



GUIDELINES FOR DISABILITY INCLUSION IN PHYSICAL ACTIVITY, NUTRITION, & OBESITY PROGRAMS AND POLICIES

Implementation Manual

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Contents

Introduction	1
Guidelines for Disability Inclusion	2
Guideline #1: Objectives Include People with Disabilities	5
Why do this?	5
How to do this	5
Example	5
Resources	6
Guideline #2: Involvement of People with Disabilities in Development, Implementation and Evaluation	8
Why do this?	8
How to do this	8
Example	9
Resources	9
Guideline #3: Program Accessibility	11
Why do this?	11
How to do this	11
Example	12
Resources	15
Guideline #4: Accommodations for Participants with Disabilities	17
Why do this?	17
How to do this	17
Resources	19
Guideline #5: Outreach and Communication to People with Disabilities	20
Why do this?	20
How to do this	20
Resources	21
Guideline #6: Cost Considerations and Feasibility	23
Why do this?	23
How to do this	23
Resources	24
Guideline #7: Affordability	26
Why do this?	26
How to do this	26
Resources	27
Guideline #8: Process Evaluation	28
Why do this?	28
How to do this	28
Examples	30
Resources	30

Guideline #9: Outcomes Evaluation	31
Why do this?	31
How to do this	31
Examples	32
Resources	32
Appendix A	37
Modification Form	37
Appendix B	38
Accessibility Checklist	38



Introduction

People with disabilities are three times more likely to have heart disease, stroke, diabetes, and cancer than adults without disabilities. Nearly half of all adults with disabilities get no aerobic physical activity. Adults with disabilities who get no physical activity are 50% more likely to have the aforementioned chronic diseases than those who get the recommended amount of physical activity.¹ Additionally, people with disabilities have a higher likelihood of being obese.²

People with disabilities face significant barriers when attempting to access health and wellness activities. They are more likely to have more than one health practitioner and to have secondary conditions requiring some type of ongoing treatment or medication, leaving them vulnerable to a lack of coordinated or long-term care. People with disabilities are also less likely to have appropriate, affordable health care coverage. This leaves this population especially vulnerable because not only do they run the risk of not receiving preventative care, but they also can have difficulty accessing health and wellness information and services if those services are not designed to consider their disability.

As part of the National Center on Health, Physical Activity, and Disability (NCHPAD), the Center on Disability at the Public Health Institute (COD-PHI) has developed these *Guidelines for Disability Inclusion in Physical Activity, Nutrition, and Obesity Program Initiatives* to assist in the updating of community health programs and policies to be inclusive of the needs of people with disabilities. The Guidelines were generated based upon previously recommended guidelines and structured input and review from a panel of national experts. The flow of the development of the Guidelines can be seen in Figure 1.

Figure 1: Use of Guidelines to Disability Inclusion to Achieve Inclusive Program Initiatives and Policies



¹CDC (2014). Physical Activity is for Everybody. Vital Signs, <http://www.cddc.gov/vitalsigns/disabilities/index.html>

²CDC (2014). Disability and Obesity. <http://www.cdc.gov/ncbddd/disabilityandhealth/obesity.html>

Guidelines for Disability Inclusion

- 1. Objectives Include People with Disabilities:** Program objectives should explicitly and unambiguously state that the target population includes people with a range of different disabilities (cognitive, intellectual and other developmental disabilities, mobility, visual, hearing, and mental health disabilities).
- 2. Involvement of People with Disabilities in Development, Implementation and Evaluation:** Program development, implementation, and evaluation should include input from people with a range of different disabilities and their representatives (e.g., community members or other experts with disabilities, potential participants with disabilities and their family members, personal assistants, and caregivers).
- 3. Program Accessibility:** Programs should be accessible to people with disabilities and other users socially, behaviorally, programmatically, in communication, and in the physical environment.
- 4. Accommodations for Participants with Disabilities:** Programs should address individual needs of participants with disabilities through accommodations that are specifically tailored to those needs.
- 5. Outreach and Communication to People with Disabilities:** Programs should use a variety of accessible methods to outreach and promote the program(s) to people with disabilities.
- 6. Cost Considerations and Feasibility:** Programs should address potential resource implications of inclusion (including staffing, training, equipment, and other resources needed to promote inclusion).
- 7. Affordability:** Programs should be affordable to people with disabilities and their families, personal assistants, and caregivers.
- 8. Process Evaluation:** Programs should implement process evaluation (with transparent monitoring, accountability and quality assurance) that includes feedback from people with disabilities and family members, personal assistants, caregivers or other representatives, and a process for making changes based on feedback.
- 9. Outcomes Evaluation:** Programs should collect outcomes data, using multiple disability-appropriate measures.

Uses of the Guidelines

The Guidelines can be used by government and private entities and organizations that create, implement, or oversee program initiatives and policies in the areas of physical activity, nutrition, and obesity. These Guidelines are intended to be broad enough to cover a variety of local, state, and national programs. They will be used to assure inclusion of disability as government agencies and community organizations develop plans to implement community health promotion strategies that are based on national recommendations. The Guidelines for Disability Inclusion can also be used to evaluate whether plans and programs effectively include people with disabilities.

The criteria approved by the national panel of experts to approve or deny each of the Guidelines can be seen in Figure 2.

Figure 2: Criteria Approved by Expert Panel

The Guidelines were unanimously approved by the expert panel, using the following criteria:

Criterion	Description
Reach	The guideline is likely to affect a large percentage of the target population.
Sustainability	The guideline has potential to endure over time.
Transferability	The guideline can be implemented in communities that differ in size, resources, and demographics.
Utility	The guideline will assist state organizations and others to plan and monitor community-level programs and strategies.
Feasibility	Required knowledge, skills, staff, equipment, or other resources to implement the guideline are not exceedingly prohibitive to putting it in place for the target population.
Inclusion	The guideline is likely to promote inclusion of people with a range of different disabilities.

The makeup of the national panel of experts can be found in Figure 3.

Figure 3: Composition of Expert Panel

The members of the expert panel included:

- **Mary Andrus** – Assistant Vice President, Government Relations, Easter Seals
- **Linda Bandini** – Professor, University of Massachusetts
- **Michelle Camicia** – Director, Rehabilitation Operations, Kaiser Foundation Rehabilitation Center
- **Jayne Greenberg** – Miami Dade County Schools
- **Erica C. Jones** – Executive Director of the Pacific ADA Center
- **June Kailes** – Disability Policy Consultant and Adjunct Associate Professor and the Associate Director of the Center for Disability and the Health Policy at Western University of Health Sciences, Pomona, California
- **Barbara Kornblau** – Health Policy Consultant
- **Jennifer Li and Sarah Yates** – National Association of City and County Health Officers (NACCHO)
- **Theresa Paeglow** – Director, Disability and Health Program, New York State Department of Health
- **Clarke Ross** – American Association for Health and Disability (AAHD)
- **Jeff Underwood** – President and CEO, Lakeshore Foundation and former state senator and USOC Paralympic Advisory Council member
- **Sandra Viera** – Prevention Institute

This implementation manual is intended to provide guidance on the inclusion of persons with disabilities to planners of program initiatives and policies in the areas of physical activity, nutrition, and obesity. It provides a description of each Guideline, why it is important, steps to accomplish the Guideline, resources for more information on the Guideline, and examples of the use of the Guidelines in the field.

Guideline # 1: Objectives Include People with Disabilities

Program objectives should explicitly and unambiguously state that the target population includes people with a range of different disabilities (cognitive, intellectual and other developmental disabilities, mobility, visual, hearing, and mental health disabilities).

Why do this?

In order to establish strong program guidance to funders, grantees, staff, and the public, the overarching objectives of the program should clearly include a statement that the program’s “target population includes people with a range of different disabilities (cognitive, intellectual and other developmental disabilities, mobility, visual, hearing, and mental health disabilities).” Program objectives will then need to be designed to include people with all types of disabilities. This statement will direct staff to develop the program’s activities to include all people, including those with the aforementioned specific types of disabilities. In addition, it will send a clear message to those inside and outside the organization providing the program or policy that the program or policy has taken steps to be inclusive of all people, especially people with each of the designated types of disabilities noted.

How to do this

In the design- or redesign- of the program plan or policy, include the phrase “The target population for this program (or policy) includes people with a range of different disabilities (cognitive, intellectual and other developmental disabilities, mobility, visual, hearing, and mental health disabilities)” in the written program or policy objectives.

Field advice: Some local public health representatives report that even after making a commitment to including all disabilities, implementation may be easier by starting to plan for one or two disabilities and adding other disabilities over time.

Example

A Safe Routes to School program is being sponsored by the local department of public health. They included an objective to “target all children in the school district, including children with a range of different disabilities (cognitive, intellectual and other developmental disabilities, mobility, visual, hearing, and mental health disabilities).”

Note that Safe Routes to School is aimed at school children, so the language targets only children. Other programs may target the entire population and thus the objective should aim at the entire population.

Once the overall objective really includes people with various disabilities, other objectives fall into place naturally. For example; the program will reach out to the deaf community to participate in defining the program applicability to deaf (Objective 2), staff will become aware of the need for captioning and/or American Sign Language services (Objectives 3 and 4) and have included funds in their budget to spend on contractors, staff training and equipment (Objective 6). When activities are planned, accommodations have already been considered and implemented to ensure full access and participation for people who are deaf/hearing impaired (Objective 4).

Be sure to include information on your target population(s), as well as the rationale and purpose of your programs and services. Your program/service objectives should describe in detail what benefits participants should expect when they participate in your programs.

Resources

Below are a few organizations that can help with conceptualizing the inclusion of people with disabilities in program and policy objectives.

Center on Disability at the Public Health Institute

<http://www.centerondisability.org/>

555 12th Street, 10th Floor

Oakland, CA 94607

(510) 285-5600

NCHPAD –National Center on Health, Physical Activity and Disability

<http://www.nchpad.org/>

4000 Ridgeway Drive

Birmingham, Alabama 35209

1-800-900-8086

AAHD-American Association for Health and Disabilities

<http://www.aahd.us/>

110 N. Washington Street, Suite 328-J

Rockville, MD 20850

(301) 545-6140

State Offices of Disability and Health <http://www.cdc.gov/ncbddd/disabilityandhealth/programs.html>

Funded States:

- Alabama
- Alaska
- Arkansas
- Delaware
- Florida

- Illinois
- Iowa
- Massachusetts
- Michigan
- Montana
- New Hampshire
- New York
- North Carolina
- North Dakota
- Ohio
- Oregon
- Rhode Island
- South Carolina

National Network of University Centers for Excellence in Developmental Disabilities Education, Research & Service: Program Contacts

List by State: <http://acl.gov/Programs/AIDD/Programs/UCEDD/Contacts.aspx>



Guideline # 2: Involvement of People with Disabilities in Development, Implementation and Evaluation

Program development, implementation, and evaluation should include input from people with a range of different disabilities and their representatives (e.g., community members or other experts with disabilities, potential participants with disabilities and their family members, personal assistants, and caregivers).

Why do this?

People with disabilities have had a long history of being excluded from planning programs and services that directly affect them. Once aware of the gap, often non-disabled experts, program planners, and other professionals will attempt to develop, implement, and evaluate program activities or policies in a way they see as appropriate to rectify the situation. Unfortunately, these efforts can have unintended consequences because they create these services without seeking the input of people with these types of disabilities. In the disability world, participation in the design of programs and plans is often known as “nothing about us without us.” Intuitively, inclusion of people with disabilities or their representatives makes sense. Specific needs known to people with various disabilities that may be unknown to planners can be described, understood, and accounted for using the personal perspectives of people with disabilities. In addition, the inclusion of people with disabilities or their representatives in this process demonstrates a true commitment to the effort of making programs and policies relevant to people with various disabilities.

The planning, implementation and evaluation of programs and services need to specifically include people with a variety of abilities in order to make them effective and accessible and to ensure ongoing participation. People with a variety of disabilities (Guideline 1) should be included in the early stages of planning any health and wellness policies, programs and services. Keep in mind that physical and social barriers can present major obstacles that may influence the participation and outcomes you are trying to achieve through your wellness initiatives. People with disabilities will provide some perspective on how to overcome those barriers.

Using the expertise of people with disabilities can also assist in developing policies, setting priorities and ideas to make programs more marketable and credible. Many people with disabilities have large social and professional networks and it is important to reach out to their representatives. When planning, you may find yourself reaching out to social service agencies, community members or other experts with disabilities, family members, personal assistants, co-workers, and caregivers.

How to do this

Contact organizations in your community that serve people with a wide variety of disabilities. A good place to start is with Independent Living Centers (ILCs), as they serve a range of people with different disabilities in local areas in every state, and are run by people with disabilities themselves. You can find the ILCs in your state through the Statewide Independent Living Council. Another organization that serves a cross-disability population in each state is the Department of Vocational Rehabilitation, which assists people with disabilities in finding employment. Additionally, there are organizations for veterans with disabilities nationwide.

If your program seems well-suited to one specific disability group, you may wish to reach out to groups or organizations that are specific to one disability. The ARC, for example, serves people with intellectual or developmental disabilities in every state. There are a number of organizations that serve people with hearing and vision disabilities. Additionally, there are chapters of mental health associations across the United States that could encourage people with mental health disabilities, like depression and post-traumatic stress disorder, to participate in your program.

In addition to people with disabilities themselves, you can also include family members and caregivers (also called “attendants” or “personal assistants”) of people with disabilities by contacting organizations that specifically serve them. As long as you don’t substitute family members or caregivers for people with disabilities in your planning process, including family members and caregivers as well can provide a valuable perspective. Further, many caregivers need to address their own health concerns, as they often put their own needs behind the needs of their family members and/or those to whom they provide assistance. If an attendant or caregiver is healthy and has a lower level of personal stress, he or she will naturally provide better assistance.

Experts in the field of disabilities can also provide a unique perspective on the services needed by people with disabilities. When possible, try to include people who may specialize in health, physical and occupational therapy, mental health, employment, and education, to name a few. They will also provide you with ideas around how to collaborate with other entities. Each will provide insights that will prove valuable when you are creating your program objectives.

Example

Eating Well, a non-profit nutrition education program, serves a portion of a rural county. Eating Well’s director has a particular interest in educating veterans with disabilities about the health benefits of eating five servings of fruit and vegetables daily. The director asks his staff to distribute information about their weekly nutrition classes to a local veterans’ administration hospital and a sports organization for wounded warriors. Soon, the veterans who attend the classes at Eating Well help the staff to write and distribute a cookbook with healthy recipes that are inexpensive and easy to prepare.

Resources

Cross-Disability Resources

Statewide Independent Living Councils:

<http://www.ilru.org/html/publications/directory/SILC.html>

Independent Living Centers

<http://ilru.org/html/publications/directory/index.html>

State Vocational Rehabilitation Agencies:

http://wdcrobcolp01.ed.gov/Programs/EROD/org_list.cfm?category_cd=SVR

Disabled American Veterans: <http://www.dav.org/>

Disability-Specific Resources

The Arc of the United States (Intellectual / Developmental Disabilities):
<http://www.thearc.org/>

American Council of the Blind (ACB):
<http://www.acb.org/>

National Association of the Deaf:
<http://www.nad.org/>

Hearing Loss Association of America:
<http://www.hearingloss.org/>

National Alliance on Mental Illness:
<http://www.nami.org/>

Family Member / Caregiver / Attendant Resources

Family Caregiver Alliance
<http://www.caregiver.org/caregiver/jsp/home.jsp>

Caregiver Action Network
<http://caregiveraction.org/>

Independent Living Centers (they often help find attendants for their consumers) <http://ilru.org/html/publications/directory/index.html>



Guideline # 3: Program Accessibility

Programs should be accessible to people with disabilities and other users, socially, behaviorally, programmatically, in communication and in the physical environment.

Why do this?

Your program planning and implementation may include people with disabilities, but if the programs are not physically and programmatically accessible, then people with disabilities will not be able to use them. In order to include people with disabilities in physical activity, nutrition, and obesity program initiatives and policies, it is necessary to consider the full range of accessibility. A program's physical environment and structure, communication methods, social elements, and interpersonal behaviors need to be accessible in order for people with disabilities to fully participate. Once people are able to get "in the door," other accessibility components should be considered and modified, as necessary. These components include accessibility of your verbal and written communications (including your website) and information about public transportation to get where they need to go.

How to do this

Social Accessibility

There may be some instances when a person with a disability feels excluded from meetings or activities or lacks motivation to participate. You may also encounter people who have had limited social experiences and find some settings particularly challenging. There are some things that can be done to make them feel connected and included.

- Help the person have a sense of belonging by valuing their thoughts, opinions and feelings.
- Ask a family member or personal care attendant for communication suggestions.
- Give the person with disability opportunities for personal growth.
- Make sure people have the supports and equipment they need to be successful.

Providing these supports, fostering relationships and treating people with dignity and respect are key elements in providing people with disabilities access to health, wellness and nutrition activities in the community.

Behavioral Accessibility

Attitudes about people with disabilities can affect self-esteem, motivation and participation. By including people with disabilities in all aspects of your program design, implementation and evaluation (Guidelines 1 and 2), you have an opportunity to model health, nutrition and obesity programs that are not only inclusive, but also promote positive attitudes about people with disabilities within your communities. This "behavioral accessibility" includes your own staff designing programs as well as leading or assisting people participating in the programs. Organizations, services, facilities, programs and activities can accomplish this by doing the following:

1. Train staff in disability awareness

2. Train staff in customer service

These trainings can be accomplished with the community resources such as local independent living centers, local intellectual and development disability organizations, and local mental health organizations.

It is important to interact with people with disabilities in a manner that is respectful and to use language that positively portrays people with disabilities. Engage in “People-First” language. Refer to the person first and then the disability, when relevant or appropriate.

Here are a few tips for proper language and etiquette when interacting with a person with a disability:

- Replace “the disabled” with “people with disabilities.”
- Replace, “autistic” with “a person with autism.”
- Instead of saying, “crippled, handicapped or the disabled,” say, “person with a disability,” or “a person who uses a wheelchair.”
- Do not assume a person with a disability needs help. Ask first and then, listen to any instructions the person gives about the best way to assist them. Even then, do not be offended if your offer for help is not accepted.
- When talking to a person with a disability, speak directly to them, not to their companion or caretaker.
- Be patient. Allow people extra time it may take for them to say or do something.
- ***Most importantly, relax and be yourself.***

Programmatic Accessibility

Some programs and activities may need to be altered in order for people with disabilities to participate. Some alterations can be planned for in advance, some may need to be done “on-the-fly”. Alterations should be done to try and maintain the goal of the activity for the person with a disability as well as the others in the activity. Flexibility in program delivery will allow for broader program accessibility.

Examples of program alterations:

A person who uses a wheelchair may need to use “T-ball” equipment while participating in a recreational softball league.

A presentation on nutrition may need to have handouts with print enlarged for someone with a visual disability.

An aerobic exercise class may need to allow a person using a wheelchair to do exercises without standing.

Technology supporting obesity interventions may need to include captioning in videos or accessible computer workstations.

Flexibility around program accessibility also involves providing understanding and expectations for program staff. Organizations, services, facilities, programs and activities can accomplish this by doing the following:

3. Train staff in disability awareness
4. Train staff in customer service

These trainings can be accomplished with the community resources identified previously such as local independent living centers, local intellectual and development disability organizations, and local mental health organizations.

Communication Accessibility

Each part of your program should be accessible to people with communication disabilities as well as those with mobility disabilities. There may be times when communicating with someone is very simple and straightforward. For example, using a pen and paper to communicate to someone who is deaf may be all that is necessary for very simple brief conversations. In other cases, more complex communication may be necessary. Some examples for communicating with people with a variety of disabilities are below and can be enhanced by meeting with a disability inclusion committee during the objective phase of developing programs and services (Guideline 2). Also, individuals in the program will be able to tell you what kinds of communication methods will work for them and may also have ideas about what resources might be available to accomplish this.

Invitation/Registration Information: Include information about the program's accessibility, which tells participants the meeting's location and how to request communication services for the meeting (e.g., availability of documents in large print, on CD, or on cassette tape for participants who are blind or have low vision; sign language interpreters or real-time captioning for participants who are deaf). You will also need to specify a deadline by which you need all accommodation requests. A typical deadline is one week in advance. You also should provide an accessible means to respond to the invitation (e.g., telephone if the website is not accessible to blind participants, teletype or TTY or text messaging for participants who are deaf, and email). Keep in mind that you can create large print documents easily by changing the font on the computer where the document is created. 14-18 point font is recommended standard for large print. You can find out more about teletypes or TTYs at local deaf organizations.

Audiovisual Presentations: If a presentation includes audiovisuals (e.g., computer presentation, video, or printed charts and graphics), it may be necessary to have the visuals described for people who are blind or have low vision. Additionally, any videos used should have captioning (which displays what is being said in text on the bottom of the screen). If the video is not captioned, you may need to hire a sign language interpreter to interpret the dialogue for participants with hearing disabilities. If the presentation is provided to participants in print, the handouts must also be provided in an accessible format like large print or on digital file or computer disk.

Agenda: At the beginning of the program, tell participants what will be covered, and remind them along the way so they know what to expect in the flow of the program. Include beginning and ending times of the program in all communications to assist people in scheduling accessible transportation and the amount of time expected for the program.

Websites and Mobile Applications: If you use a website or have an online registration, make sure that a person with a visual impairment can get the same information from and access to web pages as a person who is sighted. More information on how to make websites accessible will be covered in Guideline 5. Information via teleconferences and webinars also may be used and are good at providing access. There are certain features of these presentation technologies that make participation and navigation easier for people with disabilities: volume control, connections for accessories and screen resolution are some examples. Other types of formatting and improvements are generally easy and inexpensive.

Mobile communication can be a creative way to engage people with a variety of disabilities. Not only can people communicate and socialize with their mobile devices (via calls, texts, Twitter, Facebook), installed appli-

cations can assist people in not only accessing information, but participating in a variety of activities. There are numerous applications that users can download that can assist them in increasing their quality of life. These range from educational and financial applications, to medical, health and fitness applications. You may find your program either accessing existing applications, or perhaps creating your own physical activity or nutrition application. Some mobile phones have software or notification alerts already installed that make it easier for people with disabilities to navigate websites and applications. These include:

- Screen readers that can make mobile phones accessible for the blind, those with low vision and people with learning disabilities that involve reading ,
- Visual or vibrating alerts, relay services and hearing aid compatibility devices that make mobile phones accessible for the deaf and hard of hearing, and
- Voice recognition and auto text that can be used by people with physical disabilities.

New accessibility applications are being developed and launched frequently. Your health, obesity and physical activity initiatives can allow older adults or people with disabilities to retrieve information that makes participating in your programs easier, and therefore, more successful.

Physical Accessibility

To determine the accessibility of your space for people with mobility and vision disabilities, there are many simple steps you can take. First, make sure there is a clear, relatively flat and slip-resistant path for participants to approach your door from parking or public transportation stops. Second, make sure the entrance door is wide enough and is not too heavy for someone to open. Next, look around the inside of your site to be sure that aisles or pathways have room for people in wheelchairs to maneuver, and that there are no hazards a blind person could trip on as they walk through the space. Finally, ensure that your bathrooms have enough room for someone in a wheelchair to access the toilet and the sink. The U.S. Department of Justice has a very helpful publication that allows business owners to assess the general accessibility of their site in a simple and straightforward way, as well as how to prioritize any changes that need to be made (see the Resources section below).

If you are unsure if your meeting space or other sites where you conduct program activities are accessible, contact your regional ADA Center, local independent living center (ILC) or your city/county government office and ask to speak to an ADA Coordinator. These organizations and individuals can help you to conduct a site or building survey to determine what changes may need to be made to create better accessibility

Accessible Equipment: When planning your programs, keep in mind that people with disabilities may prefer to have equipment adapted for their use. Manufacturers of accessible equipment recognize that the most popular equipment (cardiovascular and strength conditioning) often cannot be accessed by people with mobility limitations or vision impairments because the controls for these machines have not previously been adapted. New versions of these machines have displays with audio output that a blind participant can use, and some have been adapted to be used via table top, which is convenient for participants who use wheelchairs, or who cannot stand for long periods.

Examples include:

- Large buttons/text
- Swing away or swivel seats to allow wheelchair access
- Machines with height-adjustable pedals
- Single handed seat adjustments

- Adjustable heel/toe straps to help with foot support

If you are not sure whether or not some of these features exist where you will be conducting programs, call or do a walk through with a trainer or other fitness professional. You may also want to invite a person with a disability to accompany you!

Transportation to Program Site: In addition to space, be sure to consider whether or not a location is accessible by transportation. Some people with disabilities can drive or take public transportation such as buses. However, a large percentage of people with disabilities rely on other public transit services. These services can be provided by fixed routes (buses, light rail, subway systems along prescribe route on a fixed schedule) or paratransit services (a shuttle service for people with disabilities that provides local door-to-door service). Because it may be difficult for some people with disabilities to get to a place that is far from their drop off or pick up point, it may be a good idea to choose a location that is close to public transportation routes, if possible. Almost all communities have websites that provide public transportation options, routes and schedules for the area.

Resources

Programmatic Accessibility

National Center on Health, Physical Activity and Disability: <http://www.nchpad.org/>

P.E. Central <http://www.pecentral.org/adapted/adaptedactivities.html>

Communication Accessibility

American Council of the Blind (ACB): <http://www.acb.org/>

National Association of the Deaf: <http://www.nad.org/>

Computer and Document Accessibility

Accessible Information Technology: <http://www.accessibletech.org/>

National Center on Accessible Instructional Materials:
<http://aim.cast.org/learn/disabilityspecific>

Facility Accessibility

US Department of Justice ADA Guide for Small Businesses: <http://www.ada.gov/smbustxt.htm>

US Department of Justice Standards for Accessible Design
http://www.ada.gov/2010ADAstandards_index.htm

National Network of ADA Centers: <http://www.adata.org/contact-us>

Centers for Independent Living: <http://www.ilru.org/html/publications/directory/index.html>

Equipment Accessibility

National Center on Health, Physical Activity and Disability: <http://www.nchpad.org/>

P.E. Central <http://www.pecentral.org/adapted/adaptedactivities.html>

Transportation

511.org or other local public transportation websites help people plan trips using public transportation options. Local Paratransit services should also be used.



Guideline # 4: Accommodations for Participants with Disabilities

Programs should address individual needs of participants with disabilities through accommodations that are specifically tailored to those needs.

Why do this?

If people with disabilities do not have equal access to programs and services, they will not take part in programs and will not benefit from any physical fitness, nutrition or obesity initiatives. Even though including people with disabilities and their representatives in the beginning stages of designing your programs (Guideline 1) will give you general feedback on challenges and supports that may be needed for participation by people with disabilities, some people may need specific, and/or unique changes in the way the program or service is structured to accommodate their disability. Here are some specific examples.

A person who is hearing impaired may need to request a sign language interpreter for a lecture on nutrition.

A person with a visual impairment may require, for that same lecture, handouts and evaluations in larger print.

An individual with autism may need to be able to make individualized body movements (e.g., flapping their hands) during wellness classes. This person may wish to have his/her movements explained to staff and other participants who may find the movements unsettling until they understand more about autism. In this case, it is necessary to get the permission of the person with autism or his/her caregiver or family member before disclosing anything about the person's disability.

These “modifications” will allow people with disabilities to have full access to programs, services and activities. It is important to have a clear process for how modifications can be requested. Remember to include people with disabilities in this process. They may already have access to devices or other creative ways to modify space or equipment.

Although a program modification may be requested by a participant, program staff will need to determine if that modification can be accomplished without fundamentally altering the program's purpose, and without creating undue or extreme financial burden.

How to do this

A process or policy should be put in place to allow for people with disabilities to request a modification. This can include a written procedure, public acknowledgement that there is a procedure and training and awareness of staff on how to accommodate the request.

Staff responsible for providing modifications to a program should be trained in different types of policy modifications, aids, equipment and services. Additionally, the staff should also have sensitivity training and etiquette around interacting with people who have disabilities. Part of staff training around modifications should include awareness of disability issues and individualized needs. For example, staff should be prepared to hire sign lan-

guage interpreters, make large print versions of documents, and understand how to communicate with people of a range of disabilities in meetings or other person to person settings (see Guideline 3).

Several key concepts are critical to understand when considering policy modification requests:

- A person's disability is very personal. Be sure to keep all information confidential.
- If a requested modification is not available, the person with the disability (including support staff or caretaker) and a program representative should work together to provide some type of modification so that the person is still able to participate in programs and services.
- If you are asking a person with a disability to complete a form to request a modification, that form must be available in an accessible format (Guideline 3).
- If a modification is denied, it should be done in a timely manner to allow the person time to investigate other possible supports or changes.
- If a modification is not available and the person with a disability wants to "appeal," be flexible and make time to meet with them. Ideally, you want to maintain a good relationship so that activities and services are successful and beneficial to all.

See Appendix A for sample of modification form.

Requests for modifications may come in various forms. Participants may request **modification of the program agenda** or how it is taught. Participants may also request **auxiliary aids** and **services**.

Modification of the program agenda – Requests to modify a program can come in many different forms. For example, a participant may want the class to slow down a bit, or to receive some individualized instruction so they understand better what is being taught. They may also want some materials to take home so they can practice the skills they are learning in an environment where they are more comfortable.

Auxiliary aids can include equipment, materials or personal services that help someone to experience the training.

Some examples of auxiliary aids for someone with a **visual impairment** may include: making fonts larger so that people with a visual impairment can see text; double-spacing between the lines; changing margins or double spacing text. Larger print can be produced by simply using a computer or a photocopier where large type and certain fonts can be selected. Below are some more specific ideas to assist in making materials more accessible to someone with a visual disability.

Fancy fonts are hard to read and should be avoided.

14 point font is good, but 16 point font is better.

Arial bold 18 font is a commonly preferred font.

For someone who is completely **blind**, try recording information to a digital file, or using computers with screen readers (voice output) or a screen magnifier. Screen magnifiers are already installed in most computers. Some people who are blind may need materials accessible by Braille. Many organizations for the blind will translate documents into Braille. Keep in mind that Braille is best for short documents, as it takes a considerable amount of paper to convert text into Braille. Information that is made accessible should be proof read before being given to the person with a disability.

Some people who are **deaf** may use a sign language interpreter to provide a translation of spoken language into American Sign Language (ASL). ASL is a language using signs made by moving the hands combined with facial expressions and postures of the body. This can be useful for one-on-one conversations, classes and group

meetings.

Communication Access Real-time Translation (CART) is sometimes also referred to as Real-time or Live Captioning and is used primarily for people with **hearing impairments**. The person participates in an event, (meeting, class, training, event or teleconference call) and what the person hears is being transcribed (using a stenographic or voice recognition process and converted to text). For example, a CART writer would listen to a lecturer (either on-site or off-site) and transcribe all that is said with little to no delay. The text would then be displayed so that the individual could read along and remain an active participant during the event. This is now common even on webinar software.

A TTY (often called a TDD—Telecommunications Device for the Deaf) is a device for people with **hearing or speech disabilities** that allows them to communicate by telephone. Instead of speaking a conversation, the user types what he or she wants to say into a TTY device. If the recipient of the call also has a TTY system, two people can communicate directly. If the recipient is not a TTY user, the call is translated by a live operator through the Telecommunications Relay Service. An operator reads what the hearing or speech impaired person has typed. In turn, the recipient speaks slowly into the phone and the operator types what the hearing impaired person will read. Often a person who is not completely deaf is able to speak. If so, he or she can simply talk normally into the phone and the recipient can listen. The operator will type the response so the hearing impaired person can read it. This service is available to those with TTY equipment 24 hours a day, seven days a week. Each state has its own toll-free number to call to use the TTY system. Using a TTY could be helpful for someone giving or receiving information in a one-on-one conversation.

Some people who are **hearing impaired or deaf** use captioning. Captioning is the process of translating the audio portion of a video program into text captions, or subtitles, onto a screen so people who are deaf or hard of hearing can read what they can't hear. There are two different types of captioning:

- **Open captioning** are spoken words and/or audio displayed as text (similar to foreign film sub-titles).
- **Closed captioning** are captions, spoken words and/or audio displayed as text that is encoded or hidden on a television signal.

Many states have a directory with captioning services in the area. Captioning services, as well as sign language interpreters, require advanced notice of an activity or program. When designing programs, keep costs for contractors in mind when creating your budget (Guideline 6).

Resources

A Guide to Creating Documents in Large Print <http://www.cclvi.org/large-print-guidelines.html>

Making Documents Accessible <http://atcoalition.org/article/making-documents-accessible>

These are a few examples of how auxiliary aids can make information accessible at the website of the Alliance for Technology Access at <http://ataccess.org/>

Registry of Interpreters for the Deaf <http://www.rid.org/index.cfm?>

The Caption Center at www.wgbh.org/caption

National Captioning Institute (NCI) at <http://www.ncicap.org/home.html>

Guideline # 5: Outreach and Communication to People with Disabilities

Programs should use a variety of accessible methods to outreach and promote the program(s) to people with disabilities.

Why do this?

Good outreach and marketing activities help to broaden your participant base and ensure integration of your programs and activities. Thus, program staff should target their outreach efforts to both individuals with and without disabilities. Outreach and marketing of accessible facilities, programs and activities should be designed in a variety of formats so that people with disabilities can access them. It is also important to make the outreach materials show the inclusion of people with disabilities in language and visuals to help people with disabilities understand that the program is open to them. It should be an explicit goal to attract people with disabilities to a program and for to accomplish that goal, people with disabilities need to know about the opportunities that are available to them to participate in fitness, nutrition and health-related activities. The more inclusive you are in your marketing and branding, the more people with disabilities will feel invited and motivated to participate in your health and wellness activities. When people see examples of people like themselves (elderly, young, with a disability) taking part in fitness and nutrition initiatives, it conveys that good fitness and nutrition applies to everyone.

How to do this

Communication and Branding

Communication and information regarding events, classes, fairs, forums, health and nutrition information, or access to physical activity sites is conveyed in a variety of ways: newsletters, fact sheets, webinars, evaluations or other methods of advertising. This Guideline recommends creating materials accessible to a diverse audience.

When branding materials, show inclusive images of persons with disabilities in those materials.

For example, a flyer could show a person who uses a wheelchair enjoying a cooking class or a video could show a person with a disability participating in a physical activity along with peers without a disability.

In developing language about resources available to people with disabilities, refer to the “People-First” language etiquette (e.g., “person with a disability” as opposed to “disabled person” or “crippled”, etc.). You want to use language that portrays people with disabilities in a way that is not discriminatory or disrespectful.

[Adapted from “Reporting and Writing About Disabilities,” <http://www.ndrn.org/en/media/press-kit/265-reporting-and-writing-about-disabilities.html>]

Outreach

You can do all of the Guidelines stated here, but if you do not specifically reach out to the disability community, there may be no change in the participation levels of people with disabilities in your programs. Use the

groups and individuals you have contacted for help in Guideline 2 to recommend where you can outreach. At a minimum, reach out to the local independent living centers, the local intellectual and developmental disability organizations, and the local mental health resources in your community.

Website accessibility

Surfing websites and the use social media is a key component of outreach. This is an excellent way to reach people with disabilities. Some people have assumed that people who are blind cannot access the internet, or people who have limited use of their arms and hands cannot use the internet. This is a myth. The larger issue is that many websites lack the type of accessibility needed for many people with disabilities.

If you are using websites to post images, advertise events or provide registration for training, make sure that your website is accessible. Make sure the programmers for your website and social media are aware of the web accessibility guidelines. Then, use your community resources including independent living centers, regional ADA Centers, or others with disabilities in your community to check the website to assure that it can be used by people with various disabilities.

Resources

General disability communication guidance from the US Department of Justice ADA Best Practices Tool Kit for State and Local Governments, Chapter 3: General Effective Communication Requirements Under Title II of the ADA <http://www.ada.gov/pcatoolkit/chap3toolkit.htm>

More ideas about marketing and branding to people with disabilities can be found at The Solutions Marketing Group; <http://www.disability-marketing.com/services/>

Statewide Independent Living Councils: <http://www.ilru.org/html/publications/directory/SILC.html>
Independent Living Centers <http://ilru.org/html/publications/directory/index.html>

Specific examples for creating accessible websites and mobile device accessibility can be found at the following websites.

(World Wide Web Consortium)
<http://www.w3.org/>

American Foundation for the Blind <http://www.afb.org/section.aspx?FolderID=2&SectionID=4&TopicID=167;>

New Webmasters
<http://newwebmasters.net/plan/creating-accessible-websites/>

MobiForge
<http://mobiforge.com/developing/story/why-mobile-web-accessibility-matters-best-practices-make-your-mobile-site-accessibl;>

Microsoft, Inc.
<http://office.microsoft.com/en-us/word-help/creating-accessible-word-documents-HA101999993.aspx>

Lighthouse International
<http://www.lighthouse.org/accessibility/design/web/>

Apple, Inc.
<https://www.apple.com/accessibility/>

Adobe Products
<http://www.adobe.com/accessibility.html>



Guideline # 6: Cost Considerations and Feasibility

Programs should address potential resource implications of inclusion (including staffing, training, equipment and other resources needed to promote inclusion).

Why do this?

Understanding and accounting for specific costs for training, equipment and staffing for programs and services should be an ongoing part of creating successful and inclusive health and wellness activities. Since inclusion is a continuous process, so must be the resources available to ensure that people with disabilities are included in programs and services.

To stay within your program budget, costs for making your programs accessible should be considered and incorporated into your programs when you are designing (or re-designing) your objectives (Guideline 1). As you look at your ongoing health programs, policies and initiatives, it may be helpful to breakdown individual costs for staffing and for the most common accommodations used by participants in your programs. You will see that some costs for accessibility, such as creating inclusive materials, can be achieved with little to no extra expense. For example, making materials accessible by using larger print can be done by using a particular font, a larger type and some guidelines for using color, margins, etc. The only cost your program may incur might be the type of paper used and the staff time to create the documents.

How to do this

There are two main types of costs to plan for in making your programs accessible: capital costs (for one-time changes to physical structure) and ongoing costs (like training, accommodations, and the like). To understand costs that may occur in making your program more accessible, you need to look at accessibility of your program site, staffing, equipment, auxiliary aids and services (Guideline 3) and possible program modifications. Here are the potential costs of some common modifications that your participants with disabilities may need in order to be fully included in physical activities, nutrition education and obesity initiatives.

Physical alterations of your program facilities: The cost of altering a program site can vary widely. If your building is not accessible to people with mobility disabilities, you may need to spend money over the course of several years to remove architectural barriers like steps or narrow doorways. However, some accessibility modifications are low cost and easy to accomplish (e.g., installing a door with double-swing hinges to allow someone to push open the door on both sides, replacing door knobs with lever or U-shaped hardware that can be opened with a closed fist).

Communication accessibility: As discussed in Guideline 3, there are expenditures that may be necessary to communicate with individuals who have vision or hearing disabilities. Common costs for these items are shown in the table on the next page.

Common Modifications	Price Range	Notes
Sign Language Interpreters	\$50 - \$100 per hour for independent contractors	Generally more expensive in larger urban areas and in the private sector
Captioners	\$50 - \$100 per hour for independent contractors	Price varies depending on education, experience, location and certification
Large Print	Varies, but little cost Can be created on computer	Price depends on number of copies, turnaround time, type of paper (house-stock paper is less expensive)
TTY	\$80 - \$300 depending on features	Some devices have answering machine features or printouts
Door Hardware	Double-swing hinge \$10 - \$15; Lever door hardware \$5 - \$20	Easily obtained at a local hardware store

A qualified sign language interpreter is an interpreter who is able to interpret effectively and accurately, both receptively and expressively. When hiring sign language interpreters, it is good to know that interpreters can be hired through a referral agency, and there are interpreters who work as free agents. Fees for hiring through a referral agency are generally higher than contracting directly with a freelance interpreter. However, keep in mind that if you are hiring an individual, he/she may not be available during the time that you need the service. Generally, going through a referral agency gives you more flexibility when scheduling your wellness program or activity. The general rule of thumb for hiring an interpreter is that if an assignment is more than two hours, then two interpreters are required. Similarly, the fee for a captioner working as an independent contractor can vary depending on the education, experience and certification of the contractor.

Your organization may want to consider purchasing a TTY system. These are relatively inexpensive and will provide greater access to people with speech or hearing impairments. Remember to list the phone number on publication and marketing materials (Voice/TTY).

Resources

National Network of ADA Centers:
<http://www.adata.org/contact-us>

National Braille Press
www.nbp.org

Braille Works
www.brailleworks.com

Recording for the Blind and Dyslexic
www.rfbid.org

Many foundations and grant makers have funding opportunities specifically for programs and services that support and include people with disabilities. A couple of links to get you started can be found here:

Foundation Center
<http://foundationcenter.org/getstarted/topical/disabilities.html>

US Department of Health and Human Services
<http://www.hrsa.gov/grants/index.html>



Guideline # 7: Affordability

Programs should be affordable to people with disabilities and their families, caregivers.

Why do this?

People who fall into a lower socio-economic earning bracket, both with and without disabilities, are at higher risk for poor health, as they tend to have unhealthy eating habits, smoke and abuse alcohol. Given that, it is important to remember that many people with disabilities live on a very fixed income. In 2012, 28.6% of people with disabilities lived in poverty, compared to 13.7% of people who were non-disabled (<http://www.disabilitycompendium.org/archives/2012-compendium-statistics/2012-poverty>). In 2011, people who were over the age of 16, living with a disability and in the work force had an average annual salary of \$19,735.00. This was \$10,550.00 less than a person over the age of 16, in the workforce, and without a disability (<http://www.disabilitycompendium.org/archives/2012-compendium-statistics/2012-earnings>). Because many people with disabilities have such limited income, making your health and wellness programs affordable may be the only avenue they have for receiving nutrition, obesity information and the ability to participate in your physical activity programs. This may also be true of those who are elderly, or single parent families. Consider the impact on those who are on fixed incomes when planning program activities.

Some researchers have identified the cost of fitness programs as one of the barriers to participation among people with disabilities. (Rimmer JH, Riley B, Wang E, et al. Physical activity participation among persons with disabilities: Barriers and Facilitators. *Am J Prev Med* 2004;26:419-425).

How to do this

Because program affordability allows people with disabilities to participate in health and wellness programs, it is important to find accessible activities for little to no cost, or for programs to institute a “sliding scale,” reduced fee schedule or offer scholarships. Programs that offer sliding scales or discounted fees should include a procedure to qualify. Verification of income can be a participant’s word, or other form of documentation, such as participation in a state or federal public assistance program such as Medicare, Medicaid or Social Security benefits. When developing programs and services, a sliding scale system should be developed ahead of time so that whatever policy is in place, it is uniformly applied to all participants, regardless of ability (or inability) to pay. Also, keep in mind that some people with disabilities may be accompanied by a family member or caregiver who may need some type of financial subsidy, as well.

It is a good idea to become familiar with activities, programs and services that may already be “built in” to the community culture. Some examples are here.

A local recreation center could offer space to host a physical fitness activity in the gymnasium and a cooking demonstration in the kitchen just down the hall.

A yoga studio may offer free yoga in a park for consecutive weeks.

Some public health clinics/hospitals may offer free wellness and physical activity courses for community members.

Instead of taking a group to the grocery store to teach about nutritious food, a trip to a farmer's market may be more affordable.

Consider using free public health fairs to gather and teach information regarding obesity, nutrition and exercise.

Resources

Discounted/Sliding Fee Schedule Information Package, National Health Service Corps
<http://nhsc.hrsa.gov/downloads/discountfeeschedule.pdf>



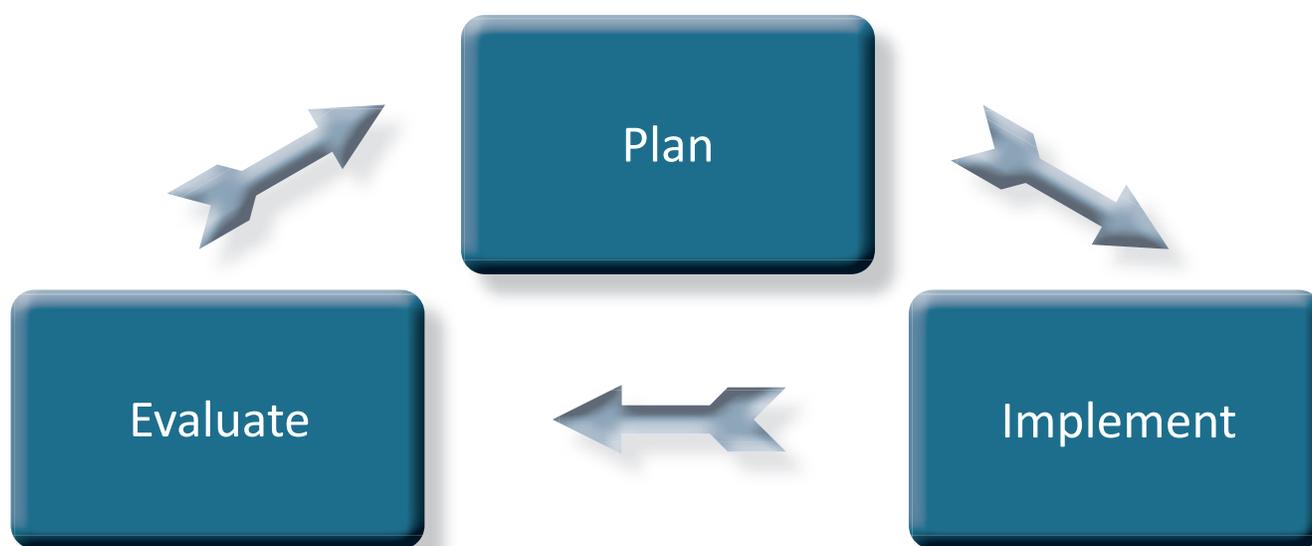
Guideline # 8: Process Evaluation

Programs should implement process evaluation (with transparent monitoring, accountability and quality assurance) that includes feedback from persons with disabilities, along with family members/caregivers or other representatives, and a process for making changes based on feedback.

Why do this?

Process evaluation is important because it focuses on the accountability, quality and monitoring of your initiatives and activities. It is through this process that you will learn whether or not your programs have been successful and the positive messages of the benefits of health and wellness. You should be evaluating your program processes periodically to determine what is working and not working, and making any necessary changes to your objectives or outcomes.

One way to look at your process evaluation is through a simple graphic:



After conducting a process evaluation, you should review what you learned and use the results to make changes to your program. This is essential to continuous program improvement – related to disability issues or not. By including process evaluation questions about disability issues and feedback from people with disabilities, you will be able to improve the relevance of your programs to people with disabilities as well as those without disabilities.

How to do this

Just as you did in Guidelines 1 and 2, your process evaluation should be inclusive of people with disabilities, experts in the field, parents, community members, your staff members, and other stakeholders. You should be reaching out to those who have been served by or have participated in, your programs, services and activities, as well as those affected by the operations and costs of those programs like your staff members.

The Centers for Disease Control and Prevention has developed tools for health and wellness programs to evaluate their activities. Specifically, there are six critical steps necessary for the evaluation of these programs.

Step 1: Engage stakeholders in the evaluation process.

Step 2: Describe the program and how it serves different types of stakeholders.

Step 3: Focus the evaluation design.

Step 4: Gather credible evidence of feedback from participants.

Step 5: Justify conclusions reached in the evaluation process.

Step 6: Ensure use of the evaluation data in program improvement, and share lessons learned with program staff and participants. For more information on the framework and foundation of evaluation tools, go to <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm>

In designing the feedback process, you should make sure that all staff members, participants, family members or caregivers have an opportunity to give feedback in a manner that is accessible to them. For example, you may need to hire a sign language interpreter for deaf participants because they may not understand the evaluation questions as they are written. As you learned in Guideline 3, many deaf individuals use American Sign Language as their first language. Thus, questionnaires or other documents written in English may not be accessible to them. Similarly, you may need to make questionnaires accessible to blind or low vision participants by creating them in large print, reading the questions and recording the answers, or creating an online survey.

Another group of people with disabilities for whom you may also need to modify the process evaluation questions are participants with cognitive disabilities. You may need to simplify the questions using word processing software that evaluates the reading level, or provide staff that can assist the individual in responding to the questions.

Once you have conducted your process evaluation and analyzed the data from it, you should decide what program changes and improvements to make as a result and develop a plan. Your plan should include specific action steps, along with a timeline for each step.

Types of questions to ask: Although a thorough summary of process evaluation questions to ask is beyond the scope of these Guidelines, it is important to include items that have relevance to people with disabilities. For example, when tracking measures of program activities (e.g., the program's capacity to deliver services; the participation rate; levels of client satisfaction; the efficiency of resource use; and the amount of intervention exposure), make sure the questions are given to people with disabilities as well as those without disabilities. Include in your questions or measures a way to identify people with disabilities so that you can see whether your program activities look to be having the same impact on those with and without disabilities.

Examples

Here are a few examples of questions programs can use to evaluate their processes:

How many people with disabilities did we reach in our efforts to recruit participants? Did we reach participants with a variety of disabilities?

This helps evaluate whether or not the program was successful in reaching out to a variety of participants or your “target audience.”

What is our program’s capacity to deliver goods/services/activities in an accessible manner? How accessible are our program’s methods for obtaining feedback about our services and activities?

Resources

For a more detailed description of program process evaluation in public health programs:

Introduction to Program Evaluation in Public Health (CDC) <http://www.cdc.gov/getsmart/program-planner/Step3.pdf>

Framework for Program Evaluation in Public Health (CDC) <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm>

Developing a Process-Evaluation Plan for Assessing Health Promotion Program Implementation: A How-To Guide. Health Promot Pract April 2005 6: 134-147 <http://hpp.sagepub.com/content/6/2/134.abstract>



Guideline # 9: Outcomes Evaluation

Programs should collect outcome data, using multiple disability-appropriate measures.

Why do this?

Outcomes evaluation helps to establish whether or not programs are effective and whether or not the primary purpose (s) for the programs has produced the intended results.

Early in your planning process, you and your work group (s) should clarify how the outcome evaluation will operate (e.g., how information sources will be selected; what data collection instruments will be used; who will collect the data; what data management systems will be needed; and what are the appropriate methods of analysis, synthesis, interpretation, and presentation). Additionally, when you create your process for receiving feedback, people with disabilities will need to have methods that are accessible for them, such as readers or sign language interpreters as described in Guidelines 3, 4 and 5. Finally, surveys and other measurement materials should be in accessible formats.

In order for the evaluation to provide useful results, measurements and data should appropriately reflect the outcomes for people with disabilities. Programs should, in their planning phases, identify data that evaluates participants based on their functional ability, and accurately measures their health and wellness understanding and behavior.

How to do this

Most outcome data will be collected directly from program participants with disabilities, though some data may come from caregivers or family members. Therefore, when developing outcome collection instruments (e.g., survey forms, smart phone or tablet-based apps), it is important to ensure those instruments have easy-to-understand instructions, are provided in accessible formats, and include specific demographic information on disability.

Outcome surveys provided to participants should be easy to understand and complete. For example, you may want to ask a question such as “do you have more energy after you exercise?” By contrast, if you ask a question like “did you achieve any health-related outcomes over the past month”, the participant may not understand how to answer and may not report outcomes that are actually happening.

As discussed in Guidelines 3, 4 and 5 above, it is important to provide accessible outcome data collection instruments or methods in the same way you provided accessible outreach and program materials. This can be done in a variety of ways. For example, participants with low vision may need any printed forms or questionnaires in large print. Other people with vision impairments or cognitive disabilities may prefer that program staff read the outcome questionnaire to them and note their answers. Or, participants with limb loss or limited dexterity may prefer electronic methods of reporting outcomes (e.g., using a computer or tablet) so they do not have to shuffle papers. The same considerations should be present in any outcome data collection instruments.

Another important consideration in tracking participant outcomes is providing alternative measures for the outcomes themselves. For example, instead of (or in addition to) asking participants, “how much weight did

you lose over the past month”, you may need to ask something like “are you able to move more easily during transfers than you were one month ago?” These alternative questions are often necessary because people who use wheelchairs cannot weigh themselves unless their doctor or the health program purchases a wheelchair accessible scale. This type of scale is used to weigh the person’s empty wheelchair first, then to weigh the person in the wheelchair and subtract the weight of the wheelchair itself. When readings are done over time, the participant can determine if he or she is losing weight. Individuals who are blind will need someone to read a traditional scale for them, or purchase a scale with voice output that tells them their weight by reading the scale’s dial out loud.

Programs may also want to ask about their participants’ sense of well being and stress reduction after participation in the program over time. An important outcome question for a participant could be to check a box next to a statement like “I feel happier and have less stress in my life since participating in the program.” Including anecdotal reports from participants about measures like having more energy or less stress can be valuable when included in addition to statistical information.

Another critical item in outcomes evaluation is tracking disability as a demographic, in addition to other demographics like age, ethnicity and gender. Very little data exists on health and wellness of persons with disabilities, or about programs that are effective in improving their health outcomes. Thus, outcome evaluations or surveys should include questions regarding disability status, and whether the disability is related to mobility, vision, hearing, cognitive functioning, mental health, or multiple disabilities. Of course, it is critical to keep this demographic data anonymous and assure the participants that it will not be disclosed except in a form where all participants’ data is aggregated together.

Examples

Here are a few examples of indicators or questions that may be useful to measure outcomes for participants with disabilities:

Did the program, service or activity change participant behavior, community norms, policies or practices?

Did participants achieve measurable health changes like lowered blood pressure or reduced difficulty in making transfers?

What was the quality of life impact for participants?

Do participants with disabilities continue participation in the program at least as long as participants without disabilities?

Resources

For a more detailed description of program outcome evaluation in public health programs:

Introduction to Program Evaluation in Public Health (CDC) <http://www.cdc.gov/getsmart/program-planner/step2.pdf>

Framework for Program Evaluation in Public Health (CDC)
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm>

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Appendix A

Modification Form

MODIFICATION REQUEST FORM

TO: _____
(Program Staff)

FROM: _____
(Name of person requesting modification)

ADDRESS: _____
Street Apt. # City State Zip

PHONE: () _____

EMAIL ADDRESS: (if applicable) _____

REQUEST FOR MODIFICATION

- () I am the person listed above requesting a modification that will allow me to participate in a program, activity or service.
- () I am requesting a modification on behalf of someone else.
Your name: _____
Relationship to other person _____

Program for which the modification is requested: _____

Date for which the modification is requested: _____

Time for which the modification is requested: From am/pm To a.m/pm

Modification requested (check one of the following options):

- () Assistive listening devices
- () Sign Language interpreter
- () Documents in an alternative format (specific Braille, large print, accessible documents or electronic format used by persons with low vision or who are blind)
- () Other (please specify)

I certify that I have a disability or medical condition that requires a modification.

Signature _____

Appendix B

Accessibility Checklist

This checklist is designed to assist program staff and other health and wellness professionals in thinking through accessible features of both public and private spaces. It can be used to assess program spaces well before the scheduling of any health or wellness activities.

Accessibility Checklist*

Name of Program	Date	Staff Responsible

	YES	NO	N/A	Comments
1. Are there accessible parking spaces or curb side drop off areas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there sidewalk access? Can a person get from their vehicle/drop off to the building?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the entrance accessible? (power door, able to be opened with a closed fist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. If the meeting on the first floor, is there clear and wide aisle space for a wheelchair to maneuver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. If the meeting is above the first floor, is the elevator(s) accessible?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. If available to all participants, is there an accessible restroom stall?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Is there seating up front for people who need interpreters or captioning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Are agendas, presentation materials and evaluations available in accessible format?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Are there other requested modifications needed for this program?

- Assistive Listening Device
- Sign Language Interpreter
- Documents in alternative formats (large print, electronic, Braille)
- Other (explain)

*Refer to US Department of Justice Standards for Accessible Design for specifications

Appendix C

Development and Approval Process

We reviewed the literature that was most pertinent to the development of guidelines and criteria for inclusion of people with disabilities (The Agree Next Steps Consortium, 2009; DRRPII Adaptation: National Institute on Disability and Rehabilitation Research; Drum, Peterson, Culley, Krahn, Heller, Kimpton, McCubbin, Rimmer, Seekins, Susuki & White, 2009; Kraus, Richards, Hong & Illog, 2012). The literature review also included a wide range of materials related to national strategies in physical activity, nutrition, and obesity, the most relevant of which are included in the Reference section (CDC Healthy Communities Program, 2011; CDC Community Prevention Guide, 2013; Khan, Sobush, Keener, Goodman, Lowry, Kakietek, & Zaro, 2009). In addition, we reviewed many examples of current state and local policies and programs in the areas of physical activity, nutrition, and obesity so that we could identify issues and concerns related to disability inclusion. On the basis of the literature review, we developed a set of draft proposed guidelines and implementation steps which were then reviewed, refined, and approved by the expert panel

Review, recommendations, and approval by the expert panel included the following steps:

1. Panel members reviewed the proposed guidelines and completed an online survey about the importance of the guidelines and usefulness of implementation steps. The panel provided detailed quantitative and qualitative feedback on the guidelines, as well as guidance about the implementation steps which will be especially valuable in development of a tool kit, scheduled for the second year of the project.
2. We refined the guidelines based on survey results, and sent the revised guidelines and criteria for their evaluation to the panel for review.
3. In meetings on April 1 and 3, 2013, the panel members reviewed and approved the criteria for evaluating the guidelines. Their discussions of the guidelines led to additional refinement.
4. The panel members unanimously approved the Guidelines for Disability Inclusion.

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