

REALTIME TEXT FILE

DISABILITY AND HEALTH PROGRAM
DISABILITY COMMUNITY PLANNING GROUP WEBINAR
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>> CLAUDIA FRIEDEL: Hello, everyone, this is Claudia Friedel with the Disability Community Planning Group. We're happy that you're here today. We're happy to have our PI, principal investigator, Dr. Shamarial Roberson.

Dr. Shamarial Roberson is the Chronic Disease Director at the Florida Department of Health. She provides direction and supervision for the bureau by overseeing operational functions such as chronic disease programs, epidemiology and evaluation, budget and grant functions, procurement and administrative support.

She joined the Department of Health in 2013 as a chronic disease epidemiologist and evaluator where she served for two years as the bureau epidemiologist.

She completed her Doctorate of Public Health at Florida A&M and her graduate and undergraduate education at Florida State University. Dr. Roberson serves as the Principal Investigator for the Disability and Health Program and is committed to advancing health equity through Chronic Disease Prevention.

Thank you for joining us, Shamarial, and take it away.

>> SHAMARIAL ROBERSON: Hello, everyone. As Claudia mentioned before, I'm Shamarial Roberson, the chief of chronic prevention here at the Florida Department of Health and we're going to tell you about people in the department and talk about activities in Chronic Disease Prevention.

So, I'll give you an overview of our agency's strategic plan and our priorities as an agency and how we're working to advance health equity and how to address the Department of Health and talk about future implications of being more inclusive of persons with disabilities throughout all of the work we do here.

So, at the Florida Department of Health, we operate on an agency's strategic plan and this strategic plan is from 2016-2018. With our agency's strategic plan, it includes all agencies and bureaus throughout the department, however, the surgeon general has focused on seven priorities and those include increasing childhood vaccinations, increasing health equity, increasing trauma services, decreasing HIV infections, infant mortality, the black/white, inhaled nicotine, and licensure time for clinical personnel.

So the way we see the Disability and Health Program is that we're working to increase health equity. The way we see it, we're working with our school health staff and other staffs to ensure that persons with disabilities are represented and, you know, we touch a lot of the other programs so we're working throughout, and this is just a snapshot what the department is focusing on in the next few years.

In our agency strategic plan, where the Disability and Health Program really resides is ensuring that Floridians in all communities have an opportunity to achieve a healthier outcome and that's regardless of race, age, disability status.

And we're also working on the priority of increasing the life expectancy, including the reduction of disparities to improve the health of all groups including groups such as persons with disabilities and we'll go into more about what we're doing later on in the presentation.

As we seek to talk about these things, one of the focal points in my department and critical roles, I'm the co-chair of the Health Equity Council and we have a number of priorities doing that and I'm doing that alongside the deputy secretary of health and we're doing that with leadership here and so we're on the same page, I want to reiterate some of the definitions and the things we're moving with.

When I say health equity, what that means is we're actually assuring the optimal health level for all people but when you put that in the example, what that really means is it's not a one size fits all.

So, for example, if we wanted to implement a physical activity program for a certain group in a certain community, we wouldn't at this time take our money and say hey, let's buy everyone in this community a bicycle and we're going to increase physical activity, that may not be what that group needs at all. Maybe they don't need equipment to increase physical activity, maybe they need social support, maybe they need economic stability with a job, maybe they need mental health counseling, in a place where they can't engage in physical activities, so when you really think about a health equity concept is not doing a one size fits all, it's assuring that you're giving that population truly what they need to get at their optimal level of health, and that's when we mean when we say health equity.

So, when you look at a health inequality that is the difference in a distribution or allocation relevant to a health resource between groups. So, for example, if you're looking at the numbers of programs that are accessible related to the diabetes prevention for persons with disabilities, if there are not a number of programs that are inclusive for persons with disabilities, we are looking at health inequality because there is a deficit and resource for a population. And when we say health equity, that is a subset of a health inequality and that is modifiable, and we'll talk about health disparities

a little bit later on, and health disparity that may be something indefinable. And these health inequities are strongly rooted in the population being disadvantaged and they may have been treated ethically unfairly and we know with people with disabilities, that's true in a lot of situations.

So the social determinants of health, why we're having these conversations, in the past we're putting money in for different groups and if you intervene, intervene, and provide money for intervention and you're really not addressing the root causes of those health inequities and disparities, those will perpetuate moving forward. And what we're doing moving forward, we're looking to address those social determinants of health and those things include places where people are born at, where they live, where they work, where they play, where they worship. So looking at faith-based initiatives, those things all drastically, you know, determine one's overall health. So it's important that we think about the entire environment, the built environment, the social environment, all of those different things when we're designing our programs and that's what we're seeking to do. We train up a workforce and look at those practices to deal with those social determinants.

So, when we take a deeper look at social determinants of health, this is looking at economic disability and this is an area in public health where we have not worked with those departments in the past and looking at housing environment, physical environment, transportation, safety. So doing work in complete streets and all of those different things, education, literacy, earlier childhood education, graduation rates, all of those things. Look at food insecurities, community and social context, and looking at support systems and adverse childhood events and the accumulation what is causing the stress. And the children encounter those adverse events and they're more likely to have lower education attainment, leading to poorer health. And looking at the way to deliver health, not patching it up and giving one individual an intervention, but actually looking at health systems to ensure that we move forth in a systematic, sustainable manner so we can ensure that persons with disabilities are included, you know, not on a case-by-case basis, but included throughout the process all the time. And all of these things ultimately play into health outcomes.

So, when we really look at this and we start to think about our program, you know, oftentimes we want to go straight to the health data and health outcome data but, again, I'll remind you that education is very important, but it's even more important for children with disabilities because their economic opportunities may be limited and no students that identify with disabilities, you know, the research shows that they may not oftentimes take apart in a full academic curriculum and they're more likely to drop out of school. So then you ask yourself in the context of what we're talking about related to health, why is this important?

It is important because education is one of the single-most predictors of one's overall health and one of the highest predictors to chronic disease status later in life. So it's important that we're addressing those root causes of things, and I'll talk about that in our future implications, to ensure that children with disabilities, as well as children overall, receive a good education and those vulnerable populations that are at risk for dropping out, that we're not just addressing secondary and primary prevention, we're looking at things like graduation rates and looking at reading levels of children and especially children with disabilities early in life to make sure they're prepared to live in a safe

environment free of bullying and other things and being healthy in those.

When we talk about health disparities, here again we're talking about those differences in outcomes and determinants of health. And like I told you before, some of the outcomes, for example, we look at geographic disparities of diabetes that can range and be different from county to county, from census tract to census tract and when we talk about health disparities and look at those in a lens, some are modifiable, some are not modifiable and some are due to genetics and genetics is not something that's modifiable. And when you say those things and think of health disparities, that may be a true health disparity. But true health and equity would say the reason we have those higher risks of diabetes is in fact not just because of genetics alone, but because they don't have access in certain communities to a diabetes prevention program to keep them from developing type II diabetes and that's what we're speaking of and moving forth from here.

So some of these health disparities, like I said, can be rooted in the things we talked about before, like inadequate access to health care, poverty, from low education attainment, environmental threats, and safe streets, behavioral risk factors, like the consumption of fresh fruits and vegetables, and educational inequality.

So, how do these disparities arise? And the difference in quality of care, and that is something that is different from access to care and life opportunities. And we know that vulnerable populations may be at risk for not receiving the same quality of care as other individuals, as well as having difficulty with accessing healthcare.

So, it's important that we take these things into consideration as we continue to plan moving forward.

So, I'm going to give you an analogy here where I'm going to talk about the three dimensions of health intervention.

So, one, providing health services, addressing the social determinants of health, and actually addressing the social determinants of equity.

So, here is a cliff analogy and I'm going to use diabetes as an example. How we have traditionally thought about these things, we thought about it in buckets, primary prevention, secondary prevention, and tertiary prevention. If we're using type II diabetes as an outcome for this cliff analogy, what is it we include? We want people to eat healthy diets and engage in physical activity so they don't develop type II diabetes and us messaging to increase physical activity and us making sure the environment is able for people to partake in that and food desserts are minimized and people have access to fresh fruits and vegetables and that type of thing.

And when we're looking at secondary, facing that program, in terms of diabetes our diabetes prevention program that we're doing is for persons who have glucose levels higher than normal but not yet at the point where they then are diagnosed with type II diabetes. But the secondary prevention mechanism would be to get those individuals in diabetes prevention programs, so that they don't develop type II diabetes.

And then what we have is tertiary prevention. So in the context of what we're doing here, we have a diabetes sub management education program, and those are programs for persons with type II diabetes and what it does is ensures that those people, you

know, they adhere to their diabetes medication and they adopt best practices so that they don't have conditions that, you know, are worse and related to their diabetes and end up, for example, in an end stage, they end up with amputation, end up with all other co-morbidities associated with diabetes. And you're saying hey, you have that but let's make sure it's not exacerbated and you will put preventions in place and make sure they're possible even though they have type II diabetes.

And that is pretty much when you're thinking of a prevention standpoint in the years past, that's what we focus on, primary prevention, secondary prevention, and tertiary prevention and focusing on primary prevention and secondary and tertiary prevention is very, very costly and we want to do it on the front end early in life with primary prevention.

However, as we really switch to this health equity focus, what is important for us to note is that everybody, they don't start at the edge of that cliff, right, they don't start at the same place. Some people, they're already close, so when you're looking at, for example, a person with disabilities, instead of starting back on the road further back, they may start already on the edge of that cliff because of a difference in exposure and opportunities.

Maybe, you know, when you're looking at the social determinants of health back there, the living environment, when you're looking at educational attainment, when you're looking at those other things, persons with disabilities, they all -- they may already be at the edge of that cliff, so, you know, they're at risk more so than other groups. So it's important that we note that there may need to be different stop points and different interventions put in place early in life to ensure that they don't fall over that cliff early.

And what we seek to do with the Disability and Health Program as well as other programs here in Chronic Disease Prevention is try to put mechanisms and changes and policy changes in place to ensure we buffer it enough to make sure that everybody's somewhat starting at the same place and ensuring that we can mitigate those differences and exposures and outcomes and especially for persons with disabilities.

When we really think about this, you know, it's just not a blanket bucket for persons with disabilities, there are differences across race and ethnicity groups. There are differences across education groups. Disparities can exist within income brackets, especially, we know, disability status, and we can have differences by rural versus urban areas and rural areas of urban counties. There are known areas of disparities with sexuality orientation and are we putting out materials and information for persons with disabilities which may be a vulnerable group already but are we addressing persons with disabilities that identify with being in a LGBTQ community? Looking at labor roles and how we're working with our partners, such as the Department of Economic Opportunity, to make sure persons with disabilities are included and there are fair hiring practices and, for example, I'll use state agencies, that has been a board I've been on and working to ensure that persons with disabilities have fair practices when they're looking at being hired by state agencies.

So, as we continue to have this conversation, it is a lot to put your head around, but how do we actually begin to achieve health equity? And, I mean, really, you know, we're

speaking to this, but it requires valuing all individuals and populations equally, and not just saying that there's a one size fits all for persons with disabilities because there are disparities amongst that group as well, depending on income, depending on race, depending on sexual orientation, and it starts with a quick, you know, I need to value in every person, every group, all the same. Additionally, it's just also recognizing; not only recognizing those historical injustices, but there are a lot of contemporary injustices, so things that are current and happening now with certain populations and making sure that we're talking about it, making sure that we're figuring out systematic ways to address it, and then providing resources according to need.

So actually using the data to figure out how we disseminate resources and not just saying it's a convenient sample in County X we're going to put diabetes prevention program for persons with disabilities there. No, looking at the data and seeing where we have a higher burden of persons with disabilities and allocate the funds accordingly and I'll give you an example of how we're doing that in a slide that's coming up.

So now I'm going to talk a little bit about how we're being inclusive at the Florida Department of Health for persons with disabilities and how we're working with partners to do this as well.

So, one example I'm going to give you is our MAPP framework and MAPP means "mobilizing for action through planning and partnerships" and that's a model used for health improvement plans. In Florida, every county has a health improvement plan which is derived in conjunction with community partners in the community and the county health department and what we did after coming from our disability and health meeting at the Center for Disease Control and Prevention is we learned of a resource to incorporate persons with disability in that community health improvement process and they're in the process of doing that now, so we shared that document with the group to ensure that persons with disabilities are included in that MAPPING process and in about a week, those counties are going to have additional training about MAPP and at that training, I will be there talking about health equity and talking about vulnerable populations including persons with disabilities and that's how we're engaging the groups, including our county health departments to ensure they have inclusive language and they're using practices.

And with this framework, just to elaborate on it a little bit more, it's not just the CHDs but community members all throughout this process to actually implement the community health improvement plan and looking at the data, as well as assessing feasibility, so it's a uniformed process, that's a documented process, and that's what they're doing in county health departments right now.

So, as we continue to talk about addressing these things, even if we're talking about a health condition that's moving forward, we need to consider all of these things, education, so partners that we have, the Department of Education, which we are working very closely with the Department of Education to deploy some activities around education, looking at housing and working with other partners with housing, so HUD and other people to ensure that we have housing policies, working with tobacco-free Florida and how they're developing policies that are smoke-free and looking at different populations and labor and workforce and looking at the opportunity and making sure that people have jobs and working with those agencies to ensure that we include

vulnerable populations.

And we work very closely with the Department of Transportation and we work on something called complete streets and that concept is ensuring that streets are safe.

So, for example, if you have a street, making sure they have appropriate bike lanes, walking lanes, rolling lanes. If a person has a disability, making sure that streets are equipped to, you know, handle wheelchairs and other things like that.

And what we found is with a lot of the county plans, a lot of these places, they're not walkable, rideable, or anything, and definitely not inclusive of persons with disabilities and we're working on that to make sure we have more complete streets in the state of Florida with more direct focus on persons with disabilities.

And with agriculture, for example, they control the school lunchroom program in the state of Florida. That has huge implications for the work that we do, because a lot of the meals that children receive, they receive them in a school setting, essentially a vulnerable population and they're fulfilling the school lunches and we want to make sure they're as healthy as possible so children can make the healthy choice and easy choice and they're valuable and culturally sensitive and what children want to eat, will eat, and that they like to eat so they're more likely to uptake these behavioral changes and make healthy choices moving forward.

So that's something we're doing with, partnering with the Department of Agriculture and Department of Education to implement those as practices.

So, how do we continue to do this? How do you incorporate health equity into a program? First of all, you have to understand the relevant health equity issues and I'll tell you, it's not easy to address poverty, it's not easy to address income, but that's the first thing you have to understand. It's not easy to say that all groups are the same and if a person has a disability, they're the same.

No, we need to look at different populations. Florida has the third largest elderly population in the United States which makes us have a more increased population that are at risk for either developing a disability or having a disability.

Additionally, in Florida, we have a very high population of Hispanics and making sure we're developing materials that we ensure are culturally competent for the Hispanic population, as well as our Haitian Creole population, we have a high population of Haitian Creole, and translating into Spanish but taking our materials and translating them as needed into Haitian Creole and taking the materials into certain places, you know, translating to French.

So, it's important that we know the populations that we serve so that we can provide culturally competent messages.

And in some cases, I'll give you an example. We've made graphics for diabetes and, you know, say you put certain individuals in the picture, if it's not representative of the population that you're wishing to seek, that population may turn off altogether and say they're not talking to me because they didn't even, you know, recognize the population that they serve, that we serve. So, you know, they made a graphic that said hey, come

and join my meeting for healthy food choices for lifestyle change choices, but if you did not reach that population because the materials aren't socially competent, they're not coming.

And also like with communication efforts with the Health Equity Program Council and working with the counties to give out messages on breast-feeding and stuff, but they've worked with focus groups that they're targeting the population they want to target and a lot of those populations ride city buses and this year we need to make sure the bus routes is culturally competent. And actually asking people how do you want to get this information, not just let me make you a card or fact sheet, maybe they don't want that, maybe they want it on a faith-based community or a church van or something and they want to reach that population and maybe they want the material on a TV screen in the form of an ad instead of one page fact sheet. Maybe you know that you have a huge population in that community that can't read. So these are all of the things that we're identifying and we're working to rectify when we're talking about identifying a priority group.

Maybe our messages are not competent for people that identify with a different sexual orientation, so ensuring that we don't use examples that say certain things and then it's offensive to other populations.

So it's important that we look at this and we have to assess feasibility of implementation, is this something that we can actually change? Is this something that a partner can change?

So, sometimes? Our wheelhouse we realize that hey, we may not be able to impact economic ability, but however, we have a partner in the economic opportunity that has a strategic plan they want to increase, you know, jobs in certain communities and that's where we work with them to do that and deliver health messages at the same time.

And, again, you want to define equitable goals, so we want to take and increase the numbers of programs that include persons with disabilities from 0-5, for example, to give direct numbers so you can measure what it is so you can achieve and say hey, we want to increase job opportunities.

No, it has to be measurable, we have to have strategies and activities to ensure that we're, in fact, moving the needle to get these things done, and then create real evaluation with focus measures and evaluation plans not on the back end of these things but actually doing evaluations from the beginning of these things and including the population groups we want to influence in the evaluation process and the planning process. And that is one area where I see in Health that we can definitely improve on is making sure we actually include the population of interest from the beginning of planning, from the beginning of evaluation, and even if you have it from the beginning, you can engage them along the way, because there's nobody better to speak to what a population wants other than the population.

So, again, as I talk about cultural competence, we hit on it a little bit before, but it's just making sure that we are aware of the people we serve and we are aware of their cultural values and what's important to that population, because, you know, if we want to work with a population and we offend them early on, we're not going to make any

headway and we've done that in years past with other things, so we want to ensure that we consider that early on.

And, you know, just moving forth with the model that we've moved forth with in disability for a long time, nothing about us without us. And again that speaks to engaging the population of interest from the beginning and we're looking at little policies, big policies, health policies, making sure we want those systematic changes and sustainable changes, that we're not implementing practices -- I mean implementing strategies on a case-by-case basis, we're looking at policies from this point forward and always be, you know, the policy to be inclusive from the beginning. So it's important that we look to change policies.

And, again, we do this here at the Department of Health by making sure we use people first language for persons with disabilities and not some other terms that have been avoided a long time. Even in communications, I'm very persistent about making sure that pictures, for example, are inclusive of persons with disabilities. You don't put a flyer out to the general public and say we're promoting walking. No, we're promoting walking, we're promoting running, rowing, all types of physical activity, and if it's any graphics that come to me without that, I'm sending it back.

And we promote that message throughout communications and we're looking at, you know, working with our Office of Communications to get that brand guide changed and get that in our brand guide as well as purchasing stock pictures, when programs request pictures for commercials or PowerPoints, they have a readily-available stock of pictures for persons with disabilities. And that's just one example.

And what we are currently doing with this program is working with schools implementing adapted physical activity and various activity programs, the DPP curriculum and looking at activity that's before, during, and after school, and that's the evidence-based practice for that and with this funding opportunity with the Center for Disease Control, what we've been doing is working first in two schools to employ these practices and figure out lessons learned to employ these practices in school districts that we've been working with, with our 1305 as well as other partners and schools, and once we pin it down, we figure out lessons learned and how to implement it and move it forward.

We've been working under the cooperative agreement with CDC to look at different sites and looking at various prevention programs and this week we've been notified that we have another funding opportunity that's coming through the national association for chronic disease directors, grant 1705, and it's to increase access to diabetes prevention programs in rural communities, with a focal point on persons with disabilities being in an application as well, and that's another way to expand diabetes prevention program to vulnerable populations because people in rural areas are already at risk for poor health outcomes usually when it relates to chronic diseases and now we have additional funding via CDC and others and we're working with rural communities in five counties to employ more DPP programs inclusive also for persons with disabilities.

We're continuing to build relationships with non-traditional partners to also increase our reach, so when I say non-traditional partners, we're working with vocational rehabilitation, we're working at a state level.

This program had done it for a long time, but we haven't always worked with vocation rehabilitation for our state health improvement plan, for example, working with economic opportunity, working with boys and girls clubs of America and using those different partners to make sure we're getting the population we want, working with HUD, working with smaller grantees with other programs to ensure we're more inclusive and then we want to increase the number of health professionals and trainers who receive training on disability, cultural competency, as well as we're working at a state level to increase the number of professionals and people with trainings for health equity and that's including persons with disabilities too.

So, additionally, we're doing a lot in the way of grants right now. We're seeking funding, again, with NCHPAD funding and working with persons with disabilities and we're actively working on that application right now. With our 1305 grant in years past, we've had many grants to increase the number of referrals to diabetes sub management education and increase the number of referrals to the diabetes prevention program, as well as increase the number of diabetes prevention programs and increase the numbers of diabetes sub management education programs.

So once we were funded with the disability grant, what they went back and did for the grant applications is made sure when we put out those requests for many applications through a third-party contract, that they were considering scoring applications higher when those programs, in fact, identified persons with disabilities as a target population and that is, you know, an example of how we take an initiative from this program and work with other grants within this agency to ensure that that's something that they're doing, not just by chance, but on purpose.

And additionally, we're working to continue to seek funding so that we can expand on the programs here and we can learn from the lessons learned and kudos to the Disability and Health Program, because they, you know, did an abstract for APHA for 2017 and it was accepted and they're going to talk about how they're working to increase comprehensive school physical activity programs and especially for children with disabilities.

So, future implications for what we're trying to do here, is our state health improvement plan, so, again, earlier I spoke about our agency's strategic plan and that is very specific for the Department of Health.

However, I'm also working with the chairs on the health equity priority area work group for our state health improvement plan and they're working on a draft and they are close and what they're identifying is working on multiple state agencies, multiple groups, a lot of groups they've identified and health equity came out as an eight-priority area within the plan and within that, the steering committee, which is comprised of a lot of agency heads and a lot of groups, it's specifically wanted another priority area to work on, you know, health equity type things and the root causes and some of these things and they're specifically looking to target from a state vulnerable population such as persons with disabilities, so that is a huge win as a state health improvement plan, has a lot of reach, and is going to span from 2017 and launch late this year until 2021.

So, if we can get it at a state level to working to really create measures and objectives to touch populations such as persons with disabilities, we're really moving in the right

direction.

And what I can tell you is they are actually identifying activities to increase graduation rates amongst vulnerable groups and I'm on that team. We're talking about a lot of different things, counties that have different outcomes and doing different things and it's an ambitious plan, and it's happening and that will be published soon and the implementation plans have not been published out yet amongst that Health Equity Group but they're actively working to do that.

Additionally, policy language and grant opportunities. So we're partnering with another group, the Office of Health Equity and we're working with them to include language in their grant opportunities that will go out later this year to different communities to ensure that we put directly in the request for application for them to address some of the chronic disease conditions, specifically in vulnerable populations with disabilities.

So that's another huge win, that's money that's awarded from the state that we're intentionally putting in language that's inclusive of health equity concepts as well as persons with disabilities.

Within Chronic Disease Prevention, we work closely with our school health staff to make sure, of course, that the nurses are trained and that they're continually trained and doing surveys to ensure they're being inclusive on purpose and they're revising guides for school health staff to be inclusive. And we work closely with our schooling's health programs to make sure the comprehensive chronic disease plans are working and working with heart disease and diabetes and chronic disease. And we have an epilepsy services program which works very closely with the Disability and Health Program to ensure that we have succinct practices across the Bureau of Chronic Disease Preventions and we have a health services block grant which we tied directly back to 1305 and we have alignment because we increase funding for things, like increasing diabetes for various programs and we give out additional funding to all 67 counties and based on the database and needs, they can deploy the practices we're deploying under 1305 and disability and health at a county level, and that's another example.

And then we're just doing it in a systematic fashion and every time we create a program and do different things, that we ensure we include inclusive language and communication efforts, that we think about the direct spectrum of health, so looking at the root causes of some of these health inequities and ensuring that we're doing something very action oriented to make a change.

So, again, I want to thank you for your time and I'm open to answering any questions.

And as we think about these things, it's not just at the end of life that we want to think about health equity for persons with disabilities, we want to think about it this preconception all the way up to death and it's important we think about this context throughout the life span and that we do things beginning early in life to ensure that people have optimal health outcomes later in life.

So, I'll take questions at this time. Thank you.

[Pause].

>> CLAUDIA FRIEDEL: Shamarial, this is Claudia, thank you so much for your

presentation, it was wonderful to hear about all of the different initiatives and grants and funding streams that you guys draw from.

I wondered, are you guys still working with the Florida Coordinating Council for the Deaf and Hard of Hearing?

>> SHAMARIAL ROBERSON: Yes, they're not in the Center for Disease Control, they're in family services, and we work with them as well and any feedback we give, we can give it to them. But they're actually not in our shop anymore, but we do work with them.

>> CLAUDIA FRIEDEL: Okay, wonderful.

[Pause].

>> CLAUDIA FRIEDEL: Does anybody have any questions for Shamarial? We also can get some e-mails out to her if anybody thinks of anything after the fact.

[Pause].

>> CLAUDIA FRIEDEL: All right. Well, we have a quiet group today. If anybody thinks of any questions, feel free to e-mail me, I can pass e-mails to Shamarial or Bryan.

>> BRYAN RUSSELL: Yes.

>> CLAUDIA FRIEDEL: We want to thank Shamarial for her time, she's a very, very busy woman, and we're just so glad to hear from you and glad to hear the department is moving in a great direction under her leadership. So, thank you, thank you so much.

>> SHAMARIAL ROBERSON: Thank you, Claudia, for the wonderful work you're doing down at the University of Florida, you know, to deploy those activities, even outside of areas that we are working in here, like, the University of Florida has been a long-standing partner and were originators and had the disability and health grant before it came here and we appreciate your expertise and we appreciate the excellent work that you're doing to ensure inclusive practices and helping us complete our tasks under our grant from CDC. So thank you.

>> CLAUDIA FRIEDEL: Well, thank you. And, you know, we obviously couldn't do it without you and I think the move from the Department of Health was probably one of the best things that happened to this grant as far as on a reach and the amount of influence you guys have statewide, it's just been wonderful to see and watch the program expand and grow and we're just very happy to be here and glad that you guys are in the lead. So, it's good all around.

Thank you so much for your time.

And, again, if anybody thinks of any questions, we will be sending out CART notes and a video recording of this call, so thank you again for your time. And I guess we can let everybody go!

>> SHAMARIAL ROBERSON: All right. Thank you.

>> BRYAN RUSSELL: Thank you so much, Claudia.

>> CLAUDIA FRIEDEL: Thank you. Have a wonderful day.

[End of presentation].

Recommendations and findings for providing PWD with accessible services:

- Tailoring programs and health promotion initiatives for PWD to specific needs in the community, rather than a one-size-fits-all initiative.
- Given that education level is the number one predictor of health, ensuring that the education system is accessible to PWD and providing quality and culturally competent education to PWD, including health education.
- Addressing differences unrelated to disability in PWD, including but not limited to race/ethnicity and gender, when creating and implementing health promotion initiatives and in healthcare settings.