Health disparities among Utah adults with disabilities

A deeper dive into health

Utah Department of
Health & Human
Services

Contents

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Executive summary

In 2022, 1 in every 4 Utah adults (26.4%) had a disability. Despite its high occurrence, significant gaps and barriers continue to affect the health and well-being of people with disabilities. This report highlights the health factors and disparities experienced by people with disabilities in Utah.

People with disabilities experience significant disparities in their health status, health outcomes, and social circumstances. People with disabilities are more likely to engage in harmful health behaviors such as cigarette smoking and vaping and less likely to use preventive healthcare services such as cancer screenings. Additionally, people with disabilities are more likely to experience barriers to accessing healthcare such as being less likely to have health insurance and more likely to experience discrimination in healthcare settings and transportation barriers getting to and from appointments.

In some cases, these disparities are greater among adults with mobility limitations and cognitive disabilities. These differences illustrate the diversity of disability and the importance to further investigate, understand, and address the needs of all people with disabilities.

Accessibility and inclusion are 2 ways to decrease barriers experienced by people with disabilities. The Guidelines, Recommendations, Adaptations, Including Disability (GRAIDs) framework can guide organizations in these principles. The framework includes 5 inclusion domains: Built Environment, Services, Instruction, Equipment and Technology, and Policy.

All sectors and organizations should work to increase the accessibility and inclusion of their programs, services, policies, and communities by implementing the GRAIDs framework. Organizations should strive for long-term, policy, systems, and environmental changes to ultimately support the health and well-being of people with disabilities.

Key findings:

Adults with disabilities are:

Nearly 5x as likely to have a stroke

Nearly 3x as likely to have depression

Nearly 3x as likely to have heart disease

Nearly 3x as likely to not receive healthcare because of the cost

Nearly 2.5x as likely to smoke

than adults without disabilities.

Introduction

What are health disparities?

Health disparities are preventable differences in health caused by economic, socio-cultural, environment, and geographic disadvantage.[1] Health disparities need to be eliminated for all people to achieve their highest level of health.[2]

One in every 4 adults in Utah and the United States has a disability.[3,4] Disability is common, and yet, the disparities and needs of this community are often unrecognized. People with disabilities use preventive services, like cancer screenings and dental check-ups, less often than people without disabilities, leading to increased adverse and costly health outcomes.[5]
People with disabilities are more likely than people without disabilities to experience more upstream risk factors, such as lower education, lower income, food insecurity. Many of these differences are avoidable, societally based, and not solely due to the nature of disability itself.[5]

Disabilities and the people who experience disabilities are extremely diverse. A person's disabilities should be viewed separate from their health. While there are some health conditions associated with disability that may result in poor health and additional healthcare needs, this is not always the case.[5] In fact, people with and without disabilities have similar needs. The poorer health status of people with disabilities is in part a result of organizations, policymakers, healthcare systems, and others who have yet to fully acknowledge and respond to the needs of people with disabilities.[6] This has created barriers to accessing healthcare, receiving competent care, and receiving accommodations within healthcare systems. As these needs continue to be overlooked, gaps in disparities will continue to grow.[6]

All people, with and without disabilities, need opportunities to participate in meaningful activities and contribute to their communities.[7] Communities, organizations, and public health agencies need to build inclusive programs and environments. Documenting and acknowledging disparities experienced by people with disabilities is an important first step to respond to needs and advance health for everyone.

Why this needs assessment?

1. To identify disparities among Utah adults who have intellectual and other developmental disabilities (IDD) and adults who have mobility limitations (ML) related to:

- Preventive healthcare, such as getting recommended cancer screenings, primary care check-ups, vaccinations, dental and vision check-ups
- Healthy lifestyle behaviors, such as exercise and eating healthy foods
- Information and resource gaps, such as accessible healthcare providers, programs, policies, and services
- Engagement barriers with preventive healthcare services and health promotion programs

2. To identify resources, tools, or action steps to respond to the disparities, gaps, and needs.

This report will primarily focus on documenting the existing disparities and gaps experienced by adults with disabilities living in Utah. Future reports and resources will provide supplemental information as we continue to collect more information to address the identified gaps.

Strategy

Existing data sources from surveys and claims data were used to identify gaps related to health, health behaviors, and access to recommended care (i.e., preventive exams) in people with disabilities. These data sources included:

- The Behavioral Risk Factor Surveillance System (BRFSS) which collects data over the phone on health-related behaviors from the non-institutionalized adult population in Utah.[8]
- National Core Indicators (NCI) which collects data on adults with IDD who receive at least 1 paid service (in addition to case management) from the state.[9,10]
- All Payer Claims Database (APCD) which contains data collected from medical, pharmacy, and dental claims gathered from health insurance carriers, Medicaid, and other third party sources in Utah.[11] APCD data captures data on the majority of insured individuals.

BRFSS data is the primary data source used in this report as it provides representative data about the Utah population. Using these data allows comparison between people with disabilities and people without disabilities. BRFSS uses 6 standard questions to identify people with disabilities. A response of "Yes" to 1 or more questions is considered a disability (Figure 1).

Figure 1. The 6 standard questions used to assess disability status in BRFSS and general type of disability

- Are you blind or do you have serious difficulty seeing, even when wearing glasses? (Vision)
- Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (Cognition)
- Do you have serious difficulty walking or climbing stairs? (Mobility)
- Do you have difficulty dressing or bathing? (Self-care)
- Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as vising a doctor's office or shopping? (Independent living)
- Are you deaf or do you have serious difficulty hearing? (Hearing)

There are some limitations to the 6 questions used in the BRFSS and other national surveys. They may capture people who do not actually have a disability and they may miss people who do have a disability. The questions also make it difficult to analyze data by specific disability type as definitions do not align with or match the survey questions.

For example, defining IDD includes aspects of self-care, language, learning and intellectual functioning, mobility, self-direction, independent living, economic self-sufficiency, adaptive behaviors, and social skills.[12] Because the 6 questions are too broad, estimates cannot be produced specifically for IDD.

Because population-level data on adults with IDD is not currently available, cognitive disabilities, as defined in the BRFSS, are used as a proxy measure in this report.

Similarly, data points are provided for mobility disabilities and are referred to as mobility limitations interchangeably throughout this report. Highlighting cognitive disabilities and mobility limitations separately sheds light on these unique populations and their specific needs.

To supplement data on adults with IDD, the NCI are also included as Appendix C. Although NCI data does not provide population-level data, the data are specific to adults with IDD receiving services in Utah and support the overall goals of this assessment to document needs and barriers within this community. Because NCI is specific to adults with IDD receiving services, there is no comparison group (such as adults without an IDD).

Data on gaps in information, resources, and barriers to engagement with preventive healthcare services and health promotion were collected through:

- BRFSS questions focused on discrimination in healthcare settings
- Local health department surveys on on-site assessments
- Existing reports in Utah
- National literature on barriers for people with disabilities

Interpreting the data

Unless otherwise noted, all data refer to percent of Utah adults. These percentages are often broken down by adults with disabilities, adults without disabilities, and by other characteristics such as ethnicity, gender, age, and functional disability type.

Data tables are also provided in addition to some figures. The data tables summarize select indicators broken down by disability status. Tables include indicator estimates and the 95% confidence interval. Confidence intervals (abbreviated CI in the reported data tables) can help determine how accurate the estimate is, with narrower or smaller intervals indicating a more precise estimate. Confidence intervals can also help determine statistical significance. The reference or comparison group for adults with disabilities is adults without disabilities for each table and figure. The reference groups for the other categories are not shown, however significant differences are noted.

For example, in Table 1, the estimate for fair or poor health among adults with any disability is 34.6%. The lower boundary of the confidence interval is 31.9% and the upper boundary of the confidence interval is 37.4%. We can say that our point estimate of poor health among Utah adults with disabilities is 34.6%, and we have a good degree of confidence that if we were to survey all adults in the state, we would find that actual percentage to be somewhere between 31.9% and 37.4%.

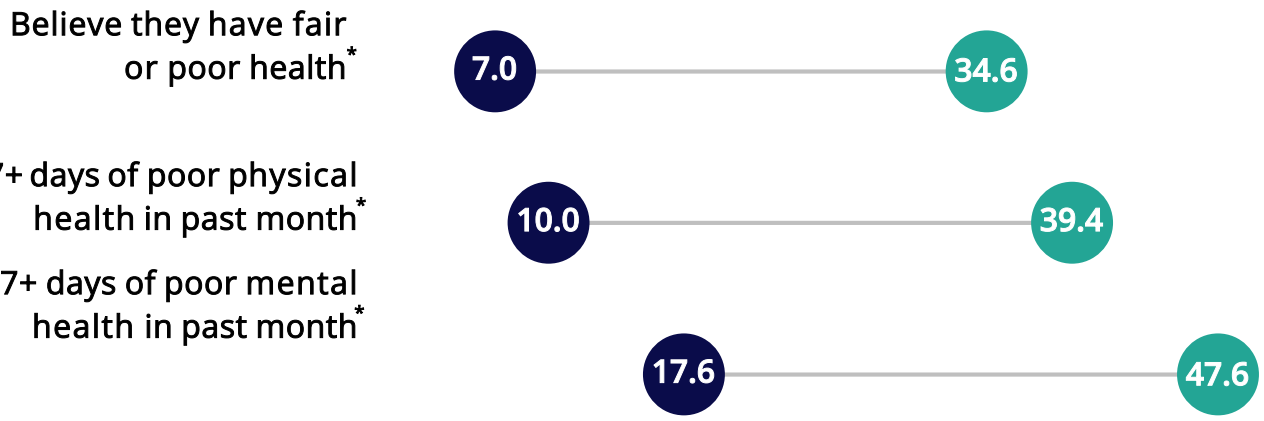
Additionally, when we compare this estimate to adults without disabilities, we can see that 34.6% percent is greater than 7.0%. To determine if these results are statistically significant, or in other words that you feel confident the difference is real and not due to chance, we can compare estimates and confidence intervals. Looking at the same indicator from Table 1, the estimate of fair or poor health among adults without a disability in Utah is 7.0% and the 95% confidence interval is 6.3% to 7.8%. Because the estimate for adults with disabilities (34.6%) does not fall within the confidence interval for adults without disabilities (6.3% to 7.8%), and because the confidence intervals for both groups do not overlap, we can confidently say that these differences or disparities are different, or in this case significantly different.

Disparities in overall health status

Utah adults with disabilities consider their health to be worse than adults without disabilities. One-third of people with disabilities (34.6%) rate their overall health as fair or poor. This is nearly 5 times higher than the amount of people without disabilities (7.0%; Figure 2).

When thinking about the past 30 days, 39.4% of people with disabilities report having 7 or more days of poor physical health compared to 10.0% of people without disabilities. When considering their mental health in the past 30 days, 47.6% of people with disabilities reported experiencing 7 or more days of poor mental health compared to 17.6% of people without disabilities.

Figure 2. The age-adjusted percent of **people with disabilities** who report poor physical or mental health is significantly higher than the percent reported by **people without disabilities**



*Statistically significant (p<0.5)
Source: 2022 BRFSS

Table 1. Overall health status measures by disability type (age-adjusted)

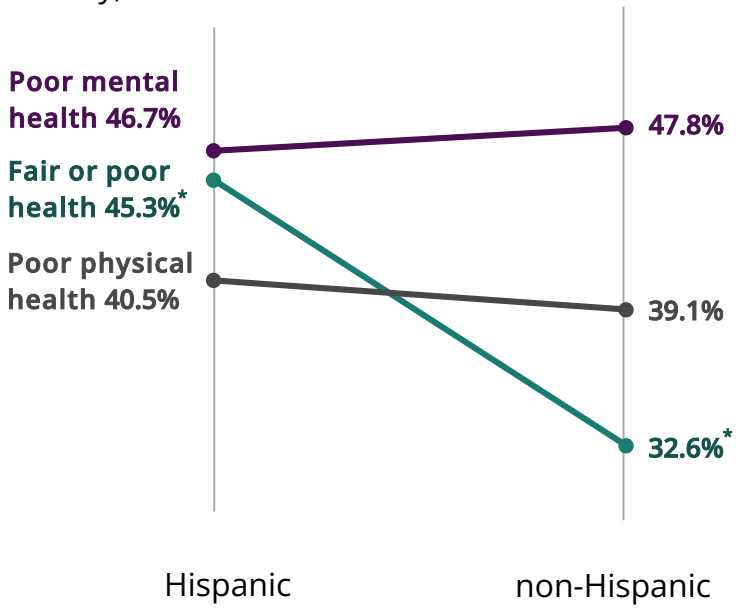
	Believe health is fair or poor[1]		7+ days of poor physical health[1]		7+ days of poor mental health[1]	
	%	95% CI	%	95% CI	%	95% CI
Adults with any disability	34.6*	[31.9, 37.4]	39.4*	[36.6, 42.3]	47.6*	[44.8, 50.4]
Mobility disability	52.2*	[46.1, 58.2]	61.1*	[54.7, 67.2]	50.7*	[45.5, 56.0]
Cognitive disability	39.0*	[35.2, 42.9]	42.7*	[38.8 ,46.7]	60.5*	[56.7, 64.3]
Adults without a disability	7.0	[6.3, 7.8]	10.0	[9.2, 10.9]	17.6	[16.5, 18.9]

*Statistically significant compared to the reference group (p<0.05).
[1]2022 BRFSS data

Disparities in health status by ethnicity

Among adults with disabilities, people who are Hispanic are significantly more likely to report fair or poor overall health compared to non-Hispanic adults (45.3% vs 32.6%; Figure 3). The percentages of non-Hispanic and Hispanic adults with disabilities who report poor mental and physical health within the past 30 days are similar.

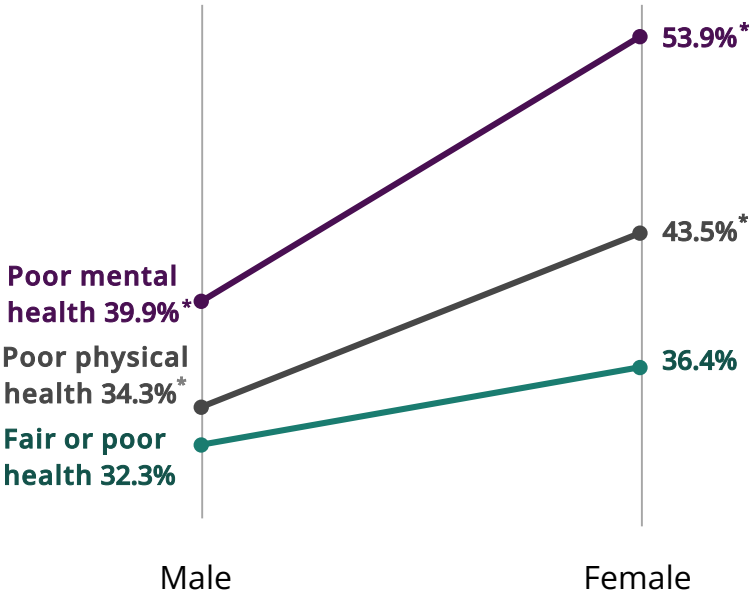
Figure 3. Age-adjusted percent of people with disabilities and reported health status, by ethnicity, 2022



*Statistically significant (p<0.5)

Disparities in health status by sex

Figure 4. Age-adjusted percent of people with disabilities and reported health status, by sex, 2022



*Statistically significant (p<0.5)

Adult females with disabilities report poorer overall health, physical health, and mental health compared to adult males with disabilities (Figure 4). More than half of females with a disability (53.9%) report experiencing 7 or more days of poor mental health within the past 30 days.

Disparities in health behaviors

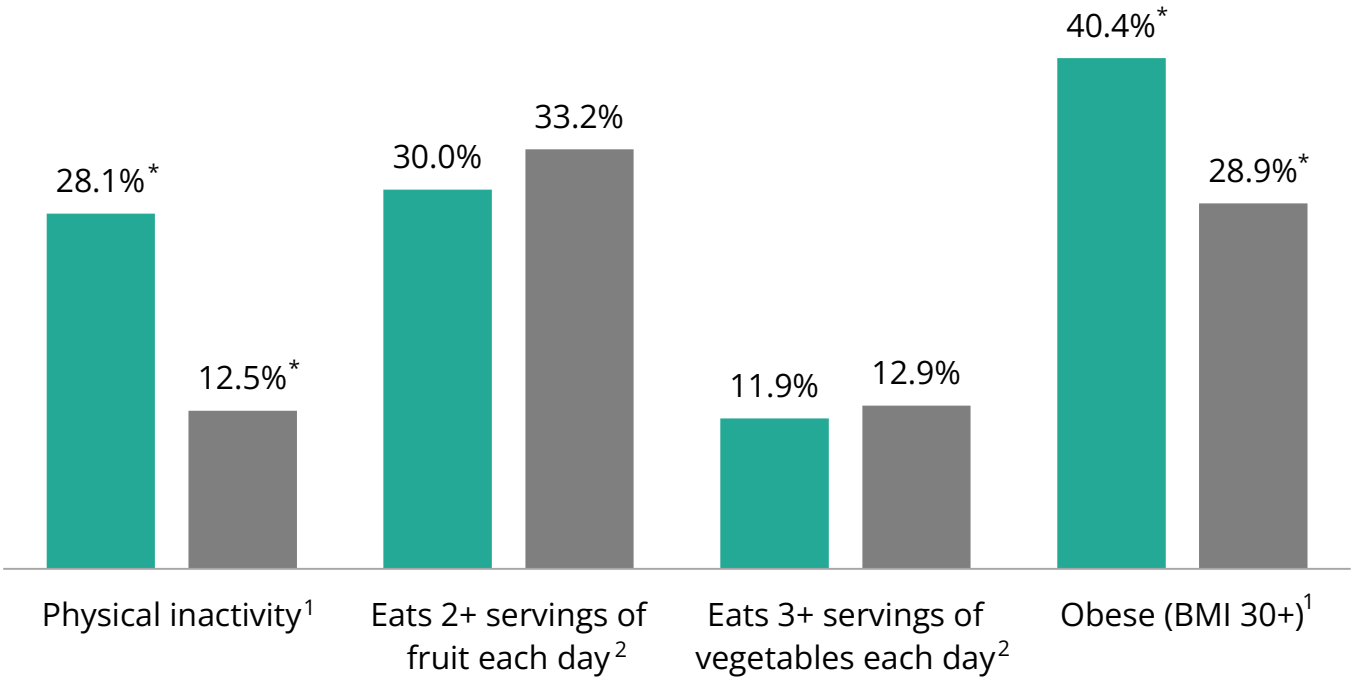
Health behaviors can directly affect health outcomes. Healthy behaviors can lower the risk for certain conditions while unhealthy behaviors can increase the risk of conditions such as heart disease, diabetes, and cancer. Utah adults with disabilities are more likely to report engaging in behaviors that are harmful to their health. Disability itself does not always cause poor health. Environmental conditions often impact the circumstances of people with disabilities, which in turn impacts health.

Physical activity and nutrition

People with disabilities are less likely to be physically active than people without disabilities (Figure 5). People with disabilities also experience obesity at a higher rate than adults without a disability (40.4% vs 28.9%). All Utah adults have a low level of eating the recommended daily servings of fruits and vegetables.

People with a mobility limitation may face additional barriers to participate in healthy behaviors. For example, 50.3% of people with a mobility limitation experience obesity and 36.8% are physically inactive.

Figure 5. **People with disabilities** are less likely to to be physically active and more likely to be obese than **people without disabilities** (age-adjusted)



*Statistically significant (p<0.5)
[1]2022 BRFSS data
[2]2021 BRFSS data

Table 2. Health behaviors by disability type (age-adjusted)

	Physical inactivity[1]		Met daily fruit intake[2]		Met vegetable intake[2]		Obesity[1]	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Adults with any disability	28.1*	[25.6, 30.7]	30.0	[24.9, 35.7]	11.9	[10.2, 13.9]	40.4*	[37.6, 43.3]
Mobility disability	36.8*	[31.6, 42.3]	27.0	[17.8, 38.8]	11.6	[8.3, 16.0]	50.3*	[43.7, 56.8]
Cognitive disability	27.6*	[24.0, 31.4]	30.9	[24.7, 37.9]	10.2	[8.2, 12.7]	37.5*	[33.6, 41.6]
Adults without a disability	12.5	[11.6, 13.6]	33.2	[30.2, 36.3]	12.9	[12.0, 13.9]	28.9	[27.5, 30.3]

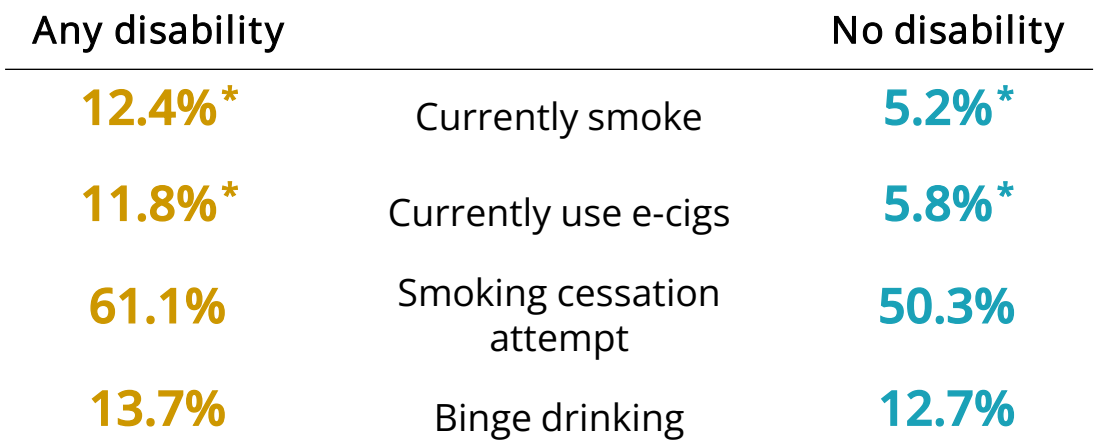
*Statistically significant compared to the reference group ($p<0.05$).
[1]2022 BRFSS data
[2]2021 BRFSS data

Smoking and binge drinking

Adults with disabilities are more than twice as likely to currently smoke cigarettes and twice as likely to currently use an e-cigarette than adults without disabilities (Figure 6). People with disabilities are also more likely to have tried to quit smoking within the last 12 months. Additional information may provide insight into successful, long-term cessation efforts and potential barriers to quit smoking.

Adults with a mobility limitation are more likely to currently use e-cigarettes than adults without a mobility limitation (15.4%; Table 3). Among adults with a cognitive disability, 13.5% currently smoke, 13.5% use an e-cigarette, and 14.6% currently binge drink.

Figure 6. **People with disabilities** have significantly higher rates of smoking and e-cigarette use than **people without disabilities** (age-adjusted, 2022)



*Statistically significant ($p<0.5$)

Table 3. Risky health behaviors by disability type (age-adjusted)

	Smoke cigarettes[1]		Current e-cigarette use[1]		Tried to quit smoking[1]		Binge drinking[1]	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Adults with any disability	12.4*	[10.5, 14.6]	11.8*	[10.1, 13.8]	61.1	[52.7, 68.8]	13.7	[11.6, 16.1]
Mobility disability	12.4*	[8.8, 17.1]	15.4*	[11.0, 21.1]	56.8	[41.2, 71.1]	10.4	[7.1, 15.1]
Cognitive disability	13.5*	[11.1, 16.4]	13.5*	[11.4, 16.0]	65.3	[55.1, 74.3]	14.6	[12.0, 17.6]
Adults without a disability	5.2	[4.5, 5.9]	5.8	[5.0, 6.6]	50.3	[42.6, 57.9]	12.7	[11.6, 13.8]

*Statistically significant compared to the reference group ($p<0.05$).
[1]2022 BRFSS data

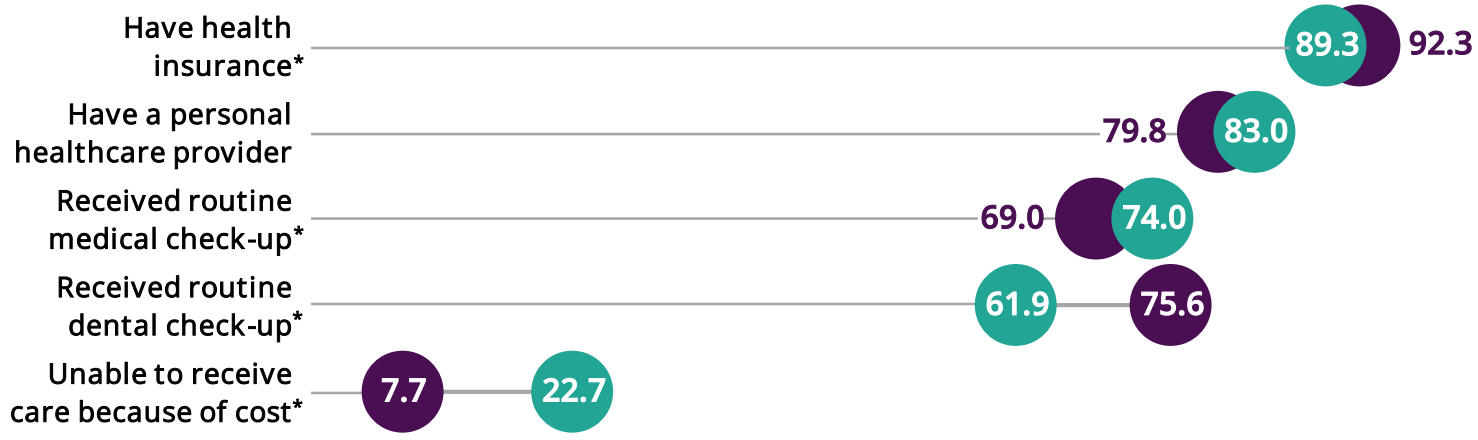
Disparities in healthcare access and preventive care

Preventive care is important because it can decrease the risk for disease and death.[13]

Access to healthcare

People with disabilities encounter many barriers to accessing and using healthcare. For example, fewer adults with disabilities have healthcare coverage compared to adults without disabilities (Figure 7). Cost is also a barrier to care. Adults with disabilities are 3 times more likely than those without a disability (22.7% vs 7.7%) to say they could not get medical care because of the cost. Adults with disabilities are more likely to receive a routine, yearly medical check-up, but less likely to receive a routine dental check-up than adults without disabilities.

Figure 7. Cost is a greater barrier to receiving care among **people with disabilities** than **people without disabilities** (age-adjusted, 2022)



*Statistically significant ($p<0.5$)

Table 4. Access to healthcare measures by disability type (age-adjusted)

	Have healthcare coverage[1]		Have healthcare provider[1]		Had medical check-up[1]		Had dental check-up[1]		Unable to receive care due to cost[1]	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Adults with any disability	89.3*	[86.9, 91.3]	83.0	[80.7, 85.1]	74.0*	[71.4, 76.5]	61.9*	[59.0, 64.6]	22.7*	[20.4, 25.3]
Mobility disability	87.8*	[83.1, 91.3]	85.0	[78.9, 89.5]	77.7*	[71.5, 82.9]	53.4*	[46.9, 59.7]	24.3*	[18.9, 30.6]
Cognitive disability	89.4	[86.3, 91.9]	84.7*	[81.9, 87.2]	73.8	[70.4, 77.0]	61.4*	[57.6, 65.2]	25.8*	[22.6, 29.2]
Adults without a disability	92.3	[91.4, 93.1]	79.8	[78.5, 80.9]	69.0	[67.6, 70.4]	75.6	[74.2, 76.9]	7.7	[6.9, 8.6]

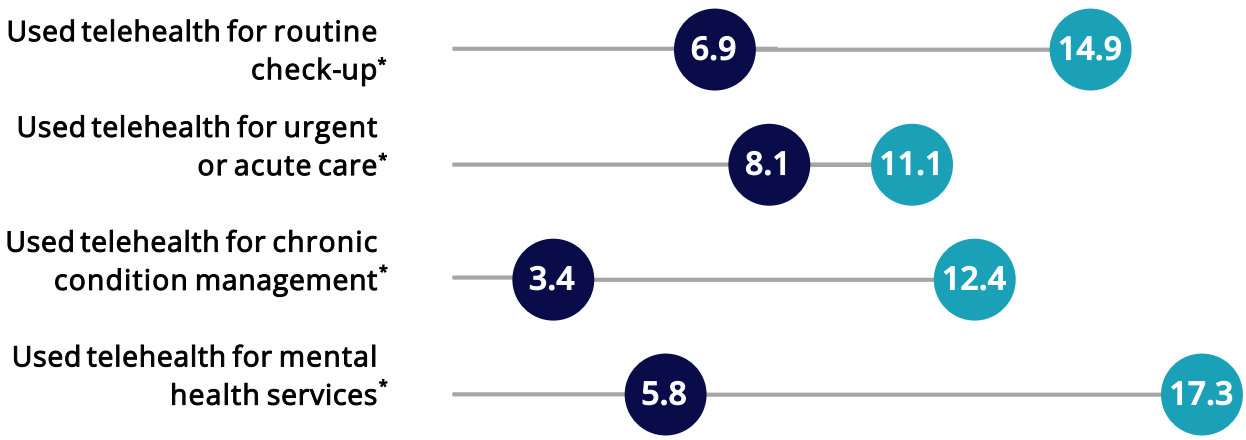
*Statistically significant compared to the reference group ($p<0.05$).
[1]2022 BRFSS data

Telehealth use

Providing quality telehealth services is one way to meet the needs of underserved populations such as people with disabilities.[14] In 2022, more people with disabilities used telehealth services than people without disabilities (39.6% compared to 24.4%).[8] Among adults with disabilities, telehealth was most frequently used for mental health services (17.3%) and routine check-ups (14.9%; Figure 8). Adults with mobility limitations most commonly used telehealth services for chronic condition management, while adults with cognitive disabilities most commonly used telehealth services for mental health services (Table 5).

Access to and use of telehealth services may depend on factors such as accessibility of the services, quality of care, and internet access (see Appendix B).

Figure 8. Percent of **people with disabilities** who used telehealth services compared to percent of **people without disabilities** (age-adjusted, 2022)



*Statistically significant ($p<0.5$)

Table 5. Telehealth use by healthcare service and disability type (age-adjusted)

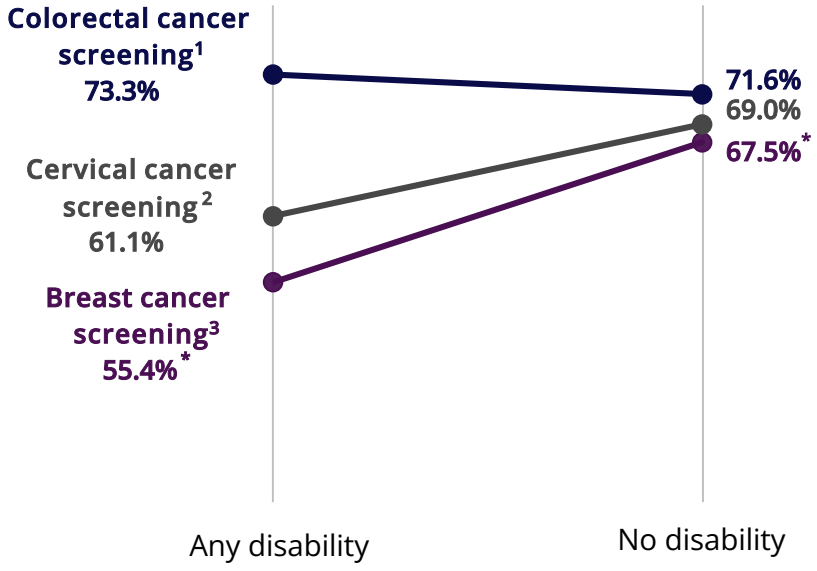
	Used telehealth for routine care[1]		Used telehealth for urgent care[1]		Used telehealth for mental health services[1]		Used telehealth for chronic management[1]	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Adults with any disability	14.9*	[12.7, 17.5]	11.1*	[9.2, 13.3]	17.3*	[15.1, 19.8]	12.4*	[10.4, 14.8]
Mobility disability	15.3*	[11.3, 20.4]	16.4*	[12.0, 22.0]	14.9*	[10.7, 20.5]	18.1*	[13.7, 23.5]
Cognitive disability	16.9*	[13.7, 20.6]	13.3*	[10.4, 16.9]	22.3*	[19.0, 26.0]	13.7*	[10.9, 17.0]
Adults without a disability	6.9	[6.2, 7.7]	8.1	[7.3, 8.9]	5.8	[5.2, 6.6]	3.4	[3.0, 4.0]

*Statistically significant compared to the reference group (p<0.05).
[1]2022 BRFSS data

Preventative cancer screenings

Cancer screenings can help reduce cancer incidence and death by detecting cancer early.[15] General screening recommendations are based on age, sex, lifestyle characteristics (such as smoking), and family history of cancer. Because of these recommendations, cancer screening questions on the BRFSS are only asked to specific age groups and genders.

Figure 9. Adults with a disability are less likely to receive breast and cervical cancer screenings than adults without a disability (age-adjusted, 2022)



*Statistically significant (p<0.5)
[1]2022 BRFSS, ages 50-75
[2]2022 BRFSS, women age 18+
[3]2022 BRFSS, women age 40+

Figure 10. **Women aged 40+ with a disability** are less likely to have received a mammogram than women aged 40+ without a disability

Mammogram screening rate (BRFSS)	
Any disability	**55.4%**
Mobility disability	**51.2%**
Cognitive disability	**55.4%**
No disability	**67.5%**
Mammogram screening rate (APCD)	
Adults with IDD	**51.0%**
Adults without IDD	**63.0%**

Source: BRFSS 2022, age-adjusted data
APCD, 2020, crude data

Figure 11. **Women aged 18+ with a disability** are less likely to have received a Pap test in the past 3 years than women without a disability

Pap test screening rate (BRFSS)	
Any disability	**61.1%**
Mobility disability	**56.2%**
Cognitive disability	**63.5%**
No disability	**69.0%**
Pap test screening rate (APCD)	
Adults with IDD	**41.0%**
Adults without IDD	**56.0%**

Source: BRFSS 2022, age-adjusted data
APCD, 2020, crude data

Breast cancer screening

Mammography is the primary screening method for breast cancer.[16] For women of average risk, screening should begin at age 45 and continue throughout their life.[16] The BRFSS considers screening recommendations met if a woman aged 40 or older has had a mammogram within the past 2 years.

Women with a disability are significantly less likely to have had a mammogram within the past 2 years than women without a disability (55.4% vs 67.5%, see Figure 10). Additionally, adults with IDD have a lower screening rate of 51.0%.

Cervical cancer screening

The American Cancer Society recommends cervical cancer screening every 5 years for individuals with a cervix from age 25 to 65.[17] A Pap test is used to screen for cervical cancer. Screening recommendations are considered met if a woman aged 18 and older has had a Pap test in the past 3 years.

Among adult women, women with a disability are less likely to receive the recommended cervical cancer screening than women without a disability (61.1% compared to 69.0%, see Figure 11). Adults with IDD experience greater disparities as the cervical cancer screening rate is 41.0%.

Colorectal cancer screening

Completing the recommendations for colon cancer screening (per BRFSS analysis) include being 50 to 75 years old and:

- Taking a blood stool test (FOBT) within the past year and/or a sigmoidoscopy in the past 5 years OR
- A blood stool test (FOBT) in the past 3 years and/or a colonoscopy in the past 10 years.

Overall, colorectal cancer screening rates are similar among adults with disabilities and adults without disabilities (Figure 12). However, adult women with disabilities are less likely to complete colorectal cancer screening than adult males with disabilities.

Figure 12. Adults aged 50-75 with a cognitive disability are less likely to receive colorectal cancer screening

Colorectal cancer screening rates (BRFSS)	
Any disability	**73.3%**
Any disability, female	**68.8%**
Any disability, male	**76.8%**
Mobility disability	**74.3%**
Cognitive disability	**72.5%**
No disability	**71.6%**
Colorectal cancer screening rates (APCD)	
Adults with IDD	**61.0%***
Adults without IDD	**59.0%***

Source: BRFSS 2022, age-adjusted data
APCD, 2020, crude data

Table 6. Age-adjusted cancer screening rates by disability type

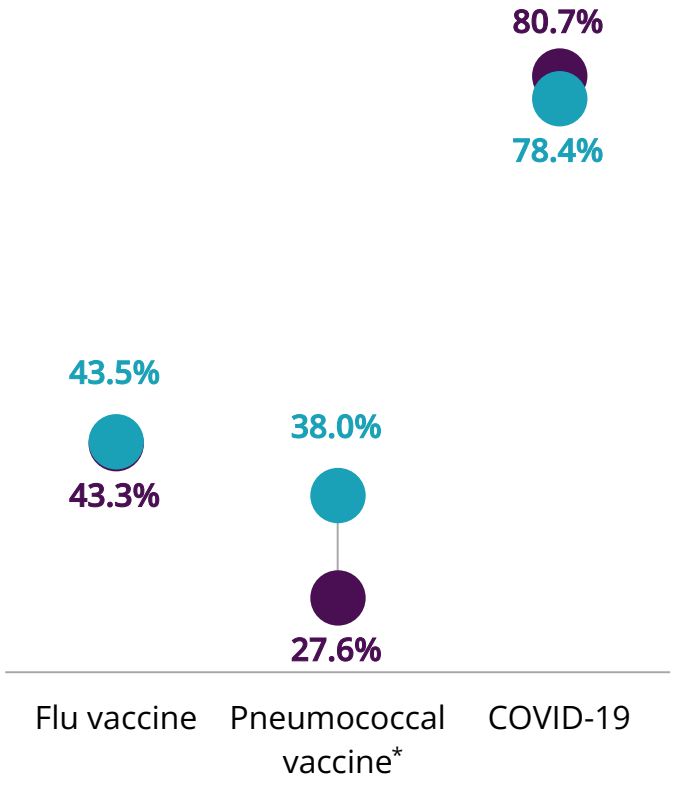
	Mammography[1]		Pap test[2]		Colonoscopy & sigmoidoscopy[3]	
	%	95% CI	%	95% CI	%	95% CI
Adults with any disability	55.4*	[50.6, 60.1]	61.1	[55.3, 66.6]	73.3	[69.3, 76.8]
Mobility disability	51.2*	[44.2, 58.2]	56.2	[44.0, 67.6]	74.3	[69.1, 78.8]
Cognitive disability	55.4	[48.1, 62.5]	63.5	[55.8, 70.6]	72.5	[63.2, 80.1]
Adults without a disability	67.5	[65.0, 69.9]	69.0	[66.0, 71.9]	71.6	[67.7, 75.3]

*Statistically significant compared to the reference group (p<0.05).
[1]Breast cancer screening: women age 40+ who received a mammogram in the past 2 years, 2022 BRFSS data
[2]Cervical cancer screening: women age 18+ who had a Pap test in the past 3 years, 2022 BRFSS data
[3]Colorectal cancer screening: men and women age 50-75 who had FOBT and/or sigmoidoscopy last 5 years or colonoscopy last 10 years, 2022 BRFSS data

Vaccinations

Adults with a disability are more likely than adults without disabilities to have ever had a pneumococcal vaccination (38.0% vs 27.6%; Figure 13). Pneumococcal vaccinations are included in the childhood immunization schedule but are also recommended for adults with certain chronic conditions or risk factors such as chronic heart disease and cigarette smoking.[18] Adults with and without disabilities have similar rates of receiving the flu vaccine within the previous year. Adults with disabilities are less likely to have received 1 or more doses of the COVID-19 vaccine than adults without disabilities (78.4% vs 80.7%). The biggest barrier to adults with disabilities to receive a COVID-19 vaccine dose was taking time off work or other responsibilities (25.1%).[8]

Figure 13. **People with disabilities** are less likely to have received the COVID-19 vaccine than **people without disabilities** (age-adjusted, 2022)

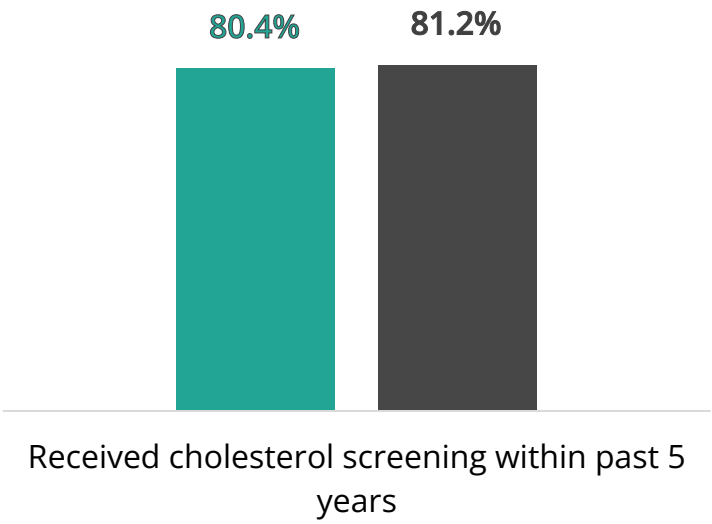


*Statistically significant (p<0.5)

Cholesterol screening

High blood cholesterol is linked to coronary heart disease, also called cardiovascular disease.[19] Managing cholesterol levels through lifestyle changes can help reduce the risk of heart disease and other chronic conditions.[20]

Figure 14. **People with disabilities** are equally as likely to have received cholesterol screening as **people without disabilities** (age-adjusted, 2021)



Cholesterol screening tests can help determine the risk of cardiovascular disease.

Cholesterol screening rates within the past 5 years among adults with disabilities do not significantly differ from adults without disabilities (80.4% vs. 81.2%; Figure 14). This rate is similar among adults with a mobility limitation (80.7%) and cognitive disabilities (80.4%; Table 7).

Access to birth control

Access to contraception is an important aspect of healthcare. Seven percent (7.0%) of adult women with disabilities needed birth control within the past 12 months but were unable to get it, compared to 2.1% of women without disabilities (Figure 15).

Figure 15. **Women with disabilities** are unable to get birth control when needed more frequently than **women without disabilities** (age-adjusted, 2021)

of women with disabilities couldn't get birth control when needed

of women without disabilities couldn't get birth control when needed

*Statistically significant ($p<0.5$)

Table 7. Receipt of other preventive services by disability type (age-adjusted)

	Flu vaccine[1]		Pneumococcal vaccine[2]		COVID-19 vaccine[3]		Cholesterol screening[4]		Birth control[5]	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Adults with any disability	43.5	[40.6, 46.3]	38.0*	[35.2, 40.9]	78.4	[74.7, 81.7]	80.4	[78.0, 82.7]	7.0*	[4.3, 11.0]
Mobility disability	45.6	[39.9, 51.5]	42.7*	[36.7, 49.0]	76.0	[66.8, 83.3]	80.7	[74.3, 85.9]	5.6~	[2.3, 13.0]
Cognitive disability	44.1	[40.2, 48.0]	39.3*	[35.4, 43.4]	77.8	[72.6, 82.2]	80.4	[77.3, 83.3]	6.9~	[3.8, 12.1]
Adults without a disability	43.3	[41.8, 44.8]	27.6	[26.3, 29.0]	80.7	[78.8, 82.5]	81.2	[79.9, 82.4]	2.1	[1.4, 3.2]

*Statistically significant compared to the reference group ($p<0.05$).
[1]Percent of people who received the flu vaccine in the past 12 months, 2022 BRFSS data
[2]Percent of people who have ever had the pneumococcal vaccination, 2022 BRFSS data
[3]Percent of people who have had 1 or more doses of the COVID-19 vaccination, 2021 BRFSS data
[4]Percent of people who received cholesterol screening within the past 5 years, 2021 BRFSS data
[5]Percent of women who needed birth control but couldn't get it in the past 12 months, 2021 BRFSS data
~Estimate is considered unreliable, has > 30% coefficient of variation

Disparities in chronic health status

Health behaviors and lifestyle contribute to long-term, debilitating health impacts and chronic conditions. Environmental conditions and policies impact the ability of people with disabilities to fully participate in crucial aspects of healthy living. This has contributed to the significantly higher rates of chronic conditions among people with disabilities (see Figure 16).

The differences in health outcomes between people with and without disabilities are not always due to the nature of disability itself. Rather, they arise for a variety of reasons, which may be related or unrelated to the underlying disability.

Heart disease, including high blood pressure, high cholesterol, stroke, and heart attack, are significantly higher for people with disabilities.

Chronic mental health conditions are also more common among adults with disabilities. For example, half of adults with a disability experience depression compared to 18.8% of adults without a disability. This rate is even higher among adults with a cognitive disability where 62.8% experience depression.

Adults with disabilities also experience greater rates of other chronic health outcomes such as cancer, COPD, and kidney disease.

Adults with disabilities are:

2x as likely to have diabetes

Nearly 3x as likely to have depression

2x as likely to have a heart attack

Nearly 3x as likely to have heart disease

Nearly 5x as likely to have a stroke

than adults without disabilities.

Figure 16. **People with disabilities** have significantly higher rates of chronic conditions than **people without disabilities** (age-adjusted)

	Any disability	Mobility limitation	Cognitive disability	No disability
Arthritis[1]	39.2%*	56.3%*	39.9%*	18.6%
Asthma[1]	19.5%*	26.8%*	22.0%*	8.4%
Cancer^[1]	10.7%*	12.0%*	11.2%*	7.2%
COPD[1]	9.9%*	10.8%*	11.9%*	2.6%
Diabetes[1]	14.8%*	22.1%*	14.0%*	6.7%
Prediabetes[3]	15.0%*	16.6%*	14.7%*	10.1%
Depression[1]	50.8%*	53.7%*	62.8%*	18.8%
Heart attack[1]	5.6%*	9.4%*	6.5%*	2.2%
Heart disease[1]	12.6%*	19.4%*	15.2%*	4.3%
High blood pressure[2]	36.1%*	40.6%*	37.0%*	24.5%
High cholesterol[2]	29.9%*	30.8%*	32.2%*	23.9%
Kidney disease[1]	5.9%*	10.5%*	6.2%*	2.0%
Stroke[1]	5.8%*	7.7%*	7.5%*	1.3%

*Statistically significant compared to the reference group ($p<0.05$).
[1]2022 BRFSS data
[2]2021 BRFSS data
[3]2020 BRFSS data
^Includes all cancer diagnoses other than skin

What contributes to these disparities?

Although disability is common (see Appendix A), the needs of people with disabilities continue to be largely unrecognized and unmet.[5] People with disabilities have endured a long history of discrimination and exclusion. Health needs vary depending on the type of limitation (i.e., mobility or cognitive) and by the condition underlying the disability.[5] Whether or not the disability came before poor health or poor health came before the disability, poor health is never fully determined by the disability alone.[6] The International Classification of Functioning, Disability and Health (ICF) framework describes disability as a product of health conditions and contextual environmental and personal factors.[21] These interactions often introduce barriers that impede health, such as barriers in the physical environment, attitudes, and policies.[5]

Identified gaps and barriers to advance the health of people with disabilities

More information is needed to fully determine the gaps in resources and barriers for people with disabilities to receive accessible care and to engage with preventive healthcare services and health promotion programs. To fully understand the needs of people with disabilities, the perspecitives and experiences of people with disabilities need to be collected rather than relying on administrative opinions and professionals to paint a picture.

The Utah Disability and Health Program contracted with the Utah State University Institute for Disability Research, Policy and Practice to assess the physcial accessibility of local health department (LHD) sites using the Community Health Inclusion Index (CHII)[22]. In addition, an electronic survey was sent to health promotion coordinators to assess policies, procedures, and staff awareness of accessibility and inclusion in health promotion programs. Eleven local health department sites were assessed for physical accessibility and 10 coordinators completed the survey. Overall, the assessments revealed a need for:

- Accessible medical and exam equipment at LHD clinics
- Trainings on disability and accessibility, including accessible documents
- Inclusive promotional materials and health promotion programs
- Organizational policies to include accessibility accommodations and include accessibility requirements in contracted work.

Additionally, reports identified healthcare access barriers for people with disabilities living outside the Wasatch Front. These include: healthcare provider shortages, especially for specialty and mental health care; providers not trained on or inexperienced treating people with disabilities; limited access to transportation or distance to services; limited access to telemedicine and internet; and limited access to information on services and assistance.[23]

To supplement the limited information in existing Utah-specific reports, the national literature was also reviewed. Among adults with developmental disabilities, further contributors to health disparities include:

- Difficulty understanding healthcare forms and issues with appointment scheduling[24,25]
- Difficulty processing information given by healthcare providers[26]
- Lack of control over treatment plans[26]
- Incorrect perceptions among providers about communication and literacy skills[27]

Table 8 summarizes the overall gaps and barriers that contribute to health disparities experienced by people with disabilities.

Table 8. Gaps and barriers to health equity among people with disabilities

Gap or barrier	Identified needs
Coverage	Frequently lack either health insurance or coverage for necessary services such as specialty care, long-term care, care coordination, prescription medications, durable medical equipment, and assistive technologies.
Training	Few professional healthcare training programs address disability in their curricula, and most federally funded health disparities research does not recognize or include people with disabilities as a disparity population.
Physical environments / equipment	There is a lack of accessible medical facilities and examination equipment.
Communication	Sign language interpreters are often missing in medical appointments. There is a lack of accessible print or electronic materials, scheduling, etc.
Transition to adult care	Significant problems are often encountered when transitioning to adult services including, primary care physicians who are not trained to provide needed care and insurance schemes that do not adequately compensate healthcare providers for the time required to provide care and care coordination.
Programs	People with disabilities can often be systematically excluded from receiving high-quality programs (i.e., people who are blind or visually impaired excluded from high-quality diabetes education). Access to vision rehabilitation services can be limited.
Data / research	No regular sources of data exist to measure participation in wellness programs such as exercise classes, smoking cessation programs, or self-help/AA-type groups, nor do surveys ask people with disabilities about their access experiences with such programs. People with disabilities are also left out of research and survey sampling methods.

Source: National Council on Disability[6]

What can we do?

To understand and address health disparities, increased efforts are needed to collect accurate data on disability status and specific disability type. Increased efforts should also focus on collecting qualitative data to capture health and well-being needs and barriers experienced by people with disabilities. Additionally, increasing access to needed mental and behavioral health providers is critical. Social determinants of health concerns should also be prioritized. For adults with IDD, the Utah Disability and Health Program developed a linkage project to address unmet needs and link participants to appropriate resources (see takecareutah.org/linkage-coordinator-project/). Finally, providers should increase their knowledge and capacity to provide accessible care through training (see responsivepractice.org).

The Guidelines, Recommendations, Adaptations, Including Disability (GRAIDs) framework was developed to increase inclusion of people with disabilities in all aspects of community.[28] The framework consists of 5 inclusion domains: Built Environment, Services, Instruction, Equipment and Technology, and Policy. All sectors and organizations can incorporate the GRAIDs framework to make their programs, plans, and policies more inclusive of people with disabilities, aiming to make long-term policy, systems, and environment (PSE) changes. Figure 17 outlines the GRAIDs inclusion domains and includes recommendations for select sectors to implement.

Numerous evidence-based tools and resources are available to learn more about disability, inclusion, and more. Although not a comprehensive list, the following provides a list of some of these resources.

- National Center on Health, Physical Activity and Disability (NCHPAD) provides guides, trainings, and resources to increase inclusion and health, see https://www.nchpad.org
- The National Association of City and County Health Officials (NACCHO) provides trainings and fact sheets to help health departments with inclusivity, see https://www.naccho.org/programs/community-health/disability
- The Centers for Disease Control and Prevention, Disability and Health Promotion Program has background information, data, and resources, see https://www.cdc.gov/ncbddd/disabilityandhealth/index.html
- The Community Health Inclusion Index (CHII) is a set of survey tools that can be used by communities, worksites, and organizations to assess inclusivity, see https://www.nchpad.org/1273/6358/Community~Health~Inclusion~Index
- The W3C Web Accessibility Initiative (WAI) has guides and resources to assess and make websites accessible, see https://www.w3.org/WAI/
- Data from Utah on people with disability can be accessed online at https://ibis.health.utah.gov/ibisph-view/indicator/complete_profile/Dis.html

Figure 17. GRAIDs inclusion domains and recommendations for implementation

	Individuals	Public health
Built environment 	❖ Participate in community walkability assessments. ❖ Ask about and participate in community workgroups and committees.	❖ Assess buildings for accessibility. ❖ Remedy structural barriers such as building signage, doors, pathways, etc.
Service 	❖ Request accommodations. ❖ Participate in healthy lifestyle changes and health promotion programs.	❖ Include people with disabilities as a priority area in programming. ❖ Make sure programs and services are inclusive and accessible. ❖ Include people with disabilities in planning, workgroups, etc.
Instruction 	❖ Participate in trainings on disability. ❖ Participate in Living Well in the Community workshops. ❖ Assess and address personal beliefs, stereotypes, and stigma about disability.	❖ Train staff and community partners on disability, inclusion, and data collection best practices. ❖ Ask for and provide accommodations for staff to fully participate in meetings, trainings, etc.
Equipment & technology 	❖ Request accommodations and assistive technology. ❖ Provide feedback on web accessibility. ❖ Use local Center for Independent Living to access available assistive technology.	❖ Assess communication needs among staff and communities served. ❖ Provide assistive equipment to allow full participation. ❖ Assess and fix web accessibility, including registration or help pages.
Policy 	❖ Advocate for disability rights throughout communities and workplaces. ❖ Participate on committees and coalitions.	❖ Review, revise, or create organization policies and procedures to include disability training. ❖ Create procedures for accessible communication strategies.

Figure 17 (cont.). GRAIDs inclusion domains and recommendations for implementation

	Healthcare systems and providers	Policy makers and community leaders
Built environment 	❖ Assess and remedy accessibility of buildings. ❖ Provide alternative waiting space for noise sensitivities. ❖ Make sure restrooms are accessible.	❖ Promote universal design in community planning and development. ❖ Create walkable communities and accessible play spaces.
Service 	❖ Document accommodations. ❖ Provide interpretation services and alternative communication devices. ❖ Provide materials in plain language and alternative formats.	❖ Provide supports, such as transportation. ❖ Make sure community programs, advertisement, and communications are inclusive and accessible.
Instruction 	❖ Require healthcare providers and staff to be trained in disability competent care. ❖ Incentivize training for healthcare providers and staff.	❖ Require staff are trained on disability, inclusion and reducing barriers, and ADA requirements.
Equipment & technology 	❖ Provide accessible medical equipment (such as adjustable exam tables, scales, x-ray, etc.). ❖ Make sure health records and websites are accessible.	❖ Provide needed assistive technology throughout communities. ❖ Provide funding opportunities or budget items to address accessibility needs.
Policy 	❖ Create and maintain organizational standard operating procedures that require disability trainings as part of continuing education and staff trainings.	❖ Create legislation and policies to reduce barriers for people with disabilities and increase opportunities to live a healthy life. ❖ Write policies in plain language.

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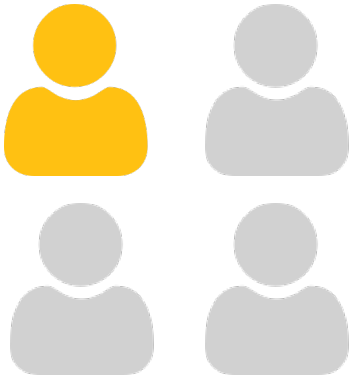
Appendix A: Disability prevalence

Disabilities are more common than people think. Some disabilities may be visible while others are not. Most people will experience a disability at some point in their life. While a disability may only last a short time, many people will experience a disability for most of their life.

One in every 4 Utah adults (26.4%), or about 647,055 Utah adults, have a disability (age-adjusted, 2022).



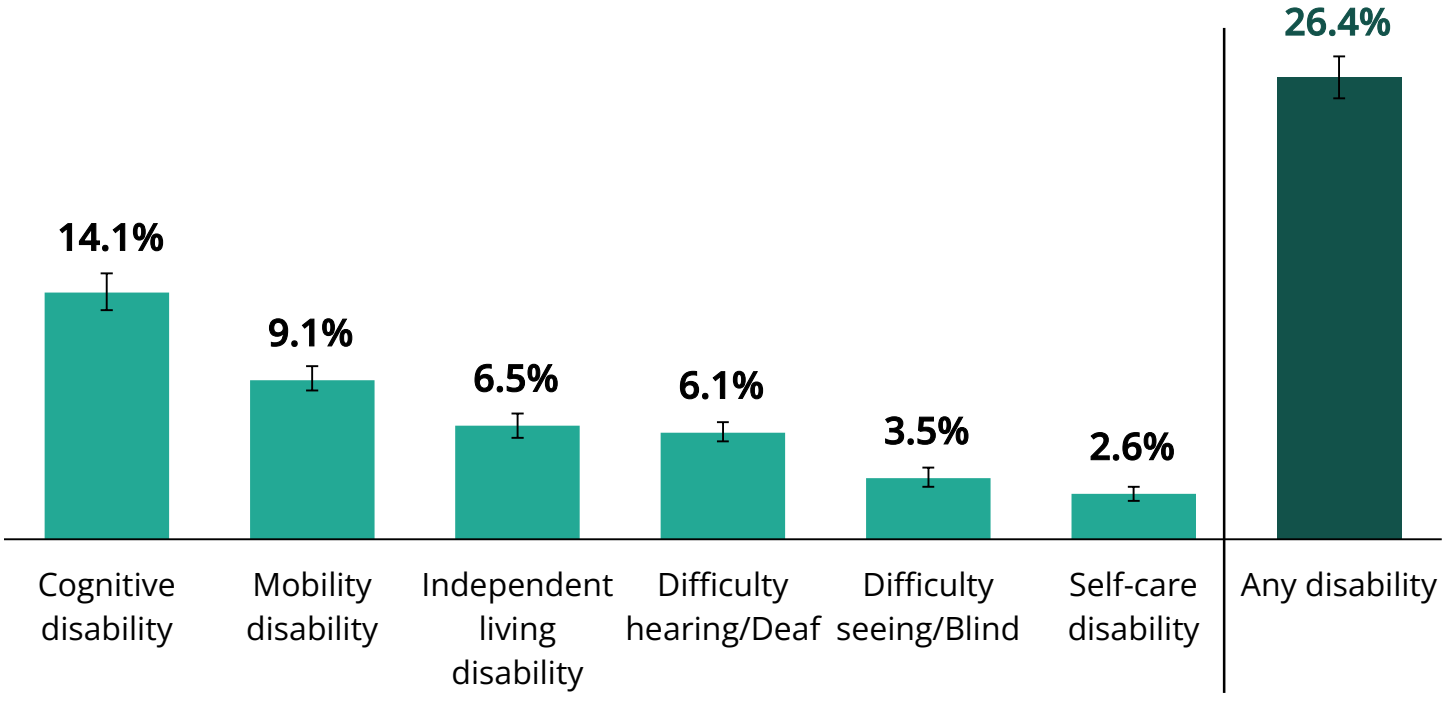
1 in 4

Utah adults have a disability

Prevalence of disability by functional type

Cognitive disabilities are the most common functional disability among Utah adults (14.1%), followed by mobility disabilities (9.1%; Figure 18). Cognitive disabilities include serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition. Mobility limitations include having serious difficulty walking or climbing stairs.

Figure 18. Age-adjusted percent of Utah adults with a disability by functional disability type, 2022)



Who is most likely to have a disability in Utah?

Some groups have a higher prevalence of disability. Some of these include:

- **Women**; more women report a disability than men. However, men are more likely to be deaf or hard of hearing.
- **Adults aged 65+**; disability increases with age. Certain disabilities such as hearing and mobility limitations increase with age.
- **Hispanic adults**; disabilities are reported more frequently among Hispanic adults than non-Hispanic adults.
- **American Indian/Alaska Native and Black/African American adults** are more likely to report a disability.

Disability by sex and age

Overall, women are significantly more likely to have a disability than men (Figure 19). This remains true over the lifespan except for hearing disabilities and vision disabilities after age 65 (Figure 20). Men are more likely to be deaf or hard of hearing at any age.

Disability is also associated with age. As someone ages, their likelihood of having a disability also increases. Higher rates of disability are experienced later in life with most rates drastically increasing starting around age 50 (Figure 20). This is especially true with mobility disabilities where rates more than double after age 50 (Figure 21).

Figure 19. Percent of Utah adults with a disability by sex (age-adjusted, 2022)

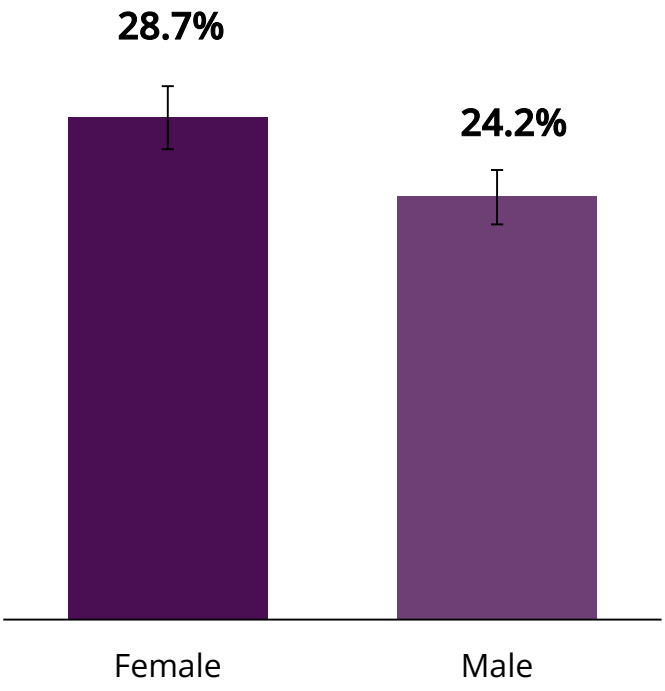


Figure 20. Percent of Utah adults with a disability by age (crude rates, 2022)

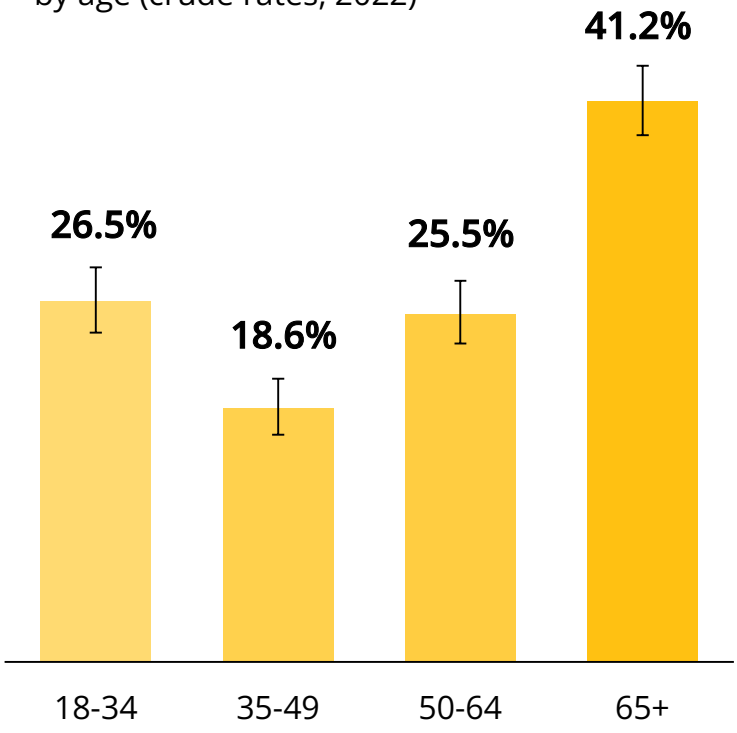
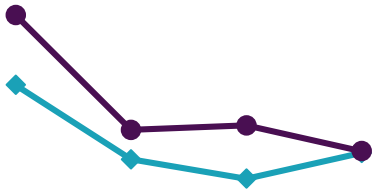


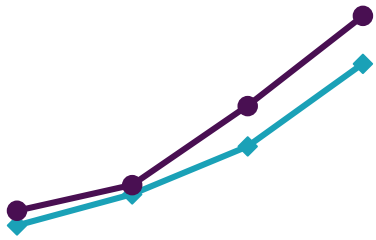
Figure 21. Disability type by age and sex (crude rates, 2022)

Cognitive disability



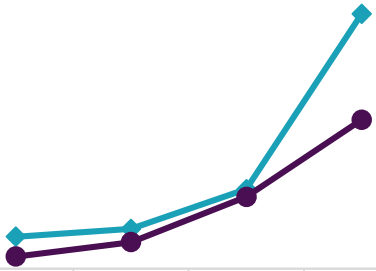
	18-34	35-49	50-64	65+
Male	17.4%	9.3%	7.2%	10.0%
Female	25.0%	12.5%	13.0%	10.2%

Mobility disability



	18-34	35-49	50-64	65+
Male	2.0%	5.4%	10.6%	19.6%
Female	3.6%	6.4%	15.0%	24.8%

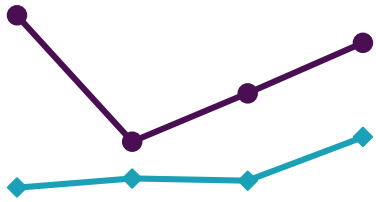
Deaf or hearing disability



	18-34	35-49	50-64	65+
Male	2.9%	3.6%	7.2%	23.1%
Female	1.1%*	2.4%	6.5%	13.5%

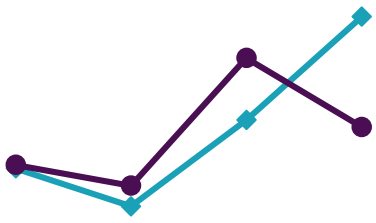
*Estimate is unreliable, has > 30% coefficient of variation

Independent living disability



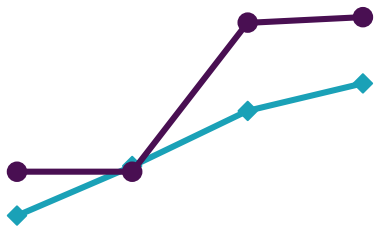
	18-34	35-49	50-64	65+
Male	3.7%	4.1%	4.0%	5.9%
Female	11.2%	5.7%	7.8%	10.0%

Blind or vision disability



	18-34	35-49	50-64	65+
Male	2.7%	1.6%	4.1%	7.1%
Female	2.8%	2.2%	5.9%	3.9%

Self-care disability



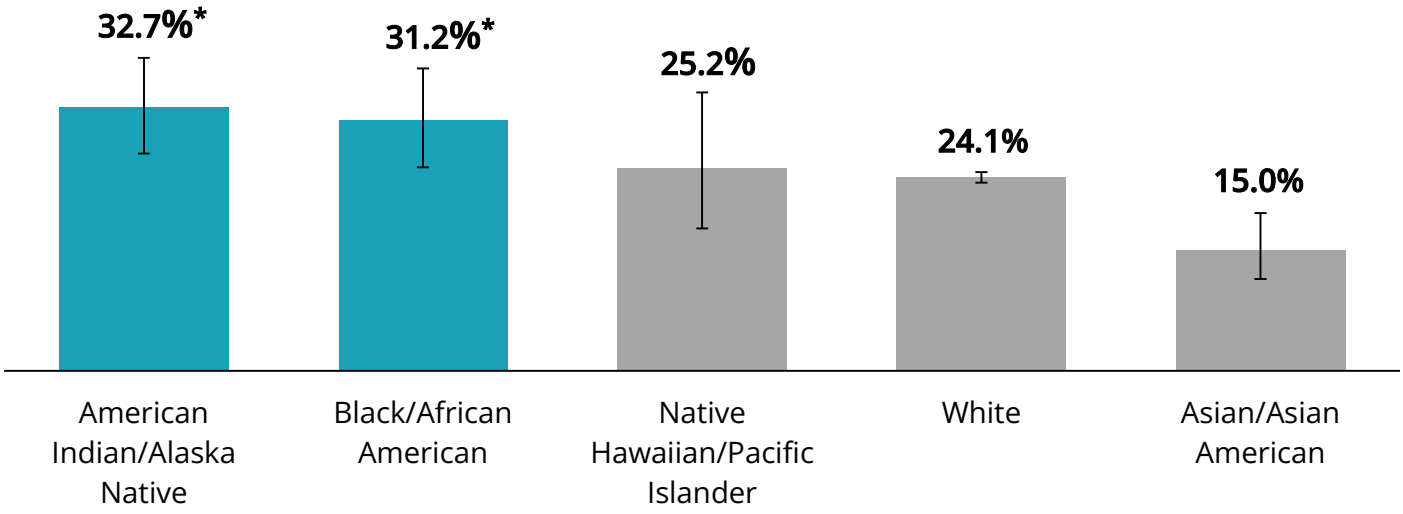
	18-34	35-49	50-64	65+
Male	1.1%*	2.0%*	3.0%	3.5%
Female	1.9%	1.9%	4.6%	4.7%

*Estimate is unreliable, has > 30% coefficient of variation

Disability by ethnicity and race

Utahns who are **American Indian/Alaska Native** and **Black/African American** are significantly more likely to have a disability (32.7% and 31.2%, respectively) than all races combined (24.5%). These racial minority groups are often underrepresented and oversampled in surveys. Because these groups are based on smaller numbers of respondents, they often have greater variability and can become less accurate. The larger variability can be seen in the larger confidence intervals, such as in Figure 22.

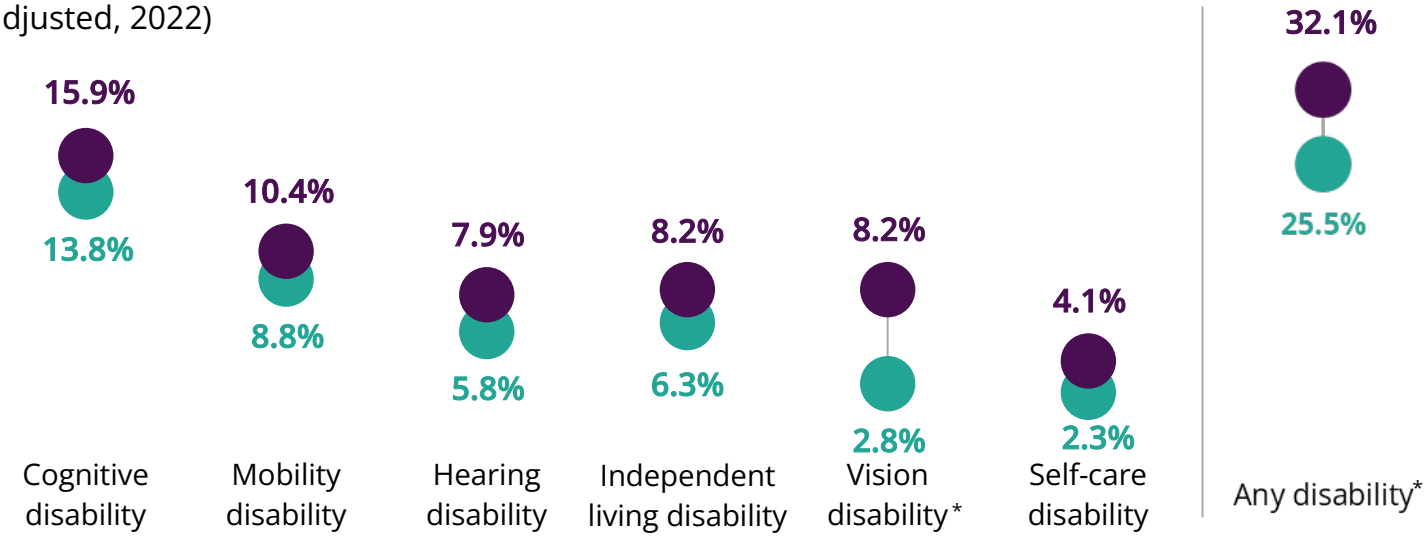
Figure 22. **American Indian/Alaska Native and Black/African American** adults have a greater prevalence of disability (age-adjusted, 2020-2022)



*Statistically significant compared to the reference group (p<0.05).

Adults who are **Hispanic** are significantly more likely than **non-Hispanic adults** to have a disability (32.1% vs 25.5%; Figure 23). Vision disabilities are also significantly more common among Hispanic Utahns.

Figure 23. **Hispanic adults** are more likely to have a disability than **non-Hispanic adults** (age-adjusted, 2022)



*Statistically significant compared to the reference group (p<0.05).

Appendix B: Social determinants of health and disability

Social determinants of health are factors such as economic stability, education, healthcare, and physical environments that influence health. Community conditions and social environments can greatly impact health behaviors and health outcomes. For example, people in lower socioeconomic groups often experience the poorest health outcomes.

As shown in the following pages, social and community circumstances put Utah adults with disabilities at greater risk for poor health outcomes than the general population.

Figure 24. Social determinants of health

Economic stability	Neighborhood and physical environment	Education	Food	Community and social context	Healthcare system
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education		Stress	Quality of care
Support	Walkability				
	Zip code / geography				

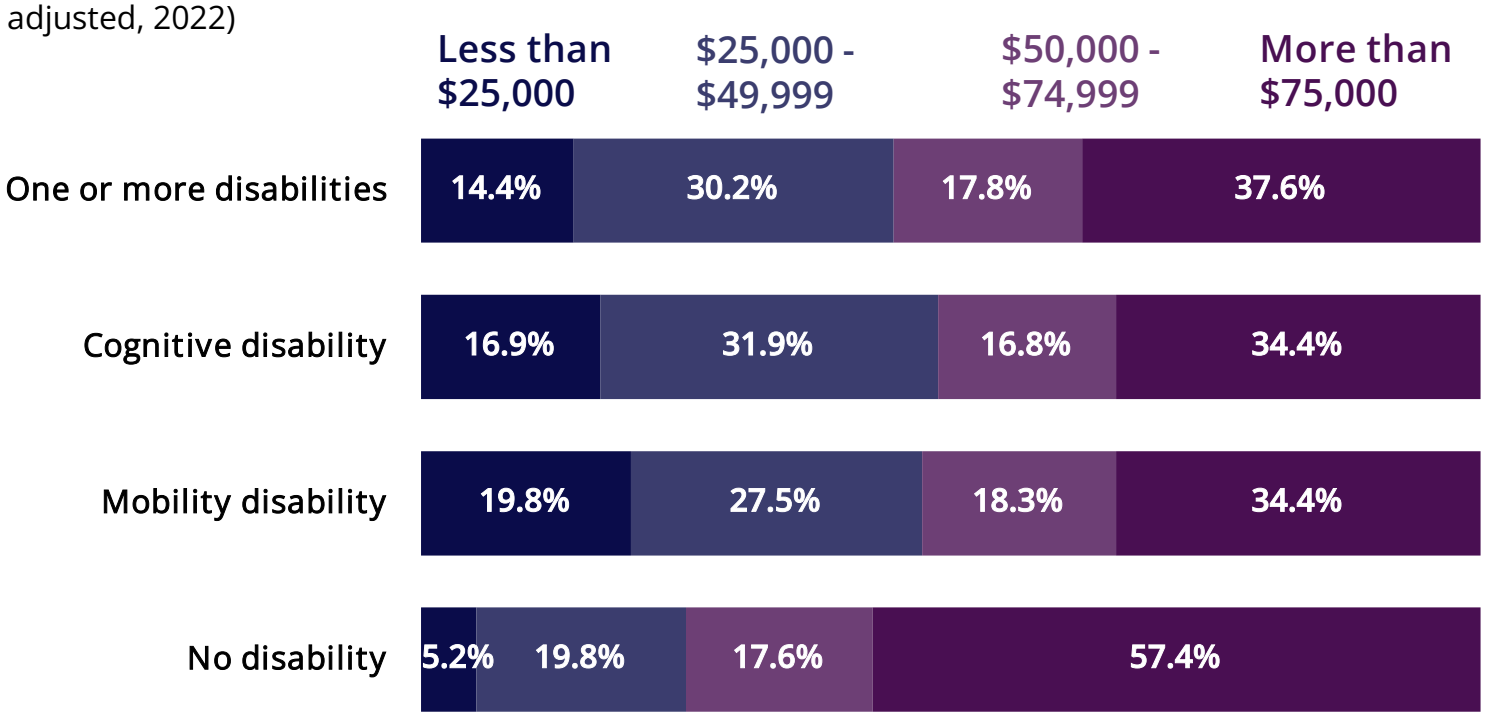
Health outcomes
Mortality, morbidity, life expectancy, healthcare expenditures, health status, functional limitations

Adapted from Kaiser Family Foundation[29]

Income

Among Utah adults, 44.6% of people with disabilities make less than $50,000 per year whereas the majority (75.0%) of people without a disability make more than $50,000 in a year (Figure 25). Additionally, nearly 15% of people with disabilities make less than $25,000 per year compared with 5.2% of people without a disability.

Figure 25. Adults with any disability have a lower income than adults without disability (age-adjusted, 2022)

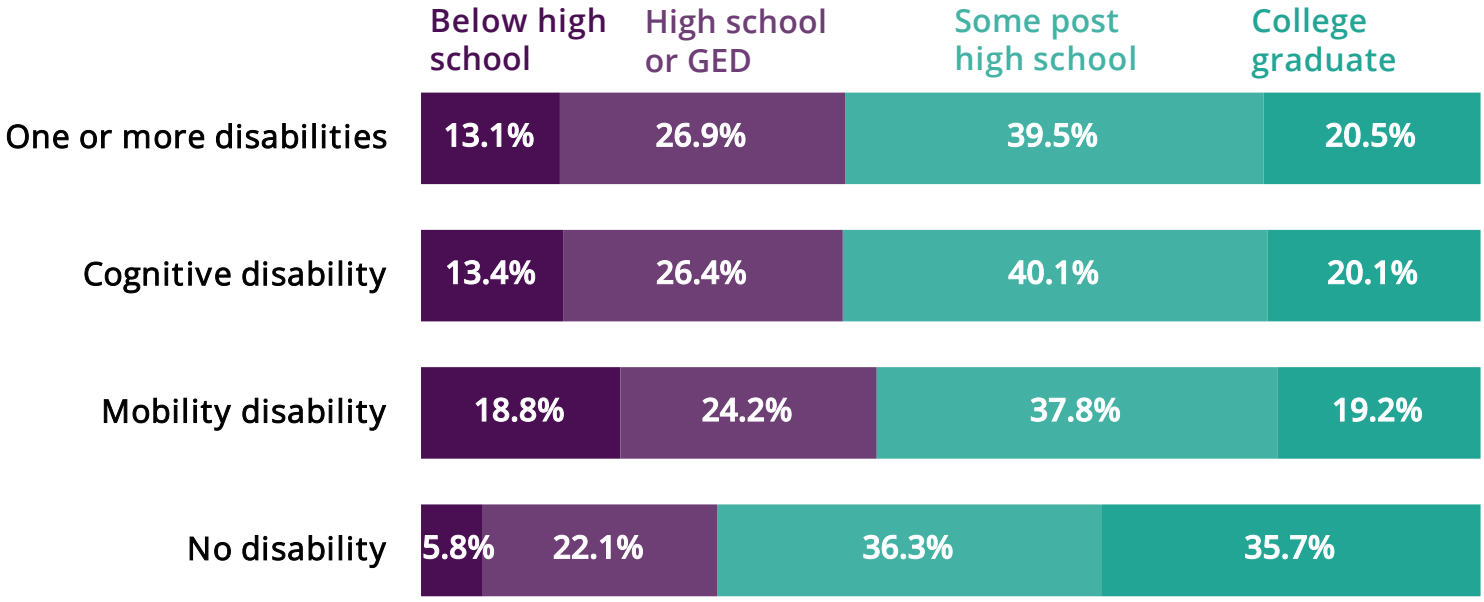


Education

People with disabilities are significantly less likely to graduate from high school or to receive a college education than those without a disability (Figure 26). The percentage of people with disabilities who do not graduate from high school is 2 times higher than people without a disability, 13.1% compared to 5.8%. This percentage is higher among people with a mobility limitation (18.8%).

Alternatively, 35.7% of people without a disability graduate from college as compared with 20.5% of those with a disability.

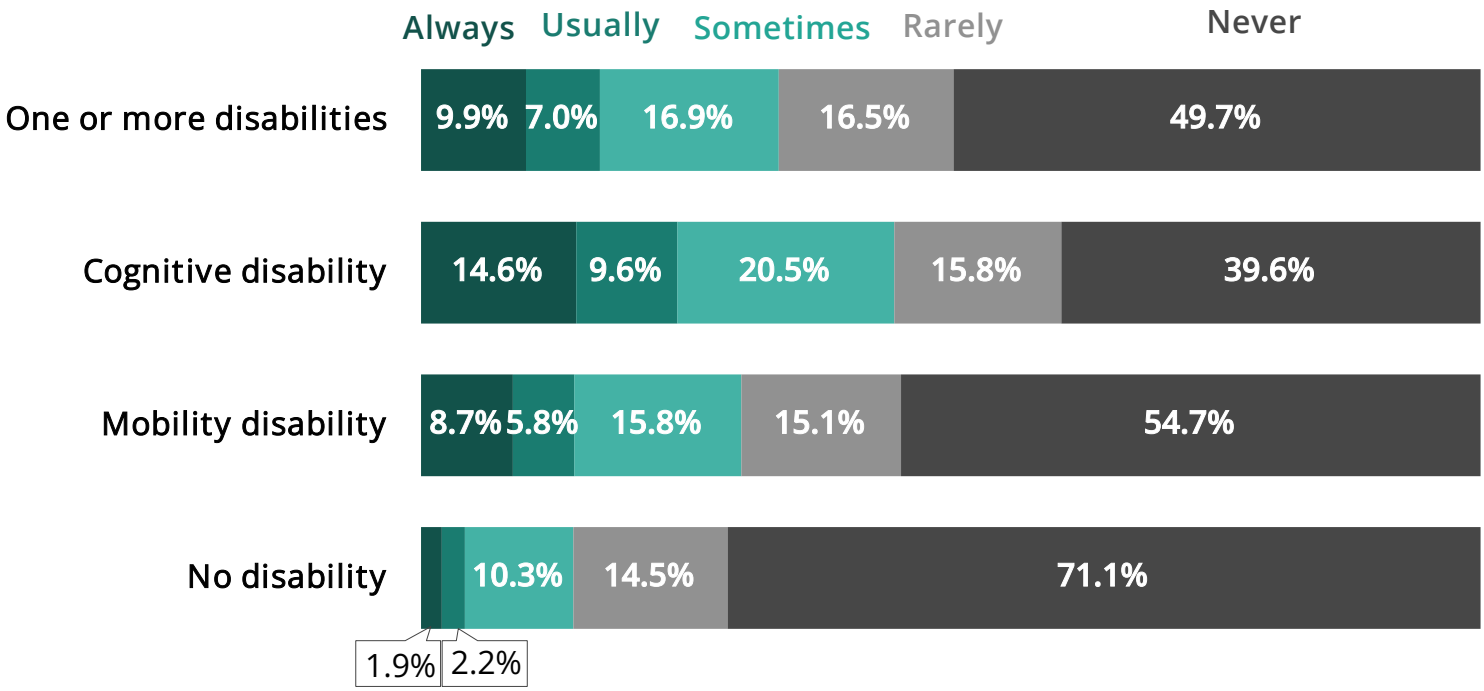
Figure 26. Adults with disabilities have lower education attainment than adults without disabilities (age-adjusted, 2022)



Food security

When asked how often they have been "worried or stressed about having enough money to buy nutritious meals" in the past 12 months (i.e., food insecurity), 36.3% of people with disabilities reported food insecurity as compared with 13.8% of people without a disability (Figure 27).

Figure 27. Adults with disabilities are more likely to experience food insecurity than adults without disabilities (age-adjusted, 2021)



Cost as a barrier to medical care

Utah adults with disabilities are 3 times more likely than adults without a disability (22.7% vs 7.7%) to say they could not get medical care because of the cost. This barrier to accessing needed care is also more severe for certain functional disability types (Figure 28).

Among those with disabilities, adults with a vision disability were the most likely to not get care due to its cost (34.3%). Cost is a greater burden to care for all functional disability types compared to adults without disabilities.

Figure 28. People with disabilities are more likely to report not receiving medical care due to cost than people without disabilities

	Age-adjusted percent of cost-burdened adults, 2022
Blind or vision disability	34.3%
Self-care disability	30.9%
Independent living disability	27.5%
Cognitive disability	25.8%
Mobility disability	24.3%
Deaf or hearing disability	16.9%
No disability	7.7%

Health insurance

Utah adults with disabilities are significantly less likely to have healthcare coverage than those without a disability (89.3% vs 92.3%).[8] Having insufficient or no healthcare coverage is a barrier to accessing healthcare services and receiving needed care. The lack of health insurance coverage may cause people to forgo needed care, such as preventive services. This increases their risk of poor health outcomes.[30-32]

More adults with disabilities do not have insurance compared to adults without disabilities (10.7% vs 7.7%).[8]

Discrimination in healthcare

People with disabilities have historically experienced, and continue to experience discrimination. Discrimination can be experienced in different situations and can impact physical health, mental health, and well-being.[33] Discrimination can also affect behaviors. For example, people who experience discrimination may reduce their participation in health promotion programs and seeking healthcare.[34,35]

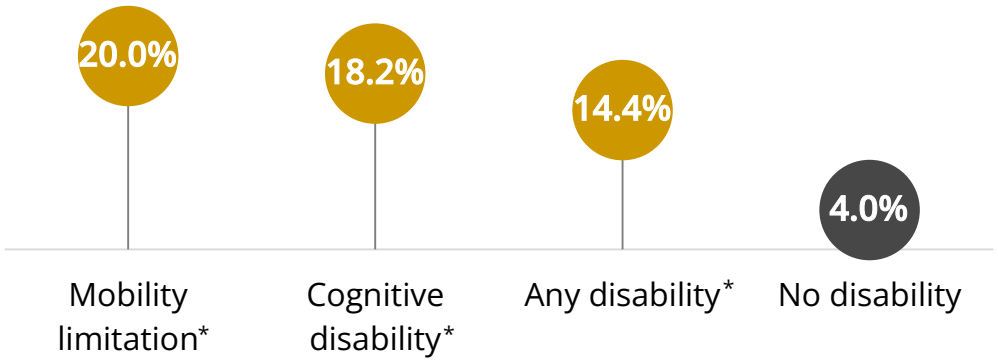
Discrimination here is defined as being treated with less respect or receiving lower quality services compared to others. Among people with disabilities, 13.8% felt discriminated against when accessing healthcare services in the past 2 years because of their personal characteristics or belonging to a specific group, compared to 3.7% of people without disabilities. (Figure 29). Nearly 4 percent (3.9%) of people with disabilities felt the discrimination was because of their disability status. Other common reported causes of discrimination among adults with disabilities were financial or socioeconomic status (5.4%) and insurance status (4.9%).

Figure 29. More **adults with disabilities** feel discriminated against when accessing healthcare services than **adults without disabilities** (age-adjusted, 2022)

*Statistically significant compared to the reference group (p<0.05).

When asked if routine or emergency medical care has been delayed in the past 2 years because of fear of discrimination or of being treated unfairly, 14.4% of people with disabilities responded yes compared to 4.0% of people without disabilities (Figure 30). Discrimination also appears to affect adults with mobility limitations more as 20.0% delayed seeking care.

Figure 30. More **adults with disabilities** delayed seeking healthcare because of discrimination than **adults without disabilities** (age-adjusted, 2022)

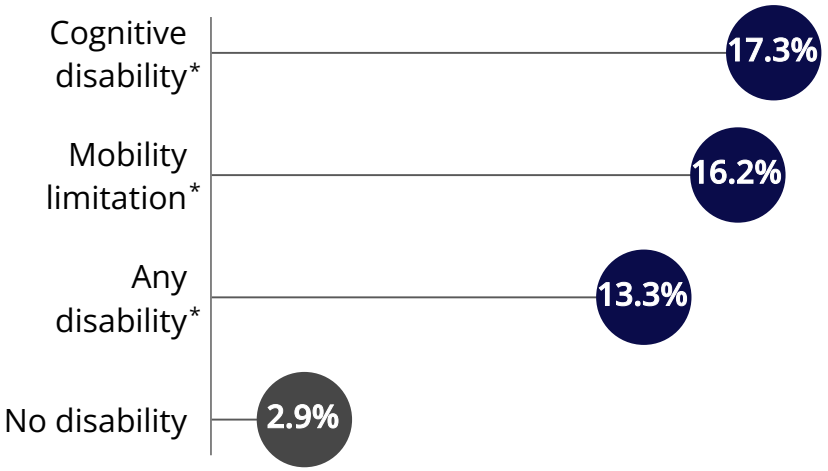


*Statistically significant compared to the reference group (p<0.05).

Access to transportation

More than 13% (13.3%) of people with disabilities have been kept from appointments because they lack access to transportation, compared to 2.9% of people without disabilities (Figure 31). The lack of transportation access is even more prominent among adults with a cognitive disability (17.3%).

Figure 31. Age-adjusted percent of adults who were kept from appointments in the last 12 months because they lack access to transportation, 2022



*Statistically significant compared to the reference group (p<0.05).

Internet access

Significantly fewer adults with disabilities have access to the internet (either through a cell phone company, mobile data plan, or internet service provider) than adults without disabilities (96.8% vs. 98.9%; Figure 32). Access to the internet can impact health outcomes, healthcare access, and other social determinants of health such as education and employment.[36]

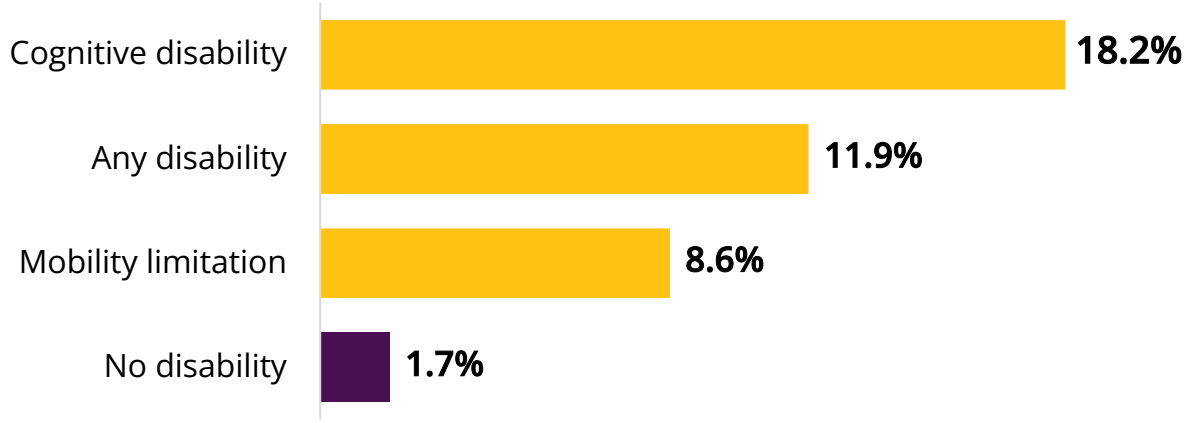
Figure 32. Fewer **adults with disabilities** have access to the internet than **adults without disabilities** (age-adjusted, 2022)

*Statistically significant compared to the reference group (p<0.05).

Social isolation

Social connection is strongly associated with better physical and mental health outcomes and overall well-being.[37] Social isolation and loneliness can also negatively affect a person's health, well-being, quality of life, and longevity.[38] While social isolation and loneliness is more common among older adults, significantly more adults with disabilities experience moderate or severe social isolation than adults without disabilities (11.9% vs. 1.7%; Figure 33). Social isolation is even more frequent among adults with cognitive disabilities, 18.2% experience moderate or severe social isolation.

Figure 33. Age-adjusted percent of adults who are moderately or very socially isolated, 2021*

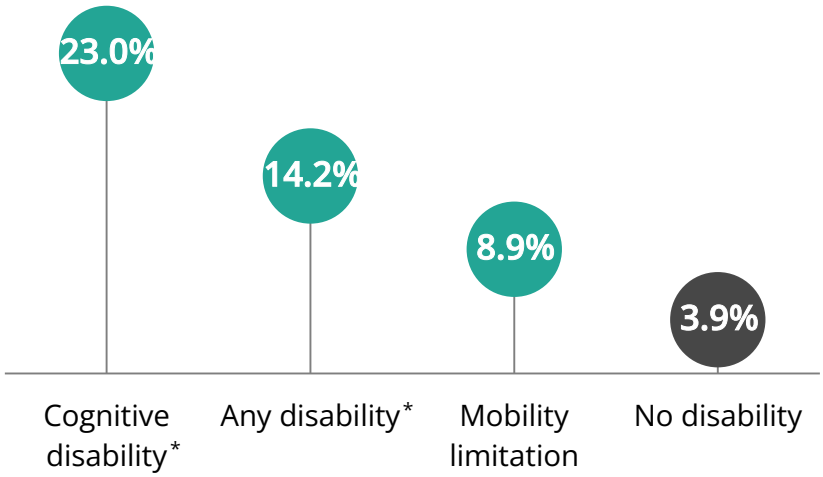


*Social isolation is measured by asking in the past 7 days, how often a person has felt 1) left out, 2) that people barely know them, 3) isolated from others, and 4) that people are around them but not with them. Responses are then scored and identified as not isolated, moderately isolated, or very isolated.

Suicidality

Among adults with disabilities, 14.2% have seriously considered attempting suicide within the past 12 months (Figure 34). This is significantly more than adults without disabilities (3.9%). Among adults with a cognitive disability, an alarming 23.0% have seriously considered attempting suicide.

Figure 34. **People with disabilities** experience more suicidality than **people without disabilities** (age-adjusted, 2021)



*Statistically significant compared to the reference group ($p<0.05$).

Appendix C: NCI data and adults with IDD

The National Core Indicators (NCI) program collects data from state developmental disability agencies.[9] The data included in this report come from the In-Person Survey administered to adults with IDD (age 18 and older) who receive case management and at least 1 paid service from their state disability agency. Some questions must be answered by the individual while others allow for a proxy to respond. Six domains are included in the indicators: self determination, service coordination and access, relationships and community inclusion, rights, choices, and decision making, employment status and goals, and health, welfare, and safety. This information in Utah is collected by the Utah Department of Health and Human Services Division of Services for People with Disabilities.

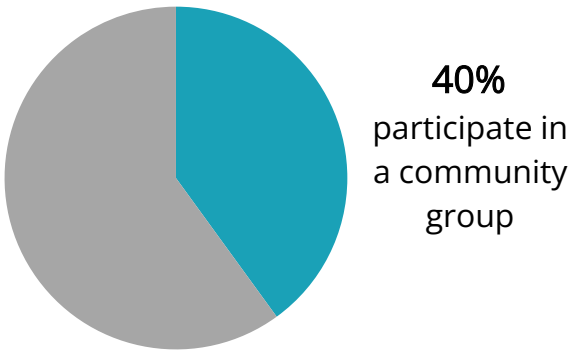
There are limitations to the NCI data. The data is not representative of all Utah adults with an IDD since only those receiving state services are surveyed. Additionally, there is no group to compare the data with to identify disparities specifically among Utah adults with IDD.

All NCI data comes from the most recent 2018-2019 report.[39] These indicators supplement the data included in the main narrative of this report since IDD as a specific disability was not possible to highlight. This information is an important step to identifying and investigating further the needs among adults with IDD.

Community inclusion

Social connectedness and inclusion are an important component of health. Forty percent of adults with IDD surveyed participate as a member in a community group (Figure 35). The large majority (89%) are able to go out and do the things they like to do in the community. No additional information was provided about barriers to community inclusion or participation.

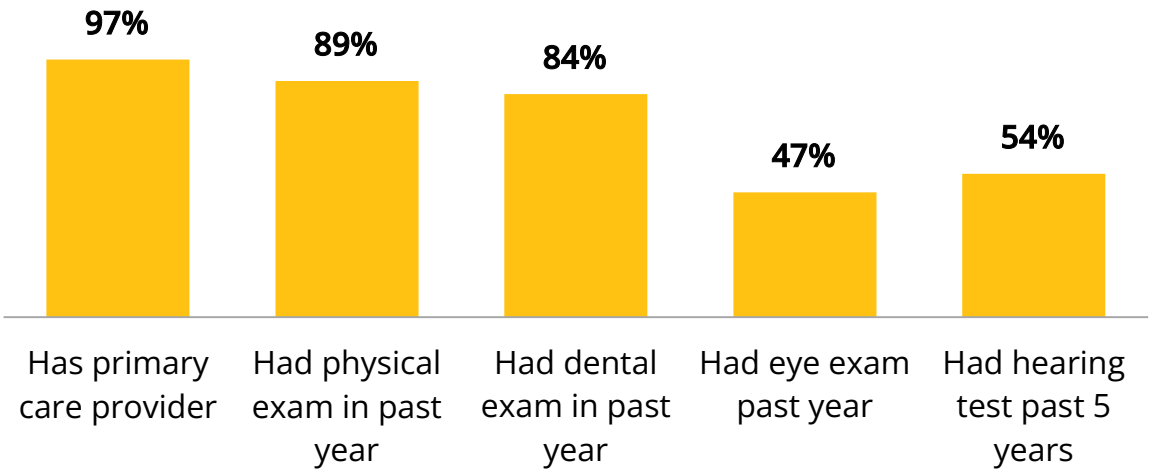
Figure 35. Percent of adults with IDD who actively participate in their community, 2018-2019 (crude)



Preventive healthcare

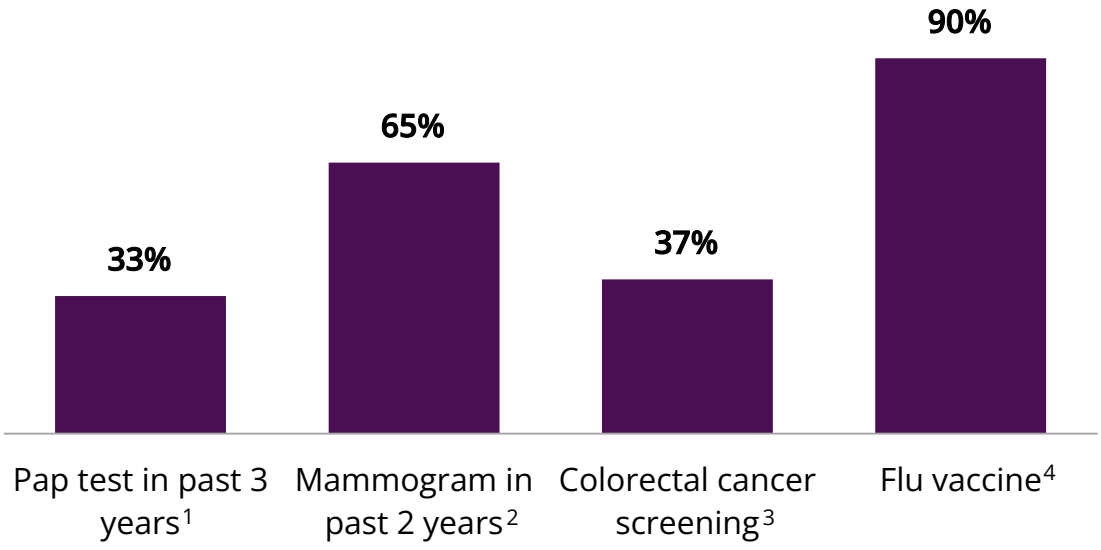
Ninety-seven percent of adults with IDD have a primary care provider (Figure 36). Physical health (89%) and dental exams (84%) were more frequently completed than eye exams (47%) and hearing tests (54%).

Figure 36. Percent of adults with IDD who received preventive health care exams (2018-2019, crude)



Additionally, 90% of adults with IDD received the preventive flu vaccine (Figure 37). Cancer screenings are less frequently completed with 65% meeting breast cancer screening recommendations (mammogram), 33% meeting cervical cancer screening recommendations (Pap test), and 37% meeting colorectal cancer screening recommendations.

Figure 37. Percent of adults with IDD who received preventive screenings and vaccines

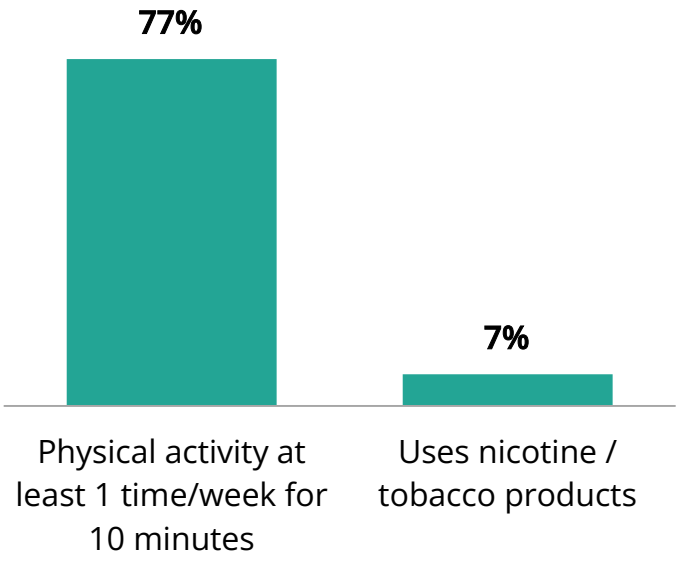


[1]Cervical cancer screening: women age 21+ who received a pap test in the past 3 years, NCI 2018-2019 crude data
[2]Breast cancer screening: women age 40+ who had a mammogram in the past 2 years, NCI 2018-2019 crude data
[3]Colorectal cancer screening: men and women age 50+ who had a colonoscopy in the past 10 years, NCI 2018-2019 crude data
[4]Had a flu vaccine in the past year, NCI 2018-2019 crude data

Health behaviors

The majority of adults with IDD surveyed (77%) engage in exercise or physical activity at least once per week for 10 minutes at a time (Figure 38). Using nicotine or tobacco products is less common among surveyed adults as only 7% reported using these substances.

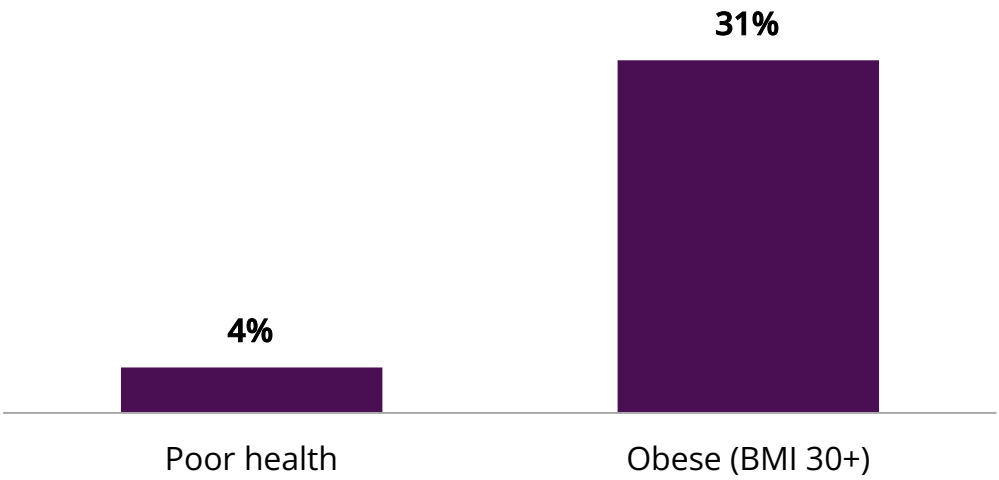
Figure 38. Health behaviors among adults with IDD (2018-2019, crude)



Health status

Four percent of surveyed adults with IDD consider their health to be poor while 31% had a BMI of 30+ (Figure 39).

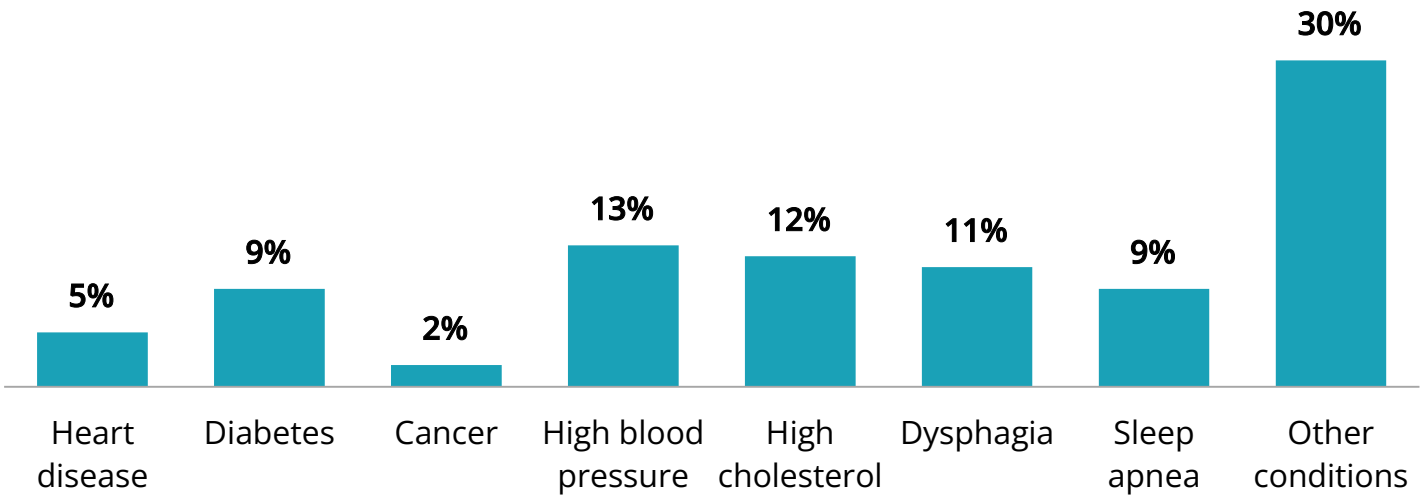
Figure 39. General health status among adults with IDD (2018-2018, crude)



Chronic health conditions

Aside from other chronic health conditions (30%), high blood pressure (13%), high cholesterol (12%), and dysphagia (swallowing difficulties, 11%) were the most common chronic health conditions among adults with IDD (Figure 40).

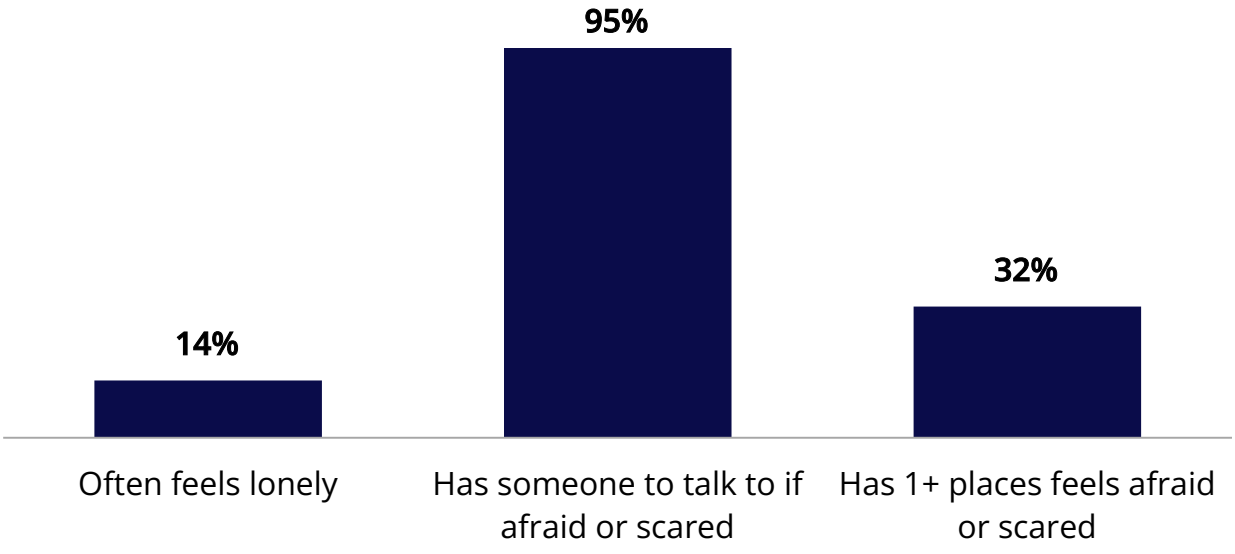
Figure 40. Percent of adults with IDD with chronic health conditions (2018-2019, crude)



Loneliness and safety

Although 32% of adults with IDD have at least one place that makes them feel afraid or scared, 95% have someone they can talk to if ever they are feeling afraid or scared (Figure 41). Additionally, 14% of adults with IDD often feel lonely.

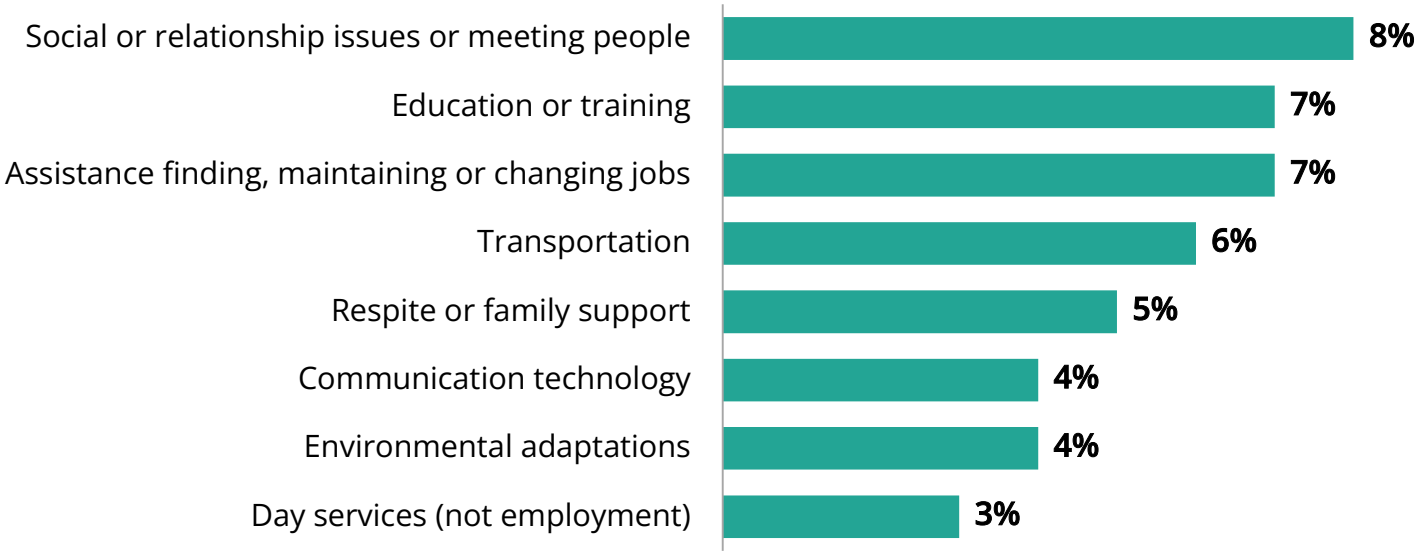
Figure 41. Feelings of loneliness and safety among adults with IDD (2018-2019, crude)



Services needed

In addition to health data, NCI collects information on additional, publicly funded services that adults with IDD need. The top 8 services identified are included in Figure 42. Among the top are needs for social and relationship connection, education, and employment assistance.

Figure 42. Additional services needed among adults with IDD (2018-2019, crude)



Although the National Core Indicators do not provide representative data of all adults with IDD in Utah, they do provide additional insight into health and needs of adults with IDD specifically. Understanding more about needs among adults with IDD in Utah is critical to reduce barriers, promote inclusion, and reduce disparities.