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HHS Public Access
Author manuscript
J Public Health Manag Pract. Author manuscript; available in PMC 2024 January 01.

Published in final edited form as:
J Public Health Manag Pract. 2023 ; 29(1): 82–92. doi:10.1097/PHH.0000000000001671.

Feasibility of Implementing Disability Inclusive Evidence-Based Health Promotion

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Abstract

People with disabilities face a number of barriers to accessing and participating in evidence-based health promotion programs offered within the community. To address these barriers, the program implementation process needs to integrate disability inclusion throughout planning and implementation. The National Center on Health, Physical Activity, and Disability's Inclusive Community Implementation Process (NiCIP) provides a framework for implementors to systematically integrate strategies into their health promotion programs that increase inclusion while maintaining the fidelity the program. The NiCIP is a community engaged process that brings key stakeholders together to guide the selection and implementation of data-driven solutions that promote inclusion in, and access to, health promotion programs. In this paper, we first provide an overview of the NiCIP. Then, we present a case study exploring one community's experience using the NiCIP to implement a disability inclusive nutrition program within their community.

Background:

One in four individuals has a disability, representing the largest minority population in the United States[1]. Recent estimates identify mobility disability as the most prevalent disability type among US adults (13.3%) followed by cognitive disability (12.1%), independent living disability (7.2%), hearing disability (6.1%), vision disability (5.2%), and self-care

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disability (3.9%)[2]. People with disabilities are more likely than those without disabilities to report poorer overall health[3] and have increased risk of secondary health conditions including diabetes, depression, and obesity[4–7]. Participation in health promoting evidence-based programs (EBPs) can improve health and mitigate secondary health conditions by encouraging healthy lifestyle behaviors (i.e., physical activity, healthy eating). While numerous health promoting EBPs have been developed, people with disabilities are typically excluded from research and program development, thereby making many of them inaccessible[8–10].

Recognizing the gap in programs associated with disability, the Centers for Disease Control and Prevention (CDC) and other federal agencies have funded health promotion programs targeting people with disabilities, such as *Living Well with a Disability*[11] and *Health Matters*[12]. While specialized programs are valuable for improving the health of people with disabilities, CDC also notes the value of including people with disabilities in all public health programs and activities[13]. Disability inclusive programs may not only expand the program's potential reach but may also be more sustainable as inclusion is incorporated into ongoing program implementation efforts.

To promote disability inclusion, the importance of contextual factors within the environment that impact access cannot be overlooked. Barriers to accessing and participating in healthy behaviors have been well documented and include environmental barriers that discourage or prevent participation of people with disabilities in health promotion programs and EBPs[14–17]. Healthy People 2020 recognizes this impact through an objective recommending reducing environmental barriers to accessing health and wellness programs for people with disabilities[18]. Access barriers can include the physical environment[19,20] (e.g., stairs, narrow doorways, lack of appropriate wayfinding), temporal barriers[20–22] (e.g., maintaining paths of travel, navigating inclement weather), programmatic barriers[23–25] (e.g., lack of adapted equipment, lack of staff knowledgeable in inclusion, not allowing sufficient time to process information, using complex or unclear language, lack of materials in alternative formats such as large print or Braille) and social barriers[22,23,26] (e.g., stigma and attitudes towards disability that create an unwelcoming environment, attitudes and effort of staff to provide adaptations or accommodations). These barriers can be found across health promoting locations (i.e., parks, fitness facilities, grocery stores, health care facilities[16,25,27,28]) and even in virtual environments when accessible technology principles are neglected[29]. Addressing access barriers is a critical step in understanding how to implement EBPs that are inclusive of all citizens, including people with disabilities.

Implementation research has become increasingly useful in establishing crucial steps in the implementation process[30] and can help identify contextual factors that affect program implementation[31]. A key lesson from implementation research is that implementers of EBPs must systematically adapt to unique contexts, such as organizational systems, social environments, available resources, community priorities and more[31]. Although disability inclusion should be considered throughout the implementation process, it is often overlooked requiring retrofitted inclusion and access solutions after the program is implemented[32].

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There is a pressing need to increase integration of people with disabilities into existing health promotion programs and services offered in the community. While tools and resources for inclusion in program content and delivery are becoming more available[9], research on systematic processes for promoting inclusive implementation are limited. Recent work by Eisenberg et al[32] evaluated an implementation model focused on implementation of inclusive policy, systems, and environmental changes (PSEs). This model showed promise in implementing broader inclusive community changes promoting healthy behaviors. However, there is a need to better understand processes for implementing disability inclusive EBPs. Moreover, understanding barriers and facilitators to integrating inclusion throughout the implementation process may help identify ways to support implementors in using inclusive processes.

To address the gap in inclusive implementation processes, the National Center on Health, Physical Activity, and Disability (NCHPAD) worked with an expert in knowledge translation to develop NCHPAD's inclusive Community Implementation Process (NiCIP) based on existing implementation models[33,34]. The NiCIP uses a systematic, community-engaged approach to implement strategies that address barriers to disability inclusion in community-based EBPs. In this paper, we first present an overview of the NiCIP and then we examine a community-based case study that used the NiCIP to implement an inclusive EBP.

Setting:

This case study took place in South Carolina (SC), where NCHPAD funded a CDC Disability and Health (D&H) state grantee[35] who demonstrated active collaborations with local disability-serving organizations. The team leads included the D&H program, a local center for independent living (CIL, Able SC), and the South Carolina Department of Health and Environmental Control (DHEC). The team focused efforts first on one locality in the state with the intention that the results of this work could be scaled up across the state. "It's Your Health … Take Charge!" (IYHTC) adult classes[36] were chosen for this project, as DHEC was already offering the classes prior to this funding opportunity. IYHTC is a federally sponsored SNAP-Ed (Supplemental Nutrition Assistance Program) program that consists of nutrition education based on US Department of Agriculture (USDA) MyPlate topics (e.g., Portion Distortion, Shopping on a Budget, and Increasing Physical Activity) and cooking demonstrations using recipes from a SNAP recipe book.

Methods:

Overview of The NiCIP

The NiCIP consists of 15 steps organized into 3 stages (table 1, supplemental figure 1). Stage 1 is the planning stage which lays the foundation for action. A group of diverse and representative community stakeholders forms an Inclusive Health Coalition (IHC) to actively lead the NiCIP work. The IHC collects and analyzes new or existing community data related to disability access and inclusion and then uses this data to identify inclusion gaps within the community. To address these gaps, inclusion strategies based on the Guidelines, Recommendations, Adaptations including Disability (GRAIDs)[9] are selected, prioritized, and shared with the larger community to obtain buy-in and feedback.

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In Stage 2, the IHC aligns the inclusion strategies with the local context (i.e., the community and the EBP implementing organization). Potential barriers and facilitators that could impact the sustained implementation of each inclusion strategy are identified. For example, for an inclusion strategy to provide disability inclusion training, the IHC should consider specific aspects of implementing the training, such as cost, content, local experts, mode of training (e.g., in-person or virtual), and time. The strategy and implementation considerations are pilot tested and evaluated. At the end of this stage, the IHC has a plan for implementing contextualized inclusion strategies and outlined evaluation measures, which together form an inclusion plan. The inclusion plan provides documentation of the process and outlines the systematic approach used to create the inclusive program. The inclusion plan should then continue to inform and guide efforts addressing additional inclusion gaps throughout the community.

In Stage 3, the final inclusion plan is implemented, and inclusion strategies are scaled up across the community. During implementation, the process is monitored, and the outcomes and impact are evaluated focusing on the impact for people with disabilities, systems change, and ensuring the inclusion strategies are in fact meeting the needs of the community. Evaluation and implementation data are incorporated into the inclusion plan, which is a living document continuously updated, to capture impact and evolution of the strategies over time.

NiCIP training and technical assistance

The team leads attended an initial 2-day, in-person training focused on Stage 1 and were introduced to resources to operationalize the NiCIP (i.e., implementation manual, assessment tools, organizing templates). A second 2-day training was completed after one year focusing on Stages 2 and 3. Trainings included didactic lectures, small group discussions, and interactive activities where team leads practiced facilitating activities/ discussions for their IHC. Technical assistance was provided through monthly phone calls and as needed with NCHPAD staff.

Data Collection

To evaluate the NiCIP, data were collected throughout the project period. The use of and progress through the NiCIP was documented by team leads and NCHPAD staff. Process evaluation measures were collected through standardized monthly and annual reports, which included process barriers and facilitators encountered. Additional details were shared on monthly phone calls with NCHPAD staff to better understand submitted reports. After Stage 1 and at the end of the funding period, semi-structured interviews with team leads provided additional insight into their experience with the NiCIP.

Results:

The SC team advanced through Stages 1 and 2 of the NiCIP between April 2018 – December 2019. The results of each stage and step are described below, including important barriers and facilitators experienced as the SC team worked through each step.

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Stage 1: The Plan

Team leads began by convening a diverse IHC (step 1) representing people with disabilities, healthcare, public health, disability organizations, community organizations not disability focused, university, and local government. Of the 38 potential IHC members originally invited to participate, 30 agreed to help if called upon but 12 of those who agreed made up the core group of the IHC. Overall, IHC member recruitment was facilitated by existing relationships with the team leads and a general interest in disability inclusion. Some health and wellness organizations without an established relationship were recruited, but ultimately did not attend any IHC meetings. The makeup of the IHC evolved over time, adapting to emerging needs of the project; some members became involved later in the process when involvement was most beneficial. The IHC had difficulty identifying accessible, free meeting space, so virtual meetings were used on occasion. To facilitate IHC work, the team leads were intentional about ensuring stakeholder involvement in decision-making tasks and empowering members of the IHC to take on leadership roles.

The IHC defined the scope of assessments based on levels of the socio-ecological model[37] (interpersonal, organizational, and community), determined who to collect data from and identified locations to conduct built environment assessments (step 2). Reaching consensus regarding assessments to conduct was difficult due to differing opinions on project scope and data priorities among IHC members. Additionally, some facilities did not respond to requests to conduct assessments. Despite these barriers, the IHC conducted assessments at six locations that impact health behaviors (i.e., grocery stores, recreation facilities). A full list of assessments is shown in table 2. The IHC then analyzed the data to identify inclusion problems.

The IHC then discussed potential inclusion strategies to address the inclusion problems. Using a checklist to assess acceptability and feasibility, the IHC prioritized the following inclusion strategies (step 3): (1) identifying built environment improvements to the buildings where classes were held (environmental change); (2) training program coaches on working with people with disabilities (program change); and (3) developing and disseminating inclusive recruitment materials (program change). Through the prioritization process, one of the challenges in selecting inclusion strategies was deciding on the appropriate scope of strategies. Sometimes the focus was too narrow, centering on strategies specific to one location. Alternatively, sometimes it was difficult to focus the strategies to fit within the scope of the project, such as addressing transportation barriers.

For the gap analysis, the IHC compared how the program was currently delivered to how the inclusive program should be delivered based on the assessment results, proposed inclusion strategies, and existing policies and procedures (step 4). Though team leads noted this step was more difficult to understand, the IHC was able to identify gaps such as lack of existing policies to select ADA compliant sites and limited capacity to create alternative format materials. The IHC then developed a call to action (step 5) through an online newsletter which shared the planned inclusive program and was distributed through the networks of IHC members. IHC members designed the newsletter to improve receptivity with community stakeholders. Feedback from the team leads suggested that the call to action

may be more impactful later in the process, after the strategies had undergone pilot testing and were ready for implementation.

Stage 2: Align the plan to the local context

In Stage 2, movement through the steps was less linear and defined. Several steps, namely steps 6–8, occurred simultaneously and were not necessarily distinct, which complicated the documentation of the individual steps in this stage.

To align the solutions and implementation methods to the local context, the IHC considered how to maximize the resources of the group. The team leads leveraged an existing relationship with a facility to host the class. This facility had experience hosting health promotion classes, but this was a new opportunity to introduce inclusive practices in classes. For instructor training, an IHC member had an existing outline for disability inclusion training that could be fine-tuned for program instructors. The IHC recognized that training would be an easy inclusion strategy to complete and could build the momentum for completing some of the more complex strategies. The other two inclusion strategies ensured participants could physically access the classes and marketing materials had inclusive imagery and formatting. The final inclusion strategies and the agreed upon implementation methods for each solution can be found in table 3.

To measure success of the inclusion strategies and outcomes from the program, the IHC developed an evaluation plan that outlined indicators, methods, and analysis (step 9) which also evolved during pilot testing. The evaluation activities included a post-program participant survey, in-person meetings with the instructors, and in-class observation of the class by an inclusion expert, all of which were completed during and after the pilot test program.

Pilot tests of the inclusion strategies and the program itself were completed to examine how the strategies worked in context and identify any unforeseen issues with implementation (step 10). Ten IYHTC instructors completed a 1-hour online training on inclusive practices by national and local experts. The inclusive IYHTC pilot class was held at a wellness center chosen due to its location, number of people served, classroom accessibility, and experience in providing community health promotion programs. The inclusive IYHTC pilot class included 30 participants (people with disabilities and caregivers) who attended one 90-minute class per week for 6 weeks. An interview with the IYHTC instructor to gather feedback on the pilot class indicated that: (1) the size of the class was larger than anticipated and was primarily individuals with intellectual disability; (2) it would have been helpful to know the number of participants and what types of accommodations would be needed before the start of the series; (3) ‘on-the-spot’ adaptations were necessary but difficult; (4) the evaluation survey for participants was long and often completed by the support person instead of the participant; and (5) observation and feedback by someone knowledgeable in inclusion would be helpful to ensure adaptations were effective. Based on the request for observation, an IHC member attended the class and noted additional adaptations and recommendations for creating an inclusive environment and further tailor the program to the needs of the participants. These program adaptations became an additional inclusion strategy within the inclusion plan.

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The findings from the pilot evaluation were incorporated into a final inclusion plan (step 11). The inclusion plan included a description of developing the IHC, steps taken to understand and develop the inclusion strategies, involvement of stakeholders, the evaluation plan, and the pilot test results. South Carolina's inclusion plan was disseminated to stakeholders involved in the process.

Overall feedback on the NiCIP

Table 4 summarizes barriers and facilitators reported throughout the NiCIP. The mid-point and final interviews with the team leads suggested that overall, the NiCIP could be improved in some areas. First, some of the language in the NiCIP materials felt 'academic' and made the process seem overwhelming. One suggestion was to incorporate real-world examples into the training materials to reduce this effect. Second, the in-person training required team leads to receive and process significant amounts of information quickly and the timing of the training may not have aligned with the community's progress through the NiCIP. Third, the process was often non-linear, and some steps occurred simultaneously making it challenging to report their progress within the outlined NiCIP steps.

The team leads also identified several facilitators. The strong partnership between the D&H state team and the disability serving organization helped the overall progression through the NiCIP and provided an initial capacity for inclusion work. Involving DHEC and program instructors throughout the process helped ensure that strategies were feasible and acceptable to the implementing organization. Additionally, technical assistance from NCHPAD was valuable for overcoming barriers and progressing through the NiCIP.

Discussion:

To our knowledge, this is the first study that used a comprehensive and systematic knowledge to action process for developing, implementing, and evaluating the inclusion of people with disabilities into an evidence-based health promotion program. The purpose of this study was to better understand the usability of NCHPAD's inclusive Community Implementation Process (NiCIP) by examining its use in one community in South Carolina. Using the NiCIP, a local community was able to successfully engage stakeholders to work through the formalized implementation steps and identify data-driven strategies and implementation methods to infuse inclusion into a nutrition education program (IYHTC). The community pilot tested selected inclusion strategies and developed an inclusion plan for implementation.

Inclusion strategies chosen by the SC team primarily addressed programmatic barriers including staff training, inclusive recruitment materials, curriculum adaptations, and site assessment for accessibility. In a study of 10 communities funded to implement inclusive PSEs, Eisenberg and colleagues similarly found that communities tended to select strategies that focused on staff training and assessing accessibility [32]. Site assessments highlight inclusion problems and ensure classes are held in locations that people with disabilities can access. Promoting staff training can help program instructors prepare to make accommodations and create a welcoming environment for participants with disabilities. Overall, these types of strategies may be considered easier to implement because they may

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not require a significant investment in time or financial resources but are likely to have an impact on promoting inclusion.

Relationships were an important facilitator across the NiCIP's stages and steps. Much of the success for this project was attributed to the strong partnership between the D&H state program and the local disability organization. A history of collaboration with community partners and relevant stakeholders can position community teams to achieve greater success implementing inclusive strategies[38]. Similarly, in recruiting members for the IHC, partners with existing relationships with the team leads were more likely to join. The prominent role of strong relationships aligns with previous research that identified partnerships as a key element for PSE implementation capacity within the community[32]. Though building these partnerships takes time, it appears to contribute to success of implementing inclusive programming.

Although the EBP had gone through a formal adaptation process, observation during the pilot test revealed that additional adaptations would further tailor the program curriculum and delivery to meet the needs of participants who may have had difficulty following and processing the information. This added another inclusion strategy in which the IHC compiled further guidance and resources to support instructors. Program adaptations are recommended to contextualize materials, increase engagement, and reach specific audiences[39,40]. In this study, examples of additional adaptations included supporting resources (i.e., visual recipes, assistive devices for cooking) and strategies for teaching the material (i.e., focus on one activity component at a time, allow more time for processing information). These adaptations, which were incorporated into the final sessions of the pilot class series, are examples of responsive adaptations (adaptations that are in response to needs that arise as the program is implemented). Responsive adaptations have been used in previous research involving people with disabilities after planned adaptations had already been incorporated into the program[41]. In the current study, the adaptations were in response to the participant's needs, but also to assist the instructor in providing an inclusive environment.

Implementation is an iterative process that should be continuously evaluated and revised based on the needs of the community, instructors, and any other influential factor[42]. The ability to implement a chosen strategy can also be influenced by larger community processes[32]. In this project, the grocery store that the IHC initially partnered with for disability training closed permanently. Partnering with a new grocery store was not feasible within the timeframe of this project, so this inclusion strategy could not be completed as originally intended. Maintaining flexibility and reacting to changing local contexts has been identified as an important component for a coalition's capacity to implement PSE changes[38]. Though this is difficult to plan for, developing alternative strategies, timelines, and implementation methods could help in preparing for unexpected changes in the community.

Some aspects of the NiCIP were more difficult to complete as intended. Feedback from the SC team leads suggested that documenting their progress within each NiCIP step was confusing, especially as steps may have occurred non-linearly or even simultaneously. Some

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steps, like discussing implementation methods (step 6), may naturally be discussed while selecting the inclusion strategies (step 3). As Harrison et al[34] note, parts of adaptation and implementation may be cyclical and not follow a linear outline. Creating flexible and customizable documentation processes and templates may facilitate clearer data collection about implementation. This feedback also supports the development of resources, trainings, and templates that are easier for the ‘end-user’ (team leads) to use. Additionally, providing supplemental “refresher” resources and materials may help in retaining information about the NiCIP as the community works through the process at their own pace. Consistent with previous work in community-based PSE change[43], technical assistance facilitated movement through the NiCIP. However, in the current study, peer-to-peer support was limited in terms of offering additional assistance to team leads[43]. Future iterations of the NiCIP should encourage more opportunities for communication and technical assistance from other communities striving to implement inclusion strategies.

Limitations:

This study had a few limitations. First, the results are limited to one community’s experience and gathered largely through self-report, which could have been impacted by social desirability[44]. Second, we did not assess the impact of the inclusion strategies on participant health outcomes due to the limited timeframe. Third, we were not able to examine sustainability of the strategies within the organization since this would have required a long-term follow-up outside the scope of the current project. Future research should assess the NiCIP in full, including longitudinal data related to the sustainability of each solution and health outcomes for people with disabilities.

Next steps:

Using the feedback from this pilot, the NiCIP has been refined to include fewer steps (12) in 4 stages. The language used throughout the training process and resources was simplified and includes more examples and activities to facilitate translation to the IHC and community members. Information on the revised NiCIP is available on the NCHPAD website (www.nchpad.org).

Conclusion:

This study provided valuable information on a formalized implementation process used to promote inclusion in an evidence-based health promotion program for adults with disabilities. The NiCIP is a community-led process aimed at selecting and implementing data-driven inclusion strategies that improve access and inclusion in health promotion programming. This case study illustrated how using the NiCIP to guide the planning and implementation process led to the selection and pilot testing of inclusion strategies. These results suggest that the NiCIP is a feasible, useful framework for implementing disability inclusive EBPs within communities and addressing barriers to participation for people with disabilities.

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Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgements:

Thank you to the National Center on Health, Physical Activity and Disability, to Dr. Ian Graham for sharing his expertise in knowledge translation, and to all the organizations and community representatives that were part of this project.

Funding Sources:

This project was supported by the Cooperative Agreement Number 5NU27DD001157, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services. The postdoctoral research associate was also supported by the National Institute on Disability, Independent Living, and Rehabilitation Research, Administration for Community Living, (grant #90ARCP0004), Advanced Training in Translational and Community Engaged Scholarship to Improve Community Living and Participation of People with Disabilities, University of Illinois Chicago. The contents of this article do not necessarily represent the policy of the U.S. federal government.

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Table 1:

Overview of steps in the NiCIP

Stage	Step	Important Actions in the step	The why behind the step
Stage 1: Plan	1. Convene Inclusive Health Coalition (IHC)	Gather diverse community representatives and stakeholders to promote inclusion in physical activity, nutrition, and weight management programs or services	Formalizing a group of individuals that represents the community and champions the work can ease individual workload, increase buy in, and bring a variety of resources to the table
	2. Conduct Assessments	Conduct inclusion assessments and collect existing data related to the inclusion and accessibility of programs, services, and policies	Clarifying the inclusion failures through various forms of data establishes data to support inclusion solutions and measure success
	3. Select Inclusion Strategies	Review and select inclusion strategies that will address the inclusion failures Ensure consensus among all coalition members Allow time for external input to selected strategies	Assessing acceptability, feasibility and applicability of potential inclusion strategies helps to identify which ones will be the best fit
	4. Perform Gap Analysis	Explore how services are currently offered compared to how inclusive services should be offered to see what is missing	Confirming what needs to change and how it needs to be changed to become a more inclusive setting or system
	5. Develop Call to Action: Community Health Inclusion	Clarify the motivation, purpose, and scope of the call to action Engage the broader community in the inclusion work	Building community support for the inclusion initiative can help increase buy in and momentum for the changes
Stage 2: Align	6. Assess Barriers/Facilitators to Inclusion Strategies	Identify barriers and supports related to the inclusion strategies, target users, and the environment	Planning for potential challenges and supporting factors can help identify resources and implementation strategies for the inclusion solutions
	7. Customize Inclusion Strategies to local context, practices, & systems	Make any adaptations or changes needed to fit the inclusion strategies to the local context	Making minor changes to inclusion strategies, such as wording or specification, can help to ensure the strategies fit into the local environment
	8. Select and Tailor Implementation Approaches	Use data and feedback from stakeholders to choose and prioritize the methods used for implementing the inclusion strategies	Taking time to consider the best implementation approaches for the context considers resources, capacity, and skills of the implementors, as well as feasibility
	9. Finalize Evaluation	Define indicators for outcomes, impact, and process evaluations and plan processes for data collection and analysis	Planning a complete evaluation allows the IHC to report what worked and what did not work in their context
	10. Pilot Test Implementation Approaches	Test implementation of inclusion strategies on a small scale	Ensuring the implementation approaches work on a small scale
	11. Finalize Inclusion Plan	Use external and internal feedback to finalize the Inclusion Plan and establish processes for plan sustainability	Updating and finalizing the plan based on what has been learned throughout the process helps to incorporate all lessons learned and plan for sustainability of inclusion strategies on a large scale.
Stage 3: Implement and Evaluate	12. Implement Inclusion Plan	Begin executing Inclusion Plan implementation	Identify who should be involved in the scale up of the inclusion plan throughout the community and begin the process of implementing the plan
	13. Monitor Inclusion Plan Implementation Process	Assess process of implementation and knowledge use	Continually assessing the implementation process can inform what is working and what needs to be addressed as implementation continues

Stage	Step	Important Actions in the step	The why behind the step
	14. Evaluate Impact on People with Disabilities, Practices, Communities, and Systems	Formally complete data collection and analysis to assess impact	Evaluating all sectors including people with disabilities, practices, systems, and community wide can demonstrate widespread outcomes and impact of inclusion strategies
	15. Nurture Change and Sustain Inclusion Plan Use	Ensure sustainability and methods for updating the Inclusion plan	Understanding what impacts sustainability (routinization, responsive adaptations, facilitation, and building capacity) helps to plan for sustainability.

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Table 2:

Summary of Disability Access and Inclusion Assessments Conducted within the Community

SEM Level	Assessment	What was Assessed	Sites or Individuals who Completed Assessments
Community and organizational	■ Community Health Inclusion Index (CHII) [45] ■ The Accessibility Instruments Measuring Fitness and Recreation Environments (AIMFREE) [46] ■ ADA accessibility grocery store assessment[47] ■ Organizational Readiness for Change Survey ■ Inclusive Health Coalition Assessment	potential program sites, facilities that support healthy living (i.e., parks and grocery stores), and community systems (i.e., transportation) and coalition participation and effectiveness.	N=13
Interpersonal	Readiness for inclusion assessment	IYHTC instructors	N=6
Individual	Survey for individuals with disabilities (barriers experienced accessing community-based health promotion programs, facilities to support healthy living, and willingness to participate in inclusive programming)	Members of the local disability community	N= 37

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Table 3:

Summary of Inclusion Solutions Selected by South Carolina's Inclusive Health Coalition

Data	Level	Problem	Strategy	Implementation method
Instructor readiness survey: 50% of the instructors are not at all aware of the needs of persons with a mental disability None of the instructors have been trained in inclusive techniques	Int	Those teaching the IYHTC inclusive classes are not trained in inclusive instructional techniques and are not aware of how to meet the needs of persons with a disability	Provide training on disability etiquette and providing accommodations to SNAP-Ed instructors	1. Create video trainings to be provided to fitness facility staff (including staff instructors) 2. In person training of 10 instructors by NCHPAD staff members
Community Health Inclusion Index (CHII)	Org	Classes may be held at locations that are not accessible to people with a disability	Utilize facilities that comply with ADA standards	1. Provide accessibility assessment form to determine accessibility of class location 2. Provide accessibility report to facility with recommendations to improve accessibility and inclusion
Review of promotional materials by IHC members	Org	Promotional materials not inclusive of people with disability	Creating inclusive promotional materials available in alternative formats	Inclusive promotional materials created, and the team ensured they were screen reader accessible
Observation of pilot class and discussion with instructor indicated a need for additional guidance in teaching curriculum^	Int	The IHC felt additional adaptations were needed for the program curriculum	The IHC developed a listing of additional adaptations and teaching strategies	IHC members will observe a class and provide additional adaptations and teaching strategies to SNAP-Ed Instructors
Community Survey: Most people with disabilities said that in the past 30 days, they got food for their household at grocery stores (95%), restaurants (65%), and big box stores (59%)	Com	Healthy habits learned in the classes should be supported through promoting accessibility where participants get their food	Training the local large grocery store staff on disability etiquette and providing accommodations	***

^This strategy was added during the pilot testing process

***Strategy could not be completed due to the closing of the partnering grocery store

Int = interpersonal; Org = organizational, Com = community

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Table 4:

Summary of Reported Facilitators and Barriers to Implementing the NiCIP

Facilitators	Barriers
Existing community interest in disability inclusion	IHC recruitment due to large time commitment and a small pool of individuals to represent different groups
Active working partnerships with disability-serving organizations	IHC facilitation and logistics
Connections and relationships within the community (disability, facilities, partners)	Recruitment of individuals with disability to share insight either on IHC or assessments
Participation of people with disabilities on the coalition	Splitting up documentation responsibility among partners
Integrating IHC within an existing local group	Prioritizing inclusion solutions to stay within the scope of the project
Sharing the workload by allowing partners and IHC members to take active roles	The NiCIP and process documentation was complex
Experience recruiting people with disabilities at public meetings/events	The language used in NiCIP did not match language already used in practice leading to miscommunication
Having the right people involved in the process	Recruiting both people with and without disabilities to participate in the program
Technical assistance to overcome barriers	