DINNER SERVICE KEYNOTE

BARBARA BALLARD: I'd like to introduce our keynote speaker this evening. And she's sitting right in front of us, and her name is Gaye Woods. Her complete biography and presentation you will find in your binders. And you will get that tomorrow morning. But I wanted to tell you a little about her before she comes up. She leads a development and research program in health disparities as a program manager for the University of Colorado Cancer Center's Department of Preventive Medicine. Under a multi-year grant funded by the National Institutes of Health and specifically the National Institute of Minority Health and Health Disparities and the National Cancer Institute, her groundbreaking work has focused on chronic disease prevention and management using diet, nutrition, and physical activity as the primary intervention model.

Ms. Woods gracefully juggles multiple roles as a researcher, a community leader who serves on the governor's council for physical fitness, as a convener who frequently brings together faith-based and community-based organizations. She's also a successful businesswoman who has founded Colorado Fitness and Wellness, helping individuals to transform their lives. And she's a wife and a mother. We have already seen one example of Gaye's work with one of our own staff members. She helped our policy director, Ajenai Clemmons, transform her life and lose nearly 40% of her body fat. When I talk with Ajenai about this, Ajenai really gives you all the credit, especially for motivating her to be able to do this. And I would also like to add, a lot of this is Ajenai's idea that we have this program. And I like to give credit where it's due.

But you know, you must have a special talent to be able to motivate people to do this because it's one of the hardest things for people to do. It's not just about eating right and exercise. Ms. Woods understands that wellness encompasses the body, the mind, and the spirit. And I can't wait to hear what she's going to share with us this evening. Please give her a warm welcome, Ms. Gaye Woods.

GAYE WOODS: Thank you so much. What a wonderful introduction. I'm so excited to be with you. And here at 18 years is significant. I hope you realize that. You know, there's nothing in today's time that kind of lasts to that degree. So many things are, you know, six months or less. We're in a very fluid kind of society, so 18 years is significant and I celebrate you for that. And I bring you greetings from the University of Colorado Cancer Center and from the beautiful Rocky Mountains. If you haven't been to Denver, I invite you to come for sure.

So much of what has already been said as a lead-in just warms my heart because I often see myself as kind of a drum major for health and I've often laughed with different audiences of color that I'll be the lone person, you know, beating the drum for health by myself. And I'm okay with it. I'm okay with it because I know that it is a hard thing to change. It is a thing that for most of us and many of us, we've kind of given up on it. And depending on where we are on the continuum of aging, we especially have given up on it. That was for a different period of our life. Being and healthy and fit was for younger -- that's for a younger generation. It's not really about when you're over 30. You can let that go. And I totally subscribe to the counter-argument to that as someone who has received my AARP card just recently. Yes, sir. Yes, sir. Yes, sir.

So it isn't often that health gets really put in a place of priority. The way this conference has been brought together, I really celebrate the intention of it and the focus on this integration of mind, body, and spirit because I do think that there's something special about that combination. And it is not foreign to us. Based on who we are, that is not a foreign concept, that mind, body, spirit. But it isn't often presented that way, and so I'm really happy to be able to just stop by and share a little bit about it.

Definitely when you get your book and binder, you will be able to see the full presentation. And just because of our limited time, I want to be considerate of that and I'm going to make some modifications so that we can get through and especially reserve some time for questions because I hope that you will have some later on.

I reviewed your past conferences and saw that you last year took a very close look at health disparities. So one of the things that I wanted to do in speaking to you tonight was really kind of bring you a perspective of being on the front lines of community health. At the University of Colorado, I actually get to do research around diet, nutrition, and physical activity, and its effect on chronic disease, cancer being specifically. But what is wonderful about some of that work lately is that everyone's starting to recognize just how much those three variables have such an impact on disease. Earlier on, that wasn't necessarily the case, but now it's really being more well-received in that respect, and people are spending and being willing to invest a lot in terms of funding for additional research around those areas, not only for cancer but for diabetes and cardiovascular disease and a number of other chronic disease.

I want to just do a quick refresher on disparities first, and then talk a little bit about disease, and then on discovery. And in that discovery, I'll tell you more about a program that I did called Living Well by Faith, that I delivered in churches in Denver, primarily to an African-American population. So in terms

of disparity, the definition for it, the formal definition, and this is actually NIH's definition of it, is that health disparities are differences in incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States. That all sounded great. Disparities are anything that is different primarily in your care as it relates to your ethnicity. Shortened version.

Now I could probably go around the room and ask you for some examples of -- you know, have I actually had an experienced of disparity? I'm not sure, have I? Well, I did indirectly a few years ago when my mom passed. And it became a joke of ours while she was in the hospital. This was a registered nurse who was non-compliant in terms of her diabetes care. Did you hear that? High blood pressure. Ultimately having to have a double bypass heart surgery. Through that process of recovery, we started to notice that some differences in what the doctors said when I was in the room and when I wasn't, when I just happened to wear my Northwestern University Kellogg School of Management jacket versus when I didn't. A disparity.

So they said [inaudible] whenever I wasn't there, but when I'm here -- and so it became a joke of ours that I would wear that jacket every day. Got to put my jacket on before I go in because it meant that I was going to get a better level of information. It meant that I could ask questions and also say, you know what? Consider -- have you considered this? Because it took her a while to actually be weaned off of support, air support, and there was a whole battle with the doctors around that. But what a difference. That was just a glimpse of disparity. And I said, you know, being able to be in the healthcare system just pushed me on to be even more passionate about the work that I do in terms of health and wellness because if I can do anything with the sphere of control that I do have, I think it's tremendous if I can help to do anything that will delay illness, because the healthcare system is broken.

This is someone who had insurance. So that's not a guarantee. So what do we have that we can really control? We need to make sure that we understand it and leverage that at all cost. And so much of it is rooted in some objects I'm going to talk about in just a second. Disparity, another issue of disparity that's driving up the difference is related to income. And actually, I think USA Today had a great front page story about the increase in terms of the numbers of poor. Their citing was 48 million, of which 18% of those are families. That number changing tremendously recently because of unemployment and extended unemployment.

Disparities. What does that mean in terms of disease specific? It can mean if you are someone who needs a kidney, that you may be the last to understand what your options are, that that system of

when you are able to be in a position to receive one may not work the best for you if you're a person of color. It could mean in terms of diabetes, an area that we lead too much, that test and diagnostic care around that may be one of the last options that's given to you. Cancer, that's the world that I live it. It could mean on cancer that some of the advanced drugs and research areas you may not always be informed about. Disparities. Difference.

In addition to just the basic of ethnic difference that exists around disease, there are also now a lot of research and investment that's looking at kind of this interrelatedness around other things, other social and societal things that also have an impact on ultimately disparities, but it's not in terms of research. We can't just look at it from strictly an ethnicity and race issue. It also has to do with some environmental things.

And you'll see that in one of the slides that basically examines kind of some of those differences. So on the slide itself, on the left side of the diagram in the slide, it says multiple environmental factors that are influenced by race and ethnicity and that potentially contribute to health disparities are depicted on that side, which those include education, culture, stress, which I know one of our presenters is going to talk about. But on the right side, there's also this genetic contribution to health disparities, which operates through a series of proxy relationships. So to unravel that cause of really issues around difference of disease and disease treatment, we have to really start to look kind of holistically. There's that word again. At everything, not just race being the only variable or a majority variable, but also other things that have a longer view of us, even back to where our origin is. There's a lot of research that's going on in that area, but not enough.

I don't know about you, but I am tired of African-Americans leading every category of death. Is there anybody -- are you tired? I want us to lead Forbes lists for a change, you know, discovery, back to all of our greatness because that's who we are as a people. You know, the creators, the inventors. I want to see us leading those things. But from where I sit in terms of my work, far too much that's what I see. we have disproportionate numbers in terms of diabetes. And what's worse, we die from it more. Same thing exists in cancer. Same thing exists in cardiovascular disease. Why is that? Why is that? That's a question we want to talk about, right? How we can turn that corner. You'll be surprised at how much is actually in your control. It's not the man, although he has his role.

There's actually a lot of slides also that kind of show not only what is going on with us in terms of disease, but also just how much life is lost because of disease and how earlier we're dying. And there's a stat that's displayed in the slides that talks about -- it's Healthy People 2010 and where we are

in terms of the measurement of where the goal was for 2010 and where we are in relation to everybody else. So white, Hispanic, Native American, Asian. And so blacks and whites in some categories are the only two groups that did not come even close to meeting the 2010 goal. Guess who met it? Hispanics. Asians. Not us. Not us.

Some solutions to disparities quickly as I move onto disease. Definitely would be rooted in a universal healthcare system as a basic. Making sure that everybody has access to just some basic preventive. A lot of the causes that are killing us are preventable. These aren't death sentence things despite what you may hear. More resources that are directed toward groups that are disproportionately affected by disease. Let's put the money towards the groups that most have the need. That changes the burden of the system. That seems so basic, but it's not the way it is. Also, some attention to just social inequities around a livable minimum wage, training, housing, adequate education, and then research. Of course I have to put a plug in for research, that we have to continue to look at new ways and to think out of the box about new ways to change people and motivate people and encourage people around that your health is important. And research is a great way to do that, especially if it can make it from research into real, sustainable practice programs.

On disease, I really primarily want to focus -- you'll see more in the slides, but I want to focus or just touch on diabetes. It's not even an area that I really work in as a primary, but I have to just tell you how much diabetes is killing us, and totally changing our lives because we don't manage the disease well. And it leads to amputations and blindness and a lot more serious things.

There's a great two slides in the pack that is very illustrative of the point in that in 1991, they show all states, so you can find your state. And it's based on BRFSS data that looked at BMI, body mass index, of which 30 is the number that you want to be less than. And so this view actually just looked at the point of BMI, of body mass index of 30 or more. And so in 1991, they highlighted the colors of the state and there were many states that were in the light blue category, so being less than 10% with a BMI of 30% or more. Some states that you would probably suspect would be higher, you know, in Southern regions, but still a great -- you know, it was a great mixture of colors: light blue, dark blue, red, et cetera.

Speed forward to 2001 and there are no light blue states. There's only dark blue, red, and then they added a green because 25% of states were 30 or more, BMI of 30 or more. So everything that was on the left in terms of lower percentage representation of BMIs suddenly changed just a mere 10 years later. And that's continuing to get worse. And then the stat that I saw recently was directed towards

children in Colorado, which is often put up as one of the healthiest states and oh, this and that. And people have really prided themselves on that. We're number two now in terms of childhood obesity.

What happened in such a short time? Well, I want everybody to pick up three things that are on your table: a fork, a knife, and a spoon. I think Bush kind of had it wrong because, you know, he was looking for weapons of mass destruction. I think those are the real weapons because it's a really -- it's a cool strategy. It's a cool strategy. Just think about it. I don't have to supply it; it's already there. And as long as I continue to supply you really poor food, because I have to be careful, this is recorded, so I don't know if I can talk about FDA the way I would want to. I'm happy to have any sidebar conversations later, but they do not have your best interests at heart at what gets to your grocery store and your table. And if you don't know how to discern that, that together with those weapons of mass destruction and you're on your way to the graveyard.

In terms of discovery, I was funded by the National Institute of Health to look at -- we could choose any area of disparity that we wanted to. We actually chose cancer. A lot of people chose HIV and cardiovascular disease, a number of different things. We chose cancer and it was actually a community-based participatory research study, which just means that we would not choose the program and style of delivery arbitrarily, but we would talk to community and ask community, what would help you to change your lifestyle? And we did that through a series of four summits.

The partnership that we had we found out was very unique because as we went to the national group with all of the 80 grantees, they were talking about how difficult it was to really enroll people or to get a community partner to really do this work, that you have to have a way that you can access people or you don't have anything. We found out that we were years ahead, light-years ahead because we had a tremendous relationship in our community partner, which is the Center for African American Health in Denver. And it is a consortium of churches that participate as part of a faith and health ministries program. And they originally existed primarily to do services for churches, so training and things that help to improve -- a consulting model that helped to improve church operation. It turned over the last five years to strictly focus on health because the need was so great there. And all of the churches which are part of them is some 80-plus churches.

And so we had this built environment of these churches that we were in conversation with and had these summits, four over the course of the initial first three years, and were averaging 200 people at these meetings. So people were really engaged on this topic and glad that someone was asking them and not just coming in to provide some program to them. Through the course of that discovery with

them, we learned that they wanted a program that focused on health and wellness. They wanted to learn how to cook foods. They wanted to understand some basics about nutrition.

They wanted to lift weights, which shocked me because I'm a personal trainer and I'm always on that tangent that you can't run yourself thin, you know, for those people that whenever they decide they're going to get back in shape, they go back to 19 -- dates are up here, numbers are down. 1929, whatever the year was that I was fit and I was running, that is what I do now. But there's a process when you get older, you can't go back that way. You got to figure out a more moderate approach. You can still get to the same end result, but you have to change up a few things. And so I was amazed that these are people of color that looked just like me who were saying, you know, strength training, that should be a part of the program. I was shocked because most of the time that's not how we're wired. And this was a representation of men and women, but definitely anchored more toward the female side.

They said that, you know, church is the optimum venue for us. It's where we're already going and we're already going multiple times a week. So you know, build it at the church, because we asked them. We used not one time, but we used multiple times, and we used an audience response system for one of those, so they got to do it anonymously to say where would you really want this? With Parks and Recreation, the community center, the Y, whatever? Church.

We asked them, who is the most influential figure for you as you think about health change and encouragement? And they said the pastor. They said the pastor. Trumped husbands, it trumped wives. It trumped the president, which at the time, we started this before our President Obama was in, but the pastor. So we thought, hm, this may present a unique opportunity if we can do this thing right. They said, we're willing to meet two times a week. We're willing to exercise. We want a buddy system. We want some actual hands on. We don't just want to be talked at. We want to have a chance to actually get our hands dirty about these things. We want to understand about disease prevention, talking to us from a cultural perspective though. Different.

So that's what we built. We built that program with Living Well by Faith. And we delivered it in a research design, so having a control group and an intervention group. Three churches in both, and we were careful to make sure that we could mix up the level of churches. We didn't want all large churches to participate. We wanted to have some small churches, a medium church, and a large church. And the attendance was tremendous in that out of the eight weeks, which I want to comment on that before I get to the results, but all of the -- in the design of it, we really wanted to use evidence-based and best practices in designing like what the program would look like.

We actually ran at it - got into a time lag and had to shorten the program because it started out, 12 weeks is really the ideal design, so three months. In order to make change, generally three months is the golden rule. We did it in two months, so already we were a little bit different because we were out of line with the standard. But our ending results were tremendous in that we had such high attendance. Most people only missed like two sessions over the course of eight weeks. The church told us what dates they wanted to and times they wanted to build it. We did it.

The result was that people lost an average of seven pounds, which doesn't sound like very much. It's hard to lose one. Seven pounds. Changed their health status in that we had a number of pre-diabetic, hypertension, high blood pressure. Just that little bit of weight. But the other pieces, the kind of qualitative side of results from the study were tremendous about people really learning some basics about nutrition, about what is a protein, what is a carb, what is fat, good fat, not fat? And to do it in a way that is right at us, because all of the project team were African American from the doctors to the nurses, so we were doing baselines all the way. With all those things, all those variables aren't always possible, but they definitely had a huge influence, I think, on the result of it.

And the other thread was what we're talking about over these next couple of days, is really the blending of mind, body, and spirit, that it's not just one of those pieces, but it's all three. And so there was prayer. There's something that happens about just community and fellowship with people, and people not wanting to miss. And a lot of transparency on people really sharing some serious things about their health, of what they didn't know in approaching -- being able to approach their doctors and et cetera.

How much time do I have? I'm out of time? One minute. If I can leave you with a couple of things, it's that grassroots efforts I think are really one of the great solutions to our problem of where our disease is and the fact that we lead so many categories. I think it can go a long way in repairing if we can help to continue to spur on all these little things that happened by one, by just one individual. That would be me, that would be you. I think that we have to think creatively and innovatively about how to do that. We can't -- we got to think outside the box, even though I hate that term. But really we have to think, be willing to go in a totally different way and believe that it is possible. We can't just throw our hands up to the fact that, you know, mama had sugar and so, oh, then I'm probably going to have sugar. I disagree. I disagree. I think that we can change mama, and that in changing mama, we change the family and the community.

The Clinton Foundation actually did a whole project that just focused on grassroots efforts. It's called the Be Well Book Project. I invite you to go and look at it. I actually got to be a part of it, and that's all they focused on was all these moms who were doing some tremendously grassroots things to affect childhood obesity. Check out the woman in Harlem who had to take four buses to be able to get fresh fruits and vegetables. Read her story; it's awesome.

Investing in prevention is my second point, that I think it has tremendous ROI. Just a little bit of investment there, can have a huge return in terms of change for health and disease. There is an initiative called Healthy Food Financing that if anyone is here from Pennsylvania may really know it because it's been very successful. And basically it's addressing that Harlem example in that going to underserved areas where there are not groceries, basics of life, in your neighborhood, and investing there. It's a great economic term because in addition to just being able to meet some basic needs about food for people, there's jobs and there's some economy.

I also love some of the things that I know are coming about tomorrow in terms of presentations that are looking at that farm to market, that are talking about stress management, because stress is one of those great areas of research that we still are looking at and how much that is killing us. And especially right now in our state of affairs, it's gone up tremendously.

My last one is on aging because I kind of touched that a little bit when I started. And just saying that I'm also doing a lot of work right now looking at boomers and what's going on with boomers, and the fact that if boomers really leave, if they really retire, it's going to be bad. It's going to be really, really bad. And so, and a lot of boomers can't retire. They want to stay in the market a lot longer, so it's a great interconnectedness between health and aging, but I think we have to start to look at this aging thing a lot more as well because of just sheer numbers of what is going on with the boomers.

So I encourage you to really stay open. I want you to consider that we really know a lot of this stuff, that there is nothing wrong with what we used to do in terms of our roots. There's some very good things there. We need to take the richness of that and bring it forward. And it's combined with that mind, body, and spirit. But we also need to be open to the fact that that can of drippings and grease that may be on the back of your stove is not a good thing. That is something we can leave in the past. Fact that -- I submit that there may be some other options for you that won't take you down so fast. I celebrate you. Thank you.