to recognize this connection! How, then, can the plan not only recognize but address the need for integration?

P. 10

Under "Key Health Status Findings," 1st line: "Illinois compares favorably to only six of 33 . . . objectives . . . ." I don't follow the grammar here—"compares favorably to" what, or "compares favorably" in what respect, exactly? Perhaps that can be restated for clarity.

P. 11

"Choosing Priority Health Conditions," 4th line: It is not clear just how these criteria for choosing the priority health conditions add up to or "assure" a *prevention*-focused approach.

Also, what is the "ecological" approach named in the bullet points in this section?

P. 12

What is "MCH"?

P. 13

In the introductory paragraph, it is said that health care service needs to "accommodate" the variety of languages and cultures it may encounter. To me, "accommodate" is a weak and passive word here. How about "engage"? Or even something like "show hospitality to"?

Last intermediate outcome: Should "support and analysis of" perhaps read "support an analysis of"? If not, something else is amiss with the wording.

P. 14

Faith-based Organizations: What are some examples of "direct health care service programs" provided by FBOs that the task force might have in mind here?

Educational Institutions: Might these institutions not only evaluate intervention elements but also—and at least as importantly—*teach* such interventions?

P. 17

"Social marketing programs" are mentioned several times—marketing what, exactly?

P. 18

What is the "Community Guide to Preventive Services"?

Please explain "cross-cutting, non-categorical approaches" to the non-specialist.

The reference to "individual sector boxes" is not self explanatory.

P. 20

What is "TA"?

"Annual data compilation" of, or regarding, what?

P. 21

Outcome 1: The long-term ATOD objective is not well worded. Alcohol and tobacco are not always "illegal" drugs, so it won't do to speak of "other illegal drugs" alongside them. Corresponding to this change, the last phrase in the outcome might instead be "the misuse of other legal drugs".

"Health Care Providers": Should the next line read "persons" instead of "person"?

Local Governments": Should the next line read "places" instead of "place"?

P. 22

The reference to a "Logic Model" needs explaining.

"Local Health Departments," 2nd line: Should "reduce" be inserted before "obesity"?

Pp. 22-23

Outcome 3, "Educational Institutions": How can educational institutions "reduce sedentary activities"? That outcome is not in their control. What is the actual intent here?

P. 23

Outcome 4, "Educational Institutions": Should it be "conflict avoidance" instead of just "avoidance"?

"Multiple Sectors," 2nd line: "and services" appears twice in that line.

"State Agencies": Is it always—or even usually—possible for state agencies to "enforce" firearm and violence prevention programs?

P. 24

"Legislature": What would be an example of a "retention" initiative?

LHDs: What is a Learning Management System?

"State Agencies": What is the interstate nursing compact?

Outcome 2, 1st line: Should the last word be "linguistically" rather than "linguistic"?

P. 25

Recruitment for diversity: Although increasing the proportion of minority groups in the healthcare workforce and "reflecting the diversity of the state" show up in the intermediate and long-term outcomes, perhaps the introductory paragraph should also directly express this idea. A sentence that explicitly mentions recruiting for diversity or the like would enhance that narrative, I think.

Partial paragraph at top of page, lines 2 and 4: I would insert "that" at end of 2nd line (after "ensure") and after "guarantee" in 4th line.

"Educational Institutions": Is it encouraging health careers among "young people" in general that is in view here, or perhaps encouraging such careers among "minority" young people or "a diverse population" of young people (or some such)?

MRSA SURVIVORS NETWORK

(A Support Group For Those With MRSA and Their Families)

Mission Statement: To increase awareness, prevention, research funding and legislation For MRSA – a hospital / community-acquired staph infection.

July 25, 2006

RE: Written Testimony for the State Health Improvement Plan

MRSA (methicillin-resistant staph aureus) is a multi-antibiotic resistant deadly pathogen spread by contact and now 60-70% of all staph infections are MRSA. I am a MRSA survivor myself and was infected during a routine ankle surgery in Dec., 2000 and became critically ill and near death. I have spent 15 months in the past 5 years confined to bed with reoccurring infections. MRSA is spread by contact by healthcare workers and is the emerging disease that is increasing at an alarming rate. Hospitals have all but ignored this problem and stuck to an outdated, failed approach of relying on hand hygiene to control this disease. Only one patient in three is even told by their doctor that they have MRSA, which is incurable.

Many lives in Illinois have been lost as hospitals have not done everything that they could be doing to protect patients from being infected and I feel that legislation is the only recourse to stop the spread of this deadly disease that is a secret , silent killer and preventable. In January of this year, I introduced a bill that called for all Illinois hospitals to screen all patients admitted for MRSA and for the hospitals to report their infection rates to IDPH, under their infectious disease surveillance program. I am currently in committee with IDPH and IHA and we are working on an amendment that will call for hospitals to adhere to the SHEA (Society of Healthcare Epidemiologist of America) Guideline (2003) which calls for hospitals to use active surveillance culturing (ASC's) for MRSA on "high risk patients" and each hospital determines where their outbreaks are occurring with patient isolation and compliance of hand hygiene regulations.

Below is a comparison of infectious diseases in **Illinois** and the MRSA infection and death rates are staggering. Data from IDPH and IHA. MRSA mortality rate calculated at 23.4%. **We have a MRSA infection epidemic happening in Illinois !**

No. of Cases	HIV/AIDS	WEST NILE VIRUS	MRSA
2004	1, 410	60 (4 deaths)	**8,783 (2,020 deaths)**
2005	1,366	252 (12 deaths)	**10, 075 (2,317 deaths)**

The HA-MRSA (hospital acquired) cases in Illinois have increased in one year by **13 %**, this is very alarming. No one knows the percentage of community-acquired – CA-MRSA infection rates as these are not being reported through a hospital's ER or physician's office.

Thousands of lives are being lost in Illinois each year, families suffering with long term disabilities, grief and financial strain. Patients with MRSA who survive are now put into the **"high risk patient"** category for the rest of their lives and many have reoccurring infections as this is an incurable disease. This is a preventable disease if hospitals would screen patients for MRSA, use isolation and aggressive hand hygiene practices. Five European countries and Western Australia has used this approach for many years and have very low MRSA rates (the Netherlands – 1%). Evanston Northwestern Healthcare has been screening **all patients** admitted to their three hospitals for MRSA in the past year and have seen a dramatic drop in MRSA infections and also a dramatic savings to the hospital.

Last year, Beth and Ken Reimer of Plainfield lost their baby girl, Maddy to a MRSA infection that destroyed her lungs and was hospital-acquired. She was seven weeks old and a twin. You can only imagine how heartbroken the Reimers' are. We are going to name this legislation after her**, "Maddy's Law"**.

I have been receiving positive feedback from legislators on this initiative and an emerging consensus is that legislators want this disease under control and MRSA screening legislation. IDPH, IHA and other key medical associations and organizations should support this bill to stop this unnecessary loss of life and infections. The Illinois State Health Improvement Plan should focus on hospital-acquired infections, namely MRSA.

Sincerely,

Jeanine Thomas
Founder

Consumer representative on the advisory cmte on the state board for the Illinois Hospital Report Card Act
Member - Chicago Patient Safety Forum

Comments on the State Health Improvement Plan (SHIP)
Made by Bruce Graham, Dean, UIC College of Dentistry
August 9, 2006 at Public Meeting
Holiday Inn, Merchandise Mart
Chicago, IL

- Oral health is inseparable from general health and well-being. We are pleased to see that the draft of the State Health Improvement Plan (SHIP) appropriately recognizes this fact.

- SHIP notes local health priorities as access to care, cancer, and cardiovascular disease.

- The most recently available data indicate that 56% of school-aged children in the state have experienced dental caries. 30% of the carious lesions were untreated. These data place Illinois off the mark when compared to Healthy People 2010 goals for caries experience in children and delineate the disparities in access to oral health care in the state.

- Recent research has suggested a linkage between periodontal disease and cardiovascular disease, diabetes, and premature births.

- Oral cancer rate is a serious concern in Illinois. The age adjusted rates for both sexes and all races is 9.3 per 100,000 but 23.2 per 100,000 for African American males. Cook County bears a disproportionate share of the oral cancer burden.

- In the context of the SHIP's objective to improve access to care and strengthen the public health system, the UIC College of Dentistry is placing its fourth year students (senior students) into community clinic sites for 60 days for service-learning experiences. The community sites are located in the greater Chicago area and as far away as Rockford.

- In this way, we project that nearly 20,000 distinct dental services will be provided to nearly 8,000 patients this year who would not have otherwise been able to access dental care

- It is our expectation that these experiences will help our dental students to better understand the issue of access to care and prompt them to devote time in their careers to provide care to underserved people and communities

- In keeping with the SHIP's Workforce strategies, we are also tracking graduates in order to assess their career choices and modes of practice.

- As the state proceeds with planning around the issues of Workforce attention should be paid to the question: does Illinois have an adequate oral health workforce currently and projected for the future – particularly considering projected absolute population growth as well as the demographic trends within that growth.

- The state has the benefit of an existing Oral Health Plan released in Spring 2002 and recently there have been several well attended public hearings around the state regarding the development of a second, or follow-up, oral health plan.

- The state's Oral Health Plan fits well into the planning structure and platform provided by the Health Improvement Plan

- The results of the state oral health plan have been assessed recently and found to have already succeeded in meeting several of its goals.

- The College is pleased to have contributed to some of that accomplishment.

- The development of the oral health plan and much of its success was attributable to having an excellent state dental health officer.

- That position is now vacant and should be filled by a highly qualified applicant without delay.

Illinois Chapter | American College of Cardiology
4242 Commercial Way • Glenview, Illinois 60025 • Phone: (847) 391-9777
Fax: (847) 391-9711 • Email: ilacc@ilacc.org • Internet: www.ilacc.org

The Illinois Chapter of the American College of Cardiology (ACC) appreciates the opportunity to comment on the recently released State Health Improvement Plan (SHIP), the first concerted multidisciplinary attempt to reduce the burden of heart disease and stroke in our state by targeting obesity, inactivity, and tobacco. As you are well aware, cardiovascular diseases account for the leading cause of preventable death in Illinois. In 2003, 39,079 lives were lost due to heart disease and stroke, or 37% of all cause mortality.

The Illinois Chapter of the ACC represents over 600 physician members and cardiovascular care associates including advanced practice nurses and physician assistants involved in the care of patients with cardiovascular disease. As primary providers of prevention services, we recommend a greater emphasis on the following points for inclusion in the SHIP document.

1. **Access to Care**. Recognize the economic barriers physicians face in providing preventative services. Emphasize the role of the ever increasing medical malpractice premiums in driving physicians from our state, declining medical student interest in primary care medicine, and the inability of practices to keep doors open when overhead rises and reimbursement declines. Emphasize that solving the medical malpractice crises will redirect dollars back into practices to provide prevention services. Lack of reimbursement for preventive services, failure of coverage for prevention drugs, failure of coverage for screening are all access to care issues and must be addressed before health care providers can divert resources away from the treatment of an increasing aging population with more complex and multisystem diseases to the prevention of these same illnesses.

2. **Greater focus on the importance of blood pressure control**. For every 6mmHg drop in diastolic blood pressure, there is a 14% drop in cardiac events and a 36% drop in the incidence of stroke. Blood pressure control in the diabetic reduces or prevents diabetic complications independent of blood sugar control. Blood pressure control significantly reduces the incidence of vascular dementia and renal failure. Incorporating hypertension screening and awareness of target blood pressure will be a very cost-effective strategy in reducing morbidity and mortality.

3. **Tobacco**. A stronger statement on a statewide ban on tobacco products in the workplace, restaurants, and around schools should be included in your document. Recommend that drug benefit plans should be prohibited from excluding tobacco cessation pharmaceuticals and nicotine replacement products from coverage or reimbursement and for funds to underwrite these medications in the disadvantaged population.

4. **Physical Activity**. Emphasize the importance of mandatory physical education in the schools and recommend legislation to make it more difficult to opt out of this

requirement. Highlight those corporations or work environment that give employees time and ways to be active during their normal work day. Provide leadership by promoting exercise time for state employees.

5. **Screening for Cardiovascular Risk Factors**. Recognize that many insurers do not reimburse citizens for cholesterol or diabetic screening. Consider the creation of local community centers to provide such services on an ongoing basis.

We wish to commend all the members on the hard work and hours spent in this worthwhile initiative and wish to extend our sincere appreciation for this movement to improve the health and life of our patients, friends, and family. We see this as a tremendous first step to effect meaningful change in Illinois and we applaud you for it.

Sincerely,

Diane E. Wallis, MD, FACC
President, Illinois Chapter of the American College of Cardiology
Governor, Illinois Chapter of the American College of Cardiology

CC: Heather Gavras, Peggy Jones, AHA, ISMS
Eric E. Whitaker, MD, MPH Director
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State Health Improvement Plan for **Illinois**

Testimony on behalf of the March of Dimes

Before the Illinois State Board of Health

August 9, 2006

On behalf of the March of Dimes Illinois Chapter's volunteers and staff, we are submitting this written testomy regarding the State Health Improvement Plan for Illinois. In general, we support the Plan for the overall health of Illinois citizens, but urge the Illinois State Board of Health to ensure the needs of pregnant women are adequately met under all goals, and specifically recommend that pregnant women be added under the priority health condition of Smoking.

The March of Dimes is a national volunteer agency who mission is to improve the health of babies by preventing birth defects, premature birth, and infant mortality. We applaud the Planning Team for putting this plan together and for the recognition of the impact of low birth weight infants on the overall health of the state.

According to the Centers for Disease Control 22.9% of women in Illinois smoke and although pregnant women are less likely to smoke, recent surveys found that 18% of those ages 15 to 44 reported smoking during the past month. In addition, non-Hispanic white mothers (25%) are far more likely to smoking than non-Hispanic back (9%) or Hispanic (7%) mothers. Pregnant women who smoke are at increased risk to give birth

prematurity and to have a low birthweight infant. In addition, smoking cessation services for pregnant women are among a handful of interventions that save enough in later medical expenses to completely offset the initial investment and actually result in cost saving. Studies suggest that every $1 spent on smoking cessation counseling for pregnant women could save about $3 in reducing neonatal intensive care costs. Pregnant women should be concerned a special category since their smoking effects their child but also because they require a different type of intervention in order to ensure they stop smoking. The American College of Obstetrics and Gynecology recommends that pregnant women are treated with counseling because the effects of nicotine replacement products have not been sufficiently evaluated to determine its efficacy or safety during pregnancy. It is imperative that the State recognizes the special needs of pregnant women who smoke and set cessation goal.

In 2003, 15,081 babies were born weighing less than 5.5 pounds with a staggering 14.2 percent of these infants born to African American Women. Illinois ranks 31st in the country in low birthweight and 32nd in the nation in preterm birth with 23,368 infants born in Illinois before 37 weeks. Low birthweight accounts for 10 percent of all health care cost for children these and four of the nine most expensive hospital stays, regardless of age, are related to infant care: infant respiratory distress syndrome, prematurity/low birthweight, lack of oxygen infants and cardiac/circulatory birth defects. Thus, the March of Dimes thinks it is imperative that the state include in their measures of success a reduction in the amount of babies born premature and/or low birthweight.

Thank for you giving us the opportunity to submit testimony. On behalf of the March of Dimes staff and volunteers, we urge you to turn your attention to health of pregnant women in Illinois. By adding this special group to the State Health Improvement Plan Illinois will be begin its path to being the healthiest state for women in the United States.

For more information, please contact Jennie Pinkwater, Associate Director of Public Affairs and Program Services for the March of Dimes Illinois Chapter. She can be reached at 312-596-4709 or via email at jpinkwater@marchofdimes.com.

COMMENTS ON THE STATE HEALTH IMPROVEMENT PLAN
Illinois State Board of Health
August 9, 2006

Kathleen Monahan, MPH
Janet Holden, PhD
Co-Chairs
Illinois Injury Prevention Coalition

This testimony is submitted on behalf of the Illinois Injury Prevention Coalition (IIPC), a group of dedicated injury prevention specialists from state, federal, and local agencies, NGO's, and academia, who work closely with the Illinois Department of Public Health to prevent injuries in Illinois.

Injury is the leading cause of hospitalization and death for all Illinois persons between the ages 1 to 44. In Illinois, motor vehicle traffic deaths continue to be the leading cause of injury death followed by suicide, poisoning, homicide and falls.

According to the State and Territorial Injury Prevention Director's Association, no matter how they are measured – in terms of deaths, temporary and permanent disability, years of life lost, or health care costs – injuries take a tremendous toll in our society. Each injury-related death and disability is even more tragic because so many are preventable with existing public health tools. Unlike other fields that await new scientific and technical breakthroughs, injury prevention has proven strategies ready to be applied. (STIPDA – Safe States)

The IIPC one of Illinois' strengths. We are currently writing a strategic plan for injury prevention for the state. This plan, when completed at the end of 2006, will facilitate the development of secure infrastructure for injury at the state department of public health; serve as a blueprint for local health departments to prioritize their injury prevention efforts; and be a resource for all injury prevention specialists within Illinois. One of the primary driving forces behind the development of the plan was the downgrade of the Injury and Violence Prevention activities within IDPH from a Division, to a Section, to a Program, within the span of one fiscal year. No state monies currently support any of this program's efforts.

While we applaud the efforts of the SHIP planning team, we have concerns about the findings. In the SHIP plan summary. Under Key Health Status Findings, injury and violence are ranked most important. We are concerned that subsequent to this finding, the word injury has been dropped, and violence – not injury and violence - is the thread that continues through the rest of the plan. We are also concerned that the term "accidents" is used throughout most of the supporting documentation, while the public health field uses the terms unintentional injury and intentional injury or violence, and has for many years. The campaign to stop the use of the word *accidents*, with its implication that we are powerless to prevent these random acts of fate, has been long and difficult. We hope that the language throughout the SHIP and all of its supporting documents will reflect the knowledge and belief that almost all injuries are preventable utilizing existing, proven public health tools and methods.

We ask the Board to consider the importance of injury, both in their own research findings in developing the report and as a public health issue. We ask the Board to maintain the use of the term Injury and Violence throughout the Plan when addressing this first ranked issue.

By incorporating this change, the State Health Improvement Plan will become a more useful tool in addressing the health of all residents of Illinois.

Please Note: These comments reflect only the views of the IIPC Co-chairs and have not been reviewed by the Illinois Injury Prevention Coalition membership.

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Strategic Issue: Data and IT

The importance of data cannot be over-emphasized. All core functions of public health require data to evaluate what progress or lack of it has been made. Just like politics, all data are local! If the health status of the country is excellent and the health status of my census block is not, the national data is of no use to me.

- I strongly recommend that as we look at standardizing race and ethnicity categories, we must also include **sub-county level** categories especially in larger counties where municipalities are as large or even larger than some counties. Issues that are masked when looking at a county as a whole include socio-economic status which is not highlighted by stratifying just by race and ethnicity alone.
- Having a centralized data system will be helpful if the data system is released in a timely fashion. A data clearinghouse or warehouse will be more efficient and cost-effective.
- HIPAA: The data system can be housed in a secure site to satisfy HIPAA. It must be noted that the more data we have out there, the better we can tell our story to the public. When possible, data should be stripped of any identifiers and released to the public to keep them abreast of our progress.
- Legal: The legal department should be more responsive in reviewing Memorandum of Understanding. Data requests should not be tied up indefinitely because of inability of the state's legal system to review MOU's.
- Local health departments should be seen as integral to the success of this project and not as outsiders. There is a fundamental difference between request for data

from a local health department that bears a direct responsibility for the success of the residents of the county and another agency that requests the data solely for research purposes. The data collected at the local level and sent to the state for safe-keeping should be able to be returned to the local health department without going through months or even years of paperwork!

- IT department should be fully staffed with experienced and competent staff.

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Illinois State Health Improvement Plan
Testimony from Luna Okada, MS, CGC – Genetic Counselor, Coordinator
Illinois Department of Public Health,
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Summary: Nine of the health priorities, identified in the SHIP, have long been recognized as having genetic components. As written in the Plan, these include: a*rthritis, asthma, cancer, diabetes, heart/cardiovascular disease, stroke/cerebrovascular disease, cholesterol, mental health, overweight and obesity*. Early detection, education, and treatment have the potential to greatly reduce the incidence of such chronic illnesses in Illinois. A key to early detection is identifying risk factors. The risk factor common in all of the above health priorities is a positive ***family history.*** Government agencies, such as the Centers for Disease Control and Prevention (CDC) and the Surgeon General have designated family history as an independent risk factor, giving it equal status with other risk factors such as high blood pressure, abnormal laboratory values and other biometric measurements. Secondly, the ***availability of pre-symptomatic genetic testing*** of 'at-risk' individuals should be made widely known to both the residents of Illinois, as well as, healthcare professionals. Individuals who are genetically predisposed to a particular chronic illness, such as breast/ovarian cancer or colon cancer, can benefit from early intervention measures thus delaying or preventing the onset of disease. Lastly, although there are laws which are intended to protect individuals from genetic discrimination in the workplace and in healthcare/life insurance coverage, it is necessary to have an ongoing review of how well these laws are working for the residents of Illinois, as well as ongoing assessment of the societal impact of the rapidly changing and emerging technologies in genomic medicine by regular review of the ***ethical, legal, and social implications, (ELSI)***, raised by such testing possibilities.

We are requesting that the SHIP Planning Team consider the emerging field of genomic medicine and its importance to improving the health of the residents of Illinois. A healthcare improvement plan, that does not recognize the ubiquitous nature of genomics, and one that does not address these issues, may be overlooking an important segment of contemporary healthcare and may be outmoded before it is published.

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This written testimony is in follow-up to verbal testimony presented at the State Health Improvement Plan (SHIP) public hearing in Chicago on August 9, 2006 at the Holiday Inn Merchandise Mart. Luna Okada offered a brief presentation and we are hoping that this written testimony will clarify these comments.

In reviewing the draft of the State Health Improvement Plan, (hereby referred to as the 'Plan'), we are pleased to see that it is a comprehensive document, addressing a broad-based scope of healthcare, including access to care, data collection, oversight of our public health system, disparities, workforce concerns and prioritizing of health

conditions. However, we did note an omission which is also broad-based and should be addressed comprehensively in this Plan.

As evidenced by the data presented in the first several pages of this Plan, the top three leading causes of death by both gender and race are heart disease, cancer, and stroke. When this data is analyzed by age, following accidents, homicide, and suicide, the most common causes of death are cancer, congenital (birth defects), and heart problems. It is also noted that in the Plan, the following specific diseases have been identified as areas of priority:

Arthritis
Asthma
Cancer
Diabetes
Heart/cardiovascular disease
Stroke/cerebrovascular disease
Cholesterol
Mental health
Overweight and obesity

It has long been recognized that each of these chronic illnesses has a significant genetic component. Individuals, with a ***family history*** of any of the above conditions, are at an increased risk, over the general population, for also developing the same chronic illness. Early detection of such 'at-risk' individuals and education regarding healthy lifestyle choices has the potential to significantly reduce the number of individuals suffering with such chronic illnesses and thereby, reducing the healthcare burden in the State of Illinois. Along with the Centers for Disease Control and Prevention (CDC) and the Surgeon General, other government agencies and professional organizations, (such as the American Society of Human Genetics and National Society of Genetic Counselors) have identified family history as an independent risk factor; one that is weighted with equal predictive value as factors such as high blood pressure, abnormal laboratory values (cholesterol, glucose, etc.), and other biometric measurements, (EKGs, etc.). Family history assessments must become a regular, common and consistent practice among primary care physicians when screening patients for chronic illnesses.

For individuals who are identified as being at an increased risk for particular chronic illnesses, such as some types of cancer, type 2 diabetes, and cardiovascular and cerebrovascular disease, ***pre-symptomatic genetic testing*** may further identify the subset of individuals at *greatest* risk. For example, for individuals, (males and females), who have a significant family history of first degree relatives (parent, sibling, child), with breast and/or ovarian cancer, the presence of a DNA mutation, (such as BRCA1 and BRCA2), which is known to be associated with breast/ovarian cancer are at a significantly increased risk for developing breast and/or ovarian cancer in female family members and breast and/or prostate cancer in male family members. Testing for these DNA mutations is already common in cancer centers around the world, is highly

predictive of risk and used by physicians in the surveillance of these patients, as well as, in providing guidance in the choice of treatment regiments.

Finally, as a corollary to pre-symptomatic genetic testing for 'at-risk' individuals, the importance of recognizing the ethical, legal, and social implications (ELSI) of such testing is necessary when formulating a 'forward thinking' plan. When initiated in 1990, the Human Genome Project (HGP), a $3 billion dollar, 15-year project to map the human genome, recognized the far reaching effects such information would impose upon humankind. From the beginning of the HGP, a joint effort between the Department of Energy (DOE) and the National Institutes of Health (NIH), 3-5% of the overall budget was dedicated to the study of ELSI issues. This created the world's largest bioethics program. The value and importance of ELSI issues has become recognized worldwide. Since there is great potential for abuse of the information gathered on an individual's genetic make-up, there is great potential for discrimination in the workplace, as well as, raising the concern of "insurability" of an individual who has inherited genes which predispose him/her to a particular disease. If an individual has genetic testing done because he/she has a significant family history of breast and/or ovarian cancer and is planning to use the information to alter both lifestyle and healthcare management choices, including a surveillance monitoring schedule, he/she may be identified as a client with a "pre-existing condition" and may be denied healthcare insurance coverage or may only be offered a policy that excludes coverage for treatment related to breast or ovarian cancer. Since cancer can involve multiple organ systems, sometimes simultaneously, this individual may potentially be uninsurable. Although this example is hypothetical in nature, it serves to illustrate the potential abuse of such information and the reason there are laws to protect against genetic discrimination. Because the technologies are constantly advancing, societal implications are predicted to also be constantly in need of revisiting, and the ethical and legal implications will need constant scrutiny, academic debate and continual updating and adjustment of our existing paradigms.

We in the Genetics Section of IDPH, are passionately dedicated to the ongoing recognition of the significance of genetics, genomics and family history in the overall healthcare of Illinoisans. Throughout the life cycle, the genes that we inherit give direction to, if not dictate, our health. Illinois' Newborn Screening Program identifies the youngest of Illinois residents who will benefit from early detection, early intervention, dietary management and improved health for their lifetimes. The system of referrals from local health departments to hospital based genetic centers for pediatric, prenatal, and adult patients, is based on the knowledge that a better educated public results in a healthier population. The efforts of the Genomics and Chronic Disease Prevention Project are focused on reaching all existing chronic disease prevention programs so that the message of the importance of family histories makes its way from the CDC and Surgeon General's offices to all residents of Illinois.

Given the significance and importance of this State Health Improvement Plan, we recognize the need for Genetics and Genomics to be included in its core recommendations. Since the Plan will only be revised every four years, we recognize the

essential need and urgency of Genetics and Genomics to be incorporated in the inaugural Plan in order to make it comprehensive and complete. We request consideration of inclusion of Genetics and Genomics in the current SHIP document. We are, of course, available to further discuss any questions or concerns you may have.

Thank you for your time.

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I l l i n o i s

October 3, 2006

To Whom It May Concern:

Under the request for comments concerning the State health plan I wish to offer the following comments. I am a fire chief and ambulance director in charge of emergency medical care for our community. I reside in a community of approximately 13,000 and provide to that community both emergency and non-emergency transport for our citizens. The emergency service is provided by the firemen in our town as part of a dual responsibility that they have and the non-emergency service is staffed by volunteer members of the community that donate their time and talents to the community. For the volunteers, there is some reimbursement, but not to the point that any member could make a living for themselves. Our community is unique to the point that we are able to provide both types of service, however that is not the case in many of the surrounding towns and communities in my area. Like many communities in my area, I rely on volunteer help and would not be able to function without it. In my tenure, 19 years, as an emergency medical technician, I have seen many changes for the medical side of the state health plan and have never voiced my opinion until now. Although I know that the entire state plan encompasses more that I wish to comment on, my expertise and concerns fall into the hospital and pre-hospital areas and at the same time offer my personal proposed solutions.

Recently our local hospital re-designated itself as a critical access hospital in order to receive better funding for its facility. I have no problem with any business trying to improve the cash flow for better operation. The new designation reduced the size of the hospital from a 50-bed facility to that of a 25-bed facility. During peak times of census, now patients must at times be sent away from the hospital in this community to those of surrounding communities for treatment, as far as 20-50 miles away. During transfer of these patients, how could one legitimately explain to the patient and the family of the patient that there are no beds left in the hospital and that they must be taken elsewhere when the room next door is sitting empty. This creates undue stress on the family as well as the patient. If they were not sick enough already, we now must transport the patient elsewhere causing extra stress to the patient for the same care that could have been given in the empty bed at the first facility. This also created the problem of tying up an ambulance and forcing it to be on the road possibly causing a shortage of emergency services while other ambulances are busy or in our case when the firemen are doing their jobs. This situation could cause the problem of no ambulance coverage being available during times of fire events because of having to take patients to other hospitals for the same basic care that they would have received in our local facility. **Proposed solution**: The size and capacity of the hospital needs to be determined by the hospital staff and from the community that it serves, not from public officials who think that they know what is best from behind the quill of a pen. Reimbursement should be the same no matter what the capacity is and not based on figures coming from those whom have never been involved in patient care.

With the recent closings of several state mental health institutions, an injustice has occurred to those that are mentally ill. Through the help of a couple of nursing homes, this community is trying to overcome the lack of mental institutions, by opening a mental wing for non and mildly violent patients in the nursing homes, there is a serious lack of specialized help, treatment and care available for these individuals. The general practice for treatment of these patients is work with them until they the nursing home cannot handle them anymore and then pass them on to the local emergency room. At this point, mental health officials and physicians evaluate the patient, decide to have the patient return to the nursing home or try to find an appropriate facility for further care. If the hospital is lucky to find an opening at one of the two facilities located 50 miles away, they are transported there. More often than not, the non-emergency transport ambulance must transport them to the nearest state supported facility more than 2 ½ hours away. Granted a transport service is available for the non-voluntary committals, but this does not help those patients that voluntarily commit themselves, as they may be mildly excitable or sometimes violent due to new and changing environments. This places ambulance crews danger during the transportation of a patient to distant facilities. This also violates the first question we ask the emergency medical technician to obtain the answer to for any scene. That question being, "Is the scene safe?" **Proposed solution**: Create, staff and support with funding the opening of state supported mental institutions. Closing of facilities such as Peoria's "Zellers Mental hospital" was and is an injustice to the patients, trouble for the local law enforcement as some of these patients are now running free in the streets, and present an endangerment to the ambulance crews that must transport such patients.

EMS also known as emergency medical services has been regulated and reregulated by the state to the point I am not sure can be fixed at this point of time. For over a year we as directors and chiefs have been promised that the EMS section for testing was going to change. It has, but for the worse. Currently the state department of public health cannot and does not offer a chance for those students completing the basic EMT course a chance to test for a state license. It was initially stated that the state test was compromised and promises were given that a replacement test would be developed. It wasn't and even through the help of an outside agency a qualified replacement test has not been developed. Those students that wish to practice now must take the national registry and then revert the national registry back to the state license adding more waiting time for the license to be in hand. We as directors were also told that a computerized testing center would be developed so that prospective members could take the test online or at a testing center and receive immediate feedback on their deficiencies in the EMS modules. This idea was to be in place January of 2007. To my knowledge as of this date no provisions or accommodations have been made to complete this goal.

The intermediate test was rewritten and has been retested through the state. Those instructors that have provided the classroom portion of the advanced level of service are veteran instructors and have over the years proven themselves as such. To date, scores have come back from the state testing of potential intermediates without successful candidates with the highest score having been 54 percent with the average score being 45 percent, still a failing grades. This is an embarrassment not only to the instructors, but also to the EMS and public health sectors of our state. Worse yet, we still do not have emergency medical technicians that can perform advanced skills in the field because of testing. Combine this problem of poor tests scores with the lack of testing sites and courses; we have just spelled out failure in rural emergency medical care.

Requirements for continuing education of basic EMT's has increased dramatically over the years that a volunteer has to make a decision between educational requirements or activities with their family. A tough decision to have to make. The increase of training over the past several years has caused many members of the emergency medical profession to make this hard decision. That decision has been to let their licenses lapse causing many communities to worry about the retention and recruitment of emergency medical technicians. It should be noted that these members are always on duty and are present at many events of the state and local community even though they may not be present in an ambulance. If needed they become the first responders until the local ambulance crew can arrive. EMT's have been making the decision as of late to retire, or allow their license to lapse due to the excessive commitments given by the job. Many of these volunteers donate their time in addition to their regular employment and at times allow their employment to suffer because of the community service that they are providing when a call interferes with their working hours. Emergencies do not occur by a time clock and members must be available at all hours, something that we do not necessarily have available today. Consequently that is why we are seeing a decline in emergency medical technicians and have seen ambulance services shut their doors to the community, because they cannot provide enough help for their community. Further more, due to the time and requirements of education of certification, we are unable to provide qualified interested individuals that would be willing to spend the time to become an emergency medical technician.

One of the best ideas that the Illinois Department of Public Health has come up with, was to allow the EMS directors of each resource hospital the opportunity to relicensure and certify the license of the EMT. In the past, all certification material had to be passed on to the state office and then wait for the license to return. Turn around took weeks or longer. Presently, by allowing access to state licenses by the EMS director of each resource hospital, this turn around is much shorter and we now are able to instantly identify and confirm the expiration of each member's license. This program also allows tracking of the licenses so that directors can follow the relicensure process and can direct and guide members through the process. This in the long run will improve retention and the quality of emergency medical technicians through out the state.

As a licensed professional the emergency medical technician must present to the resource hospital and ultimately to the Illinois Department of Public health certification requirements of his or her continuing education. For comparison the following is offered.

- A basic EMT must have 40 hours of continuing education per year and present to their medical director proof of classroom education to renew their license every 4 years. Advanced providers also must present proof of clinical experience by working in the emergency room under the supervision of the physician and nurses depending upon system requirements of the local resource hospital before he or she can continue practice in the emergency medical field.
- Medical imaging technologists must present to their boards proof of 12 credit hours of basic certification requirements annually. Specialty areas such as mammography and CT must present an additional 12 hours of study per mode of specialty.
- Physicians must attend additional educational classes to retain their license.
- Licensed hairdressers (cosmetology) must present an average of 6 continuing education hours annually.

- Nursing (the primary care givers of patient care) unless required by their place of employment for continuing education only need a signed check that clears the bank to retain their license.
- Certified city clerks must attend annual refresher training either at their state association convention or similar meetings.

A simple question should be asked as to why the only group that presents the most patient care needs the least continuing educational requirements unless required by their employer to have further educational requirements. This has been the same group that has been making the rules at the regional and upper state levels of IDPH.

Through out the last couple of years, the biggest item of concern for all emergency services was attacks of terror by way of bio-terrorism. In response, emergency services obtained grants for the purpose of facemasks and presented them to their ranks should a bio-terror incident occur. The law enforcement agencies took care and provided to their personnel Avon face masks, the fire service provided MSA millennium masks to their agency personnel and even public works members were provided masks for their members. All are provided with the intention that they would be working with the public to provide evacuation and care to the community. Unless the local fire departments included into their rosters, the members of the EMS community, this group, a primary health care giver to the public, was left out and never thought of by the leadership of the public health department that represents the EMT's. Unfortunately, these members of the emergency services like their counterparts in the fire and law enforcement agencies will also be in the public supporting operations, but will be unprotected like the other first responders.

Proposed solutions:

- Remove the emergency medical services from the Illinois Department of Public Health. If necessary place the operations into the hands of those that work in the field and out of the nursing sector. It might be suggested to place it into a group that has proven themselves in the fields of emergency service such as the fire service or through the Office of the State Fire Marshal's office. At the very least, decentralize the system and let each regional trauma center govern their own system. Central and southern Illinois trauma centers can be located 50 –100 miles away from each other as compared to Chicago, which may have one every 5 miles apart. Cultural and demographic differences for each area may and do dictate operations of that areas EMS and not all parts of the state are the same.
- Develop methods for recruitment and retention and unfortunately this may cost the state financially. These members represent their communities at all hours of the day and not all communities can afford a full time service. For those who actively volunteer (as confirmed by local directors) give the volunteers an incentive such as a tax break or free tuition at a state university. If nothing else, this can be a small way just to say thank you to the volunteer EMT for the services provided. This incentive would cease upon lapse of the license to practice or if the EMT became inactive. Confirmation of active work could be coupled together with the new relicensing program operated by the local system EMS coordinators.
- Retain the present method of relicensure by the system EMS coordinator. It is finally something from the Department of Public Health that works! Unfortunately, it took getting it away from the directors of IDPH and placing its operations into the hands of the local system EMS coordinators.
- Provide the testing mechanisms as promised including classes and sites that are fair, and provide immediate feedback. Courses should be developed and directed by the regional

hospital system as far as materials and protocols providing that the content is consistent with the National Transportation Board curriculum.

- Remember that emergency medical technicians are also part of the first response in cooperation with the fire and police agencies.

State reimbursement is always a concern for any ambulance service. Services can only provide a given amount of free services especially with the rising costs of supplies, fuel, educational classes, and insurance. Reimbursement is behind on behalf of the state and minimal when it is received. As directors of emergency medical services, we cannot afford to continually write off the ever-increasing amount of uncollectible accounts. Many times those with public aid cards have reached out and expect free handouts for medical care just because they receive public assistance. Abuse is also evident, as members will go to the emergency room because they know that they will be taken care of immediately and they don't want to wait in the reception room of the doctor. **Proposed solution**: Direct the state to fully fund the Medicaid reimbursement. In order to prevent the abuse of Medicaid cards, develop a system that causes a deductible figure on their public aid reimbursement for frivolous and nuisance calls. The Medicaid program is designed for assistance, but also use it to help prevent abuse of the system and prevent the abusers of using the system as a free ride.

In conclusion, to put into medical terminology, the Illinois Department of Public Health emergency services division is very gravely ill and unless some miracle comes forth to bring it back into life, the emergency services of this state as we know it may cease to exist. Though mismanagement and negligence the department has brought on to this state a huge liability in emergency medical care and something has to be done about it immediately. Thank you for taking time to review my comments concerning my opinion of the state of the Illinois Department of Public Health.

Respectfully submitted,

Thomas J. Weston
City of Kewanee Fire chief

IPHCA

Illinois Primary Health Care Association

State Health Improvement Plan:
Comments from the Illinois Primary Health Care Association

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August 9, 2006

Thank you for the opportunity to provide written/oral testimony to the State Health Improvement Plan Planning Team and the State Board of Health.

The Illinois Primary Health Care Association (IPHCA) is Illinois' sole trade association representing Illinois' forty four Community Health Center (CHC) organizations. We also have member organizations in Iowa and Wisconsin. Illinois health centers served over 900,000 patients in 2005 at one of over 280 primary care delivery location or clinic sites across the state. Health Centers are mandated by the federal government to serve areas of the country designated as being a Medically Underserved Area (MUA) or to serve populations designated as Medically Underserved Populations (MUP). As a result of where and who CHCs are required to serve, they treat a predominately low income, minority population who are disproportionately afflicted with a wide range of chronic illness such as, Hypertension, Diabetes, HIV and Asthma being the most prevalent.

In 2005, 74.2% of health center patients belonged to a racial or ethnic minority, 33% of their patients were uninsured, and 75% of CHC patients were at or below 100% of federal poverty. Health centers provide a wide range of primary medical care services, i.e. internal medicine, family medicine, pediatric, OB/GYN, oral and mental health services as well ancillary services including patient transportation, interpretative services for patients who do not speak English, social services such as WIC and Family Case Management, child care, job training, after school programs and others as determined by the federally mandated 51% clinic user, community based Board of Directors of each health center organization.

Illinois has enjoyed an explosive growth in the reach of community health centers to provide comprehensive primary and preventive health care services to the people of Illinois. Since 2000, Illinois health centers have more than doubled the number patients served annually (2000: 399,000/2005: 903,000) and since 1999 Illinois is second only to California in the number and amount of federal health center grants coming into Illinois to start or expand existing health center organizations. Additionally, Illinois has added its own resources to the mix by funding a state sponsored CHC expansion program which to date has helped finance the creation or expansion of nineteen CHC health care delivery sites across the state. The program is administered by the Illinois Department of Public Health (IDPH) and IPHCA anticipates the awarding of seven to eight new grants in FY 2007.

Comments on Overall Assessment Activities

Overall, IPHCA is pleased to participate in these kinds of planning and assessment initiatives and we note that over the years we have participated not only in the current initiative (IPHCA participated in the June 2004 statewide assessment *From Silos to Systems: Assessing Illinois' Public Health System*) but in other, similar statewide assessment and planning exercises whose goals were at least similar in spirit. Our hope is that the plan developed by the Planning Team/State Board of Health and for which we are providing comment is actually utilized by stakeholders, local, state and federal policy makers, and future Illinois governments. The state should avoid trying to replicate this kind of statewide Public health system improvement plan development and instead consider this plan a work in progress or a benchmark document which is constantly under review to ensure relevancy and to account for system changes and changing health care needs within Illinois. The alternative is the re-creation of the wheel, so to speak, which is wasteful of scarce resources and does not lend itself to long term credibility among stakeholders, policy makers, or the public. We note that within the findings of the *Statewide Themes and Strengths Assessment* that the authors acknowledge that Illinois possess a "strong planning culture" which is laudable but perhaps what's needed now is the creation of an even stronger culture of action/implementation.

Comments to the Plan:

State Health Profile Assessment

IPHCA applauds the effort to collect the amount and kind of data contained in the *State Health Profile Assessment.* Health Centers are strongly encouraged to design health plans to meet Healthy People 2010 measures or potentially risk the loss of federal funding. In fact it would be interesting to determine whether health center patients, as a sub-group, would fair better against the HP 2010 measures versus the public at large as a result of CHC's being held accountable for quality. Attached to this testimony is an analysis of Illinois CHC data from the Health Resources and Services Administration (HRSA) funded Health Disparities Collaboratives (HDC) which is a national effort designed to integrate best practices for the treatment of chronic disease and then measure outcomes of enrolled patients. The HDC focused on five chronic diseases: Diabetes, Cardiovascular Disease, Asthma, Depression, and Cancer. While CHCs have not reached all of the goals of HDC, they can actually document progress and barriers to meeting the established goal which is light years ahead of their other provider colleagues who are now just beginning to think about documenting quality measures.

Statewide Themes and Strengths Assessment

IPHCA notes this assessment with particular interest in that it speaks to the issue of the "Public Health" system versus the "Primary Medical Care" delivery system which incorporates ambulatory, tertiary and specialty care providers across the state. IPHCA believes that community assessment and planning activities have historically been vested to local health departments (we acknowledge that some LHDs do a better job than others primarily due to issues of staffing and resources) while the actual provision of care to the population is performed by primary care providers, hospitals, physician practices and specialty groups. The findings of this assessment are much more relevant to the groups of providers who make up the medical care delivery system than it does for the public health system. Lack of cultural and linguistic competency among providers, access to care, educating patients in the prevention of chronic disease, and awareness of health disparities all speak more precisely to shortcomings in Illinois' medical care delivery system and less so to our current public health system. The inclusion of these findings in a document designed to put Illinois on a path to make fundamental improvements in the "public health" system fails to recognize the distinction between the two.

IPHCA is proud of our public entity members such as the Lake County Health Department/Community Health Center, Whiteside County Community Health Clinic, the Will County Community Health Center and the clinic network operated by the Chicago Department of Public Health. These public health entities understood the distinction between their role as health departments and the role they all now play as a provider of primary care services. The result was the spin-off of independent organizations designed to meet the federal requirements for the development of a community health center, i.e. provision of primary and preventive health care services to underserved areas or populations in accordance to the federal program requirements and distinct from the health department, yet cognizant of opportunities to maximize resources and avoiding duplication of services. The end result for the local public health system is a system squarely focused on core mission/functionality rather than transformation.

The significance of this issue is the investment of resources. Where should future governmental, philanthropic, and private sector resources be invested? Should resources be invested in trying to transform the public health system into a direct care provider system or should the existing ambulatory care system be incentivized to address its shortcomings? We believe the latter has already begun. Pay for performance both in the private and public sector holds great promise for coaxing the ambulatory care delivery system to be

more responsive to the kinds findings/issues contained in this assessment and is evidentiary of the kind of innovation and investment being made to improve the system. Embracing the concept of a "Medical Home" i.e. a single point of contact and delivery point for a patient's primary and preventive health care needs is critical to transforming the primary care delivery system into a care continuum with incentives to provide greater quality of care which in turn begins the process of eliminating health disparities, decreasing the prevalence of chronic disease and educating patients to not only better manage chronic illness but to adopt lifestyle changes to avoid them.

We note that within the Illinois Department of Healthcare and Family Services (HFS) Primary Care Case Management program- Illinois Health Connect- local instruments of the public health system, i.e. local health departments have secured a desired status of a "Direct Access" provider. Direct access provides are able to treat patients enrolled in Illinois Health Connect, bill and receive reimbursement for services, despite not being selected by the patient to serve as their Primary Care Provider (PCP) or assigned to serve as the patient's PCP. Non- direct access providers are penalized for serving a Medicaid patient who has not selected them as their PCP. While the status of direct access provider may be viewed as a positive among local public health departments, some of whom have the capacity to provide at least limited services to this population, direct access does undercut the fundamental premise of the program which is the selection of a Medical Home for the patient and thereby elimination of random health care selection within the Medicaid population based on convenience which inevitably, for many Medicaid patients, has led to poor treatment outcomes, zero continuity of care, over or under prescribing and a wasteful drain on state and federal resources.

In order to address issues of access to health care that is affordable, of high quality and culturally and linguistically competent, resources and innovation are needed within the current ambulatory care delivery system. Trying to re-invent the public health system into something it historically is not is a massive, costly and we would argue unnecessary venture. State and federal investment have dramatically increased the reach of health centers into communities where they did not exist just five years ago. Rural Health Clinics, Critical Access Hospitals, small community based hospitals, i.e. the group of providers commonly referred to as the safety net should be encouraged to expand to try and fill gaps in access to care. State and Federal governments as well as the private sectors have a number of initiatives aimed at attracting providers to serve underserved areas of the state and country. The state and federal programs are in desperate need of re-design. However, they exist and with a reasonable amount of political will and resources could be more effective.

Increased investment in technology to better collect, organize and use patient data is underway. The federal government and some states have begun to make these kinds of investments. The provider community seems to be ahead of the curve in this respect. Provider groups are moving to the use of Electronic Health Records and advanced patient management systems to ultimately increase practice efficiencies and improve patient outcomes. In Illinois, our association has operated a statewide practice management system for over five years. There are currently sixteen community health centers on the system. Through economies of scale the current users have purchased and maintained a system which would have been cost prohibitive if they had attempted to purchase it as a stand alone. The initial $1.1 million to develop and purchase the system's components came in the form of a grant to IPHCA from HRSA. We have begun to plan for the development of an Electronic Health Record system for Illinois health centers to sit on top of our practice management system. We anticipate releasing an RFP for the project later this summer and are seeking federal support for the project in the coming federal fiscal year. Already in existence is a health records system for a small group of health centers and hospitals serving the north side of Chicago and the Illinois Hospital and Health Systems Association has developed its own project. These ventures, collectively, demonstrate that the wheels of change within the ambulatory care delivery system have already been set in motion. We strongly support fostering the current momentum in improving that system but we do not believe in slowing the changes which are occurring to try and re-invent the public health system.

Forces of Change Assessment

IPHCA agrees in general with the findings contained in this Assessment. The planning team has done a credible job of listing the changing environmental factors affecting both the health care market place and the Public Health system.

Inherent in the findings however, is a theme of challenges to the public health system by increased investment in the ambulatory health care delivery system versus the public health system. We note with surprise that the within the summary assessment for the *Forces of Change Assessment*, the assessment actually refers to Medicaid, Medicare, and the AllKids programs as both an opportunity for the public health system and a "challenge" to the system. Earlier, the assessment outlines concerns raised about lack of support from government officials, lack of advocacy efforts with legislators and lack of funding due to funding of other priorities. This portion of the summary assessment speaks to the fear among some that the public health system is taking a back seat to other, arguably more

pressing health related concerns, as well as other priorities. We doubt that the authors of the assessment feel "challenged" by recent expansions of the Medicaid program or the development of the AllKids program because it is universally accepted that increased health insurance coverage rates are tied to better health outcomes for patients. Therefore the reader is left with the understanding that the challenge facing the public health system from expansion of these government subsidized programs and funding of other health priorities is greater competition for resources which is another way of acknowledging that the public health system is currently not the priority relative to government investment.

IPHCA believes a strong public health system is a value to all the people of the state. The key for public health stakeholders, in our view, is to look inward at core functionality and try to determine what core functionality is most relevant, i.e. in demand by the community and marketable to decision makers who determine levels of investment.

State Public Health System Assessment

Our comments have focused on certain undercurrents or themes within the draft plan document, particularly the idea of transforming the public health system into a quasi ambulatory/public health delivery system. We have obviously argued against that kind of approach, instead favoring an inward, re-examination of core functions which is what the *Public Health Systems Assessment* begins to do by identifying what core functions are performed well and what functions need more attention, more resources or better/more collaboration with community partners.

We note that the evaluator's top five Essential Public Health Services (EPHS) are numbers 2,7,6,8 and 1. In our estimation EPHS 2, 6, 8 and 1 begin to formulate a core set of functions. A possible next step, in terms of planning, is determining how much value the public and policy makers place on identified strengths and on services which were deemed to be weaknesses and then formulating strategies to garner increased investment to improve upon strengths and to shore up weaknesses.

Finally, we note that the evaluators gave EPHS 7 the most points, slightly above the "substantially met" score range. EPHS 7 or *Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable* speaks to the public health systems role of connecting people to providers within the ambulatory care delivery system who are willing to treat underserved populations. IPHCA is delighted that the evaluators thought that role was being substantially met and we stress again the distinction between helping underserved people find appropriate, comprehensive medical care and the actual delivery of that care.

Thank you again for allowing IPHCA to comment on the draft State Health Improvement Plan.

Testimony of Deborah W. Wolf IAHPERD Past President
(Illinois Association of Health, Physical Education, Recreation, and Dance)

Aug. 4, 2006, SHIP Forum, Mt. Vernon, IL

IAHPERD represents over 7000 health and physical educators in Illinois. The membership of IAHPERD is delighted that physical activity is one of the four major outcomes of SHIP. Te hard work of the planning committee is to be applauded!

Research confirms that physical activity can reduce obesity, drug and alcohol abuse, and violence in schools – physical activity has a crucial relationship to the other three important outcomes in the SHIP document.

We know that children born today have a shorter life expectancy than their parents due to lack of physical activity and obesity. Physical education in schools is the place where children and adolescents learn to develop healthy physical activity habits These habits must be developed early so that they are well ingrained for the remainder of an individual's life. The goal of physical education is to inspire children to pursue an active lifestyle throughout the entire lifespan.

There is a new delivery system in Physical Education to help achieve this goal. Characteristics of this system include:

Individual goal setting

Health related Fitness activities which promote cardiovascular fitness, muscular strength, muscular endurance, flexibility, and desirable body composition.

Variety of activities – roller blading, rock climbing and adventure education, bicycling, aerobic dance, salsa dancing, swimming, as well as individual sports

Technology – heart rate monitor, pedometers, Tri – Fit, Fitnessgram motivate students and allow teachers to collect important data relative to health related fitness.

Cooperative learning is encouraged – activities foster cooperation rather than competition.

Programs are designed to be enjoyable for learners through the use of a variety of activities.

Programs are taught by a certified physical education teacher.

It is hoped that the SHIP document will include an expanded outcome for educational institutions in the area of physical activity which will include some of the above components (pg. 23 – SHIP document). Educational institutions should provide an

increased opportunity for daily physical education, taught by physical education specialists, so that children and adolescents can learn how to develop healthy, active lifestyle habits.

IAHPERD will be happy to help and support efforts of the Illinois Department of Public Health to implement SHIP. IAHPERD membership hopes that Physical Education in schools will be improved and increased as a result of SHIP.

Some questions arose regarding exercise for the aging population. Institutions of higher education are now training undergraduates and graduate students in a variety of fields. Many graduates are now prepared to work with adult fitness programs offered at community facilities (YMCA's, senior centers, city recreation departments, assisted living facilities, nursing homes, cardiac rehabilitation programs, etc.). It is important to include fitness programs and exercise opportunities for this population as communities plan expanded programs for their residents.

As a part of our advocacy efforts her at the Leukemia& Lymphoma Society - Illinois Chapter, we forward the following position papers from our Legislative Priorities & Position Statements.

In forwarding this we are showing our excitement that Illinois has made the effort to put in place The State Health Improvement Plan to address it's six strategic issues for health improvements in Illinois.

It is our hope that as Illinois moves forward that our positions will be considered as they fit into any of the six priority areas.

Sincerely,

Pilar D. McKinney
Community Outreach Manager

Click here to view the page:
http://www.leukemia-lymphoma.org/all_page?item_id=100367

Hello -

I provided oral testimony at the SHIP public hearing held in Chicago on August 9, 2006.

As an epidemiologist and dental public health specialist (boarded by the American Board of Public Health Dentistry), a concern that I have with the SHIP is the face validity of the health priorities for Illinois. I bring up specifically the ranking of oral health. An ongoing concern in capturing the priority of oral health is whether the respondents perceive that health includes oral health. People generally accept that oral health is in general health - but only if mentioned to them or there is someway that they are reminded that they can include oral health in a discussion of health. The finding of oral health being a low priority in Illinois is strongly contrasted with the findings of others - including examples of researchers in Illinois: Dr. Sharon Telleen has found a high ranking in low-income Mexican Americans and Dr. Paul Goldstein has found Oral Health as a top priority among Substance Abuse Treatment Programs. Please note that both Drs. Telleen and Goldstein are not oral health researchers and were suprised by these findings because Oral Health was not in their previous fields of focus.

A very strong contrast of the finding of low prioritization for Oral Health in Illinois is seen in the Rural Healthy People 2010. (http://www.srph.tamhsc.edu/centers/rhp2010/Volume1.pdf) On page 8 - Oral health is the #5 priority - below 1) access to quality health services, 2) heart disease and stroke, 3) diabetes, and 4) mental health & mental disorders, and above tobacco use, substance abuse, educational and community programs, and maternal, infant and child health which were all tied for 6th. On the same page, oral health is listed the 5th priority for the Midwest. The Northeast, South and West actually ranked it higher at 4, 4, and 3 respectively.

The Rural Health People 2010 summarize oral health on page 10: "Oral health is increasingly recognized as a serious rural health problem. Nationally, rural areas record higher rates of people 65 and older with total tooth loss than do their urban counterparts. Among the four regions, only in the Midwest is this rural rate exceeded by the small metropolitan counties. Shortages of dentists are more common in rural areas in all four regions of the country. Dental care, as measured by dental visits within the past year, tends to be lower among 18-64 year-old people in rural areas than in urban areas across all four regions of the country. Dental conditions, too, are identified as "ambulatory-care-sensitive conditions." Dental shortages are identified as major rural health concerns among state offices of rural health. Oral health is named by over 50 percent of national and state experts as

a rural health priority behind access to health care and mental health. Oral health is the fifth ranking rural health priority in a survey of state and local rural health leaders."

The Illinois State Oral Health Plan 1 - "Roadmap to the Future: Oral Health in Illinois" has as Policy Goal 1 - "Change perceptions regarding oral health and disease so that oral health becomes an accepted component for general health." It appears that work remains to be done to have this goal accomplished in our state. But what appears to be learned from this first Plan as the second Plan is being developed, is that the Oral Health community can not drive this goal by itself. The greater health community must recognize the roles of and concerns for good oral health in the state and also work to assure that Oral Health is captured and valued to make progress towards all health.

Thank you

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In the Decatur newspaper article describing the Plan, there was no mention of working in the schools to slow the spread of contagious diseases. I attend many sporting events in many schools each year, and most schools do not provide hot water in their rest rooms. Washing one's hands after using the toilet facilities is a standard public health principle, yet schools are not required/not given sufficient funds to provide hot water. I encourage you to consider this issue. A supplemental step would be to "indoctrinate" students
on the importance of washing their hands with hot water, especially among elementary school children where there is likely to be a stronger effect.

Al Scheider
239 N. Dennis Ave.
Decatur, IL 62522

Subject: Feedback on SHIP

The feedback I have to offer on SHIP follows:

1) This Summary is showing remarkable interdisciplinary collaboration and input, and I say Bravo to the Team who has brought it this far along. It is certainly prevention focused.

2) I'm wondering if a section for references will be included? It would assist the reader to know exact sources.

3) I'd like to see a complete sentence to explain the vision statement - p. 2.

4) The subcommittee is un-defined (p.5) and wonder if that might be found in an appendix?

5) Clarifying which 7 questions were asked of the seven focus groups would be of interest to all (p.8, para 2).

6) The schematic on p. 12 is outstanding!

Thanks, Jan Allen

Strategic Issue: Access

Health Care Providers:

Incorporate prevention into client interactions
Assure health care coverage for all health care workers

Strategic Issue: Data and IT

The intermediate outcomes of the State Health Improvement Plan for Data and IT:

IDPH lead an effort to integrate state and federal environmental data bases with Health Data bases to enable improve environmental health planning by agencies, local governments, and community organizations.

Strategic Issue: Disparities

The intermediate outcomes of the State Health Improvement Plan for Disparities:

Public health system partners incorporate strategies to reduce poverty, environmental exposure inequities, and adverse childhood experiences, increase educational opportunities, and address other social determinants of health ,

(This refers to for instance developing strategies to reduce lead exposure in poor and minoirty communities)

The intermediate outcomes of the State Health Improvement Plan for Measurement, Management, and Improvement:

Align organizational plans with SHIP objectives

Health Insurers:

Assure coverage by sickness and accident insurance until disputes with workers compensation coverage resolves.

p

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August 10, 2006

Ms. Elissa Bassler, Executive Director
Illinois Public Health Institute
James R. Thompson Center
100 W. Randolph, Suite 6-600
Chicago, IL 60601

Dear Ms. Bassler:

On behalf of the Illinois Public Health Association, please accept our appreciation and gratitude for the opportunity to provide the enclosed written testimony on the efforts of the task force and the draft SHIP plan. Although we would have preferred to have given oral testimony, our schedules did not allow time to attend any of the public hearings scheduled for this purpose.

If you have any questions or need anything further, please contact the Association offices at (217) 522-5687.

Sincerely,

Nancy Bluhm

Nancy Bluhm, RNC, MS
President

Enclosure

- On behalf of the Illinois Public Health Association, please accept our appreciation and gratitude for the opportunity for public comment on the efforts of the task force and the draft SHIP plan.

- The Illinois Public Health Association, founded in 1940, is a 6,000 member organization devoted *exclusively* to matters of public health.

- IPHA membership includes a wide variety of individuals and organizations. Our members are local health departments and their employees; nurses and other health professionals employed in hospitals and community health centers; employees of not-for-profit agencies providing case management to high risk pregnant women and families; and physicians, social workers and other health related professionals.

- IPHA submits this testimony in an effort to support the work and detail of the Task Force report and to continue to express our concern and bring attention to the fact that additional funding is absolutely needed for the local health system in general, and specifically for the Local Public Health Protection Grants.

- Appropriate levels of funding for this line would make a significant difference in the public health system and in the ability of local health departments to deliver public health services throughout Illinois.

- Our message is simple:

    - Public Health programs – real public health programs – are the foundation for the lifestyle we have become accustomed to in the US. But these very basic, population-based public health services that assure our safety are sorely under-funded and need attention - now.

- We take it for granted that when we eat at a local restaurant the food we eat will not make us sick. We take it for granted that an outbreak of the measles can be contained and treated and will not put entire communities and at-risk populations in danger. We assume that when the lot next to our house has a new home going up that the private wastewater disposal system is done in such a way that it will not create a health hazard for those around us.

- While we take that for granted – it is becoming harder and harder to assure those very basic assumptions. And on top of that, our local health system is now working even harder to deal with new and emerging threats to the public's health.

- Having the infrastructure and capacity to respond to public health emergencies is not something that can be addressed or taken care of when it happens – it is a commitment that has to be made and in place before there is a food borne outbreak – or before an epidemic occurs.

- The State of Illinois has an interest in assuring that *all* local health jurisdictions provide certain services and programs to ensure the public's health. Each and every local health department, from Chicago and Cook County to the Southern Seven Health Department, must be funded and staffed to have the ability to respond to any public health emergency.

- That is really the basis for the Local Health Protection Grant line – to assure that a minimum level of dollars is available to local health jurisdictions across the state to ensure the provision of population based public health programs.

- While the report makes occasional reference to funding, we believe that the issue of appropriate funding is much more significant than it appears in this draft. Additionally, the references that are made include reference to the delivery of medical care and do not focus on public health services.

- IPHA supports improved access to medical care for all Illinoisans. And while we also support the idea that the two systems have become blurred, and that that is not necessarily a negative, we believe that there continues to be a role for public health that is not intertwined with other parts of the "system".

- The Local Health Protection Grant is the only support that local health departments receive that is non-categorical and allows them to do the day-to-day work of disease prevention and health promotion.

- The current level of funding for Local Health Protection at $17 million does not provide a sufficient base to assure that local health jurisdictions have the capacity and infrastructure to provide these basic health services to the citizens of Illinois.

- Local public health programs are provided by local health departments – and nobody else. There is not a competition to see who gets to identify faulty septic systems that could contaminate private water supplies, where lead is poisoning kids and impacting their ability to learn – nor do we have folks jumping up to be the entity to identify, track and be responsible for containing the spread of infectious diseases. That is okay though – local health departments are the right entities for these tough jobs; but, if we want them to be able to do these important jobs and to be in a position to respond when the next big problem comes along – like SARS, the pandemic flu, or some other threat – we have to make sure there is the financial support to do that.

- Whether in Chicago, Arlington Heights, Morris, or Carbondale, the Local Health Protection Grant makes it possible for local health departments to hire the right people for the right jobs to do the work of Public Health.

- On behalf of the members of the Illinois Public Health Association, we respectfully request that the SHIP report be amended to provide more of a focus on the insufficient

amount of general funding for local health departments and strongly recommend adding dollars to the Department's grant line for the Local Health Protection Grant.

- Thank you very much for the opportunity to express our concerns.

SAVE A LIFE FOUNDATION
RECOMMENDATIONS FOR THE STATE OF ILLINOIS

September 11, 2001 has become as much of a turning point in our nation's history as December 7, 1941 the day Pearl Harbor was attacked. The events of September 11 have clarified in the American collective consciousness the need for citizen preparedness. Although much discussion and debate has taken place on this subject, very few results have been implemented in our communities nationwide.

One of the Department of Homeland Security's primary initiatives since 2003 has been to address this lack of citizen preparedness. While programs like Citizen Corps, CERT and Medical Response Corps have largely worked to involve citizens in emergency response, little has been done to prepare the average citizen to respond to an emergency.

The impact of Hurricane Katrina, the imminent threat of terrorist attacks in our cities and the continued rise in deaths due to every day accidents and injuries have all exposed this lack of preparedness in Illinois and across the nation.

Exacerbating the issue of citizen preparedness is the condition of Emergency Medical Services in our nation. A recent report by the Institute of Medicine explores the many problems EMS is facing.

IOM suggests that the infrastructures of EMS is so severely damaged that unless steps are taken, the ability of individuals to obtain assistance through 911 system will be nonexistent within the next two years.

Emergency Medical Technician professionals are among the lowest paid medical components within the EMS ranks, averaging 0 to $7 per hour nationally. Meanwhile the increasing demand for emergency services requires EMTs to obtain more education and training to effectively perform their jobs.

The under funding of EMS as well as lack of leadership and national standards are major factors in the erosion of the quality of emergency services. Coupled with the state of hospital emergency rooms, many of which are closing due to un-profitability, the nation has eroded toward disaster, according to the IOM report.

Meanwhile, as we search for ways to stem this growing dilemma, existing problems such as the steady rise of teenage traffic deaths plague the already over burdened EMS system. National Highway Traffic Safety Administration statistics show that in 50 percent of all fatal automobile accidents, lives could have been saved if bystanders had rendered prompt aid. Despite these facts, Americans on the whole are no better prepared to cope with a life and death emergency than they were following the September 11, 2001 terrorist attacks.

The above stated problems require complex solutions that will take time and resources of a variety of sectors to resolve. The key recommendations of the Institute of Medicine include creating a coordinated, accountable EMS system, creating a lead agency for EMS, enhancing emergency care research and promoting EMS workforce standards. The use of previously untapped resources will be central and in turn create a broad based, integrated network of educators and outreach at the community level. The infrastructure should include the pre-hospital system and it's providers, other allied health providers, educators and existing organizations. Coupled with that, the infrastructure should develop and evaluate new technologies for training in the dissemination of effective pre-EMS interventions and facilitate provisions of these technologies to the broader community. Illinois needs to provide and maintain a comprehensive, cost effective method of delivering life sustaining first aid skills training to individual citizens, while additionally providing a component to bolster the training of EMS personnel and a pipeline to provide for the development of the EMT workforce. This will assure the future of EMS services at the baseline, pre-hospital level, as well as citizens becoming the link between life and death.

A copy of the IOM report brief can be downloaded at
http://www.iom.edu/CMS/3809/16107/35007/35014.aspx.

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Certified - Return Receipt

Ship Public Comment
c/o Zoe Zhang
100 W. Randolph St. Suite 6-600
Chicago, IL 60601

August 14, 2006

Dear Illinois State Board of Health:

Thank you for announcing via the Edwardsville Intelligencer on Aug. 8 that the State Health Improvement Plan (SHIP) is available for comment until Aug. 17.

According to your website (www.idph.stat.il.us/ship/), "SHIP must include priorities and strategies for health status and public health system improvement in Illinois, with a focus on prevention." Please excuse that because of the shortness of the period for comments, a more detailed statistical background is not possible.

Issue: Noncoverage of Temporo-mandibular Disease (TMD) in Illinois Health Plans

This is to bring to your attention a most serious shortcoming in Illinois health insurance plans, state as well as private. Diseases and dysfunctions of the temporomandibular joint (TMJ or jaw joint) are not covered, neither in medical nor in dental plans. This is the more astounding since the TMJ is the most important and most complex joint of the human body. The TMJ is involved in eating, speaking, breathing, giving the face a normal appearance, posture, and the release of stress, i. e. all the functions that make us typically human.

Dental medicine distinguishes among TMJ (or cranio-mandibular) disorders dozens of different conditions. All are accompanied by certain kinds of pain (almost always including severe and disabling headaches). General symptoms range the gamut from occasional to permanent and disabling. Treatments span the gamut from dietary recommendations to orthodontic, prostho-dontic and surgical interventions. Because of the connection between the jaw joint and the vertebral column (through the atlas joint), untreated TMD often affects the vertebral column, causing tightness and pain in body muscles, and disturbances in the digestive, nervous and immune system. TMD can be a multi-system disease.

TMD is much more frequent than is commonly known. E.g., among the 9-12 million fibromyalgia patients in the US, at least 30% require a TMD evaluation if not intervention (*Robert O. Uppgaard, D.D.S., Taking control of TMJ, New Harbinger 1998; Mark J. Pellegrino, M.D., Fibromyalgia up close and personal, Anadem 2005*).

Consequences of non-coverage by health insurance plants:

1. Patients must pay for treatments themselves (in children, their parents). As a result, few people among those who go to a dentist (your published oral health statistics for poor and non-white Illinoisians are grim enough) can afford TMD treatment. Many TMD conditions develop during childhood, others from accidents, preventing the adult from leading a productive life.

2. Because dentists do not treat patients for free, there has been little interest in TMD clinical research and developing treatment modalities. As a result, TMD clinical knowledge is underdeveloped in comparison to other countries, and so is its teaching.

Among the 50 states with 55 ADEA listed dental schools, Illinois is fortunate to have three (http://www.adea.org). Two are in the Chicago area; in addition, surgical specialties are available at the University of Chicago. The population in the southwestern and southern part of the State, during the 1960s, had access to two dental schools in St. Louis, MO, which provided TMD diagnostic and other services but have since been closed. This area (about a third of Illinois counties), which includes the city of East St. Louis, has, since the 1980s, been served by the new SIU Dental School. This school has so far developed the specialty of implant technology. But most TMD cases are non-surgical. There is interest among area dentists, but the lack of health plan coverage limits their services. E.g., patients requiring prosthodontic services that exceed the competence available through dental students at SIU are limited to the 8 hours per week the SIU prosthodontist has available for private practice!

3. Because of the lack of both, TMD clinical research and training, many dentists fail to recommend timely preventative intervention or make mistakes that harm a patient's TMJ.

Strategy for Improvement:

The Illinois State Board of Health needs to recommend to the Governor and the Legislature

> to pass a law requiring all health insurance plans to cover disorders of the temporo-mandibular joint.

The following is an example for a text used in another US state:

> "... (chapter number) No policy or certificates of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under Chapter ..., or health maintenance organization regulated under Chapter ..., shall be issued, renewed or continued, delivered, issued for delivery, or executed in this state after ..., unless the policy, plan or contract specifically provides coverage for surgical and non-surgical treatment of Temporomandibular Joint Disorder and Cranio-mandibular Disorder. Coverage shall be the same as that for treatment to any other joint in the body, and shall apply if the treatment is administered or prescribed by a physician or dentist."

Such a law would encourage Illinois dental schools and dentists to improve their knowledge of the TMJ and its disorders, improve preventative care, reduce the amount of erroneous dental treatments, and improve the care of current cases.

Any consideration you may be able to give my Comment shall be gratefully appreciated.
Sincerely yours,

G. Wittig

Gertraude Wittig, Prof. Emer. SIUE, Dr. rer. nat., e-mail: *gwittig@empowering.com*

For further information after Aug. 28, please contact

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Or:

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ST. CLAIR COUNTY
HEALTH CARE COMMISSION
PARTNERS FOR HEALTH

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August 4, 2006

Eric E. Whitaker, MD, MPH, Director
Illinois Department of Public Health
Co-Chair SHIP Team

Robert Kieckhefer
Blue Cross/Blue Shield of IL
Co-Chair, SHIP Team

Dear Dr. Whitaker and Mr. Kieckhefer:

The St. Clair County Health Care Commission was established in 1991 and serves as a county-wide partnership of members of the local public health system. Our mission is to mobilize private and public sectors to identify health care problems facing our community and to develop and implement interventions to achieve our vision of a collaborative public health system that mobilizes resources to meet identified health needs and promote the health and well-being of all of the residents of St. Clair County.

In July 2006, the Commission adopted the **Community Health Assessment and Planning Project: Mobilizing for Action through Planning and Partnership (MAPP).** This community assessment and health plan has identified the following six strategic issues:

- *How can the St. Clair County health care community strengthen the public health workforce?*
- *How can the St. Clair County health care community address the needs of those who require behavioral health services?*
- *How can the St. Clair County health care community improve health outcomes for cardiovascular diseases, maternal and child health, and respiratory diseases?*
- *How can the St. Clair County health care community create a broader community connectedness?*
- *How can the St. Clair County health care community improve health services to the aging community?*
- *How can the St. Clair County health care community improve access to care?*

The Commission is moving forward with our community partners to define goals and action steps that we will implement to address these issues. We have reviewed the **State Health Improvement Plan Summary for Public Comment** and the draft strategic issues and have noted the similarity of many of the statewide strategic issues with those identified in St. Clair County. The findings of the SHIP Planning Team are clearly supported by the input from a variety of sources and resonate with our findings at the community level.

In addition the SHIP strategic issues that address disparities and access to care also mirror health needs that we have identified in our community. Enclosed for your reference is a copy of written testimony presented by the Commission at the Health Care Justice Act, Adequate Health Care Task Force hearing that was held in our region. Upon review, you will note many of the same issues as were identified by your team.

We believe this cross-connectiveness with local assessments and plans strengthens the reliability and validity of the State Health Improvement Plan and increases the opportunities for collaboration between the local public health system and the statewide public health system in achieving our mutual goal of promoting the health and well-being of all of the residents of the State of Illinois. Accordingly, the St. Clair County Health Care Commission is pleased to support the State Health Improvement Plan as proposed by the SHIP Planning Team.

Thank you for the opportunity to review and comment on this plan. We look forward to working with you and other members of the public health system to implement action needed to realize the SHIP vision statement.

Sincerely,

Kevin D. Hutchison, R.N., M.S., M.P.H.
Chairman

Enclosure

KDH:ld

East Side Health District

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August 4, 2006

STATE HEALTH IMPROVEMENT PLAN ORAL HEALTH CONSIDERATIONS

ORAL HEALTH

SHIP appears to have overlooked oral health needs of the average person and how it affects them in their day to day life.

Even though oral health is an integral component of overall health and has links to all of the four priority areas in the State Plan, it is not highlighted in the plan. Even the vision statement of the Plan should include oral health with mental health in order to bring oral health to the forefront.

Oral health is being discussed and recognized nationally by other states. The Surgeon General published the first ever report on **Oral Health in America in 2000**. **Healthy People 2010** has a chapter on oral health.

Perhaps a perceived lack of oral health data or proven strategic interventions predicated the oversight. This perception should lead to a larger focus on oral health by the State Board of Health to assist Illinois communities in coping with oral health needs.

There is a gross under funding of dental Medicaid services and no Medicaid funding for adult preventive oral health care; lack of dentists and dental hygienists employed in public health settings; few safety net facilities especially in rural Illinois and even fewer dental providers offering specialized care for very young children and complex oral surgery needs; and a ubiquitous lack of value of oral health from all sectors throughout the state. These are significant health problems that require significant attention in the State Health Improvement Plan.

Oral health impacts all four priority areas addressed in the Plan not just "Alcohol, Tobacco and Other Drugs" and "Violence." Physical activity is linked to oro-facial injuries and the need for preventive mouthguard use. Poor nutrition is a risk factor for both obesity and oral health and how can we expect people to eat a diet rich in fresh fruits and vegetables if they have poor oral health. Good oral health should be considered a protective factor against obesity.

Consider this as a ponderable, if the field of Dentistry was truly an integral part of the Medical field a Physician who specializes in Dentistry rather than Cardiology would have had profound impact on oral health. Rather than having field of Dentistry as a separate entity. As we search for answers in our quest to improve the overall health of all the people throughout the State of Illinois we must consider and include oral health as a crucial component that will create healthier people within each respective community throughout the State of Illinois.

Submitted by: Hardy Ware, Assistant Administrator
East Side Health District

Chicago End-of-Life Care Coalition

Statement to the
Illinois Department of Public Health
Concerning the
State Health Improvement Plan

August 9, 2006
Chicago, Illinois

The proposed State Health Improvement Plan represents significant and valuable work on the part of the Illinois Department of Public Health and the Planning Team charged with its development. Finalizing this plan and taking action to implement it are ambitious and highly appropriate activities, and you deserve high praise for this undertaking. The Chicago End-of-Life Care Coalition (CECC) is pleased to have this opportunity to present this statement and make recommendations to more fully involve the public as partners in maintaining and improving the health of the citizens of Illinois.

Background

The Chicago End-of-Life Care Coalition was organized in January 2000 in association with the PBS television documentary series "*On Our Own Terms: Moyers on Dying in America.*" This program was a starting point for local community education efforts to improve care for the dying. The CECC began as a grassroots effort as a first step toward establishing an ongoing coalition of like-minded organizations and facilities in the Chicago area. The CECC is a membership group representative of hospices and hospitals, as well as physicians, nurses, clergy, social workers, patient advocates, and community members who work together to educate Chicago's diverse community about the opportunities in comprehensive care near the end of life. The CECC is an all-volunteer, not-for-profit corporation, led by a board of directors (see the attached appendix) that includes some of Chicago's most dedicated and talented health care representatives and leaders dedicated to improving care for patients and individuals at the end of life.

The CECC participates in outreach and educational efforts for health care professionals, institutional providers and the public. The Chicago End-of-Life Care Coalition aims to advance the conviction that people should expect excellent care at the end of life, and that health care institutions should be able to meet this expectation.

Recommendations

In reviewing the July 14 draft, we focused on how or if the proposed state plan recognized the need to advance self-management and access to palliative care. While there is mention of self-management, the document fails to mention palliative care or expound on the role of the public.

- The importance of *self-management* needs to be expressed more strongly;
- Addressing *palliative care* needs should be included in the discussion on access; and
- The *role of the public* as the beneficiaries and partners in advancing public health should be incorporated into the final plan.

Self-management – Looking to the ten essential public health services identified on page four, the importance of the individual and the people in the state is readily seen. Easily half of the services have direct links to the people of the state. They tie to the role of the individual being aware of personal and public health issues and the need for the individual to manage his or her own contacts with the health care system. (An example of self-management is the Medicare requirement for hospitals and long-term care facilities to inquire on admission whether patients have executed advance directives and identified someone to have power of attorney for health care decisions.) In finalizing the State Health Improvement Plan, far more should be done to recognize the importance and value of self-management. In this regard, the Department should consider establishing a reporting requirement on advance directives and related compliance, as well as other information on self-management activities. This will go a long way in addressing the one essential that is identified as "not met:" the development of "policies and plans that support individual and statewide health efforts."

Palliative Care – Advancing the health of the public is, appropriately, a very broad subject. From birth to death, the range and quantity of health care experiences and services an individual encounters are voluminous. Our concern is that the document fails to address the reality that patient needs often shift from cure to care, and that self-management includes the decision to seek palliative care. Hospice care, a recognized Medicare benefit, focuses on palliative care. This focus is a very different concept from even long-term care, and it must be included in the identification of services for necessary access.

Role of the Public – In addressing potential roles for "each sector of the public health system," the proposed plan identifies ten sectors (business, community-based/Faith-based organizations, educational institutions, health care providers, health insurers, legislature, local health departments, multiple sectors, state agencies, and voluntary health organizations), without identifying any role for the public. We can ill afford to forget that the public, each of us as well as our family members and everyone else, constitutes those who need and receive health care services, including palliative and end-of-life care. We believe that the public must be included as one of the key sectors of the public health

system, and that this will be a valuable tool in recognizing the role of the individual in effective self-management.

Based on these three identified areas that we strongly believe need to be addressed, we recommend making the following specific changes in finalizing the State Health Improvement Plan:

Specific Recommendations

Page 2, Vision Statement: Consistent with the need to have a more effective focus on self-management, the vision should include recognition of individuals as part of the public health system. We recommend adding the phrase "individuals as well as" to the statement as follows:

> Optimal physical, mental, and social well-being for all people in Illinois through a high-functioning public health system comprised of active individuals as well as public, private, and voluntary partners.

Page 2, Identification of Strategic Issues, third bullet: In identifying access as one of the strategic issues, the document should be expanded to recognize the importance of palliative care. We recommend adding this as follows:

> Improving access to prevention programs, mental health, and medical, ~~and~~ long-term and palliative care services.

Page 13, Access, framing question: The question that frames this strategic issue should be modified to recognize the role for palliative care as follows:

> How can the people of Illinois gain access to quality prevention programs, mental health, and medical, long-term and palliative care when they need it?

Page 13, Intermediate Outcomes, seventh bullet: This is the point in the document where self-management is mentioned, and this needs to be strengthened. This can be done by the identification of the individual in setting and making care decisions, and we recommend adding an example of self-management as follows:

- Information, motivation, and skills in prevention and self-management (such as completion of advance directives and identification of someone to hold durable-power-of-attorney for health care decisions) for individuals.

Page 14, Public Health Care Sectors, Access: The importance of self-management needs to be included in the responsibilities for both health care providers and insurers. Absent this, it appears that the patient or client is not a key partner in the decision making process. We recommend adding the phrase "and self-management" after the word "prevention" in the first bullet under both the provider and insurer headings, and change the word "part" to "parts" in the first bullet under the insurer heading.

The public itself, with the importance of self-management, needs to be identified as a key sector within the public health system. We recommend including this as a new final sector on page 14 as follows:

The Public:

- Take part in and act on public health initiatives, and taking responsibility for self-management

Page 16, Public Health Care Sectors, Data and IT: The identification of the public as a key sector within the public health system needs to be included in the discussion on data and IT. In the self-management role, especially with the growing importance of electronic health information, individuals play a key part in ensuring the accuracy and completeness of personal health information. This can be addressed by adding a new sector on page 16 as follows:

The Public:

- As an element of self-management, individuals should ensure the accuracy and completeness of personal health information.

Page 18, Public Health Care Sectors, Disparities: The public has a role as a public health care sector in identifying and ultimately eliminating care disparities. To this end, we recommend adding a new sector on page 18 as follows:

The Public:

- Have information available on access to high quality health care services

Page 18, Public Health Care Sectors, Measure, Manage, and Improve the Public Health System: As the ultimate beneficiaries, the public needs to be recognized as an active participant in efforts to measure, manage and improve the public health system. To this end, we recommend adding a new sector on page 20 as follows:

The Public:

- Be active participants in support of educational and other initiatives to maintain and improve public health

The Chicago End-of-Life Care Coalition appreciates your attention to our views and the recommendations set out in this testimony. The CECC is available to continue acting as a resource in your efforts to develop the State Health Improvement Plan. Please contact us if there is any further information or assistance that we may provide.

Chicago End-of-Life Care Coalition
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DuPage Medical Group
ADMINISTRATIVE OFFICE

1100 W. 31st Street, Suite 300, Downers Grove, IL 60515 • p 630 469 9200

August 1, 2006

SHIP Public Comment
c/o Zoe Zhang
Illinois Public Health Institute
100 W. Randolph Street, Suite 6-600
Chicago, IL 60601

Via email @DPH.SHIP@illinois.gov

To Whom It May Concern:

I am writing on behalf of DuPage Medical Group to commend the Illinois State Board of Health for their work on the State Health Improvement Plan (SHIP). As a multi-specialty group providing health care to 25% of DuPage County residents, we believe it is important to educate all Illinois physicians about the general health status of Illinois residents so that we can undertake focused efforts in our practices and through community service to improve the health of Illinois citizens.

Although many laudable goals are included in the Improvement Plan, we believe that the most important is ensuring that all people have access to health care services. DuPage Medical Group and many other physicians and hospitals in DuPage County provide health care services to the uninsured through Access DuPage. This organization is a public-private partnership that mobilizes health care providers to share in solving the problem of health care access for the uninsured.

I noted that part of the mission of the SHIP team is to answer the question of "what assets do we have that can be used to improve Illinois' health?" I submit that one of the most powerful assets we possess is our dedicated health care community. I believe that partnerships such as Access DuPage could be implemented statewide to improve access to health care services. I urge the SHIP team to explore how organizations such as Access DuPage could be used in this effort.

Please feel free to contact me if you have any questions regarding this matter. I can be reached at 630-942-7962.

Sincerely,

James R. Dan, M.D.
President

CC: The Honorable Dan Cronin
The Honorable Kirk W. Dillard
The Honorable Chris Lauzen
The Honorable John Millner
The Honorable Carole Pankau
The Honorable Peter J. Roskam
The Honorable Arthur J. Wilhelmi
The Honorable Patricia R. Bellock
The Honorable Lee A. Daniels
The Honorable Joe Dunn
The Honorable Paul Froehlich
The Honorable Brent Hassert
The Honorable Randall M. Hultgren
The Honorable Roger A. Jenisch
The Honorable Patricia Reid Lindner
The Honorable James H. Meyer
The Honorable Sandra M. Pihos
The Honorable Harry R. Ramey, Jr.

STATE OF ILLINOIS
OFFICE OF THE LIEUTENANT GOVERNOR
JAMES R. THOMPSON CENTER, SUITE 15-200
Chicago, Illinois 60601

Tuesday, August 8, 2006

Contact: Peter Newell 312-814-5240
Susanne Hack 312-814-8440

Statement by Lt. Governor Pat Quinn
Regarding the Illinois State Health Improvement Plan:

August 8, 2006

"While the State Health Improvement Plan identifies four priority areas – obesity, violence, physical activity, and substance abuse – it is silent on an epidemic plaguing Illinois children – poor oral health.

"Tooth decay is the number one cause of chronic illness in children and toothaches are the leading cause of school absenteeism. In fact, in 2003 the U.S. Surgeon General estimated a staggering 51 million school hours are missed each year due to the effects of dental disease.

"Additionally, poor oral health can lead to the very problems the Plan seeks to address. For example, dental decay can lead to problems with eating, speaking, concentrating and learning in school. Once these problems occur, students inevitably fall behind. This leads to poor self esteem which can result in disruptive, violent behavior and substance abuse.

"That's why I have made access to quality oral health care for all people a top priority. With the help of the Illinois legislature's only dentist, Rep. David Miller (D-Dolton), we helped pass the *Health Smiles Initiative* requiring dental exams for every Illinois child entering Kindergarten, 2nd, and 6th grade.

"Dental disease is an education issue, public health issue and economic issue facing every Illinoisan and we need to continue to battle this growing epidemic by making it a priority of the Illinois State Health Plan."

SHIP Hearing

The McLean County Health Department is pleased to see that much emphasis has been placed on prevention and evidenced based programs in the State Health Improvement Summary. However, the needed resources are not available for the suggested prevention programs addressing tobacco, obesity, and cardiovascular programs such as Heart Smart for Women and Teens. In fact, resources have been held constant at best and in many cases, have dwindled. An example of decreased funding for local health departments would be the reduced amount of money allotted from the Master Tobacco Settlement funds for prevention messages and tobacco cessation programs. The state granted more than $30 million for such programs in FY2000 and is now is appropriating approximately $10 million. McLean County Health Department first received $153,000 For FY 2000 and then the money was slashed to $53,859 forcing us to reduce staff and cut programs.

The message from the recent Surgeon General's report is so powerful when stating that smoking is the single greatest avoidable cause of disease and death. In fact, scientific evidence indicates there is no risk-free level of tobacco exposure! There is so much work to do to educate the public and so little funding to accomplish that great task. We know that:

- Millions of people in the US are exposed to second hand smoke in their homes and work places.
- Approximately 30% of indoor workers are not covered by smoke-free workplace policies
- Tobacco smoke and second hand smoke contains hundreds of chemicals known to be toxic or carcinogenic
- Children exposed to secondhand smoke are inhaling the same cancer-causing chemicals as the smokers. Thus, they are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory problems and asthma.
- Smoking and exposure to second hand smoke causes coronary heart disease and lung cancer as well as contributing to many other cancers.

Health professionals must deliver the prevention messages to a variety of audiences: To the kids before they begin using tobacco. Evidence shows that if adolescents and teens do not begin tobacco use prior to age 18, most likely they will never take up the habit. To parents and future parents that tobacco use is hazardous to the health of children in their homes as well as to their unborn children. And, we must help the many persons wanting to quit smoking. All these programs are necessary to reduce the morbidity and mortality rates in McLean County, Illinois, and the United States due to cardiovascular disease, lung and other cancer, SIDS, asthma, and other respiratory conditions. We at McLean County Health Department ask the State of Illinois to reinvest in the health of your citizens by allocating more money for the needed tobacco programs in all local county health departments.

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