

CDC *Vital Signs* Town Hall Teleconference

Increasing Physical Activity Among Adults with Disabilities

May 13, 2014

2:00 pm EDT

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen only mode for the duration of today's call.

During the Q&A Session, you may press star 1 on your touchtone phone, if you wish to ask a question. We will be having several question and answer sessions throughout the conference, so at any time, please feel free to dial Star 1 to ask a question or comment on any of the discussion.

Today's conference is being recorded. If you have any objections, you may disconnect at this time.

Now I would like to your meeting over to Dr. Dan Baden. Dr. Baden you may begin.

Dr. Dan Baden: Thank you very much Stephanie. Good afternoon everyone. I'm Dr. Dan Baden, the associate director for External Partner Outreach and Connectivity in CDC's Office for State, Tribal, Local and Territorial Support.

Welcome, I'm glad you could join us today. We'll be discussing the latest *Vital Signs* report on increasing physical activity among adults with disabilities.

Before we get started, let's go over some housekeeping details. You can go online and download today's PowerPoint presentation, so you can follow along with the presenters.

The web address is www.cdc.gov/stltpublichealth—that’s S-T-L-T, public health.

There’s a link directly to the *Vital Signs* Town Hall web page under the highlighted products and resources on the lower right side of the page.

On this Town Hall web page, you can also find bios for each of the presenters and this is where we’ll post the audio recording and transcript for today’s teleconference and they should be available next week.

And back to our topic, increasing physical activity in adults with disabilities is an important public health topic, because more than 21 million US adults, 18 to 64 years of age, have a disability and nearly half of all adults with disabilities get no aerobic physical activity.

Adults with disabilities are three times more likely to have heart disease, stroke, diabetes or cancer than adults without disabilities. Physical activity benefits all adults, whether or not they have a disability, but only 44% of adults with disabilities who visited a doctor in the past year, were told by a doctor to get physical activity, yet adults with disabilities were 82% more likely to be physically active if their doctor recommended it.

States and communities can make sure physical activity, recreation, and sports based program opportunity are accessible to adults with disabilities and incorporate community features, such as proper curb cuts on sidewalks, ramps for wheel chair access to improve safe access to public places of physical activity and more.

On today's call we're going to hear from four colleagues. First we'll hear from Dr. Dianna Carroll a senior health scientist in the Division of Human Development and Disability in the National Center on Birth Defects and Developmental Disabilities at CDC.

She'll provide a summary of this month's *Vital Signs* report. Dr. Carroll will then hand the call over to Jevettra Devlin, the project manager for the Interagency Office of Disability and Health at the University of South Carolina, Arnold School of Public Health in the Department of Epidemiology and Biostatistics.

Jevettra will discuss progress made using the Steps to your Health Program in South Carolina to increase physical activity among adults with disabilities. She will then hand the call over to Candice Lee, the project coordinator for the Disability Health Unit at the Michigan Department of Community Health and Meghan Faulkner, the community health associate in the Arthritis Program at the Michigan Department of Community Health.

Candice and Meghan will talk about *EnhanceFitness*, an evidence-based group of physical activity program being implemented in the Michigan communities, for people with all abilities and all levels of fitness.

There will be time for questions after or presentations today, but you can get in queue at any time to ask a question. Just press star 1 and record your name when prompted.

And now I'll turn the call over to Dianna.

Dr. Dianna Carroll: Thank you. Thank you Dr. Baden and thank you everyone for attending the call. I really appreciate your interest in increasing physical activity among adults with disabilities.

So we're now on slide 5. Our key message in our *Vital Signs* report this month, is that physical activity is for everybody and every ability. The 2008 Physical Activity Guidelines for Americans recommend that all adults get two and a half hours of moderate intensity aerobic physical activity each week, for substantial health benefits.

These guidelines are for all adults, including those with disabilities. Meeting those guidelines can be achieved in multiple bouts of activity throughout the week lasting as little as ten minutes at a time.

We know that physical activity lowers risk of heart disease, stroke, high blood pressure, diabetes, certain cancers, and depression. For adults with disabilities who can't achieve this recommended amount, they should start slowly based on their abilities and increase their activity over time.

It's so vitally important that all adults, including those with disabilities, avoid inactivity doing some activity is better than none.

On slide 6 we show some of our key evidence from our *Vital Signs* report. We found that there are over 21 million adults between the ages of 18 to 64 years who have a disability.

We define disability as, "A serious difficulty walking or climbing stairs, hearing, seeing, or concentrating, remembering or making decisions."

And among adults with disabilities who didn't report that they were unable to do physical activity, nearly half of them got no aerobic physical activity.

And this is very concerning, because we found that inactive adults with disabilities are 50% more likely to have cancer, diabetes, stroke, or heart disease than those who get the recommended amount of physical activity.

But although only 44% of adults with disabilities who visited a doctor in the past 12 months got a physical activity recommendation, they were 82% more likely to be physically active compared to those adults with disabilities who did not receive a recommendation from their doctor.

We're now on slide 7. Now up to this point, we've discussed our findings for all disability types and I'd like to now highlight the level of physical inactivity for specific types of disability.

So regardless of disability type, adults with disabilities have a higher prevalence of getting no aerobic physical activity compared with adults without disabilities. Adults with mobility limitations have the greatest prevalence of inactivity among all the types of we included in our analysis, but what is striking about this slide, is that a greater percentage of adults 18 to 64 years of age, who have each type of disability, are more likely to get no aerobic physical activity than their peers without disability.

On slide 8, we have, we list out some barriers that adults with disabilities have identified to - engaging in regular aerobic physical activity. Some of these barriers include having limited information on accessible facilities and programs.

Another barrier is physical barriers in the built and natural environment. Physical or emotional barriers to participating in physical activity is another barrier identified by adults with disabilities.

And finally, another barrier is that fitness and recreation professionals lack training and accessibility for adults with disabilities and then how to communicate to make a more positive experience for adults with disabilities.

So for example, when working with someone with a disability, it's important to see the person first and not the disability. Use people first language. For example, say "person with a disability" rather than "disabled" or "handicapped person."

So what can be done to increase physical activity for adults with disabilities? In our *Vital Signs* report we focused quite a bit on what the health professionals can do by knowing the Physical Activity Guidelines, knowing that they apply to people with disabilities as well, and recommending physical activity to their patients and connecting them to resources that are available for their specific types of disability.

Really we want to encourage the health professional to have the discussion at every visit. But we also on page 4 of our fact sheet in the *Vital Sign* lists some things that states and communities can also do.

For example, they can bring together adults with disabilities, health professionals and community leaders to address resource needs to increase physical activity.

They can also make sure that physical activity, recreation, and sport based program opportunities are accessible to adults with disabilities.

They can incorporate community features, such as having proper curb cuts on sidewalks, ramps for wheel chair access, and well maintained trails and sidewalks to improve safe access to public places where adults with disabilities can be physically active.

They can also encourage fitness and recreation facilities to have low counter front desks for wheel chair users, family changing areas in locker rooms, and push button operated doors and elevators.

All of these items, as you can see, can help diminish the barriers that I mentioned in my previous slide.

Now on slide 10, I'd like to acknowledge all of my colleagues who've helped develop this *Vital Signs* report. We enjoyed doing it and we hope that it resonates with all of you and that it provides some motivation and some momentum for you as you carry out your activities in your states and communities.

And again, our key message is, that physical activity is for everybody, every ability.

Thank you.

And now I'd like turn the presentation over to Jevettra from the University of South Carolina.

Jevettra Devlin: So good afternoon. Everyone should be on slide 12. My name is Jevettra Devlin and I'm the project manager of the South Carolina Disability Health Project and today I will be discussing the progress made in South Carolina in increasing physical activity among adults with disabilities.

Next slide. So South Carolina statistics. In analyzing the 2011 BRFSS data, we found that 42% of individuals who screened of having a disability were classified as obese based on height and weight; while 26.9% of people with no disability were classified as obese.

Furthermore, almost 40% of people who screened as having a disability reported no physical activity in the past month, compared to 22.8% of people with no disability.

Next slide. So the Health Promotion Program that has been implemented in South Carolina is the Steps to Your Health Program (STYH). They began in 1998, partnered with the South Carolina Department of Disabilities and Special Needs to promote wellness and increase physical activity to people with disabilities in the state of South Carolina.

This partnership actually still remains. Steps to Your Health is a ten week evidence based wellness program that uses a participatory model and social cognitive approaches.

The program was designed specifically for adults with intellectual disabilities, brain injury and associated conditions; however, through time the program has become inclusive of all disability types and has been proven to be successful for all disabilities.

So the goal of the program is to promote healthy lifestyles in people with disabilities and prevent debilitating secondary conditions. Steps to Your Health provides information about achieving and maintaining a healthier lifestyle, through good nutrition, preventing obesity and its complications, increasing physical activity, dealing with stress, and improving communication.

We are currently also partnering with the ABLE South Carolina (ABLE-SC), a center for independent living, to conduct the Steps for Your Health classes and the train-the-trainer classes.

In the train-the-trainer classes are those classes in which we train leaders to conduct the Steps to Your Health classes. The ABLE-SC, they have a great reach throughout the state of South Carolina and actually service all disability types. And for this - we actually, for recruitment purposes, we actually do that through a network of community disability and special needs boards and other local disability agencies.

Next slide. So for our impact and results. Since 1998, 5,200 individuals from 40 of the 46 counties in South Carolina have participated in the program and 200 health professionals have completed the train-the-trainer course.

We've actually - during the program, on week one and week two, we complete assessments of weight, nutrition, and exercise knowledge. Some of the results that we have were short term results, we have seen that participants have increased their knowledge about health, developed healthy behaviors, and learned strategies to promote optimum help.

On average, participants lost about five pounds. Some of the long term results that we've seen are improved health of participants including

increased energy, strength and stamina, and roughly 70% of participants were able to increase or maintain their physical activity.

And we did a post-test at 10 weeks and then we followed up with them in six months.

Next slide, weight management education. So the training of health professionals has met a direct component of the Steps for Your Health Program, what is essential increasing the health and wellness of people with disabilities?

So partnering with the University of South Carolina School of Medicine, the program conducts a class of year two and year three medical students who are in the family medical rotations.

And the class covers weight management, proper nutrition, smoking cessation, and physical activity for people with disabilities. This program has trained around 800 residents.

And in 2012 we actually extended our training to the Greenville Technical College instructing other specialties of care professionals using video modules. So three modules have been developed and they cover the overview of disability, proper communication with people with disabilities using person first language, and physical assistance for people with mobility disability.

And we believe that the training of healthcare professionals is very beneficial for the care of persons with disabilities because we really want them to look beyond the disabilities to provide the best care for the patient.

Next slide. So we should be on the equipment accessibility, slide 17. So in speaking about weight management, weight can only be managed in its track, yet people with mobility disabilities are less likely to be weighed at a doctor's office because of the lack of wheel chair accessible scales.

So partnering with the health department's Best Chance Network and the Office of Rural Health, our program has been able to assess over 140 primary care clinics.

Unfortunately, only 2% of these clinics have a wheel chair accessible scale. This is the best way to accurately measure - managements which can affect physical activity counseling.

Next slide. So some of our key successes within the last two years, we've actually be able to purchase two wheel chair accessible scales that we are able to take the weight of individuals at week 1 and week 10 of the Steps to your Health Program.

We've also purchased reusable water bottles and exercise scales for the participants and the items were initially purchased through the decrease of attrition rates, but I've also set up an increasing water intake and physical activity of the participant.

The participants will actually - we'll give the water bottle to the participant after their exercise lesson and they actually will bring the water bottles back so every class, as they come to the Steps to your Health Program.

Like some of the greatest lessons we've learned with the program have been – this truly is a team effort between the participants, the family members,

and the staff. Everyone really has to be onboard to create a support system to create that sustainability in those lasting changes that are learned.

Also information reinforcement and understanding how lessons can be incorporated into everyday life are imperative to improve a sustained lessons taught in the program.

For this program it can be easily incorporated into local services, such as residential rehabilitation, day program options, rehabilitative support, social and recreational activities, self-advocacy groups, and quality improvement plan. So identifying organizations who - and this is – similar to yours, will increase the likelihood of the program being sustained.

So that concludes my presentation and next we will have Candice and Meghan from the Michigan Department of Community Health.

Candice Lee: Thanks Jevettra. We are on slide 20. I'm Candice Lee, project coordinator for the Health Promotion for People with Disabilities Project at the Michigan Department of Community Health.

Meghan Faulkner: And I'm Meghan Faulkner. I'm a community health associate for the Michigan Arthritis Program also at the Michigan Department of Community Health.

Candice Lee: We're going to talk about a collaboration between our two programs that brought a physical activity intervention, called *EnhanceFitness*, which originally had been designed for older adults to people with disabilities.

It's a great example of how Michigan Public Health is working to make existing public health programs accessible and welcoming to people of all abilities.

Meghan Faulkner: So moving onto slide 21, *EnhanceFitness* or EF, is an evidence-based group physical activity program that's designed for older adults and it's been shown to be effective at helping older adults at all fitness levels become more active and maintain their independence.

The program was developed in the 1990's, by Senior Services of Seattle, that's a non-profit for older adults, in partnership with the University of Washington and Group Health Cooperative, our non-profit health care system.

Moving onto slide 22, *EnhanceFitness* has classes that are one hour long. They meet three days a week and they're led by certified instructors that - the classes are relatively low cost. They require only chairs for balance, and/or seated participation and flexible wrist and ankle weights.

Each one-hour class, consists of a warm up, aerobic strength training, balance and flexibility exercises, and then a cool down. Classes typically have less than 25 participants in them.

The class is designed to be highly adaptable. People from fit to frail can participate together and the program's incredibly popular with participants. Over 99% would recommend it to a friend.

In terms of reach, from October 1, 2012 to September 30, 2013, there were over 4,000 participants reached in Michigan. We had 11 affiliate organizations delivering 90 classes to 76 different sites across the state.

So moving onto slide 23, in terms of evidence-base, the class was proven to increase strength. People who regularly attend class, grow stronger, they improve their balance, and they become more limber.

The class also boosts activity level, even the unfit quickly find themselves able to do things that they want to do safely and independently.

And finally it elevates mood. Research has shown that exercise can help prevent depression and *EnhanceFitness* participants say they feel better physically, as well emotionally.

Candice Lee: As Meghan said, *EnhanceFitness* was designed to be highly flexible. Inherently it was for people of all abilities and levels of fitness. So instructors were already trained to meet people at the level of ability they come into the program with, so there was no adaptation needed in the program itself in order for it to be appropriate for people with disabilities.

And in fact, we wouldn't be able to make changes to the program because interventions with an evidence-base, can only deliver on the results that their research shows, if they're delivered the same way they were created, and this is referred to as program fidelity.

So *EnhanceFitness* was inherently accessible.

Meghan Faulkner: And moving onto slide 24. While we didn't change the program itself in Michigan, we added support for inclusion to the infrastructure that supports *EnhanceFitness* implementation.

Advocacy on the part of the Michigan Arthritis Program changed the way that *EnhanceFitness* accesses its disability status of participants, not just in Michigan but across the nation.

Our data collection forms, participants had previously been asked, “Do you consider yourself disabled?” However, in 2012, *EnhanceFitness* implemented the disability screening questions used by the Behavioral Risk Factor Survey (BRFSS), that’s a randomly dialed telephone survey of the health of the state citizens.

The questions that are now asked are, “Do you have any health problem that requires you to use special equipment, such as a cane, wheel chair, special bed, or special telephone?” and “Are you limited in any activities because of physical, mental, or emotional problems?”

Asking the questions this way, revealed how many people in *EnhanceFitness* are living with functional disability, not just how many identify as having a disability.

This helps instructors understand how many participants with disability they were already serving and underlying the importance of having accessible locations and practices for their classes.

And in Michigan, 26% of participants from that time period of October 2012 to September 2013 answered “Yes” to one or both of the disability questions.

Every year the *EnhanceFitness* instructors meet in a statewide meeting for everyone who practices that program in the state. And we have a National Center on Health, Physical Activity and Disability come to one of the annual

EnhanceFitness meetings and talk to the instructors about making the workout environment accessible.

We've also provided training on disability etiquette and person first language. We've had some very candid discussions about what exactly inclusion means, since we implement group intervention, you're constantly balancing the good of the individual participant against the good of the group as a whole, right.

So our golden rule is that anyone can participate as long as they can do so without disrupting the functioning of the group. That's a policy that's applied to everyone and it's discussed the first time a group ever meets.

In the beginning, the Michigan Arthritis and the Disability Health Program, provided technical assistance on disability issues to the instructors, but as the instructors have gained more experience, they've developed their own pockets of expertise on these issues and now they rely mostly on one another as questions come up.

At the annual meeting this year, coming up next month in June, a portion of the cardio refresher sessions for *EnhanceFitness* instructors will be demonstrated from a seated position.

The instructor who's performing the demonstration, leads a class that is completely 100% seated. Most of the participants are people who use wheel chairs or are otherwise unable to stand independently.

And this is being brought to the group at the request of our partners who wanted to see that seated aerobics in action.

So if you go to slide 25, here are a few of the things that we've learned along the way. Michigan's preference is to make existing public health programs accessible, rather than to create separate programs.

Inclusion benefits the public health community, it benefits the disability community, and it stretches limited dollars and it increases reach.

In addition to *EnhanceFitness* we've also been successful in bringing the Stanford Chronic Disease Health Management Program to people with disabilities using a similar approach.

Now that doesn't mean that's it one size fits all. There's a place for opening up access to existing programs, for creating targeted programs, and a continuum of everything in between.

But if this kind of integration and inclusion is going to be your focus, it's important that the intervention you start with should be inherently inclusive, or at least have quite a bit of potential.

It's also more likely to be successful if there's an existing infrastructure for implementation that you can plug into.

And finally we've used that annual conference I mentioned, for instructors as an opportunity to reach the instructors when everyone's together to give them those tools and the support that they need for real inclusion.

And we just don't do it once, returning again and again to different facets of inclusion sends the message that this is a mindset. This is an expectation to make sure that inclusion is baked in rather than sprinkled on top.

And that is all we have for you today. Thank you.

Back to Dr. Baden.

Dr. Dan Baden: All right. Thank you very much. Thank you for the excellent presentations. At this point, I'd like to remind everyone that they can get in queue to ask questions, by pressing star 1, and just say your name when prompted and you'll be announced into the conference by the operator, when it's your turn to ask a question.