

>>> GOOD AFTERNOON, EVERYBODY. IT'S 1:00. WELCOME TO THIS THE CDC "GRAND ROUNDS." HERE IS SOME GENERAL INFORMATION FOR THOSE OF YOU WHO I THINK IT'S A VERY SMALL NUMBER, I HOPE, MAY BE JOINING US FOR THE FIRST TIME, ABOUT THE VENUES WHERE YOU CAN FIND INFORMATION ABOUT CDC "GRAND ROUNDS." HERE IS SOME INFORMATION ABOUT THE TOPICS THAT WILL BE DISCUSSED IN THE UPCOMING YEAR. WE HAVE CONDUCTED 35 "GRAND ROUNDS" SO FAR SINCE SEPTEMBER OF 2009. SO HERE'S A LIST OF THINGS THAT ARE COMING IN THE NEXT FEW MONTHS. TODAY'S TOPIC IS DISABILITY AND PUBLIC HEALTH PRACTICES TO INCLUDE PEOPLE WITH DISABILITIES. AS WE ALWAYS DO, WE COORDINATE CDC TOPICS IN THEM WITH THOSE THAT WE COVER IN OUR MONTHLY "GRAND ROUNDS." HERE IS A LIST OF ARTICLES THAT HAVE BEEN FEATURED IN THIS WEEK'S SCIENCE CLIPS. AND WE THANK MICHAEL FOX FOR THE SELECTION OF THIS WEEK'S CLIPS THAT COORDINATES WITH OUR PRESENTATION. LET ME SAY A FEW WORDS ABOUT OUR PRESENTERS THIS WEEK. THIS MONTH, THIS IS BLESSED AMONG WOMEN. THAT'S DR. GEORGES BENJAMIN. THIS IS INDEED A SPECTACULAR GROUP OF WOMEN AND I HAVE TO SAY THAT THIS IS OUR 36th "GRAND ROUNDS." AND THE FIRST ONE WHERE WE HAVE ACTUALLY COMPLETED EVERYTHING 24 HOURS AHEAD OF SCHEDULE. SO WE HAVE HAD A GYMNASTICS FABULOUS FIVE AND THIS IS REALLY A FABULOUS FOUR. THE FABULOUS FOUR IN ADDITION TO DR. BENJAMIN, ARE JENNIFER HOOTMAN, MONIKA MITRA, CATHERINE GRAHAM. I WANTED TO ENCOURAGE YOU TO GO TO THIS WEBSITE THAT WAS BROUGHT TO OUR ATTENTION BY OUR ASSOCIATE DIRECTOR FOR COMMUNICATION AT THE HUMAN DEVELOPMENT AND DISABILITY. SO YOU CAN TAKE A DEEPER LOOK INTO THE LIVES OF PEOPLE WITH DISABILITIES AS THEY OVERCOME BARRIERS TO LIVE, WORK AND PLAY. THIS ALBUM HIGHLIGHTS THEIR FULL AND ACTIVE LIVES WITH DISABILITY TELLING THEIR STORIES IN PICTURE. IT REALLY IS FANTASTIC.

>> GOOD AFTERNOON. JUST AS THE LAST FEW DECADES HAVE SEEN THE INCLUSION OF PEOPLE WITH DISABILITY INTO THE BROADER SOCIETY, I THINK WE'RE NOW FINALLY BEGINNING TO SEE THE INCLUSION OF DISABILITY INTO ALL

OF PUBLIC HEALTH. THAT TO A GREAT EXTENT IS WHAT THIS SESSION IS ALL ABOUT. DISABILITY DOESN'T HAVE TO MEAN ILL HEALTH AND YET, FOR FAR TOO MANY PEOPLE IT DOES. AT CDC, WE'RE THE NATION'S PREVENTION AGENCY AND WE THINK ABOUT BOTH PREVENTING DISABILITY AND PREVENTING THE LOSS OF FUNCTION THAT PEOPLE WITH DISABILITY CAN AVOID. SO I THINK THE VISION FOR SUCCESS HERE IS IMPORTANT BECAUSE WE RECOGNIZE THAT THE NUMBER OF PEOPLE WITH DISABILITY IN THIS COUNTRY IS GROWING. WE RECOGNIZE THAT ELIMINATING HEALTH INEQUALITIES IS A CORE MISSION FOR PUBLIC HEALTH AND A CORE MISSION FOR THE CDC. AND WE KNOW THAT DISABILITY CUTS ACROSS EVERYTHING WE DO IN THE CDC. WE KNOW THAT IT'S NOT MERELY A PUBLIC HEALTH ISSUE, BUT AN ISSUE FOR SOCIETY MORE GENERALLY. AND IF WE'RE GOING TO BE EFFECTIVE AT ADDRESSING BOTH PREVENTION AND LIVING OPTIMALLY WITH DISABILITY, WE'RE GOING TO HAVE TO HAVE TO A MULTISECTIONAL APPROACH THAT INVOLVES ALL OF SOCIETY. THIS I THINK IS NOT JUST A CHALLENGE, BUT AN OPPORTUNITY TO WORK CREATIVELY AND EFFECTIVELY AND ACHIEVE EVEN BETTER RESULTS AS WE WORK IN THE FUTURE. I THINK WE'RE VERY WELL POSITIONED TO MAKE REAL PROGRESS. WE HAVE MORE INFORMATION THAN EVER BEFORE. WE HAVE MORE TOOLS ON WHAT WORKS THAN WE'VE EVER HAD BEFORE. AND WE HAVE THE ABILITY TO USE THE TOOLS THAT WE HAVE AND USE THE INFORMATION THAT WE HAVE TO IMPLEMENT PROGRAMS, SEE IF THEY'RE WORKING AND CONTINUOUSLY IMPROVE THEM. THERE ARE MANY THINGS THAT WE NEED TO DO. WE NEED TO INCREASE THE AVAILABILITY OF SURVEILLANCE INFORMATION ON DISABILITY. WE NEED TO SCALE UP EXISTING PROGRAMS THAT WORK USING A MULTISECTIONAL APPROACH AND I WOULD HIGHLIGHT ONE AREA THAT CUTS ACROSS BOTH PREVENTION OF DISABILITY AND OPTIMAL LIVING WITH DISABILITY AND THAT INVOLVES PHYSICAL ACTIVITY. YOU KNOW, HERE'S SOMETHING ABOUT PHYSICAL ACTIVITY, BUT IT'S KEY. BECAUSE NOT ONLY CAN IT PREVENT DISABILITY IN MANY CASES, BUT FOR VIRTUALLY EVERYONE WITH A DISABILITY IT CAN REDUCE FUTURE DISABILITY AT ALMOST EVERY LEVEL OF DISABILITY. IT CAN IMPROVE HEALTH OVERALL. THAT ULTIMATELY IS WHAT WE'RE ALL ABOUT.

SO I WANT TO THANK THE PRESENTERS FOR BEING HERE AND THANK THE AUDIENCE FOR PARTICIPATING.

>> GOOD AFTERNOON. MY NAME IS GLORIA KRAHN AND I DIRECT THE DIVISION OF HUMAN DEVELOPMENT AND DISABILITY AT CDC. SORRY, WE'RE HAVING TROUBLE WITH -- TRY THIS ONE. PEOPLE WITH DISABILITIES IS A SOMEWHAT AMORE SIS TERM THAT THEY NOT COMMUNICATE WHOM WE'RE TALKING ABOUT. THEY INCLUDE CHILDREN BORN WITH SPINAL BIFF ADA OR SOMEONE WHO LOSES A LIMB DUE TO INJURY. A PERSON WITH CHRONIC ILLNESS LIKE DIABETES THAT'S LED TO A FUNCTIONAL AND A LIMITATION LIKE AMPUTATION OR VISION LOSS. OR AN ELDER WITH INCREASING FRAILTY OR DEMENTIA. PEOPLE WITH DISABILITIES ARE PEOPLE WITH LIMITATIONS IN HEARING, VISION, MOBILITY, COGNITION AND EMOTIONAL AND BEHAVIORAL DISORDERS. THEY ALL EXPERIENCE A SERIOUS LIMITATION IN FUNCTIONING THAT CAN MAKE IT HARDER FOR THEM TO ENGAGE IN VARIOUS ACTIVITIES WITHOUT ACCOMMODATION OR SUPPORT. ACCORDING TO THE WORLD HEALTH ORGANIZATION, THERE ARE THREE WAYS OF CONSIDERING DISABILITY. THE FIRST IS IMPAIRMENT IN BODY FUNCTION OR STRUCTURE LIKE LOSS OF A LIMB OR COMPLETE RETINAL DETACHMENT. THE SECOND A LIMITATION IN ACTIVITY LIKE PROBLEMS SEEING, WALKING AND THE THIRD, A PERSON EXPERIENCES RESTRICTIONS IN PARTICIPATING IN ACTIVES LIKE DIFFICULTY IN PREPARING A MEAL OR DRIVING A CAR. SHOWN GRAPHICALLY, THESE THREE TYPES OF LIMITATIONS RELATE TO A HEALTH CONDITION OF AN INDIVIDUAL THAT IS EXPERIENCED WITHIN THE ENVIRONMENT IN WHICH PEOPLE LIVE AS WELL AS OTHER PERSONAL FACTORS. ENVIRONMENTAL BARRIERS CAN BE PHYSICAL BARRIERS LIKE STAIRS BUT NOT HAVING RAMPS AVAILABLE. COMMUNICATION BARRIERS LIKE WEBSITES THAT CAN'T BE READ BY SCREEN READERS. DISCRIMINATORY POLICIES LIKE PHYSICAL WORK REQUIREMENTS FOR EMPLOYMENT. OR SOCIETAL ATTITUDES THAT ARE MORE OR LESS WELCOMING TO DISABILITY DIFFERENCES. CONSEQUENTLY, DISABILITY IS NOT THE HEALTH CONDITION ITSELF, BUT IS THE LIMITATION VIEWED IN THE CONTEXT OF THE

COMMUNITY AND SOCIETY IN WHICH A PERSON LIVES. SOCIETAL AND ENVIRONMENTAL ACCOMMODATIONS ARE CRITICAL IF PEOPLE WITH DISABILITIES ARE TO PARTICIPATE IN PUBLIC HEALTH PROGRAMS THAT PREVENT DISEASE AND PROMOTE HEALTH. USING THE NEWLY ADOPTED DEPARTMENT OF HEALTH AND HUMAN SERVICES IDENTIFIERS FOR DISABILITY IN SURVEYS, IN OUR COUNTRY ONE IN SIX ADULTS HAVE A DISABILITY. THAT'S 37.5 MILLION ADULTS OR 16% OF THE U.S. POPULATION. HEALTH CARE COSTS ASSOCIATED WITH DISABILITIES ARE ESTIMATED AT ABOUT \$400 BILLION PER YEAR. MORE THAN ONE-QUARTER OF ALL HEALTH CARE EXPENDITURES. THIS GRAPH SHOWS THE ESTIMATED PROPORTION OF PEOPLE WITH DISABILITIES BY AGE AS REPORTED ON THE NATIONAL HEALTH INTERVIEW SURVEY IN 2010. WHILE THE PROPORTION OF PEOPLE WITH DISABILITIES INCREASES WITH AGE, THE MAJORITY OF PEOPLE WITH DISABILITIES IS STILL UNDER THE AGE OF 65. MORE THAN ONE-THIRD OF ALL PEOPLE WITH DISABILITIES ARE THOSE BETWEEN THE AGES OF 45 AND 64, THOSE PRIME YEARS OF WORK FORCE. SO WHAT ARE THE KINDS OF LIMITATIONS REGARDLESS OF THEIR CAUSE? WELL, 46% OF PEOPLE WITH DISABILITIES REPORT SERIOUS TROUBLE WALKING OR CLIMBING STAIRS. ALMOST 39% HAVE PROBLEMS TROUBLE SOLVING. THAT'S TROUBLE CONCENTRATING OR REMEMBERING OR MAKING DECISIONS. 21% HAVE SERIOUS DIFFICULTY SEEING, EVEN WHEN WEARING GLASSES. AND 35% NEED HELP WITH SELF-CARE LIKE BATHING OR HAVE TROUBLE DOING ERRANDS ALONE LIKE SHOPPING. THESE PERCENTAGES TOTAL MORE THAN 100 BECAUSE 43% OF PEOPLE REPORTING DISABILITIES REPORT HAVING MORE THAN ONE LIMITATION. SO WHAT ARE THE CAUSES OF DISABILITY? THE MOST COMMON CAUSES ARE ARTHRITIS AND BACK PROBLEMS. FOLLOWED BY HEART, RESPIRATORY, EMOTIONAL PROBLEMS, DIABETES, HEARING, LIMB PROBLEMS, VISION AND STROKE. NOW, PEOPLE WITH DISABILITIES HAVE THE SAME HEALTH NEEDS AS NONDISABLED PEOPLE. THEY ALSO MAY EXPERIENCE A NARROWER MARGIN OF HEALTH BECAUSE OF POVERTY AND OTHER SOCIAL DETERMINANTS OF HEALTH OR THEY MAY BE SUSCEPTIBLE TO PRESSURE SORES AND THEY HAVE PROBLEM ACT SELSSING HEALTH AND PUBLIC HEALTH SERVICES AND YOU'LL MORE ABOUT THE DOCUMENTED HEALTH

DISPARITIES. THERE WAS INCREASING RECOGNITION THAT DISABILITY IS PART OF THE NORMAL HUMAN EXPERIENCE. AND THAT PUBLIC HEALTH HOLDS THE RESPONSIBILITY TO IDENTIFY HEALTH DISPARITIES THROUGH DATA, PROMOTE THE HEALTH OF PEOPLE WHO HAVE DISABILITIES AND CLOSE THE GAP IN HEALTH DISPARITIES. AT CDC, WE STRIVE TO ACHIEVE THE BROADEST IMPACT BY FOLLOWING THIS STRATEGY. FIRST, WE WORK TO HAVE PEOPLE WITH DISABILITIES INCLUDED IN MAINSTREAM SERVICES WHEREVER POSSIBLE BY ACCOMMODATING TO THEIR LIMITATIONS. AND WE ADDRESS THE HEALTH NEEDS THAT ARE UNIQUE TO THOSE WITH DISANDS SUCH AS ENVIRONMENTAL ACCESS. THIRD, WE USE CONDITION SPECIFIC FOCUS WHERE THAT IS ESSENTIAL. AT CDC, WE'RE WORKING TO INCLUDE PEOPLE WITH DISABILITIES IN OUR SURVEYS, PROGRAMS, POLICIES AND COMMUNICATION. WE FUND A NETWORK OF 18 STATES DISABILITY AND HEALTH PROGRAMS THAT WORK WITHIN THEIR STATE TO IMPROVE HEALTH CARE ACCESS, HEALTH PROMOTION AND THE EMERGENCY PREPAREDNESS. WE ALSO FUND A NETWORK OF PUBLIC HEALTH RESOURCE CENTERS TO REACH KEY POPULATIONS ON HEALTH COMMUNICATIONS AND INTERVENTIONS. THESE CENTERS ADDRESS INTELLECTUAL DISABILITIES, LIMB LOSS, PARALYSIS AND PHYSICAL ACTIVITY. AND NEXT PRESENTER IS DR. MONIKA MITRA.

>> THANK YOU. GOOD AFTERNOON. I'M MONIKA MITRA, AN ASSISTANT PROFESSOR OF FAMILY MEDICINE AND COMMUNITY HEALTH AT THE UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL. THIS AFTERNOON I'LL BE TALKING ABOUT HEALTH DISPARITIES AMONG PEOPLE WITH DISABILITIES IN MASSACHUSETTS. IN 1990, THE AMERICANS WITH DISABILITIES ACT WAS PASSED. IT WAS FIRST CIVIL RIGHTS LAW TO SPECIFICALLY ADDRESS THE NEEDS OF PEOPLE WITH DISABILITIES IN THE UNITED STATES. THERE'S BEEN AN INCREAING INCLUSION OF THOSE IN FEDERAL EFFORTS RELATED TO HEALTH CARE. ONCE THE EFFORT WAS THE INCLUSION OF ELIMINATING DISPARITIES BETWEEN THOSE WITH OR WITHOUT DISABILITIES. IN CONTRAST TO THE EARLIER FOCUS ON DISABILITY BEING PREVENTABLE OUTCOME OF DISEASE. HOWEVER, DESPITE ALL

OF THESE EFFORTS, PEOPLE WITH DISABILITIES CONTINUED TO FACE ENORMOUS HEALTH DISPARITY. THE DATA IN MY PRESENTATION IS PRIMARILY BASED ON TWO SOURCES. THE BEHAVIOR RISK SYSTEM AND THEY'RE BOTH CDC FUNDED. IT'S A RANDOM DIGITAL TELEPHONE SURVEY OF ADULTS IN THE U.S. IT'S THE PRIMARY SOURCE OF STATE-BASED HEALTH INFORMATION AND TWO QUESTIONS IDENTIFYING DISABILITY HAVE BEEN INCLUDED IN THE BUREAU SINCE 1998. IT COLLECTS STATE-BASED POPULATION BASED DATA ON WHATTERNAL ATTITUDES -- MATERNAL ATTITUDES, BEFORE, DURING AND AFTER PREGNANCY. IT'S CONDUCTED IN 40 STATES AND NEW YORK CITY, HOWEVER, ONLY TWO OF THE STATES INCLUDE -- IN THEIR SURVEY, MASSACHUSETTS AND RHODE ISLAND. THIS AFTERNOON, I WILL PRESENT DATA ON SPECIFIC DISPARITIES WE LATING TO THE HEALTH OF MASSACHUSETTS WITH DISABILITIES AND COMPARING THEM TO THOSE WITHOUT DISABILITIES. I WILL FOCUS ON DISPARITIES IN GENERAL ON THE MENTAL HEALTH STATUS, RISK FACTORS, PREVENTIVE BEHAVIORS AND HEALTH CARE ACCESS. I WILL START WITH ILLUSTRATES DIFFERENCES IN THE OVERALL HEALTH AND SPECIFICALLY IN THE MENTAL HEALTH OF PEOPLE WITH DISABILITIES. APPROXIMATELY 20% OF ADULTS WITH DISABILITIES IN MASSACHUSETTS SELF-REPORTED -- BASED ON THE HEALTH STATUS QUESTION. COMPARED TO ALMOST 6% OF NONDISABLED ADULTS. THESE STARK DIFFERENCES ARE COMPARABLE TO THE OVERALL NATIONAL PICTURE. THE DIFFERENCES IN SELF-REPORTED FOR HEALTH REMAINS UP TO THE DATA STRATIFIED BY EDUCATIONAL LEVEL. PEOPLE WITH DISABILITIES WERE MORE LIKELY TO REPORT THE HEALTH IRRESPECTIVE OF THEIR LEVEL OF EDUCATION. WE ALSO LOOKED AT -- FOR MENTAL HEALTH. PEOPLE WITH DISABILITIES IN MASSACHUSETTS AND IN THE COUNTRY OVERALL ARE MORE LIKELY TO REPORT EXPERIENCING 14 OR MORE DAYS OF POOR MENTAL HEALTH IN THE PAST MONTH COMPARED TO THOSE WITHOUT DISABILITIES. ALMOST 25% OR ONE IN FOUR ADULTS REPORTED POOR MENTAL HEALTH IN THE PAST MONTH, COMPARED TO 6% OF NONDISABLED ADULTS. THESE DIFFERENCES IN SELF-REPORTED MENTAL HEALTH REMAINS AFTER WE STRATIFIED THE DATA BY EDUCATIONAL LEVELS. OVER THE NEXT FEW SLIDES I WILL ILLUSTRATE DIFFERENCES IN THE RISK

FACTORS AND PREVENTIVE BEHAVIORS OF ADULTS. IN MASSACHUSETTS, 22% OR MORE THAN ONE IN FIVE ADULTS REPORTED SMOKING COMPARED TO 13% OF NONDISABLED ADULTS. WE KNEW THAT SMOKING DURING PREGNANCY IS RECOGNIZED AS ONE OF THE MOST IMPORTANT PREVENTABLE RISK FACTORS FOR A PREGNANCY OUTCOME. WE USED DATA FROM THE 2007 TO 2009 MASSACHUSETTS GRANTS AND FOUND THAT MOTHERS WITH RECENT DISABILITIES WERE MORE LIKELY TO SMOKE BEFORE, DURING AND RIGHT AFTER THE PREGNANCY AND MORE LIKELY TO SMOKE THROUGHOUT THEIR PREGNANCY COMPARED TO THOSE WITHOUT A DISABILITY. ONE OUT OF THREE ADULTS WITH DISABILITIES IN MASSACHUSETTS IS OBESE COMPARED TO ONE OUT OF FIVE NONDISABLED ADULTS. 20% REPORTED A DISABILITY COMPARED TO 17% OF THOSE WHO ARE NOT OBESE. SIMILARLY, 34% OR ONE OUT OF EVERY THREE ADULTS REPORTED NO LEISURE TIME ACTIVITY COMPARED TO 16% OF NONDISABLED ADULTS. REGARDLESS OF AGE THERE ARE DIFFERENCES IN OBESITY BETWEEN PEOPLE WITH OR WITHOUT DISABILITIES. FOR THOSE WITH OR WITHOUT DISABILITIES PEOPLE IN THE YOUNGER AND OLDER AGE GROUPS ARE LESS OBESE THAN THOSE BETWEEN 25 AND 64 YEARS OF AGE. OBESITY RATES FOR CHILDREN WITH DISABILITIES IN THE UNITED STATES ARE APPROXIMATELY 38% HIGHER THAN THOSE CHILDREN WITHOUT DISABILITIES. GIVEN THAT THE BODY WEIGHT IS A SIGNIFICANT ISSUE FOR MULTIPLE MEDICAL PROBLEMS, IMAGINE THE HEALTH FUTURE OF THESE CHILDREN AS THEY AGE. MEN AND WOMEN WITH DISABILITIES ARE AT A HEIGHTENED RISK FOR LIFETIME AND CURRENT SEXUAL VIOLENCE VICTIMIZATION. WOMEN WITH DISABILITIES ARE AT A GREATER RISK FOR ATTEMPTED RAPE AND SEXUAL VIOLENCE IN THE PAST YEAR. INTERESTINGLY THE PRESENCE OF SEXUAL VIOLENCE, COMPLETED AND ATTEMPTED RAPE WERE AGAINST MEN WITH DISABILITIES WERE MORE -- WITH COMPARABLE TO THOSE AGAINST NONDISABLED WOMEN. IN FACT, THE VICTIMIZATION RATE AGAINST MEN WERE DISABILITIES WERE GREATER OR EXCEEDED THAT OF WOMEN WITHOUT DISABILITIES. OTHER RESEARCH HAS SHOWN THAT INDIVIDUALS WITH INTELLECTUAL DISABILITY OR MENTAL ILLNESS ARE AT A GREATER RISK OF VIOLENCE COMPARED TO THOSE WITH

OTHER DISABILITIES. USING THE MASSACHUSETTS BRAND DATA, WE EXAMINE PHYSICAL ABUSE BY A CURRENT OR FORMER PARTNER AGAINST RECENT MOTHERS WITH OR WITHOUT DISABILITIES AND FOUND THAT WOMEN WITH DISABILITIES WERE AT GREATER RISK OF PHYSICAL ABUSE. THAT IS BEING PUSHED, KICKED OR PHYSICALLY HURT BEFORE OR DURING THEIR PREGNANCIES. IN THE FINAL SECTION OF MY PRESENTATION, I WILL HIGHLIGHT THE DIFFERENCES IN HEALTH CARE ACCESS BY DISABILITY STATUS. WHILE THERE ARE STRIKING DIFFERENCES BETWEEN NATIONAL AND MASSACHUSETTS PERCENTAGES, PEOPLE WITH DISABILITIES IN MASSACHUSETTS AND IN THE U.S. OVERALL ARE MORE THAN TWICE AS LIKELY TO REPORT NOT SEEING A DOCTOR DUE TO COSTS IN THE PAST YEAR. THESE DISPARITIES ARE EVEN GREATER FOR RACIAL AND ETHNIC MINORITIES WITH DISABILITIES COMPARED TO WHITES WITH DISABILITIES. PEOPLE WITH DISABILITIES AS COMPARED TO THOSE WITHOUT WERE MORE LIKELY TO NOT SEEK MEDICAL CARE BECAUSE OF COST. REGARDLESS OF THEIR EDUCATIONAL LEVEL. EVEN PEOPLE OF COLLEGE LEVEL EDUCATION EXPERIENCE DISPARITIES IN ACCESSING CARE. 9% OF COLLEGE GRADUATES WITH DISABILITIES COULD NOT SEE A DOCTOR DUE TO COST COMPARED TO 3% OF THOSE WITHOUT DISABILITIES. LACK OF ACCESS TO DENTAL CARE IS A SIGNIFICANT ISSUE WITH THOSE WITH DISABILITIES. COMPARED TO THE NONDISABLED COUNTERPARTS REPORTED SEEING A DENTIST IN THE PAST YEAR. WOMEN 40 YEARS AND OVER WITH DISABILITIES IN MASSACHUSETTS AND IN THE U.S. OVERALL WERE LESS LIKELY TO HAVE A MAMMOGRAM IN THE PAST YEAR. AND RATES ARE EVEN LOWER WHEN WE LOOK AT WOMEN WITH GREATER FUNCTIONAL NEEDS INCLUDING WOMEN WITH MOBILE IMPAIRMENT. PEOPLE WITH DISABILITIES EXPERIENCED SIGNIFICANT HEALTH DISPARITIES IN VARIOUS CARE COMPARED TO THOSE WHO DO NOT HAVE DISABILITIES. THE NUMBER OF PEOPLE WITH DISABILITIES BOTH CHILDREN AND ADULTS ARE RISING. THEREFORE, ELIMINATING HEALTH DISPARITIES SHOULD BE A NATIONAL PUBLIC HEALTH PRIORITY. A MULTIPRONGED APPROACH IS REQUIRED TO ELIMINATE THIS HEALTH DISPARITY AND TO STRUCTURE THE HEALTH CARE SYSTEM FOR THOSE FACED WITH DISABILITIES. WHAT CAN WE DO

ABOUT IT? MULTIPLE STRATEGIES ARE NEEDED TO ADDRESS THESE COMPELLING DISPARITIES. FIRST INCLUSION OF STANDARDIZED DISABILITY SCREENER AND DATA COLLECTION INSTRUMENTS. THE ADVANCEMENT ON INTERVENTION. THE TRAINING OF HEALTH CARE PROFESSIONALS AND PUBLIC HEALTH PROFESSIONALS IS CRITICAL. WE NEED TO MOVE TOWARDS A BARRIER FREE ENVIRONMENT SO THAT PEOPLE WITH DISABILITIES CAN ACCESS MEDICAL OFFICES, DIAGNOSTIC EQUIPMENT, GYMS AND THE COMMUNITY AT LARGE. AND FINALLY, TO QUOTE THE DISABILITY ADVOCACY MANTRA. NOTHING ABOUT US, THE INCLUSION AND THE MEANINGFUL INVOLVEMENT OF THOSE WITH DISABILITIES IN THE DEVELOPMENT AND IMPLEMENTATION OF PUBLIC HEALTH PROGRAMS IS NEEDED. THANK YOU VERY MUCH. OUR NEXT SPEAKER IS JENNIFER HOOTMAN.

>> GOOD AFTERNOON. MY NAME IS JENNIFER HOOTMAN AND TODAY I'LL BE SPEAKING ABOUT THE CDC'S ARTHRITIS APPROACH TO THE EVIDENCE BASED OUTREACH PROGRAMS FOR THOSE LIVING WITH ARTHRITIS. ARTHRITIS IS ONE OF THE MOST COMMON CHRONIC DISEASES AFFECTING 50 MILLION U.S. ADULTS AND ABOUT 300,000 CHILDREN. AMONG THE 50 MILLION ADULTS, 40% REPORT BEING LIMITED IN THEIR USUAL ACTIVITIES BECAUSE OF THEIR ARTHRITIS. 33% REPORT HAVING SEVERE PAIN AND 11% REPORT BEING RESTRICTED IN VALUED SOCIAL ACTIVITIES. ALL OF THESE FACTORS CONTRIBUTE TO POOR QUALITY OF HEALTH. BY 2030 WE EXPECT 67 MILLION ADULTS WILL HAVE ARTHRITIS, OF WHICH 25 MILLION WILL BE LIMITED IN THEIR USUAL ACTIVITIES. THESE ESTIMATES ARE LIKELY CONSERVATIVE BECAUSE THEY ONLY ACCOUNT FOR THE AGING OF THE POPULATION AND DO NOT TAKE INTO ACCOUNT THE CURRENT OBESITY EPIDEMIC WHICH IS EXPECTED TO CONTRIBUTE TO RISING ARTHRITIS PREVALENCE. ARTHRITIS IS THE MOST COMMON CAUSE OF DISABILITY AND IT'S MAINTAINED THIS NUMBER ONE RANKING FOR AT LEAST TWO DECADES. AMONG ADULTS ARTHRITIS IS MORE COMMON AMONG WOMEN THAN MEN AND THIS IS TRUE AT ALL AGES. THE HIGHER PREVALENCE OF ARTHRITIS AMONG WOMEN IS NOT JUST DUE TO THE HIGHER NUMBERS OF WOMEN IN THE POPULATION. IT ACTUALLY

HAS HIGHER RATES OF ARTHRITIS AMONG WOMEN PARTICULARLY OSTEOARTHRITIS AND RHEUMATOID ARTHRITIS. SURPRISINGLY ARTHRITIS IS NOT JUST A DISEASE OF THE ELDERLY. IT'S TWO-THIRDS OF ADULTS WITH ARTHRITIS ARE UNDER AGE 65 AND ALMOST HALF OF THESE AGED 45 TO 64. FORTUNATELY, PREVENTING PROGRESSION OF ARTHRITIS DUE TO WORSENING OF SYMPTOMS AND LOSS OF FUNCTION IS POSSIBLE. TYPICALLY, PHYSICAL FUNCTION DECLINES WITH AGE. HOWEVER, MAINTAINING REGULAR PHYSICAL ACTIVITY CAN ACTUALLY REDUCE THIS AGE-RELATED DECLINE BY ABOUT 32%. PHYSICAL ACTIVITY MAY ALSO REDUCE THE RISK OF LIMITATIONS AN LOSS OF FUNCTION. FOR EXAMPLE, ONE RANDOMIZED CONTROL TRIAL AMONG ADULTS WITH KNEE OSTEOARTHRITIS REPORTED THE RISK OF INCIDENT ACTIVITY OF DAILY LIVING DISABILITY WAS REDUCED BY 43% OVER 18 MONTHS. CDC IS FUNDING 12 STATE ARTHRITIS PROGRAMS TO IMPLEMENT ARTHRITIS MANAGEMENT PROGRAMS IN THE COMMUNITY. I WILL FOCUS ON PHYSICAL ACTIVITY AS A STRATEGY TO PREVENT ARTHRITIS RELATED DISABILITY AND OUR WORK WITH THE STATE HEALTH DEPARTMENT. THE CDC ARTHRITIS PROGRAM IS A EVIDENCE-BASED, ACTIVITY PROGRAM AS ONE THAT CAN ACCOMMODATE PEOPLE WITH DIFFERENT LEVELS OF FUNCTION, HAS BEEN SHOWN TO REDUCE ARTHRITIS SYSTEM AND CAN BE EASILY IMPLEMENTED IN COMMUNITY SETTINGS. WE CURRENTLY HAVE SIX EVIDENCE-BASED PHYSICAL ACTIVITY PROGRAMS THAT ARE APPROVED. THE FIRST THREE ARE OFFERED BY THE ARTHRITIS FOUNDATION AND THE LAST THREE ARE OFFERED BY OTHER COMMUNITY ORGANIZATIONS. WE JUST COMPLETED A FOUR-YEAR COOPERATIVE AGREEMENT WITH 12 STATE HEALTH DEPARTMENTS WHO ARE CHARGED WITH IMPLEMENTING EVIDENCE-BASED PROGRAMS. OVERALL, ALL 12 STATES INCREASED THEIR REACH AND SOME STATES DOUBLED THEIR REACH IN THE FIRST THREE YEARS. THE TOTAL REACH OVER FOUR YEARS WAS 132,443 ADULTS WITH ARTHRITIS. BUT THREE-YEAR EVALUATION STUDY WE CONDUCTED FOUND THAT THE FACTORS THAT WERE MOST SIGNIFICANTLY CORRELATED WITH INCREASED REACH INCLUDED WORKING WITH MULTISITE DELIVERY SYSTEMS AND ARTHRITIS PROGRAM FOCUSING THEIR EFFORTS ON INCREASING PROGRAM REACH. ON JULY

1, 2012, THE ARTHRITIS PROGRAM FUNDED A NEW ROUND OF 12 STATES TO IMPLEMENT ARTHRITIS MANAGEMENT PROGRAMS. THESE STATES SHOWN HERE IN PURPLE ARE AWARDED AN AVERAGE OF \$427,000 A YEAR FOR THE NEXT FIVE YEARS. DURING THIS FUNDING CYCLE, REQUIRED ACTIVITIES INCLUDE INCREASING THE AWARENESS OF THE IMPORTANCE OF PHYSICAL ACTIVITY, AND IDENTIFYING AND EMBEDDING PROGRAMS INTO EXISTING DELIVERY SYSTEM. WE DEFINE A DELIVERY SYSTEM AS THREE OR MORE DELIVERY SITES, ACTUAL PHYSICAL LOCATIONS IN THE COMMUNITY AND AREAS OF AGING AND PARKS AND RECREATION DEPARTMENT. REACH IS DEFINED AS THE NUMBER OF ADULTS WITH ARTHRITIS ENROLLING IN EVIDENCE-BASED PROGRAMS. AND CAPACITY IS DEFINED AS THE NUMBER OF DELIVERY SYSTEMS, DELIVERY SITES, CLASSES AND ACTIVE INSTRUCTORS. THE PRIMARY GOAL FOR ALL 12 STATES OVER THE NEXT FIVE YEARS IS TO REACH 5% OF THEIR STATE'S POPULATION WITH ARTHRITIS. THAT TRANSLATES TO ABOUT 12,500 ADULTS IN SMALLER STATES LIKE RHODE ISLAND AND 50,000 ADULTS IN LARGER STATES LIKE CALIFORNIA. IF EACH STATE REACHES THE REACH GOAL, 8,000 NEW ADULTS WILL BE REACHED WITH NEW EVIDENCE-BASED ARTHRITIS PROGRAMS BY THE YEAR 2017. AN ADDITIONAL GOAL IS TO DECREASE THE PROPORTION OF ADULTS WITH ARTHRITIS WHO REPORT DOING NO LEISURE TIME ACTIVITY BY 5% OVER FIVE YEARS. THIS WOULD MEAN ALMOST 300,000 FEWER ADULTS WITH ARTHRITIS WILL BE PHYSICALLY INACTIVE BY 2017. ARTHRITIS AFFECTS 50 MILLION ADULTS IN THE U.S. AND IS THE MOST COMMON CAUSE OF DISABILITY. PHYSICAL ACTIVITY AND OTHER PUBLIC HEALTH STRATEGIES THAT IMPROVE PAIN AND FUNCTION AND MAINTAIN INDEPENDENCE. THERE ARE EVIDENCE-BASED PHYSICAL ACTIVITY PROGRAMS THAT CAN BE FURTHER SCALED UP. SUCCESSFUL INGREDIENTS ARE INCREASING THE AWARENESS OF THE IMPORTANCE OF PHYSICAL ACTIVITY THROUGH HEALTH COMMUNICATION CAMPAIGNS AND EMBEDDING PHYSICAL ACTIVITY PROGRAMS INTO EXISTING DELIVERY SYSTEMS. OUR NEXT SPEAKER WILL BE CATHERINE GRAHAM.

>> GOOD AFTERNOON. I'M A REHABILITATION ENGINEER WITH THE SCHOOL OF MEDICINE. I'M EXCITED TO BE HERE TO TELL YOU ABOUT THE PROGRESS WE'RE MAKING IN SOUTH CAROLINA TO ACTUALLY REDUCE SOME OF THESE HEALTH DISPARITIES. PEOPLE WITH DISABILITIES LIVING IN SOUTH CAROLINA ARE ALMOST SIX TIMES MORE LIKELY TO REPORT FAIR TO POOR HEALTH AS FAR AS THEIR STATUS, THEIR HEALTH STATUS. IN SOUTH CAROLINA, KEY PARTNERSHIPS ARE A VERY CRITICAL ROLE AND WE FORMED OURS ABOUT 15 YEARS AGO WHICH INCLUDED THE STATE UNIVERSITY AS THE COORDINATOR, THE HEALTH DEPARTMENT WHICH PROVIDES HEALTH PROMOTION AND AWARENESS THROUGHOUT THE STATE. THE MAIN DISABILITY SERVICE AGENCY WHICH HAS A REALLY STRONG INFRASTRUCTURE AND THEN THE DEVELOPMENTAL DISABILITIES COUNCIL WHICH ACTS AS THE ADVISORY COMMITTEE. THE COMMON GOAL OF ALL OF THESE GROUPS WAS HEALTH AND WELLNESS FOR THOSE WITH DISABILITIES. SO I'M GOING TO TALK ABOUT THE PROGRESS IN THREE MAJOR AREAS. HEALTH PROMOTION AND EMERGENCY PREPARENESS, AND I'LL START WITH ACCESS TO HEALTH CARE. THE ISSUE WITH PHYSICAL ACCESS TO PHYSICIANS' OFFICES FOR PEOPLE WITH DISABILITIES IS THAT THEY MUST BE ABLE TO PARK, ENTER THE BUILDING, CHECK IN, GET LAB WORK DONE, GO TO AN EXAM ROOM AND EVEN USE THE RESTROOM IN ORDER FOR THEM TO EVER RECEIVE EQUAL QUALITY CARE. OUR GOAL WAS TO ASSESS AND THEN IMPROVE THE ACCESSIBILITY OF OUR PRIMARY CARE SITE. OUR PARTNERS INCLUDED THE HEALTH DEPARTMENT BEST CHANCE NETWORK WHICH PROVIDES FOR FREE BREAST AND CERVICAL CARE SCREENINGS AND THEN WE PARTNERED WITH THE OFFICE OF RURAL HEALTH TO RECRUIT PARTICIPANT SITES THAT COULD THEN APPLY FOR LOW INTEREST LOANS TO MAKE THE MODIFICATION. WE HAVE ALSO LEVERAGED MONIES FROM SOUTH CAROLINA, BLUE CROSS/BLUE SHIELD IN THE PAST IN ORDER TO PROVIDE MINIGRANTS TO SOME OF THE SITES TO HELP OUT WITH MODIFICATIONS. WE HAVE ASSESSED OVER 150,000 PRIMARY CARE SITES SO FAR WITH THE PATIENT LOAD OF OVER 750,000. ABOUT ONE-THIRD OF THOSE PRACTICES HAVE MADE CHANGES THAT WE'RE AWARE OF SO FAR. AND WE ARE EXPANDING INTO OTHER CARE PRACTICES. AS FAR AS THE EQUIPMENT, THE

ISSUE -- SOMETIMES PEOPLE WITH PHYSICAL DISABILITIES OFTEN RECEIVE PHYSICAL EXAMS WHILE STILL SITTING IN THEIR WHEELCHAIRS. DUE TO A DIFFICULTY GETTING ON AND OFF THE REALLY HIGH EXAMINATION TABLES. SUCH PHYSICAL EXAMS DON'T EVEN ALLOW FOR THE HEALTH CARE PROFESSIONAL TO FEEL THE ABDOMEN, THE PELVIS, THE BACK LIKE THEY SHOULD. SO OUR GOAL WAS TO ASSESS THESE SITES AND THEN INCREASE THE NUMBER OF PROVIDERS THAT HAVE A HEIGHT ADJUSTABLE EXAM TABLE, UTILIZING THE SAME PARTNERS THAT WE HAD BEFORE. OF THE SAME 150 SITES THAT WE HAVE ASSESSED, ONLY 34% HAD THE HEIGHT ADJUSTABLE EXAM TABLE AND ONLY TWO HAVE AN ADJUSTABLE EXAM TABLE, AND SAID COST WAS THE LIMITING FACTOR. ONE OF THE PARTNERS, THE ONE FOR BREAST AND CERVICAL CANCER SCREENING, THEY NOW INCLUDE A DISABILITY SCREENER QUESTION FOR THEIR PARTICIPANTS SO THAT THEY CAN BE DIRECTED TO A SITE THAT IS ACCESSIBLE AND WILL ACTUALLY MEET THEIR NEEDS. SO WE HAVE TALKED ABOUT WEIGHT AND OBESITY AND WEIGHT CAN ONLY BE MANAGED IF A PERSON CAN ACTUALLY GET ON THE SCALE. AND WE FOUND A LOT OF SITES HAVE A LACK OF AN ACCESSIBILITY SCALE. AT THAT COUNSELLED ON WEIGHT MANAGEMENT AND PHYSICAL ACTIVITY. OUR GOAL WAS TO INCREASE AND IMPROVE THE NUMBER OF THOSE WITH AN ACCESSIBLE SCALE. LESS THAN 2% OF THOSE 150 SITES THAT WE SAW, SO THREE OUT OF 150, HAD WHEELCHAIR ACCESSIBLE SCALES. SINCE THE ASSESSMENT, 11 SITES HAVE PURCHASED THE SCALES AND THAT'S AT A COST OF ABOUT \$1,500. SO NOW I'M GOING TO GIVE YOU A COUPLE OF EXAMPLES OF PROGRESS WE HAVE MADE IN THE AREA OF HEALTH PROMOTION. A STAGGERING 29% OF SOUTH CAROLINIANS ARE OBESE. BUT AN EVEN HIGHER PERCENTAGE AT 42% OF SOUTH CAROLINIANS WITH DISABILITIES ARE OBESE. HUGE NUMBER. 23% OF SOUTH CAROLINIANS ARE PHYSICALLY INACTIVE. BUT ONCE AGAIN, ALMOST DOUBLE THAT AT 43% OF SOUTH CAROLINIANS WITH DISABILITIES ARE INACTIVE. SO AS FAR AS BODY MASS INDEX, SOUTH CAROLINIANS WITH DISABILITIES WERE LESS LIKELY TO HAVE A NORMAL BMI COMPARED -- AND BE OVERWEIGHT. SO 26% COMPARED TO 35% HAD A NORMAL BMI. AND THEN OVERWEIGHT, 37% OF PEOPLE WITH DISABILITIES

AS OPPOSED TO THE 32%. OF COURSE, THOSE WITH DISABILITIES AS MENTIONED WERE MUCH MORE LIKELY TO HAVE A BMI OF OVER 30. WE UTILIZED AN EVIDENCE BASED PROGRAM CALLED STEPS TO YOUR HEALTH WHICH WAS SPECIFICALLY DESIGNED FOR PEOPLE WITH DISABILITIES. IT'S AN EIGHT-WEEK PARTICIPATORY PROGRAM COVERING HEALTHY EATING, AND PHYSICAL ACTIVITY AND WE HAD OVER 1,300 PARTICIPANTS USING A TRAINER MODEL. PARTICIPANTS HAVE HAD A WEIGHT LOSS OF AT LEAST FIVE POUNDS AND AN INCREASE IN THEIR KNOWLEDGE OF HEALTHY FOOD CHOICES. IN 2012, WE BEGAN COLLABORATING WITH THE ARTHRITIS FOUNDATION EXERCISE PROGRAM. WHICH IS AN EIGHT-WEEK PROGRAM THAT USES THE SAME TYPE OF TRAIN THE TRAINER MODEL WITH SENIOR CENTERS AND DISABILITY SERVICE PROVIDERS. WE'RE NOW STUDYING THE EFFICACY OF THAT PROGRAM WITH PEOPLE WITH DISABILITIES. SO SO FAR WE HAVE TRAINED OVER 700 MEDICAL STUDENTS AND HEALTH PROFESSIONALS ABOUT CARE OF PEOPLE WITH DISABILITIES. AND THAT INCLUDES WEIGHT MANAGEMENT, PROPER NUTRITION, NOT SMOKING AND PHYSICAL ACTIVITY. WE'RE NOW EXPANDING TO OTHER SPECIALTIES IN PROFESSIONS SUCH AS HEALTH CARE PROFESSIONALS THROUGH THE TECHNICAL COLLEGES. WE HAVE CONDUCTED IN-PERSON STAFF TRAININGS AT FEDERAL, STATE AND LOCAL PARKS AND RECREATION CENTERS. GYMS, YMCAs AND HEALTH DEPARTMENTS AND COVER DIFFERENT TOPICS SUCH AS COMMUNICATING WITH PEOPLE WITH DISABILITIES, AND THEN HOW TO MODIFY YOUR POLICIES, PROCEDURES AND SERVICES AND EQUIPMENT MODIFICATION TO INCLUDE PEOPLE WITH DISABILITIES. SUCH AS AT A PARK, A WHEELCHAIR ACCESSIBLE MAT TO GET OVER THE SOFT SAND SO THAT SOMEONE CAN GET TO THE HARD PACKED AREA OR ALTERNATE WAYS TO USE PHYSICAL FITNESS CENTER EQUIPMENT. WE HAVE ALSO COLLABORATED WITH OUR DEPARTMENT OF TRANSPORTATION TO UPDATE THE AMERICANS WITH DIFFICULTIES ACT TRANSITION PLAN. THAT'S SO THEY HAVE DRAWINGS, MEETINGS, PLANNING, ET CETERA. THEIR NEW TRANSITION PLAN CALLS FOR ACCESSIBLE SIDEWALKS, CURB CUTS, PEDESTRIAN ACCESS SIGNALS. AND ALL OF THESE SPECIFICATIONS ARE NOW IN PLACE SO THAT NEW CONSTRUCTION AND ANY MODIFICATIONS ARE

INCLUSIVE NOW FOR PEDESTRIANS OF ALL ABILITIES. WE HAVE TRAINED OVER 95% OF THEIR ENGINEERS AND PLANNERS ON THIS ACCESSIBILITY ISSUE. AND IT INCLUDED BOTH A LECTURE PORTION AND A HANDS ON EXPERIENCE. AND NOW SOME EXAMPLES OF THE THIRD CATEGORY OF EMERGENCY PREPAREDNESS. SO SOUTH CAROLINA IS A COASTAL STATE, WE'RE HURRICANE PRONE, RURAL STATE, HIGH LEVEL OF POVERTY. MAKES YOU WANT TO MOVE THERE, RIGHT? SO WE FORMED AN EMERGENCY PLANNING COMMITTEE FOR PEOPLE WITH FUNCTIONAL NEEDS. THAT'S FEMA'S TERM WITH A WHOLE DIFFERENT GROUP OF STAKEHOLDERS. ONE OF THE THINGS IS SHELTER ACCESSIBILITY. SO WE COLLABORATED WITH THE RED CROSS, THE RED CROSS ASSESSES ALL OF THE HURRICANE SHELTERS AND OUR COMMITTEE WORKS WITH THEM ON THE ACCESSIBILITY PORTION OF THAT SHELTER CHECKLIST TO LOOK AT THINGS LIKE DISPENSER HEIGHT AND CURB CUT SLOPES. THEN AT THE END OF THEIR SHELTER CHECKLIST IS A SMALL PORTION THAT SAYS IS THIS SHELTER ACCESSIBLE, DOES IT NEED A LITTLE WORK OR SHOULD WE NOT USE THE SHELTER AT ALL? WE HAVE ALSO COLLABORATED TO CREATE A WELCOME TO YOUR SHELTER DVD. IT INCLUDES PICTURES, IT INCLUDES SIGN LANGUAGE AND IT'S LOOPED ON A DVD WHENEVER A HURRICANE EMERGENCY SHELTER IS OPEN. IT CAN ALSO BE FOUND ON YOUTUBE IF YOU'RE INTERESTED IN WATCHING THAT ONE. OUR SHELTER MANAGERS SOMETIMES HAVE NO CLUE ON WHAT ASSISTIVE TECHNOLOGY IS AND HOW THAT CAN HELP SOMEONE MAINTAIN THEIR INDEPENDENCE IN THE SHELTER SO WE INCLUDE A DEFINITION SHEET IN THEIR SHELTER TO GO KITS. WE ALSO INCLUDE THINGS LIKE A PLASTIC MAGNIFIER AS AN AID, A PICTURE AID AND THEN WASH CLOTHS AND RUBBER BAND TO BUILD UP THE EATING UTENSIL, TO BRUSH YOUR HAIR, WRITE, SO PEOPLE CAN MAINTAIN THEIR INDEPENDENCE IN THE SHELTER. WE CONSIDER IT A HUGE SUCCESS TO BE ADDING TWO QUESTIONS TO THE SOUTH CAROLINA BRFS IN 2013 IN SOUTH CAROLINA TO DETERMINE THE PREPAREDNESS OF PEOPLE WITH DISABILITIES. SPECIFICALLY LOOKING AT DO THEY HAVE A PROPER EMERGENCY SUPPLY KIT AND A PROPER DISASTER EVACUATION PLAN? FOR THE CDC IS CURRENTLY FUNDING 18 STATE DISABILITY AND HEALTH PROGRAMS. OVERALL OBJECTIVE IS THIS IMPROVING

THE QUALITY OF LIFE OF PEOPLE WITH DISABILITIES. THE PROGRAM SHARE INFORMATION ALL THE TIME. SO IT WOULD BE VERY VALUABLE IF WE COULD HAVE THAT IN EACH ONE OF THE STATES. SO IN ORDER TO DO THIS IN A STATE, YOU HAVE TO BUILD A PROGRAM AND TO DO THAT YOU HAVE TO HAVE COLLABORATORS AND TO BUILD COLLABORATIONS, IT TAKES TIME AND SOME REALLY SUSTAINED EFFORT. IT'S AGENCIES AND PERSONNEL CHANGE, YOU HAVE TO GO BACK IN AND MAKE SURE YOU HAVE THEIR BUY-IN AND WHY THIS IS SO IMPORTANT. YOU HAVE THE HAVE COLLABORATORS WHO ARE FUNCTIONING AT A HIGH LEVEL WITHIN THEIR STATE. THEY HAVE POWER. AND HAVE COMMON GOALS. WE DON'T WANT TO DUPLICATE EFFORTS HERE. THE PUBLIC HELP HAS TO IMPLEMENT PEOPLE 2020 SO IT INTEGRATES PEOPLE WITH DISABILITIES INTO ALL FACETS WHICH IS SURVEILLANCE, PROGRAMMING, PLANNING, MARKETING, ET CETERA. AND THEN WITH THE CDC SUSTAINED EFFORTS AND SUPPORT AS WELL AS IDENTIFICATION OF PEOPLE WITH DISABILITIES, AS A MANDATE FOR PROGRAMS AND SURVEILLANCE IS CRUCIAL. I REALLY THINK THAT TOGETHER WE CAN MAKE A DIFFERENCE WITH THIS PROBLEM. THANK YOU. OUR NEXT SPEAKER IS GEORGES BENJAMIN.

>> WELL, HELLO. I'M GEORGES BENJAMIN, I'M THE EXECUTIVE DIRECTOR OF THE AMERICAN PUBLIC HEALTH ASSOCIATION. MY PRESENTATION IS GOING TO BE DIFFERENT. I'M GOING TO SHOW YOU OF INCLUDING THE PEOPLE WITH DISABILITIES IN ALL ASPECTS OF ACTIVITIES. BUT MORE IMPORTANTLY OUR NEW EFFORT TO THE GOOD -- TO BECOME A NATIONAL MODEL, HOPEFULLY FOR OTHER ORGANIZATIONS TO EMULATE. FOR THOSE OF YOU WHO ARE UNAWARE, APHA IS THE OLDEST AND LARGEST PUBLIC HEALTH ASSOCIATION IN THE ORDINARY. WE'RE A NONPARTISAN ORGANIZATION THAT STRIVES TO PROTECT ALL AMERICANS FROM PREVENTABLE AND SERIOUS HEALTH THREATS. WE HAVE MANY INTEREST GROUPS AND SEVERAL MAJOR PROGRAMS THAT SUPPORT OUR WORK. WE HAVE THREE STRATEGIC PRIORITIES THAT DRIVE OUR WORK. ONE IS ADVOCATING FOR INSURANCE -- ENSURING THAT WE HAVE INFRASTRUCTURE AND PUBLIC HEALTH. NUMBER TWO, BY CREATING HEALTH EQUITY BY

ADDRESSING AND ELIMINATING HEALTH DISPARITIES. FINALLY, ENSURING THE RIGHT TO HEALTH AND HEALTH CARE BY RECOGNIZING THAT HEALTH INSURANCE COVERAGE IS NOT ENOUGH. NOW, WE HAVE WORKED FOR MANY YEARS TO BE A MODEL MOYER FOR OUR STAFF. AND TO THAT END WE HAVE SUPPORTED A SUCCESSFUL WORKPLACE, SPECIFICALLY WHEN WE BUILT OUR BUILDING, OUR HEADQUARTERS BUILDING IN 1999. WE PRACTICED NONDISCRIMINATION IN OUR HIRING PRACTICES AND PROVIDE UNIVERSAL HEALTH INSURANCE COVERAGE TO ALL EMPLOYEES. AND COVERAGE FOR THEIR FAMILIES TO INCLUDE DOMESTIC PARTNERS. WE INCLUDE SCIENTIFIC PROGRAMMING AROUND PUBLIC HEALTH DISABILITY ISSUES. WE HAVE A STRONG ACCESSIBILITY PROGRAM AROUND THE MEETING. AND I NEED TO POINT OUT THOUGH, WE DO HAVE A WAYS TO GO HERE. NOW, OUR DISABILITIES -- CLEARLY OUR SUBJECT MATTER ARE EXPERTS AND THEY BRING THE INCLUSION OF DISABILITY ISSUES TO OUR BROADER PROGRAMS. PARTICULARLY OUR BROADER POLICY AGENDA. OUR ANNUAL MEETING HAS BEEN THE BENCHMARK OF OUR WORK. SO HERE ARE SOME OF THE THINGS THAT WE DO AT OUR MEETING. ONE OF THE HALLMARKS IS WE HAVE A WEB PAGE DEDICATED TO ACCESSIBILITY RESOURCES AND SERVICES FOR PEOPLE ATTENDING THE MEETING. SOME OF THE OTHER THINGS ARE SHOWN ON THIS SLIDE. INCLUDING THE FACT THAT WE HAVE AN ACCESSIBILITY GUIDE TO THE CONVENTION CITY. OBVIOUSLY, MOST CONVENTION CENTERS HAVE THAT, BUT WE SPECIFICALLY DO ONE FOR OUR MEETING ATTENDEES. LIKE MOST ASSOCIATIONS, WE HAVE A RANGE OF ONLINE EDUCATIONAL TOOLS TO INCLUDE WEBINARIES AND PODCASTS. WE DO WORK TO CLOSE CAPTION ALL OF THE VIDEOS, ALTHOUGH I HAVE TO ADMIT ANOTHER PLACE WE CAN IMPROVE. BUT IT SOMETIMES DOES TAKE TIME TO DO THIS. BUT WE'RE GETTING BETTER. AND DOING THAT IN EACH AND EVERY WEBCAST OR VIDEO THAT WE DO. WE HAVE A WEBSITE THAT ALLOWS FOR MOST ASSISTIVE TECHNOLOGIES. AND WE INCLUDE MESSAGING ON THE PUBLIC. WE TALK ABOUT DISABILITIES THROUGHOUT OUR PROGRAMMING. THIS YEAR IS NATIONAL PUBLIC HEALTH WEEK IS AN EXAMPLE OF THAT INCLUSION. SO FOR EXAMPLE, PUBLIC HEALTH WEEK IS CELEBRATED AS A FIRST

FULL WEEK IN APRIL AND THIS YEAR WE SPECIFICALLY ADDRESSED MENTAL HEALTH AS A PUBLIC HEALTH ISSUE ON ONE OF THOSE FIVE DAYS IN WHICH WE CELEBRATED PUBLIC HEALTH WEEK. WE HAVE A VERY STRONG ADVOCACY AGENDA. EXAMPLES INCLUDE OUR WORK TO LEAD THE HEALTH COMPONENT OF A NATIONAL COALITION CALLED TRANSPORTATION FOR AMERICA. THIS COALITION WAS PUT TOGETHER TO HELP REAUTHORIZE THE FEDERAL TRANSPORTATION BILL. ONE OF OUR MANY GOALS IS TO GET HEALTH ISSUES INCLUDED IN THE BILL INCLUDING ISSUES AROUND THE ACCESSIBILITY. PARTICULARLY AROUND WHERE YOU BUILD THESE TRANSPORTATION CENTERS, HOW DO YOU INCENTIVIZE STATES TO INCLUDE ACCESSIBILITY AS PART OF THAT PROCESS. WE RECENTLY PASSED A NEW POLICY ON PUBLIC HEALTH INFORMATION ON MUSCULOSKELETAL DISEASES LIKE ARTHRITIS. WE HAVE BEEN AN ADVOCATE FOR OCCUPATIONAL HEALTH AND SAFETY AND WE HAVE ADVOCATED FOR INCLUSION AROUND ACCESSIBILITY IN THE AFFORDABLE HEALTH CARE ACT AND WE'RE ONE OF THE LONG-STANDING SUPPORTERS OF MENTAL HEALTH PARITY. WE'RE EXCITED THAT WAS ACTUALLY SIGNED INTO LAW. OF COURSE WE'RE LOOKING TO STRENGTHEN OUR CAPACITY. WE BELIEVE WE SHOULD WALK THE TALK SO WE HAVE MADE A COMMITMENT TO ENSURE FROM BEING PROBLEM SOLVERS. MY STAFF IS GOOD WITH PROBLEMS. SOMEONE WITH AN ACCESSIBILITY ISSUE, MY STAFF ARE EXCITED ABOUT SOLVING THE PROBLEM. BUT THAT'S NOT GOOD ENOUGH. WE WANT THIS ORGANIZATION TO BECOME ONE THAT ADDRESSES THE ISSUES WITH PROACTIVITY AND INTENT THAT MEANS YOU THINK ABOUT IT BEFORE IT ACTUALLY HAPPENS. THAT'S WHERE WE'RE TRYING TO MAKE A BIG CHANGE IN THE WAY WE THINK ABOUT THINGS WITHIN OUR ORGANIZATION. IS IT A MODEL FOR OTHERS TO FOLLOW? BOTH AS AN EMPLOYER AND AN ORGANIZATION AS WE GO FURTHER? NOW, TO ACCOMPLISH OUR GOALS, WE HAVE EMBARKED -- AN ASSESSMENT. WE BROUGHT A CONSULTANT IN WHO SPENT SOME TIME IN OUR MEETING IN SAN FRANCISCO THIS YEAR. KIND OF WATCHING WHAT WE DO. AND THEY'RE LOOKING AT BOTH US AS AN EMPLOYER, AS AN -- IN TERMS OF OUR PROGRAMS. AS AN ASSOCIATION. THAT REPORT IS GOING TO BE DUE EARLY NEXT YEAR. WE ALREADY DO

PERIODIC REVIEWS ON THE ONLINE TECHNOLOGY. WE KNOW THERE ARE IMPROVEMENTS THAT NEED TO BE MADE THERE. WE HAVE DONE SOME THINGS ALREADY. WE HAVE BEEN VERY AGGRESSIVE IN ENSURING OUR STAFF HAS TRAINING IN DIVERSITY IN THE WORKPLACE AND IN THEIR PROGRAMMING AND WE'RE WORKING TO HELP THEM INCLUDE THAT IN ALL ASPECTS OF WHAT THEY DO. WE'RE GOING TO THEN TAKE A COURSE WHERE WE HAVE LEARNED AND THE GENERAL CONSULTANTS, CONFIDENTIAL ASSESSMENT OF OUR ORGANIZATION, OUR FACILITIES AND OUR WORK PRACTICES AND OF COURSE CRAFT A PLAN TO FIGURE OUT HOW WE GET TO BE AT THE TOP OF THE HEAP IN TERMS OF ASSOCIATION -- ASSOCIATIONS THAT DO THIS. AND OF COURSE THAT PLAN WILL INCLUDE MILESTONES AND SOME DEFINED MEASURES OF SUCCESS. I THINK AT THE END WE HOPE THAT THERE WILL BE CHANGES IN OUR POLICIES, PROCEDURES, MAYBE IN OUR PHYSICAL PLAN THAT WILL MAKE US MUCH MORE ACCESSIBLE AND FOR PEOPLE WHO HAVE DISABILITIES BE MUCH MORE COMFORTABLE IN WHAT WE'RE DOING. NOW, THE BEHAVIORAL CHANGE WE SEE AGAIN IS FOR STAFF AND ASSOCIATION MEMBERSHIP TO SEE AND ADDRESS THE ACCESSIBILITY AS A NORMAL COURSE OF BUSINESS AND NOT SIMPLY AS AN ADDITIONAL TASK. NOW, FROM OUR PERSPECTIVE, THIS IS GOING TO BE EASY, BUT WE BELIEVE FAILURE IS NOT AN OPTION FOR US. WE BELIEVE AS THE NATION'S LARGEST ASSOCIATION AND OLDEST ASSOCIATION WITH THE STRONG CORE BELIEF IN THE CIVIL RIGHTS THIS IS IMPORTANT FOR US TO ACCOMPLISH. WE THINK THE PRICE OF NOT DOING THIS MEANS OUR MEMBERS WILL NOT BE ABLE TO FULLY PARTICIPATE IN THE ACTIVITIES OF ACHA AND BECAUSE WE HAVE A MAJOR INFLUENCE ON THE HEALTH OF THE PUBLIC AS DO YOU HERE AT CDC WE BELIEVE THE PUBLIC CANNOT GET THE HEALTH CARE THEY DESERVE AND THAT MOST FOLKS WON'T ACHIEVE THE QUALITY OF LIFE THAT THEY DESERVE. SO WE THINK WE CAN BE EFFECTIVE FROM A HEALTH IMPACT PERSPECTIVE IF WE WALK THE TALK. SO TO SPEAK. WITH THAT, I THANK YOU VERY MUCH.

>> THANK YOU TO ALL OF OUR SPEAKERS. AND THIS IS THE FUN PART. OPEN FOR QUESTIONS AND ANSWERS. IN COMING FORWARD WITH A QUESTION, PLEASE INTRODUCE YOURSELF AND THEN KEEP THE QUESTIONS SIMPLE AND KEEP IT TO ONE QUESTION, PLEASE. DO WE HAVE A QUESTION TO START FROM THE AUDIENCE? WELL, WHILE YOU'RE WARMING UP AND GETTING OVER YOUR BASHFULNESS, I'M GOING TO ASK A COUPLE OF QUESTIONS TO THE PANELISTS. DR. BENJAMIN, WE'RE THRILLED TO HEAR ABOUT APHA'S COMMITMENT TO ACCESSIBILITY AND ALL OF US WANT TO DO THINGS AS QUICKLY AND CHEAPLY AS WE CAN. SO COULD YOU TELL US WHAT THE SIMPLEST, BUT MOST PROFOUND CHANGE WAS THAT YOU'VE MADE WITHIN APHA TO INCREASE ACCESSIBILITY?

>> YEAH, WE HAD AN ACCESSIBILITY TEAM THAT WAS VERY FOCUSED ON OUR ANNUAL MEETING. YOU KNOW, THAT'S OUR BIGGEST EVENT. SO WE'RE VERY FOCUSED ONLY MAKING SURE THAT WAS ACCESSIBLE. WE HAVE EXPANDED THAT. SO IT INCLUDES NOT ONLY MEMBERS OF MY STAFF BUT ALSO MEMBERS OF THE ASSOCIATION. AND THE BREADTH OF INVOLVEMENT AND THE IDEAS THAT HAVE COME UP HAVE REALLY CHANGED THE WAY WE THINK ABOUT EVERYTHING. WE LEARNED THAT LESSON AS WE'RE MOVING TO BECOME -- REDUCE OUR CARBON FOOTPRINT. WE PUT TOGETHER A GREEN TEAM AND WE TOOK THAT LESSON AND WE APPLIED IT TO ACCESSIBILITY AND DISABILITY ISSUES. AND WE HAVE ALREADY BEGUN TO SEE BEHAVIOR CHANGE LIKE I DESCRIBED IN OUR STAFF.

>> THANK YOU.

>> AND IT WAS FREE.

>> WE HAVE A QUESTION OVER HERE.

>> THANKS. TOM SINKS WITH ENVIRONMENTAL HEALTH. COLLEEN BOYLE ASKED ME TO ASK A QUESTION, SO THANKS, COLLEEN. I DON'T NEED THE

ENCOURAGEMENT. IN ENVIRONMENTAL HEALTH WE FREQUENTLY HAVE BEEN LOOKING AT COMMUNITIES THAT ARE CHALLENGED BY HAZARDS. HAZARDOUS COMMUNITIES ARE POISON COMMUNITIES AND WE'RE STARTING TO LOOK AT BUILDING HEALTHY COMMUNITIES. WHAT'S IMPORTANT IS INSTEAD OF LOOKING AT HAZARDS, HOW DO WE DESIGN COMMUNITIES THAT ARE HEALTHY AND SUSTAINABLE? AND WHEN I THINK ABOUT DISABILITIES ACROSS CDC, I THINK ABOUT THE OPPORTUNITY FOR ALL OF US TO BE THINKING ABOUT PERSONS WITH DISABILITIES IN OUR PROGRAMS AND HOW DO WE TAKE ADVANTAGE OF THAT AND ARE THERE WAYS THAT WE CAN THINK ABOUT BUILDING HEALTHY COMMUNITIES THAT SPECIFICALLY LOOK AT PEOPLE WITH DISABILITIES AND FOCUSING ON HEALTHY COMMUNITIES FOR EVERYBODY INCLUDING THOSE WHO ARE DISABLED?

>> YEAH, YOU KNOW, IT STARTS WITH BOTH MAKING SURE THAT THE COMMUNITIES THAT NEED TO GET REPAIRED, YOU KNOW, WE FIX SIDEWALKS, WE MAKE SURE THEY'RE CUT OUT AND THOSE KIND OF THINGS AND OF COURSE AS WE'RE BUILDING NEW COMMUNITIES WE BUILD THEM WITH THE CONCEPT IN MIND. WHAT WE WERE DOING WITH TRANSPORTATION FOR AMERICA IS OF COURSE TALKING TO THAT COALITION A LOT ABOUT THE IMPORTANCE OF JUST STEPPING BACK AND ASKING YOURSELF -- BECAUSE PEOPLE THINK OF THE WORLD HERE. THAT'S GREAT. BUT, YOU KNOW, HOW WOULD A PERSON SIMPLY GET -- IF YOU HAD A BABY IN A STROLLER, HOW WOULD YOU GET FROM POINT "A" TO POINT "B." JUST THINK OF THAT. IF YOU CAN GET A BABY IN A STROLLER FROM POINT "A" TO POINT "B" ASSUMING THAT THE DOORS ARE WIDE ENOUGH, ET CETERA, YOU CAN GET A PERSON IN A WHEELCHAIR, CANE, ET CETERA. BUT TRYING TO GIVE YOU A MENTAL PICTURE OF WHAT IT'S LIKE FOR EVERYBODY TO JUST MOVE IN ONE POINT TO ANOTHER. AND THEN BUILDING SYSTEMS THAT ACCOMMODATE ALL OF THOSE FOLKS. BUT AGAIN, THINKING ABOUT IT PROACTIVITY. NOT TRYING TO FIX IT ONCE YOU HAVE A PROBLEM.

>> WE OFTEN CALL THAT UNIVERSAL DESIGN. A QUESTION HERE?

>> YES. THIS IS FROM OUR TWITTER FOLLOWERS FOR GRAHAM, HOW CAN ALL OF US WORK TOGETHER WITH LEADERSHIP PROVIDED BY CDC TO LAUNCH NATIONAL PUBLIC AWARENESS CAMPAIGNS ABOUT THE NEED TO INTEGRATE DISABILITY INTO THE OVERALL PUBLIC HEALTH AGENDA?

>> WELL, THAT IS A GREAT QUESTION. IT IS A QUESTION WE'RE ACTIVELY ENGAING WITH OUR PARTNERS ON RIGHT NOW. I'LL TAKE A STAB AND THEN ASK OTHERS TO RESPOND TO THAT AS WELL. THE ISSUE OF REALLY INCREASING VISIBILITY WITH DISABILITY IS A BIG ISSUE WE HAVE BEEN TALKING ABOUT. THIS "GRAND ROUNDS" IS A KICKOFF FOR THAT. FOR CDC, THERE'S A HEALTH WORK GROUP THAT'S WORKING ACTIVELY AROUND GETTING DISABILITY INCLUDED IN THE POLICY, PROGRAMS AND THAT'S A LEADERSHIP ROLE THAT CDC IS PLAYING. THAT'S WORKING UNDER THE OUT OF OF DIRECTOR. DR. FRIEDENS' OFFICE.

>> I THINK ONE OF THE CRITICAL THINGS IS ONCE AGAIN, THE HEALTH DEPARTMENT AND PUBLIC HEALTH ARE DOING SUCH GOOD WORK WITH HEALTH PROMOTION, WELLNESS ACTIVITIES. ARTHRITIS PROGRAMS THAT ARE OUT THERE, BUT GETTING PEOPLE TO UNDERSTAND THAT DISABILITY IS A DEMOGRAPHIC AND IT'S NOT A SEPARATE GROUP. SAD TO SAY PEOPLE WITH DISABILITIES WE ARE A GROUP THAT INFILTRATES EVERY OTHER GROUP, WHETHER IT'S GENDER, RACE, ETHNICITY. SO IF WE CAN GET PEOPLE TO MOVE FROM THE SILO EFFECT TO INCORPORATING PEOPLE WITH DISABILITIES INTO THEIR LITTLE SILOS, WHICH WE'RE PART OF, I THINK THAT MAKING THAT MENTAL ADJUSTMENT, THAT THOUGHT PROCESS ADJUSTMENT, GOES A LONG WAY BECAUSE THEN THEY WILL MARKET TO DESIGN INCLUSIVELY, HAVE UNIVERSAL DESIGN.

>> AND THE OTHER PART IS ALSO, YOU KNOW, THE INTEGRATION OF PEOPLE WITH DISABILITIES IN PUBLIC HEALTH PROGRAMS. FOR EXAMPLE, SMOKING

CESSATION PROGRAM HERE. WHEN YOU'RE PROVIDING FUNDS TO THE STATE HEALTH DEPARTMENT AND YOU INCLUDE DISABILITY AS ONE OF THE DEMOGRAPHIC GROUPS, JUST AS YOU WOULD INCLUDE RACIAL ETHNIC MINORITIES AND THAT'S GOING DOWN TO THE STATE LEVEL AND THE LOCAL LEVEL. I THINK IT'S A GREAT QUESTION.

>> ANOTHER QUESTION IN THE BACK. OKAY. THANK YOU.

>> HI, I'M MARY McDONALD FROM THE OFFICE OF HEALTH DISPARITIES. THANK YOU FOR YOUR REALLY EXCELLENT PRESENTATIONS. I LEARNED A LOT BEING HERE TODAY. I JUST WANTED TO ASK A QUESTION IN LIGHT OF WHAT'S BEEN HAPPENING IN THE NATION. I THINK WE'RE REELING FROM SANDY HOOK AND I WONDER IF ANY OF YOU MIGHT HAVE ANY COMMENTS ABOUT THE SOCIAL DETERMINANTS OF MENTAL HEALTH DISABILITIES? PROBLEMS WITH THESE NOT ACTUALLY BEING IDENTIFIED AND ACKNOWLEDGED AND HOW THIS MIGHT REQUIRE SOMETHING DIFFERENT FROM THE KINDS OF RESPONSES YOU HAVE TALKED ABOUT. THANK YOU.

>> SOMEBODY WANT TO TAKE THAT QUESTION?

>> I'LL TAKE MY GENERAL STAB AT IT. I -- THIS IS ME PERSONALLY SPEAKING, I THINK ONE OF THE KEY ASPECTS WITH ALL DISABILITIES BUT PARTICULARLY WITH MENTAL HEALTH IS THE STIGMA ASSOCIATED WITH IT. NO MATTER WHAT YOU SAY, THE FACT THAT I USE THE WHEELCHAIR PEOPLE IN SOCIETY VIEW ME AS LESS THAN OR HAVE FEWER EXPECTATIONS OF OR IT MUST BE HORRIBLE TO BE HER. AND IT'S THE SAME WAY WITH MENTAL HEALTH, BUT I THINK PROBABLY EVEN INCREASED BECAUSE PEOPLE UNDERSTAND IT EVEN LESS. THEY CAN SEE THAT MY LEGS DON'T WORK, SO OKAY, SHE USES WHEELS. WITH MENTAL HEALTH IT'S HARDER FOR THE GENERAL SOCIETY TO GRASP IT. AND I THINK PERSONALLY -- I THINK THAT HAS TO HAPPEN BEFORE WE MAKE SOME REALLY

GREAT STRIDES IN IT WHICH MEANS PEOPLE HAVE TO BE WILLING TO SEEK OUT SERVICES AND SAY THAT THEY HAVE WHATEVER THE DISABILITY IS.

>> WE HAVE TIME FOR ONE MORE QUESTION. THANK YOU.

>> [ INDISCERNIBLE ]. -- INDIVIDUAL PEOPLE WORKING AS A TEAM. FOR EXAMPLE, PEOPLE -- OH, WE DON'T -- BUT THAT'S NOT ME. THAT'S NOT HOW IT SHOULD BE. I'M PLANNING ON HAVING A MEETING WITH A GROUP CALLED DIDA, A GROUP WITH DISABILITIES, AND TALKING ABOUT THE VARIETY OF DISABILITIES. WHEELCHAIR. PEOPLE WHO ARE DEAF. AND SO WE CAN ALL BE WORKING TOGETHER AND FEEL COMFORTABLE TOGETHER INSTEAD OF BEING IN SEPARATE GROUPS. I'M TRYING TO DEVELOP THAT ALLIANCE. SO I CAN SEE THOSE PEOPLE -- OTHER PEOPLE WHO HAVE DISABILITIES, NOT JUST FOCUSING ON OUR OWN DISABILITY IN THE COMMUNITY. I THINK THAT'S AN IMPORTANT PART THAT WE WORK TOGETHER.

>> THANK YOU. THANK YOU FOR THE COMMENTS. THANK YOU.

>> THANK YOU VERY MUCH FOR REALLY GREAT QUESTIONS. I THANK OUR FABULOUS FOUR AND FABULOUS SIX. AND I APOLOGIZE FOR SOME TECHNICAL DIFFICULTIES WE HAD FOR THOSE WHO WERE NOT ABLE TO PARTICIPATE AND VIEW US IN THE ENTIRETY OUTSIDE OF CDC. BUT THE ENTIRE SESSION IS GOING TO BE POSTED SHORTLY. THANK YOU ONCE AGAIN AND SEE YOU IN TWO WEEKS. SAME TIME, SAME PLACE. THANK YOU.