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Healthy Communities: An Assessment and Implementation Framework to Achieve Inclusion of Persons with Disability

Moderator: Hello and welcome to Public Health Live, The Third Thursday Breakfast Broadcast. I'm Rachel Breidster and I'll be your moderator today. Before we get started I would like to ask that you please fill out your online evaluation at the end of the webcast. Continuing education credits are available after you take our short post-test and your feedback is helpful in planning future programs. I also want to let you to know that planners and presenters of Public Health Live do not have any financial arrangements or any affiliations with any commercial entities whose products, research, or services may be discussed in this activity. And no commercial funding has been accepted for this activity. As for today's program we'll be taking your questions throughout the hour by phone at 1-518-402-0330 or by e-mail at phlive.ny@gmail.com. Today's program is entitled "Healthy Communities: An Assessment and Implementation Framework to Achieve Inclusion of Persons with Disability." Our guest today is Mr. Yochai Eisenberg who is a Senior Research Specialist at the Center on Health Promotion Research for Persons with Disabilities at the University of Illinois at Chicago and an affiliate at the National Center on Health, Physical Activity and Disability. Thank you for joining us.

Moderator: So thank you so much for joining us this morning. We have a lot to talk about. I know we hear a lot these days about how we work and where we play and how our communities really influence our health, but our program today we're focusing on insuring that persons with disability can effectively benefit from healthy community efforts as well. Now I understand that the projects that you're going to be describing today were funded in part by the CDC National Center on Birth Defects and Developmental Disabilities. We're glad to hear about that. Now can you describe for us what you'll be sharing today and why it's important?

Mr. Eisenberg: Thank, Rachel. So, yeah, healthy community initiatives have been thought of as population based initiatives that have population level impact. They often have to do with improving access to healthy living opportunities such as physical activity and healthy eating. Today I'm going to outline how an important subgroup of the population, people with disabilities, may not be receiving the same benefits as the general population. To understand why, I outlined three important points that I've laid out here in the learning objectives, so the first one is to recognize persons with disability is a demographic group that experience health disparities. Second is that thinking about if community health assessment tools are not sensitive enough to identify factors that relate to people with disabilities that affect their ability to be physically active and eat healthy foods that the effort that's are then planned and tailored are not able to benefit people with disability. The second learning objective is to identify two ways the community health assessment tool can guide the development of community health improvement plans and the policy systems and environmental level.

Moderator: Sure.

Mr. Eisenberg Then, the third objective to identify two ways that environmental factors have unique impact on community participation and access to healthy lifestyle opportunities for people with disability.

Moderator: Thank you for outlining that for us. Can you start off by explaining for us how disability is described in the context of communities?

Mr. Eisenberg: Yeah, for sure. I'd like to describe two perspectives on disability. I'd like to illustrate it with a story of two cartographers. My background is in geography. I like to think about maps. Let's say there are two cartographers and they are asked to make a map related to disability. They both basically develop the same map. That we see here in this slide. It's a map of the Chicago land area where I'm from which is made with data from the American Community Survey from 2010 to 2014. Visually it's a way to represent the prevalence of disability, where it's higher and lower. We see that from this map there are definitely areas that are higher or lower. Now once the map is made, the two cartographers put a different title on it. So one of the titles is where is disability? And another title is where are people with disability? And so the point is that the interpretation and meaning of these maps relates to the two different perspectives. One perspective views disability predominantly as an outcome. And this comes more from kind of a medical background, right? And people might use this map to help identify where work on preventing disability is needed. The second perspective sees disability as a demographic group as a characteristic and for many people as an identity. It's a large subpopulation of the US and they may use this map to examine how current programs and resources are meeting the needs of this demographic group. It's also important to recognize that disability is multidimensional. It's not one size fits all. Broadly includes people with physical, sensory and cognitive limitations and even within those three categories, there's lot of subcategories that people identify with.

Moderator: Now you mentioned that persons with disability is a large subpopulation of the United States. I wonder if you can talk to us a little bit about the prevalence of disability.

Mr. Eisenberg: Yeah, for sure. I think this is an important point for people to get situated in. People with disability comprise 13% to 22% of the US population, US adult population. That is roughly 38 million to 57 million people. This range reflects differing definitions of disabilities that we see across national surveys. You can see it's a large subpopulation, a large demographic group. It is one that anyone can join at any time in their lives. It cuts across income, race, and ethnicity and in terms age, we see that 16% of people with -- 16% of people 18 to 44 have disability, 27% of people 45 to 64 have a disability, and 36% of adults 65 and older have a disability. So it is very common, a lot more common than people recognize. In addition, we know the percentage of people with disability is growing as people age into disability and these figures come from the 2014 behavioral risk factors survey. That's available -- the data is available through the disability and health data system that is put on by that National Center on Birth Defects and Developmental Disabilities.

Moderator: The numbers you shared that, is certainly a large and significant portion of the

population. Can you talk to us about the health and how the health of persons with disabilities differs from the health of people who don't have disabilities?

Mr. Eisenberg: Yeah, for sure. We see the differences are substantial. This is an infographic that is from the NCHPAD website. It shows some of the large health disparities that exist. People with disabilities are more likely to be obese. We can see people with disabilities the rate of obesity is 38.4% compared to 24.4% for people without disability. Also more likely to smoke, almost twice as much, have high blood pressure and be physically inactive. So a lot of differences there.

Moderator: Absolutely. What about differences or the relationship between chronic disease and disability?

Mr. Eisenberg: Yeah, so this is another important point. We see very similar differences in rates of chronic disease as well. People with disability are also two to three times more likely to have stroke. We can see 6.8% for people with disability compared to 1.4% with people without. This is for nationally. If you look at just New York State data, we see that's 4.4% for people with disability versus 1.3% for people without. For heart disease, similar. It's three times as much for people with disability. Similar rates in New York, 11 versus 3.7% and then the same with diabetes, twice as much for people with disability. And the same in New York, 16.9% versus 6.7%.

Moderator: So certainly those disparities are well established.

Mr. Eisenberg: Yeah. They're important ones. These are important kind of disease markers because these are disease that's can be prevented. The effect of them reduced if people are able to improve their diet and physical activity.

Moderator: So can you talk to us about specific types of disability and health disparities that occur?

Mr. Eisenberg: Yeah, for sure. I think it's important to, again, recognize the differences in types of disability and see how each of those segments relate to the outcome we are looking at or the behavior. This slide shows the percentage of adults 18 to 64 who get no aerobic physical activity at all by disability type. We see at the top there people who have mobility disability or serious difficulty walking or climbing stairs are at 57% no aerobic physical activity. People with cognitive disability, serious difficulty concentrating, remembering or making decisions are at 40%. Then the same for vision and hearing also at 36% and 33% compared to people without disability who are at 26%.

Moderator: As a person that is active, hearing those numbers is startling. It's very clear there is a need to include persons with disability in public health initiatives to help remedy those. Can you tell us about what we mean when we say inclusion?

Mr. Eisenberg: Yeah. I think this is also an important point to kind of define that. One of those terms that people use a lot but if we ask everyone to define it, they may have very different

answers. I'm going to share a definition that was developed through a working group that was put together through the National Center on Health, Physical Activity and Disability and it's a really, I think, a well put definition to try to solidified what inclusion means. It is to transform communities based on social justice principles in which all community members are presumed competent, recruited and welcomed as valued members of their community, fully participate and learn with their peers and experience reciprocal social relationships.

Moderator: That sounds like a great working definition to start from.

Mr. Eisenberg: Yeah. I think the key point is that inclusion is needed to ensure equal access to health. It's an important point.

Moderator: Excellent. Thank you. Now let's take a look at part of a piece that NCHPAD been working on about inclusion in public health programs.

Roll-in Video Footage

Speaker 1: What does inclusion mean to me?

Speaker 2: To me, inclusion means, it means, like, include everyone in it no matter if you are in a wheelchair, walker, whatever. You got to include everybody.

Speaker 3: When I look at inclusion, I see it as part of an economic driver of a community. They're just part of it, the person next door. People see you as the person next door.

Speaker 4: Inclusion is a way of life.

Speaker 5: For us, inclusion is having our children be involved in every walk of life. Your child can be part of a league. You can have that normalcy going to see a baseball game because that's what they want. Just like every other parent.

Speaker 4: Inclusion started in elementary school as I broke down barriers to be included.

Speaker 6: It’s so much fun. It’s like you include people. And people that go in wheelchairs or standing up, it doesn't matter.

Speaker 7: Inclusion means to me I get to play with my friends at PE.

Speaker 8: It sounds like he seems happy in his bedroom but he's not. He seem happy in there but he seems happier when he's getting included in triathlons.

Speaker 9: That everyone is joining the party.

Speaker 10: Not of just being inviting to the dance but being invited to dance.

Speaker 11: It means actually inclusion means being included in things. A variety of things.

Speaker 12: It means absolutely everyone being able to be included in all the activities, all the programs and facilities that we have and offer.

End of Roll-in Video Footage

Moderator: Certainly a wonderful piece and really good to hear what inclusion looks like. Now why was the community health index or the CHII, as we will call it, needed? What was the gap that it was really trying to bridge?

Mr. Eisenberg: Yeah, sure. Let me try to explain that through this visual representation. We're trying to show here that it's a visual representation of the barriers that people experience in community healthy living related to four subgroups. So looking at the general population, minorities, Asian populations and people with disability. What we're trying show is that greatest number of barriers to community health initiatives, to physical activity and healthy eating are experienced by people with disability who are at the base of the pyramid. These are people who have again mobility, cognitive and sensory limitations. These barriers impose significant restrictions on the use of community based facilities and the inclusion in healthy living, healthy communities initiatives. Often to a much greater degree than the general population who is at the top of the pyramid. These barriers range from environmental such as transportation and sidewalks to attitudinal, social and policy oriented barriers. And there are several instruments out there community level instrument that's audience may be familiar with. The community healthy living index or CHII is one that is out for a while and the CHANGE tool, the community health and group evaluation tool as well. And, you know, these are very useful instruments. But they have a limited number of disability, aging and minority items. And at the same time, there's several micro level instruments. Instruments that examine accessibility for a specific area in our communities. Fitness centers, grocery stores, sidewalks. And get at very specific areas. The goal is not really to replace any of the tools. They all have their important places in the process of assessment, but rather to develop a new instrument with a new purpose that would bridge this gap between the more micro level audit tools that get at accessibility of environments and the community level tools that are focused on the general population.

Moderator: So talk to me about why there is a focus and why it's important that there is a focus on policy, systems, and the environment.

Mr. Eisenberg: So there are three terms that often focus on in public health nowadays. I think partly has to do with the emergence and use of the socioecological model in research and practice. Initiatives that use that socioecological model focus on broad levels across the different factors that affect health and access to health. They go from individual, interpersonal, organizational, community, and public policy, so they go from individual to very broad. I think CDC's -- was also a driving force in terms of the focus on PSEs as funding shifted from more clinical and counseling to implementing initiatives that focus on the socioecological aspects. This health impact pyramid is useful for thinking about why we focus on policy systems and environmental changes and it was developed through a paper by CDC Director Dr. Freeden. What we see in this health impact pyramid is different types of interventions. The level of population impact and the individual effort that is needed for them. It goes from the more individual areas of counseling and education to clinical interventions, long lasting protective

interventions, changing the context to make individuals default decision healthy, and then socioeconomic factors. The arrows on each side what their saying is increasing population impact. As you go to the top of the pyramid, there is increasing individual effort. More of the ones at the bottom will have a larger impact. Really the focus is on that fourth level of changing the context to make the individuals default decision healthy. Some examples of this include, you know, trying to change the pricing of healthy foods to make them equivalent, making foods healthier foods closer to checkouts and having more options for physical activity available in one's neighborhood.

Moderator: Excellent. Now how does the CHII fit in with all this information you just presented?

Mr. Eisenberg: Yeah. The issue is that even though we're trying to change some of the interventions at the bottom of the pyramid, they don't always effect people with disability because there still are still segregated systems in place, there is lack of accessibility and lack of inclusion. The focus of the CHII is to try to impact that fourth level, trying to change the context to make the individual choice healthy. We want the CHII to fit into existing public health intervention. We don't want to have separate interventions, separate initiatives. We want CHII to fit into the existing interventions working at that same fourth level.

Moderator: Excellent. Can you talk to us about what are some of the barrier that's persons with disability really face or really experience in terms of trying to have healthy living?

Mr. Eisenberg: Yeah. So I want to give examples and images to help illustrate this. In healthy communities, there is a lot of active living and a lot around being able to get around one's neighborhood, being able to walk to destinations or just walk to exercise. There still a lot of issues with accessibility of the pedestrian environment, so there's issues with sidewalks and curve cuts and not being able to transition from the sidewalk to the road. Because of that, some people end up in the street they have to walk or roll in the street because of these barriers and obstacles. Then, you know if, they're able to get to facilities, sometimes there can be problems with the entrances of facilities, things like having stairs at a facility that make it more difficult for people to get into a facility. Once people are in facilities, there can be different environmental barriers. An example here is having benches in a locker room that prevent people from actually get together locker. The barriers keep compounding on each other and what they're doing is really not making the healthy choice the easy choice. They're making the healthy choice this thing that I have to get through and experience all these barriers before I can actually get to engaging in physical activity or accessing healthy foods.

Moderator: Which is the opposite of what we're looking for.

Mr. Eisenberg: Right. Exactly.

Moderator: So in contrast to that then, what are some factors that would act as facilitators as oppose to the barriers you discussed.

Mr. Eisenberg: Our research has indicated there is lots of important facilitators that can help

in making that healthy choice the easy choice. One of the key ones is transportation in any community, rural, suburban, or urban, is having transportation to be able to independently get to these healthy venues is critical. That transportation is accessible for people with disability. Once people get there, having equipment that is adapted equipment that people with disability can actually use to engage in aerobic activity is key. Then having staff who are trained and feel confident in working with people with disability gets to, you know, overcoming the attitudinal and social barrier that's people with disability often experience. Having universally designed environments such as a ramp entrance to -- sorry, a zero depth entrance pool. Something that everyone benefits from and then, you know, having a pedestrian environment that is accessible and has curb cuts, so people can roll down them and roll across intersections is key. Having in this image is a detectible warning. It's kind of a colored strip of pavement that helps people with visual disabilities detect when they're going into a street. So again, getting into that area of independently walking and rolling around in one's community.

Moderator: Excellent, thank you. Now let's take a look at how Syracuse, New York, has used the CHII framework as a foundation to improve walkability in their community.

Roll-in Video Footage

Ms. Katie Wood: The CHII definitely helped us think about how we could kind of make a framework for making Monday miles and walking opportunities more inclusive for people, so we could have people with all disabilities be able to use these walking routes and be able to get the physical activity that they desire. The Monday mile is an accessible one mile walking route and we have 17 around the Onondaga County and about five in the neighboring county of Madison. So pretty much this is a really easy and fun way for people to kind of get out there and get active because it's an easy walking route for them to be able to access. The process was developing the inclusive Monday mile policy was being able to work with our partners and people with disabilities so we can with properly address the barrier that's people come into contact with when they're using the Monday mile. Some communities might be able to widen the sidewalks and put curve cuts into the sidewalks because they have more resources. We really wanted to keep in mind some communities that may not have those resources.

End of Roll-in Video Footage

Moderator: Talk to us how the CHII would help in changing the context.

Mr. Eisenberg: I like to illustrate how the CHII would help change the context through a conceptual model. Again, I like to think of things in maps. I show another map here. What I'm trying to look at is the current context in community. Any community, the current context will have a certain number of opportunities for healthy living. I'm representing those with these black dots on a given map. And these are, you know, factors that would help in supporting physical activity and healthy eating. And what is not clear is which of these are inclusive, so which of these would help change the context of people with disabilities. Which of these would help people and give them the opportunity for equal access to the same health and wellness programs and initiatives that are offered to other members of the community, so there is this information gap. This is where the CHII comes in when communities use it to help identify both

assets and gaps and provide a picture of inclusion in a given community. That picture then is a launching pad for preventive policy systems and environmental works. That's represented through now the black dots become red, yellow and green dots because we have some information that helps tell us about what level of inclusion the different opportunities are. This follows the same logic of the pyramid in terms of changing the context in what we're doing is thinking about changing the context of inclusion so that we're making it easier to engage in healthy living.

Moderator: And so how does the CHII help provide communities with the data that they need to make things more inclusive?

Mr. Eisenberg: When communities use the CHII, it's a multilevel instrument that cuts across different levels going from the macro community level to the organizational down to the actual physical environment. It can be use add cross a variety of settings or sectors that go from schools, workplaces, community institutions, health care and the community at large. These are sectors that are defined and have been defined previously. They're used in the other tools that I mentioned, the CHANGE tool. So again, we're not trying to reinvent anything, but trying to ensure that this work also has an impact for people with disability. Within all those sectors, there are specific venues that CHII examines and that data is gathered on, specific venues for physical activity, healthy eating and community mobility. Then all the items within the CHII, all the questions, they're organized around five domains. These domains really help define what inclusion is and how -- the inclusion for a particular organization and different settings in a community. These have to do with the built environment, equipment, programs, staff and policy.

Moderator: And how do communities then use the CHII?

Mr. Eisenberg: The communities can start off doing the macro community at large assessment and what they're looking at here is transportation policies, community design policies and community level health promotion policies. Once they do that, they can develop a purpose sample of organizations and sites across the community where they can conduct the organizational and on-site assessments. These might be across cross different sectors or in one specific sector that they're already working on. It's often helpful to work with places that's you gained commitment and interest from and I'll go into that in a little bit.

Moderator: Excellent. How do communities go about assessing inclusion at the organizational level?

Mr. Eisenberg: The organizational assessment is really a self-assessment for organizations to look at themselves in terms of their level of inclusion. And this is done through an online survey that organizations fill out. What it asks about is different inclusive -- it's about programs and different inclusive aspects of nutrition and physical activity programs. It looks at staff training so the extent to which staff are educated and working with people with disability, and then it looks at policy, health promotion policy, aspects of healthy eating and physical activity as well as inclusion policy within physical activity and healthy eating.

Moderator: And so moving beyond that, how do communities examine environmental factors?

Mr. Eisenberg: Yeah. So this is where we kind of look at the physical environment and we have raters who have gone through a training come in and look at the built environment and equipment domains at a site. And it's often helpful that when we do this assessment that there is someone from the site, an organizational representative to go along on the tour, call it a tour, and to be able to see what the raters are seeing. It's really a really valuable learning experience for them to be able to look at these different aspects of accessibility. It starts off by looking at the external environment, the way that peoples navigate to the site, via public transportation, walking and driving. Somehow seeing how people can connect to that site, how easily it is for people to access that site. Once people are in there, you know, it's important to look at the internal environment, the paths, entrances, and rest rooms. Then specific venues where people can be physically active, access healthy foods or get health care. So it looks at cafeterias, grocery stores, farmer's markets and community gardens. Then physical activity, it looks at fitness rooms, pools, playgrounds, and multiuse trails. Then for health care, we look at waiting rooms and exam rooms.

Moderator: Excellent.

Mr. Eisenberg: It gives a full picture of inclusion across those different domains.

Moderator: Yeah, which is really terrific. Hearing you describe that, it is very interesting to me. Now do you have any results that you can share with us from communities that you're familiar with who have used the instrument?

Mr. Eisenberg: Definitely. So the CHII was used in a pilot study. That was called the Reaching People with Disability through Healthy Community Study. It involved 10 communities in 5 different geographically diverse states. It was funded through the CDC National Center on Birth Defects and Developmental Disability. The implementation was a collaboration between the National Association of Chronic Disease Directors and the National Center on Health, Physical Activity and Disability. Really the goal was to try to merge or intersect what I have in this image of the two different roads kind of maybe they're more parallel roads that were mainly working in different areas, working in terms of disability. Then work in terms of healthy communities. This pilot study is really trying to get to their intersections, so that they work together to try to make sure that healthy community work was also impacting people with disability. They used the CHII and several other tools that were developed to do this. So communities were asked to use the CHII and use them on a certain number of sites across the different sectors. And, you know, this resulted in doing these organizational assessments at 163 different organizations across the different sectors, so that is a really useful information that came from this pilot study.

Moderator: Absolutely. So now let's take a look at a video produced by NCHPAD as they learned to use the CHII in their communities.

Roll-in Video Footage

Ms. Karma Edwards: In the past couple of days the participants learned about how to assess their community for accessibility and inclusion for people with disability. Certain things that can be changed to make all people have access to healthier choices in areas of their community where they live, where they learn, where they go to work and where they receive care. You think about that and it's all the major sectors of a community and all the major sectors should be inclusive and accessible for all people that live there.

Ms. Susan Havercamp: I think that people in the general public may not realize how prevalent disability is. It represents 20% of the population now and before the end of your life, you'll be affected by disability or someone close you to will be. What I hope to do today is interpret the findings and prioritize our activities.

Mr. John Robitscher: I think we just need to be more about the mobility issue on this place in, this world, in this work, I think it's about how accessible do we make it for people who have disabilities in lots of different areas.

Ms. Theresa Paeglow: This event is about creating healthy communities for people with disabilities and just really excited to be here. These tools are being put in a package of something I'm familiar with for many years now. It’s nice see it come together into a package that we can use in the communities throughout the durations project.

Ms. Cathy Costakis: Inclusion means to me that we're not just helping people access. We're helping people become more involved. And actually be able to experience their communities in a way that everybody does. And that's just what we should do.

End of Roll-in Video Footage

Moderator: So can you describe for us some of the results of the macro-assessment?

Mr. Eisenberg: Yeah. The results look at these community level policies. There are some specific content areas that I'll share with you related to community design and transportation inclusion. These results look at specific constructs or groups of items that are related and show a mean score across the different communities. This looks at things like transit oriented development, complete streets policies and safe routes to school policies. So what we're seeing is that communities may or may not have these policies. But often they don't have provisions within those policies that get at aspects that would make sure that when those policies are implemented that they would ensure accessible and inclusive environments. An example that is complete streets policies. They may or may not have language that includes people with disability. And they may not have provisions to ensure that when priorities for new street development is created that those are related to where people with disability live and work to ensure that those environments are accessible. In terms of transportation as well, we see aspects of looking at whether alternative accessible transportation is available or travel training and these are, you know, additional aspects that make transportation easier and we see that some of them are still limited in terms of the number of communities that actually have

these different transportation options.

Moderator: And what results did you see related to inclusive programs and policies?

Mr. Eisenberg: Yeah. This is another important area looking at programs, policy and staff domains is what we look in the organizational assessment. And this, again, really helps us understand what programs are available and to what extent those are inclusive. So what we see is that things like school walking programs, safe routes to school, they may be there but they may not have gone through thinking about how they might make sure that the routes that people go on are accessible or that there is a staff member there who might be able to help a student with a disability to ensure that they can get along in that route. Policy is another important area and we look at healthy eating policy, school inclusion policy and organizational readiness. These are just some examples of the programs and policies. There are several more. Really we -- when we think about looking at the results, we don't just give like a score. Your community is 75% inclusive. In some respects that is helpful if you want to compare with other communities, but in other respects it doesn't give you a detail to help move towards action. We really focus on giving a profile of accessibility and inclusion to communities and to organizations. That's why we see the different constructs and areas where there are needs for improvement. We see that staff training is another important one. We talked about how that such an important facilitator. And one that we still see is not necessarily prevalent in the community that's we assess. Some communities have that. Only 61% is the score that communities had across the communities for staff training.

Moderator: And that's all very interesting information. I'm going even beyond that. What did the assessment find regarding the built environment?

Mr. Eisenberg: I talked about how these environmental factors are critical for ensuring inclusion. Again, I'm kind of showing just a few of the different things that we look at on the on sight assessment. There are several others that we look at. Kind of just trying to show the highs and lows of the on sight assessment.

Moderator: Sure.

Mr. Eisenberg: And, you know, thinking about the way I talked about it earlier, you know, are people able to get to these physical activity and healthy eating environments across the community? The score for transit was 56%, so a lot of barriers still in terms of just being able to get to facilities. Paths are a little better at 70%, but still a lot of room for improvement in terms of barrier that's someone might experience on their walk to a facility. Once in a facility, there are different aspects that become barriers, access at food locations is pretty good. The menus themselves are often not accessible for physical activity, again, the exercise equipment, has a score of 57%. So having specific adapted equipment, aerobic equipment or strength equipment available to people with disability can actually use is not that common. Then just general access being able to get in the building is actually was fairly good at 81%. Then once in the building, being able to navigate around it having signage that is accessible, having paths and walk ways that people can easily get through without facing obstacles seems to still be a problem.

Moderator: Excellent. Thank you for all of that information. Now what do communities do with the information that they gather in the CHII and how does this help to change their context to become more inclusive and reduce health disparities?

Mr. Eisenberg: The CHII doesn't work on its own. You can't just, you know, any assessment tool doesn't work on its own. You can't do a tool and say bye-bye. You have to situate it in a larger healthy community model. And we thought about that and we really want our tools to fit into that larger healthy community model. I'm showing in the next slide a model that will is very common in public health that goes from an assessment, planning, implementation, evaluation. What is key here that is not always in these models is the commitment phase. This is a phase where I wish there was a lot more money going into this phase. It is really critical for all the other phases. And, you know, all the phases are not necessarily linear. Often you go from one and then it kind of bleeds into another and then you might go back to an earlier one and really commitment is one that goes along the whole gamut. And what that involves is having community organization that's are in coalitions really think about themselves as assets, as opportunities that can be important for facilitating physical activity and healthy eating for communities. It's really important that in this phase that coalitions think about how they can become inclusive, how they can ensure there is representation for people with disability on the coalition. And that really ensure that's as you go from the different phase that's you have input from people with disability from organization that's represent people with disability. Then after the first phase, comes the assessment phase, the CHII and then the planning and prioritization phase. That takes the data gathered in the CHII, looks at the results and then uses another resource I'm going to talk about called the GRAIDS to help in prioritizing strategies and developing those inclusive strategies. From there, communities work on the implementation of the strategies. They then try to evaluate the impact of that. Then it's important to disseminate the success stories. Let other communities know what works so that can be replicated through other public health departments and communities across the country.

Moderator: So you mentioned the GRAIDS. Can you tell how the GRAIDS were developed?

Mr. Eisenberg: Yes. The GRAIDS were developed as part of a research and rehabilitation grant led by Dr. James Rimmer at the University of Alabama to adapt set of guidelines used for the general population. The guidelines people might be very familiar with they're called the 24 Recommended Community Strategies to Prevent Obesity. And these are being used in communities across the country for policy systems and environmental work. The process of adaptation included very extensive process and there is a very useful paper on its development. And it included a scoping review of the literature and input from both an expert panel and people with disability.

Moderator: So moving ahead, I wonder if you can tell us how do communities plan and prioritize for inclusion.

Mr. Eisenberg: The important step of taking the GRAIDS and thinking about what are priorities from those is a key step. It's critical to have representation of disability service organizations such as independent living centers to help inform those prioritization of

strategies. You know, when you look at the CHII results, you may find lots of different things you could do, and you really want the ones that have the largest impact and be the most meaningful for people with disability.

Moderator: Excellent. Thank you. It sounds like the CHII leads to a planning and assessment process that is very comprehensive. We also recently visited with the community partners in Olean in western New York State to hear their perspectives on how they use the CHII results to help them develop strategies for inclusion.

Roll-in Video Footage

Ms. Sandra Brundage: Once we received the CHII data and the GRAIDS information, that information was very helpful. It actually helped us to focus on areas that we knew were the neediest or areas that we knew needed the most intense efforts on our behalf. It also helped increase our awareness. For example, the process and the data helped to really materialize a plan that focused on those areas that were the most in need.

Ms. Debra Nichols: Doing the CHII assessments really once again bring to the forefront the issues and challenges we all face in serving people with disabilities. You don't realize until you talk and meet with people and walk around a building inside and out the issues that we face with barriers to our consumers, to our population.

Ms. Brundage: I think the tool that we have used that we would like to have maybe other health departments consider in the process and planning are just that. They're tools. They are means to an end and can be helpful. You have to use them and embrace the concepts they help to promote in this case, I think that our health department who has been outstanding to work with has embraced the process, has embraced the tools and embraced the data sets that we have and really attempted to push the work forward.

End of Roll-in Video Footage

Moderator: So can you show some examples of how the CHII and GRAIDS were used to develop a community action plan?

Mr. Eisenberg: I'll take an example from that pilot study that I talked to you about. Across the example community that I'm going to share with you, the community found that accessibility of exercise equipment was an issue. They sampled nine sites but the score regarding the inclusion of that equipment was 48 out of 100. This included several our items related to strength, having strength equipment, having adaptive aids for equipment. They went through their community process and looked at different options for how to remedy that. They developed these goals and objectives, so the goal was to increase awareness of and access to inclusive physical activity opportunities and in this example by a certain date. Then the objective was to increase the number of sites to physical activity equipment inclusive to persons with disability from one to two sites. Kind of getting specifically at that equipment issue and this was kind of a smaller objective because it was very quick project when working in larger projects. I think you want to think about how you would affect the availability of adaptive

equipment across a community, so you have a broader population impact.

Moderator: Sure. Now what have communities worked towards implementing?

Mr. Eisenberg: I'd like to share the policy systems and environmental strategies that communities developed. I think this will hopefully help ground our audience in terms of what those might look like and sound like. In terms of the policy area, one of the interesting ones I saw was a community in New York was working to influence policies around zoning and transportation to ensure accessibility. In terms of systems, one of the communities in Montana was focusing on developing inclusive way finding systems. Then both of these are really important in terms of being strategies that get to making sure that the population base interventions are inclusive as they are built. Instead of sometimes at the other end what we're trying to do is really ensure that opportunities in the community are accessible so the third strategy is accessibility for environment is accessibility improvements to built environment at facilities. So this is really a critical piece to getting through those environmental barrier that's I mentioned earlier. It's really something that comes after all this -- after some place is already built. So we want to, you know, affect the situations where things are going to be built or planned. It is also important that we look at these existing environments and how we can reduce those barriers. Kind of this twin approach of looking at the population level and also at these targeted levels.

Moderator: Excellent. Now all this information that you shared with us this morning has been terrific. Wonder what do you and your colleagues at NCHPAD plan to do next with this work?

Mr. Eisenberg: I think the pilot interventions and sites have been really helpful to help us identify what communities need. And, you know, we're doing evaluation to learn more about that, but we realize that there is some additional tools and resource that's can be used to help communities interact with each other. Learning from each other as they're working on these initiatives as well as making the process more seamless, so that we have to play less of a role in it. So we're developing a community health inclusion dashboard that would allow communities to visualize the results of the CHII, so kind of looking at different ways through mapping and other visualizations. Then being able to connect the results to these GRAIDS that I mentioned, the strategies that would help people in terms of planning out and prioritizing and developing their community action plans. Then allow them to compare to other communities, seeing how do their results for transportation compare to other similar communities? We're also going to be doing a lot of web based training and by we, I'm talking about the National Center on Health and Physical Activity and Disabilities if you go to their website www.nchpad.org, can you find out more about the web-based training that's will be available. There is also technical assistance available through NCHPAD to be able to work in any community and work towards implementing that healthy community model that I shared. Then we're also looking at community health needs assessment or CHNAs. These are an important piece of public health work and thinking about how we can communities can integrate the CHII as well as also just thinking about disability as a target population and conducting surveys with people with disability about their participation and barriers that they experience, so that again you have this local level data that can inform community health improvement plans and that is part of a continuous process that communities use. Again, not a separate process but an

inclusive process.

Moderator: Excellent. Thank you so much. We have time for some questions from our audience. Let's see where we're going to start this morning.

Moderator: Great. The first question that we have is can you say a little bit more about the differences between treating disability as an outcome versus a demographic group?

Mr. Eisenberg: I think it's a really important piece to change in thinking in terms of seeing disability for more of the medical model. Seeing disability as an outcome versus seeing people with disability as a demographic group. I that it is another important piece that is part of local public health work by thinking about it as a characteristic of the population and thinking about those participation and environmental and social barriers for this demographic group within the work that you do. I think it really changes how public health departments think about their work and think about inclusion versus having a separate program or thinking about preventing disability.

Moderator: Excellent. Thank you. The next question we have is the assessment tool seems very useful. Do you have any suggestive strategies to encourage organizations to participate in the assessment process?

Mr. Eisenberg: Yes. Again, I think that points to the commitment phase, the phase early on. I would suggest if you go on to www.nchpad.org, they have a whole initiative called the commit to inclusion initiative. There are a lot of resources and useful tools that organizing bodies and coalitions can use to start that conversation to get communities and organizations to think about collusion and commit to inclusion. There is a set of nine policy guidelines that go along with that. Again, they help to get people to -- organizations as cross those different sectors to think about inclusion of people with disability.

Moderator: Excellent. The next question is it sounds like it takes a lot of effort to assess a community and then work on developing and implementing strategies. How can communities get this done without special funding?

Mr. Eisenberg: Yeah, so that's a great question. I'm sure one that is on a lot of people's minds. I think our intent from the beginning has been not to have a special type of assessment. This isn't something that you only do if you get funding to do. The idea is, we built it in a way to be organized around the same structure that other community health assessment tools are such as the change tool or the CHII tool. When communities are doing those, they're also looking at the CHII. They can do it at the same time, so that they have this data about disability inclusion at the same time that they have data about healthy communities that they then use for planning and prioritization.

Moderator: Excellent. The next question what are some community interventions for people with cognitive disabilities?

Mr. Eisenberg: In terms of community interventions, I think it's more related to we're trying to

change the context. It's not necessarily an intervention that is separate for people with cognitive disability but it will be how do we change the context of the existing assets in our community, the existing physical activity or healthy eating assets such as nutrition classes? How do we change those to make sure they're inclusive? A lot of that has to do with more of the programs, staff and policy domains that's I mentioned earlier. Having staff training that helps to get people to know and feel comfortable working and including people with cognitive disability I think is the way that you can change the context so that people with cognitive disabilities have more opportunities for engaging in these activities and potentially doing them independently.

Moderator: All right. The next question we have, let's see. Alright, we have another question. You mentioned the coalition a few times and suggested that a disability services program be a member. Who else should be at the table?

Mr. Eisenberg: Yeah. So I think the coalition makeup is a critical piece. That is something we're evaluating right now as part of our pilot study that I mentioned. I think it's critical to have people from different sectors. The more sectors you can have involved, the broader the impact is. The more of those black dots there are, right? And so I think having organizations from schools, having organizations from the planning departments and transportation departments I think is critical. Then they hear about what is going on. If there is a person representing the disability community from an organization or persons with disabilities, family members and caregivers, then they're able to -- the transportation and planning officials are able to hear what they're saying. Then it becomes not just what's going on in this community health improvement plan, but they're able to take that back to thinking about the transportation plan that's they're conducting, the other kinds of plans that municipalities are conducting in terms of pedestrian environments and ADA transition plans. They're incorporating that into what they're doing as well.

Moderator: Fantastic. Now the next question you talked about the five pilot states. Can you tell us who they are and what other states are doing?

Mr. Eisenberg: Yeah, definitely. I mentioned New York is one of our pilot states. We heard very interesting things from the folks in New York. The other ones are Montana, Oregon, Ohio and Iowa. Vary geographically diverse areas and communities are really, you know, vary in terms of urban, suburban, rural communities. Then I think these are important resources for other public health departments in those states to work with and then there is also 19 funded disability and health states funded through the National Center on Birth Defects and Developmental Disability. They're also interested in working towards changing the context. Again, you can go to the NCBDDD website to learn about the 19 states and how you can partner with them to make your healthy communities' initiatives more inclusive.

Moderator: Perfect. Thank you so much for answering the questions for all the information that you shared today. I think was a tremendous amount of really valuable and beneficial information.

Mr. Eisenberg: You're very welcome. Thank you for the opportunity.

Moderator: Thank you very much for joining us today. Please remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs and continuing education credits are available for today's program. To obtain nurse continuing education hours, CME, and CHES credits, learners must visit www.phlive.org and complete an evaluation and the post-test for today's offering. And now you can also let us know how you use Public Health Live by taking a brief survey at www.phlive.org. This web cast will be available on demand on our website within two weeks of today's show. Please visit our web page for information about information of upcoming webcasts and recordings of past programs. Additional information can also be found on our Facebook page. Don't forget to like us on Facebook to stay up to date. I'm Rachel Breidster. Thank you for joining us on Public Health Live!