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July 19, 2021

DHDS Data to Action Webinar

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>> ANNA COSTALAS: Hello. And welcome to Disability and Health Data System, using data to take action. We would like to thank you all for joining us today. Before we begin I would like to address a few logistical details. You can submit questions at any point in the chat box or the Q&A box in your Zoom console.

If there are time for questions, we will read them out loud to accommodate our attendees and we'll go through the submitted -- when we go through the submitted questions. We have CART captioning available and we also have ASL sign language interpreter available. You can change the size of the interpreter by hitting the three little dots on the window to enlarge it. And you can also do the same thing with the captions.

This meeting is being recorded and will be available a few days after this event. And we will also be having a short evaluation survey at the close of the Webinar. We invite you to provide feedback on the Webinar and provide suggestions for future topics. I will now pass the mic over to Dr. Adriane Griffen who will start off the Webinar. Adriane?

Adriane, your mic is muted.

>> ADRIANE GRIFFEN: Wow, that is such a 2020 rookie mistake. (laughter)

Thanks, Anna. Appreciate it.

I was saying hello and welcome to all of you. For those of you who don't know me, I'm Dr. Adriane Griffen. I'm the senior director of public health and leadership at AUCD. And it's my pleasure to welcome you to today's Webinar. Today's Webinar is going to take place in four parts. We're going to hear from three dynamic speakers, and then the last part is you. You will get to ask questions and answers. We are preserving a good chunk of time at the end. So as you have questions throughout the Webinar, please feel free to make note of those. And if you put a note in the chat, we will be prepared for the Q&A at the end of today's session.

I first want to just review who we're going to hear from and the order of the speakers. We're going to hear first from Dr. Qi Cheng from CDC and I will introduce her in just a moment. Then we will hear from David Ellsworth with some examples of how the data has been used in Ohio, and then we'll hear from Bryan Russell with examples of how this data has been used in Florida.

So without further ado, I'm going to introduce our first speaker. Dr. Qi Cheng serves at a health scientist at the Disability Science and Program Team for the Disability and Health Promotion Branch at the national center of birth defects and developmental disabilities at the Centers for Disease Control and Prevention. In this role, she devotes herself to surveillance, research, and prevention work to better understand disabilities in adults and to promote health.



Dr. Cheng is also part of the Disabilities Health and Data System leading efforts of annual data analysis. Dr. Cheng received her doctorate in medical science from the Yokohama University School of Medicine in Yokohama, Japan. Without further ado, I will pass the virtual stage over to you, Dr. Cheng. Thank you.

And you are also on mute. We are making the 2020 --

>> QI CHENG: Yes.

>> ADRIANE GRIFFEN: Very famously.

>> QI CHENG: Sorry.

>> ADRIANE GRIFFEN: No worries. Thank you so much.

>> QI CHENG: Yes. Thank you. Thank you for the introduction, and thank you for the invitation.

Next slide, please.

So today I'm going to talk about disability and the health data system, DHDS. DHDS is a Web portal to provide vital information needed to better understand the health needs of adults with disabilities at the national-wide levels. The co-risk 95% of individuals, this is online, interactive, easy-to-use data tool. It can be used to buy epidemiologists, disability advocates, researchers, policymakers, and the public health professionals in general, even for the people who are interested in the topic of disabilities. Disability data can be used -- sorry. DHDS's data can be used in many ways. Here is some examples. First is to monitor the health of people with disability in the population level.

The second is to support the health program language such as state intervention programs.

The third one is to support researchers on their research questions.

Next slide, please.

Defining disability, I would like to talk a little bit more how to define the people having a disability because it's important to what we use to interpret the DHDS data.

There are models for defining a disability. The model is here. The first is the international classification of functioning disability in the health, ICF. It's published by the World Health Organization, the WHO, in 2001. The "disability" refers to the interaction between the individuals who have a health condition, for example, cerebral palsy, Down syndrome, depression, and the personal and environmental factors, for example, negative attitudes, inaccessible transportation, and



public health buildings, and limited social supports. The ICF provides a standardized language for define people having a disability.

Other models include functional model which is often used in measuring a disability in medical models. They are used in the medical field and by clinicians. The last one is the social models.

Next slide, please

The functional disability measurement in the Behavioral Risk Factor Surveillance System, BRFSS. BRFSS utilizes a functional disability model available in disability. Six disability questions adapted from the American Community Survey-disability question set. Six disability questions contains the disability of vision, hearing, mobility, cognition, self-care, and independent living.

Next slide, please.

BRFSS is a self-reported, state-based, landline and cell phone survey. The survey is designed to collect information on health-related risk behaviors, chronic health conditions, and use of preventive services among noninstitutionalized adults age 18 years old and older who reside in the U.S. and the selected U.S. territories. The first survey was administered by the states in cooperation with the Centers for Disease Control and Prevention.

A landline telephone and a cell phone respondents were both used in the BRFSS survey. Since landline telephones are often shared among a person living within a residence, household sampling is used in the landline sample. Household sampling requires interviewers to collect information on the number of adults living within the residence and then selected randomly from all eligible adults.

Cellular telephone respondents are weighted as a single adult household.

Six disability questions are asked in core Section 8, which is called demographics in the BRFSS.

BRFSS reports the median survey response rate for all jurisdictions. It's usually around the 50% each year. In 2019, median survey response rate was 49.4%, and they range from the 37.3 to 17.31%.

Next slide, please.

Our DHDS estimates are solely based on the BRFSS data.

Next slide, please.

Yes, this slide shows the six BRFSS disability question set used to define the disability status and the types in the DHDS.



For example, the first question asked hearing disability. Are you deaf, or do you have serious difficulty hearing? We categorized the disability types as variable. If respondents provided an affirmative response to the question, then they were considered reported having that type of disability. It's coded as yes. For this case, it's having hearing disabilities.

In terms of disability status, it's characterized as a variable as well if the respondent provided an informative response to one or more of six disability types, meaning that people having any disability is coded as yes.

Next slide, please.

This slide shows the demographics factors in the DHDS. Eight demographic factors are listed here including age, sex, race/ethnicity, veteran status, income, education level, marital status, and employment status.

They are all coded as categorical variables. The estimates from DHDS for these demographic factors were calculated by disability status and the disability types and by subgroup of each factors.

Next slide, please.

This slide shows health indicators used in estimates of DHDS. Each is grouped into six categories including health risks and behaviors; prevention and screenings; barriers and costs of health care; general health conditions; chronic conditions, and mental and emotional health. In every category there is several health indicators. There is not a master list here, but I do provide supplemental slides for the indicators in detail in each category.

And the next slide, please.

And to move on to the next topic about DHDS data uses and actions. The DHDS data can be used in many ways. Here are at least some questions that DHDS can answer. For example: What is the percentage of adults with a disability in my state? How does this population vary by age, sex, and race/ethnicity? How does my state compare with other states and the nation? How does the percentage of depression, diabetes, obesity, or smoking vary among people with select disabilities?

So you can -- okay. Sorry. You can use these questions and you can generate your own research question to find the answer from DHDS.

Next slide, please.

Now I want to show how to view the DHDS data. So DHDS can be viewed in multiple ways. First -- sorry. First, we can view the DHDS data by exploring by indicators.



Would you please open the link of this slide? Thank you.

Yeah. In this DHDS Web portal, in the middle you can see "Explore by indicator." Just click the "Explore by Indicator" above.

Yes. Yes. Thank you.

When you click the "Explore by Indicator," you can see that page of the estimates of indicators.

Can you go back to the slide? Thank you.

There's three ways you can see the information. You can explore the indicators, view the graph, view the table. Here is a map. So you can click each state. You can see the whole data in that state.

Next slide, please.

This is so the DHDS data can be explored by location, as I mentioned, as well explored by the indicator. It's in the same place in the DHDS Web portal. You can click on the "explore by location" so you can see select the states you'd like to look at from DHDS. And you can view the estimates through the mapping, table, and the graph as well.

Next slide, please.

This is another way to view the DHDS data, comparison report. When you click on that comparison report, you can see from 2016 to 2019 all the data in one page and all the indicators. When you click on one indicator, you can see that indicator in detail.

Next slide, please.

The last way for us to view the DHDS data is customized data. You can go to the DHDS data portal to see the data in full data set of the DHDS, and you can customize the data what you would like to use to generate your own graph or the tables.

Next slide, please.

Right now I would like to give you a demonstration for all examples of how to use the DHDS data using our 2019 data.

So, first, I asked: What was the estimate of disability status in the United States? and I pull out the DHDS 2019 data. And you can see here the result is among the 418,268 U.S. adults age 18 years and older, 127 138 reports having a disability. The weighted age of having prevalence of a disability was 26.7%. Please note here in this year the state of New Jersey didn't have collected data. So in the DHDS data, New Jersey is not in the Web portal.

Next slide, please.



This slide shows the estimates of disability types in the United States through the DHDS estimates, 2019. As you can see in the table, age of adjusted prevalence of disability types are pulled from DHDS Web portal directly. The highest prevalence found among six disability types was mobility disability, which is 12.8% followed by cognitive disability, 12%.

The lowest prevalence seen was self-care disability which is 3.8%.

Next slide, please.

This is a 2019 DHDS snapshot. I would like to give this as an example for how to use DHDS data to answer your own question. The research has shown that adults with cognitive disability report experiencing more poor mental health compared to those without. The BRFSS has asked the question of a depressive disorder. The question is: Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression. Response was coded into two categories in DHDS, yes or no.

The first research question asked was prevalence for depression for the U.S. adult. I pull out the data for these estimates by explore indicators. So as you can see here, age-adjusted prevalence of depression among U.S. adults age 18 years or older with any disability was three times higher compared to those without any disability. That is 41.8% versus 12.1%.

There is a disparity in the prevalence of depression across the jurisdictions. The prevalence in eight jurisdictions is greater than 47%. And the prevalence in ten jurisdictions was less than 41.1%.

Among the disparity in the prevalence could be visualized by the U.S. map, which is on the left side of this slide. The states highlighted with the dark blue colors are those that have a higher prevalence of depression.

Next slide, please.

Then we ask the question: Is there a disparity on the prevalence of depression among the type of disabilities? I pulled the data by exploring by indicator, and the prevalence is of depression is by disability type, including vision, hearing, cognition, and mobility disabilities.

The prevalence of depression among the people with cognitive disability was higher compared to those without cognitive disability, but other three types of disability did not.

Then we ask what the prevalence of cognitive disability across the states. The U.S. map on the right side shows the prevalence of depression among adults with a cognitive disability. It's visualized as a way to see across the states for these estimates. Also, when you click each state,



the numbers will show in that state.

Next slide, please.

This slide shows the 2019 snapshot for the continued depression and disability. We ask the question: What's the trends for the prevalence of depression among the people with a cognitive disability? The DHDS data is available from 2016 to 2019. Using a comparison report, the trends in the prevalence of depression of adults with cognitive disabilities show in this graph. You can have all the jurisdiction data in the one graph. But for demonstration purpose, I only list four states in the graph. And the yellow color represents a national level of the prevalence for the depression. The trend data can tell us the changes in the prevalence of depression for adults with a cognitive disability. This can help to answer your research question. You can also look at this estimate to compare your state with the other states.

Next slide, please.

Here I showed another example for the DHDS uses. We use CDC's estimates for disabilities. State health profile is a fact that provides an overview of a disability and health in that state. Here shows an example. The example is Arkansas.

In 2019, state health profile, we focused on four health indicators: Have obesity, smoke, have diabetes, and have heart disease. Next slide, please.

Here is some additional consideration when you use the DHDS data or estimates. The first thing is that BRFSS data are cross-sectional and self-reported which may be subject to recall bias and some limitation from BRFSS survey also applied to the DHDS data interpretation.

The next consideration for us when we use the DHDS data, disability estimates vary based on the survey method, including sample design and the weighting methods, survey source, for example, ACS and NHIS or BRFSS. The methodology differs from one to another. So that may cause some variation for the disability estimates.

And in the BRFSS one, it's more likely it differs from the BRFSS sampling strategy and the response rates.

Next slide, please.

I would like to take the opportunity to thank you, all the states and the territories of the United States working with the administration of the BRFSS survey each year. It's a great effort, so thank you so much. And also I would like to list some of my colleagues at the CDC for the continued support on the BRFSS disability questions. Last one, I would like to thank you from our team and



the branch college for this presentation. Thank you so much. That's all that I have to present today. Thanks.

>> ADRIANE GRIFFEN: Thank you so much, Dr. Cheng. Really appreciate you joining us today and hearing the 2019 updates to the Disability Health and Data System. There's some fantastic functionality there. So we really appreciate you sharing that with us today.

Next, we're going to shift gears a bit to talk through how states can use this Disability Health and Data System. And we're going to go through two different examples. The first one will be from Ohio, and I will class the virtual podium over to David Ellsworth who is with the Ohio Disability Health Program. So take it away, David.

>> DAVID ELLSWORTH: Hi, everyone. I'm David Ellsworth, I'm with the Ohio Disability and Health Program. I'm at The Ohio State University Nisonger Center, but I actually live at the Ohio Department of Health and my job is to make sure that across all of our program areas that we are taking into consideration the needs of people with disabilities. So the DHDS has been very helpful in that regard.

Next slide, please.

So I love the DHDS. I use it probably almost weekly. And I really have used this to effect change within our own health department and make the invisible visible and show people data. And I'll say that I'm not a stats guy. I am very grateful that CDC has put this wonderful tool together because it makes me sound much smarter than I actually am. And it's incredibly helpful in my job in public health. Next slide, please.

So why does this matter? Good public health data is needed to raise awareness of problems and to highlight alarming statistics, such as nearly one in four people in Ohio report having a disability. It's needed to support quality planning, to implement population-based interventions, and to improve community health. It allows you to target where resources are needed most, and it allows you to advocate for additional resources that might be needed in your area to address health needs or health concerns or just better serve the population.

Next slide, please.

Good data helps make the invisible visible, including disability indicators needed to document the health needs for people with disabilities. It is needed to advocate for the policies and programs to address those needs, and it allows you to evaluate the impact of policies and programs on people with disabilities. You don't know what you don't know. A lot of people in public health still don't recognize that disability is a demographic, and that concept is new to a lot of people. There's the



misconception that disability is always to be avoided, and we can see this in our language that we use in public health.

We still talk about disability-adjusted life years or DALYs in public health, kind of inferring that the years that you have absent of disabilities are the only ones that matter. And that's not true. And the DHDS has helped me kind of show that to a lot of people.

Next slide, please.

So, for example, suppose you're a health policy specialist working with local public health offices. You would like them to consider people with disabilities in their planning efforts. But these local officials aren't aware of people with disabilities in their region and assume that it's not their responsibility. And I get this a lot. I hear: Oh, I don't see people with disabilities or I don't see that many people with disabilities. Or: Is this the board of DD's responsibility? And it really isn't, and that's what the DHDS kind of helps us to do.

So consider this argument: I work on the tobacco prevention program in Ohio and I think we should include people with disabilities in our public health efforts. First of all, not a bad argument. But see how this stacks up to the next one.

I work on the Tobacco Prevention Program in Ohio where an estimated one in four people experience some form of disability. Furthermore, 32% of people with disabilities in Ohio are current smokers, nearly double the rate without people with disabilities. People with disabilities actually attempt to quit smoking just as frequently as people without disabilities. Therefore, our tobacco cessation efforts need to include of people with disabilities at minimum and should target this population with additional resources to reduce the tobacco burden.

Of those two arguments, the second one is better. You are more likely to effect change using that argument. And all of that data came from the DHDS.

Next slide, please.

So that's how you effect change. You need data. You need to share relevant and actionable data with the people who make decisions, manage budgets, and make policies. Showing this data can be used to improve population health. And you really need to forecast your entire discussion around relevant data to tell that story.

Next slide, please.

So this is where I got the data. Seeing this data is believing it. So this is 2019 data in Ohio. It is a bar graph, and it shows the disability prevalence in Ohio across the disability -- the six disability types that were already mentioned.



Next slide, please.

I really like this data because it's intuitive. It's easy to use. It's easy to show. So this is the first part in my argument where you can see -- well, technically second. So, first of all, I showed the disability prevalence on the last slide. This is where you can see that people with disabilities smoke at higher rates compared to people without disabilities. In Ohio, it's 32% and that's shown in the bar graph to the left here.

So blue is people with disabilities. The red bars are people without. And you can see that the people with disabilities are a little bit higher.

And just with a click of a button, you can switch between the charts that I have on the left or a table. If that's the view that's going to help you more, that is just a click away. So it's very easy to use.

Next slide, please.

And this is kind of the last part of my argument. So I also said that people with disabilities quit smoking at the same rates as people without disabilities. And that is shown on this slide in this bar graph, so you can see that people with disabilities do, in fact, report to attempt to quit smoking at just about the same rate. And that's important because it avoids some of the misconceptions that perhaps people with disabilities aren't trying to quit. So you can really frame your entire argument around the data that's all right here with just a couple button clicks. I don't have to carve out an afternoon to get this data or to analyze this data. It's all right there.

Next slide, please.

So here's how we've used this data in Ohio. We've used it to educate our LEND trainees. Our LEND trainees are students that are trained up to kind of experience and be experts in disabilities of their field. They love this presentation. If it sounds like I might have done this before, I have. I teach them how to use the DHDS each year, each cohort, and they really like this because it is so easy to use. And it looks at health outcomes among people with disabilities, not just disability prevalence. So it's incredibly helpful.

We've used this to quickly update our health fact sheets in Ohio. If we have a statistic that's getting a little old or a little stale, it's really easy to look at the DHDS and update that accordingly. So we try to keep our materials current.

In Ohio, we do a state-level review of all the grants that go out our door. And that's to make sure that we have the potential to reduce health inequities. I use the DHDS data to show our health program areas where disparities might exist. If we're talking about smoking, I have that data on



hand. If we're talking about falls-prevention program, that data is also in the DHDS. I come prepared with all this data so I know what I'm talking about, and I can make the case for advocating for people with disabilities where there are health disparities.

And then, lastly, we use this to inform our state health improvement plan. That is the roadmap for health in Ohio. It really informs a lot of the public health work that we do in our state. And having this data always gets incorporated into that process. And it's wonderful that it uses the BRFSS data. And it's all here on the DHDS Web page.

Next slide.

And that was it for me. Thank you!.

>> ADRIANE GRIFFEN: Thank you so much, David. We really appreciate that. I really appreciate how you have framed the data to take specific actions with different groups in Ohio. So thank you so much for sharing.

Next up we will hear from Bryan Russell from the Department of Health in Florida. So take it away, Bryan.

>> BRYAN RUSSELL: Hi, and thank you so much, Adriane, for this opportunity to speak.

So, yeah, so my name is Bryan Russell. I manage the disability and health program here at the Florida Department of Health. Our main office is located in Tallahassee, which is kind of in the big bend in northwest Florida area. I like to remind people, Florida is much more than Orlando and Miami. We do have other areas of the state, and Tallahassee is one of them. But we do go to Orlando quite often.

Next slide, please.

So, yeah, I'm just going to -- I want to just -- my presentation is going to focus mainly on kind of what we do, how we've worked with the DHDS or the Disability Health and Data System, how we've worked with that, how we use the data, what our data looks like, and how we continue to use the data throughout the state to effect change for people with disabilities.

Go to the next slide, please.

These are just some acronyms you may hear me use, BRFSS. IDD is intellectual developmental disabilities, or I may say DHP which is our Disability and Health Program.

Next slide, please.

And next slide.

Thank you. So, yes, so this right here, this is just kind of a quick overview of our counties



by -- of our disability-by-county prevalence. Here in Florida, like I mentioned earlier, a lot of people think -- outside of the state think Florida is mainly beaches and big cities like Orlando, Miami, Jacksonville, Tampa. The fact is here in Florida, if you're not in a large city like those I just mentioned, you're going to use -- you're probably going to live in a very rural area. Florida has a lot of rural country areas and as you can tell by this chart, we have at least ten of our counties in Florida are in rural and underserved areas and they all lead the state in disability prevalence. So I like to remind decision makers here in the state, whether it's policymakers or county health officials, especially in these counties, to not take your disability rates for granted just because you're in a rural county. You definitely have a higher disability prevalence.

And by having a higher disability prevalence and being in a rural county, that's definitely going to show a lack of need, a lack of access to services and programs.

Next slide, please.

And so here in Florida, this comes straight from the DHDS. And this is what we use. This is how we use our DHDS data, highlighting that people with cognitive disabilities in Florida, around 13% of the population. People with mobility disability are around 13% of the population.

Next slide, please.

And so one area that we really focus on here within our Disability and Health Program, my program is held within our Bureau of Chronic Disease Prevention. And as a result we use the DHDS to really focus on those chronic disease risk factors and chronic diseases. So we look at things like heart disease, cholesterol, obesity, blood pressure, lack of physical activity, diabetes, pre-diabetes. A lot of these -- a lot of the precursors and risk factors to getting a chronic disease. And we always want to make sure we highlight the gap and I want to highlight -- look at the difference for someone with a disability who has high blood pressure at 41% as opposed to somebody without a disability and less likely to have to deal with high blood pressure or heart disease.

Next slide, please.

You know, and we also highlight the other chronic diseases and chronic conditions. You know, depression here in Florida is -- that stat right there really stuck out to me as just the discrepancy between people with disabilities and without disabilities. So we're using especially this -- especially this stat -- this data piece from the DHDS to direct some of our work with our mental health prevention and mental health service colleagues.

So with our Disability and Health Program, a lot of what we do is using the DHDS to help drive our decision making, to help drive our plans. And all of our plans really surround are centered on



improving life of people with disabilities, adapting and working within the structures we have or creating something completely new. But we use data from the DHDS to do that.

Next slide, please.

And so these are kind of the ways we've worked within our program to reach those with disabilities. Some of the ways we've used the DHDS especially is through our policy -- through some of our policy actions, working on increasing -- improving access to care for people with disabilities through our training and especially on emergency preparedness and recovery efforts. We've been able to use the DHDS working with county emergency managers and county health department directors to highlight the need for them to be more inclusive of people with disabilities, especially as it relates to COVID prevention and COVID response.

Go ahead to the next slide, please.

And so through using the DHDS, we've also been able to identify barriers to care. So currently a lot of the BRFSS data shows that annually people with disabilities have a higher prevalence, that they're at a much higher risk of developing chronic diseases. They face higher risk factors than people without disabilities. So we use a lot of the DHDS data in working with our county health departments, with the department program managers, with their directors and administrators, highlighting the need to have better access to care, highlighting a need to do things like improve their access to prevention or self-management programs; creating new and inclusive policies; making sure you use your local disability prevalence data in all of your communication products.

We're working right now with our legal team here at the main office. We want to make sure that we can draft some policies around using data from the DHDS at the local level. Requiring our county health department directors and teams to include disability as a key demographic indicator on all of their data products, whether it's on their websites or any product that -- any communication product that they use.

We want disability -- make sure the disability is recognized as a key demographic indicator. At least here at the state office we use it, and we use disability data from the DHDS to drive our programs, to drive our other chronic disease prevention programs, including tobacco. It's taken a while, but we've gotten tobacco identifying and addressing disability in their materials.

With our other chronic disease prevention programs, it's been a lot more effective with our program within this chronic disease prevention program.

And as it relates to other programs across the state and at the county level, that's the one thing we're doing, we want to make sure that they have -- that county health department staff understand



how to use the DHDS and are trained in understanding how to use the DHDS and BRFSS data for people with disabilities.

So we've really been able to use it. It's been a great tool for us, and we look forward to continue using it.

Next slide, please.

And that's me. That's my info. Thanks again for this opportunity to speak. I appreciate it.

>> ADRIANE GRIFFEN: Thank you so much, Bryan.

So next we will invite all of our panelists back to have a little bit of a Q&A with the audience. If you are able to submit a question, if you are curious, please feel free to go ahead and share either in the Q&A module or in the chat box. And I had just a couple questions to kick us off here.

This first one is for you, David. So for our panelists, if you would like to join us, you can all turn your cameras back on. I think we will probably have a question or two for all of you in the next ten minutes that we have left here.

So, David, the question for you was talking through the process of how you contrasted using the data in a good, tight communication versus having it be more weighed down and longer. If you can talk through the process of how you were able to see the difference and those contrasts and then use those contrasts to your advantage to make some changes happen with your partners.

>> DAVID ELLSWORTH: Yes. Thanks. That's an excellent question.

So just working along my partners and colleagues at the Ohio Department of Health, I need to know a little bit about their areas. I very much respect them as the expert in whatever it is that they do, but I'm here to kind of advocate for the disability community.

So what I try to do is anticipate what questions they might have and what data I need. If we're looking at, like, the H.I.V. program, for instance, the first thing that I would probably do is see if I can dig up any data on that. Falls prevention, similarly. And at least on the DHDS, I know that that data is there. So I'll kind of come prepared with that data. And I've found that kind of using bits and pieces of the data that's on the DHDS to tell a very short but compelling story often does the trick to kind of motivate policy change or motivate some public health change. So if you can show that, again, going back to kind of the smoking argument, that people with disabilities smoke at higher rates but they're also trying to quit, right? That suggests that they're motivated to quit but perhaps our efforts to engage them aren't working, and that's something that we can suggest.

So I've always tried to use the data that's there to tell a story to try to drive some change. And some people just want the punch line, like, they just want the data and you can just show them



people with disabilities smoke more and that's it, that's all that's needed. But a lot of times in our public health programs, it's a lot of resources and money and you want to make sure that that is all directed appropriately to where it's needed most. So I think the DHDS is really helpful in that regard, and I hope that answers some of that question.

>> ADRIANE GRIFFEN: Sure does. Thank you so much. Appreciate that. Yeah.

The next question that I had for our discussion time here is for you, Bryan. You mentioned some of the barriers. One in particular being around materials access. That kind of reminded me of some of the work that we've done through our Prepared for All initiative around really setting a goal of having same-time access to everyone in the community. So I was curious how you have addressed the materials access in terms of taking this data and making sure that the points were accessible in your communications and in your materials.

>> BRYAN RUSSELL: Right, yeah, absolutely. And we've noticed that a lot of the stuff that was going out was not accessible. So, you know, sometimes it's showing -- showing some of the county-level data to some -- let's say, Hillsborough County where Tampa is. If the Hillsborough County emergency manager is wanting to know more info within their county, we are able to drill down and get them that information.

And so by sharing that information on the county level, it's able to help them understand and better reach their actual population. Same with any other area within the state.

And as far as the communication materials, yeah, definitely. One of the big challenges statewide has been things like ASL interpreters at all of our press conferences and press briefings. And so, you know, trying to figure out the best ways to get that but also recently one of the benefits was recently one of our colleagues in Tampa at Saint Petersburg college created -- and I want to show it to you -- an emergency prepared response guide.

>> ADRIANE GRIFFEN: Great.

>> BRYAN RUSSELL: For people with disabilities. It's really great. It's a flip chart. We all like flip charts. So it's a flip chart of an all-hazards emergency management tool. And so that's one way that we're going to create a disability list and disability plan now, now that I have about five boxes in my office. Trying to figure out a way to get rid of them effectively. So things like that.

We've been able to use some data to justify even this is why we need this toolkit. One in three have a disability in Florida. This is why we need this toolkit. One in four Floridians have a disability. That's why this county needs this or this many people with disabilities use special needs shelters in Miami-Dade County, that kind of thing. We have been able to use the DHDS for that,



absolutely.

>> ADRIANE GRIFFEN: That's great. Thanks, Bryan. Appreciate that.

So our next question is actually for all of you, but we'll start with you, Dr. Cheng, just to give you a moment to also expand on your remarks, too.

So it's a two-part question. The first part is: Do you have a specific example of using or sharing DHDS data or summaries that have resulted in a specific change? Or have you been able to make a specific impact beyond increasing knowledge, which this person also writes is a huge success and an important first step. So Dr. Cheng, your thoughts on that. I will let you go first. You are on mute.

All right. There you go.

>> QI CHENG: Yeah. I think the first point, I think DHDS is consistently improving. So we try to look at the whole picture of health indicator for people with disabilities. There is a lot of different indicators, by event year provided by BRFSS. But we try to improve more, have more indicator pictures in the future, if possible.

In terms of the example of the question, how to use -- yeah, can you just repeat your second point? Sorry.

>> ADRIANE GRIFFEN: Sure. The other part was do you have any other specific impact examples beyond increasing knowledge, any other parts to this?

>> QI CHENG: Okay. So in terms of impact, I think just as recently as Ohio and Florida shows that they often use DHDS data and it's our pleasure the more people who use them. And I didn't remember exact numbers, but we do report -- gather reports from states increasing using DHDS, dramatically increasing that.

And I think that's important for the impact on the DHDS.

>> ADRIANE GRIFFEN: Great. Thank you so much.

Any other thoughts from either -- from you David? We'll go to you, first. Thoughts on this question? Any other examples?

>> QI CHENG: Yeah. Actually, so I have a question to Bryan Russell. I'm very interested in your county-level table, the chart. I would just like to learn about more detail of the data sources for the county level.

>> BRYAN RUSSELL: Yeah. So the county-level data, we're able to pull every two years. I wish we could pull every year, but my data people say we can't do that. My background is



communication and public health. And so math -- me and math never really got along. So I let our data people handle that.

But, yeah, so fortunately -- like I said, the data either comes every other year from BRFSS or from the ACS or the Disability Compendium that something releases every year. Either Washington or Oregon or Montana -- I'm sorry, it's New Hampshire. Sorry.

Sorry, Kim, if you're out there listening.

>> ADRIANE GRIFFEN: So we are at time. We are at time. I'm getting the chime here. So this is Adriane. I'm sorry I need to draw this to a close. This has been a really great discussion. And I would invite those of you who perhaps had other questions and didn't get a chance to jump in there, please do follow up with us. This Webinar will be archived on the AUCD Webinar library and the slides will be there, too, with all of the presenter contact details so please do follow up.

I want to thank our presenters. Thank you so much for joining from the CDC and then perspectives from Ohio and Florida. This is really tremendous. Thank you all so much. This is just great timing, seeking current data for your outreach next week. Thank you so much.

>> BRYAN RUSSELL: Thank you. Appreciate it.

