

Abstracts of Research Presented at the Annual American Public Health Association Meeting 2009*

1. Certain Groups of People with Disabilities May Disproportionately Lack Health Care

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Background and Importance

People with disabilities in the U.S. report more unmet healthcare needs and receive fewer clinical preventive services than the general population. Yet, access to quality and timely healthcare is an established leading indicator of population health. People with disabilities from traditionally underserved groups may experience even greater barriers to healthcare. The present study examined healthcare access disparities among people with disabilities.

Methods

Data were collected via an online survey of adults with disabilities in the U.S. The online survey included assessments of unmet healthcare needs and common barriers to needed care. A total of 943 individuals participated in the study.

Results

People with disabilities of minority race or ethnicity were significantly more likely than White non-Hispanic people to say they had not gotten needed health care in the past year. Women were significantly more likely than men to indicate that there was a time in the past year when they needed healthcare but did not get it. Likewise, people with multiple disabilities were significantly more likely to have had unmet healthcare needs than people with only one type of disability. The most common barriers to accessing healthcare included cost, limited insurance, and lack of providers. However, there were differences between the groups in ranking these and other barriers.

Conclusions

Findings suggest that certain groups of people with disabilities may be disproportionately lacking in needed healthcare services. Efforts to reduce disability-related disparities should pay particular attention to the barriers faced by minorities, women, and individuals with multiple disabilities.

2. Literacy and Mental Health Disorders

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While both limited literacy and mental disorders are prevalent problems, little is known about the relationship between the two, though they both cause considerable distress, stigmatization, diminished quality of life, and impaired functioning. Capabilities suggests that ***literacy is a central component of well being, providing people with access to knowledge and the freedom to reason and think in a reasoned and articulate way.*** (emphasis by CIDNY)

This pilot study uses a participatory research model to examine the role of literacy in the lives of people with severe psychiatric conditions. A team of researchers, providers and service users developed a qualitative interview guide to better understand how literacy and struggles with literacy impact the lives and recovery of people living with mental illness. We conducted 20 interviews, 10 with people with limited and 10 with people with higher literacy who were receiving Massachusetts Department of Mental Health case management services. Preliminary results highlight differences between those with limited and with higher literacy in several areas. This pilot study is the first step in a research trajectory to better

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understand the relationship between literacy and psychiatric disability, and to ultimately design and evaluate interventions that will increase literacy and reduce its impact on the lives of people with severe mental illness.

3. Intellectual Disabilities and Health Risks

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Background:

People with intellectual disabilities (ID) have typically had limited access to health promotion opportunities, and experience greater health risks than the general population. Healthy Lifestyles for People with Intellectual Disabilities (HLID) is a 3-day health promotion workshop with six months of follow-up meetings focused on improving health behaviors and meeting health goals. This presentation will report on findings from a randomized controlled trial of the HLID program.

Methods:

A total of 131 adults with ID were assigned to the intervention condition (n=71) or the control condition (n=60). Participants completed measures of health knowledge, health behaviors, self-efficacy, health status, health care utilization, and secondary conditions at baseline, one month after the workshop, at the end of the full intervention, and six months post-intervention.

Results:

At baseline, control group members demonstrated significantly better health knowledge, but this difference was no longer apparent after the workshop. By the end of the HLID program, intervention participants scored significantly higher on self-efficacy and health behaviors. Six months after the end of the program, intervention participants reported significantly fewer secondary conditions than control group members.

Conclusions:

Findings indicate that the HLID program helps adults with ID improve and maintain their health as compared to no intervention. Future efforts will work to increase the efficacy of the program through greater involvement of support networks (e.g. family members, transition classrooms, group home staff).

4. Culturally Appropriate Interventions for Adults with Hearing Loss

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Adults with hearing loss face many health-related challenges, including those unrelated to their hearing loss. A subset of those with hearing loss, members of the Deaf community, comprise a unique cultural and linguistic minority. An estimated 500,000 adults are members of this cultural group. Previous research has suggested that there may be health disparities in this group. For example, deaf adults have higher rates of HIV/AIDS and heart disease.

Ecological models have been used in public health to explain the diverse impacts on health from a number of sources; these models describe the personal and environmental factors that contribute to behavior. We apply this model to explain how different factors might be contributing to health disparities in the Deaf community. Individual level impacts might include lack of knowledge about health and body processes and lower self-efficacy to perform certain health behaviors. Interpersonal level impacts might include language barriers between Deaf children and parents or friends, tightly knit social circles in which

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misinformation pervades, and unique social norms that limit discussion about certain health behaviors. Organizational level impacts might include lack of health education curricula developed for this population. Community level impacts might include reduced access to media campaigns due to language or cultural barriers. Policy level impacts might include unintended consequences of the Americans with Disabilities Act, and health care financing of effective communication strategies.

We demonstrate how this model can be used to design culturally appropriate interventions for members of the Deaf community on a variety of health topics.

5. Youth with Mobility Disabilities and Physical Activity

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Youth with mobility disabilities are less likely to participate in physical activity compared to non-disabled youth because of environmental, architectural, and programmatic barriers that hinder their access to physical activity opportunities. Extracting data from an ongoing national survey addressing the health status of adolescents with disabilities (N=540), the present study examined programmatic and transportation barriers associated with physical activity participation of adolescents with mobility disabilities (e.g., cerebral palsy, spina bifida, brain injury, muscular dystrophy, and limb loss). In the programmatic domain, existing programs available at sports/recreation venues were "slightly" (25.6%) or "not at all" (10.6%) accessible to adolescents with mobility disabilities.

For sixty percent of adolescents with mobility disabilities, there were "no" programs in which they could participate at their closest park district or community center. In the transportation domain, 82.5% of the adolescents could not travel independently; 73.8% "always" needed special transportation due to their disability; and only 39.1% reported that a ride is "always" available to take them to sports or other physical activities. Future research should emphasize the removal of barriers focusing on these two domains, in addition to other domains in which barriers may exist such as socioeconomic (i.e., cost, culture), psychological (i.e., motivation, perceptions and attitudes) or structural (i.e., built environment, accessible equipment and facilities). This study is supported by Grant No. H133A060066 from the National Institute on Disability and Rehabilitation Research.

6. Integrating People with Disabilities In Public Health Initiatives

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Objective: Implement a policy approach within the New York State Department of Health (NYSDOH) to integrate persons with disabilities in public health initiatives.

Disability is a major public health concern. Disability is often equated with inferior health status and persons with disabilities are traditionally underserved in public health programs. Management of the primary disabling condition is frequently the overriding concern, with little attention paid to recognized standards of health promotion, screening and disease prevention. Accordingly, effort needs to be directed to integrate persons with disabilities in health promotion and health risk reduction programs.

To advance integration efforts within the NYSDOH, the Disability and Health Program (DHP) developed an inclusion policy which became a requirement for procurements released by the NYSDOH Center for

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Community Health. The NYSDOH CCH typically has 3,100 contracts competitively procured to fund public health programs, with an approximate aggregate value of \$1.03 billion/year. The policy requires programs to incorporate strategies throughout procurements to ensure persons with disabilities are integrated in funded initiatives.

In implementing this policy, the DHP is proactively providing assistance to support inclusive procurement development. Assistance includes meeting with individual programs, providing statistical profiles and demographics; promoting evidence-based and promising practices; and identifying resources applicable to a program's initiative.

This policy approach is innovative because it requires identification of methods to integrate persons with disabilities in the initial stage of procurement development. Programs designed to be inclusive at the outset expand reach, ensure accessibility and are more cost effective than retrofitting or modifying inaccessible programs.

7. Accessing Outpatient Care and People with Disabilities

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The IOM recently released a report suggesting that hospital visits for certain conditions were avoidable and that lack of access to outpatient care may be one factor contributing to hospitalizations. A similar argument may apply to emergency room (ER) use and may be especially true for individuals known to have difficulty accessing the health care system, such as adults with disabilities and chronic conditions. In order to better understand these issues among working age Americans (18-64 years of age) we examined access to care and ER use among nationally representative groups of adults with and without chronic health care needs. Adults with chronic health care needs (ACHCN) included three subgroups, all of whom had at least one chronic condition: those without self-reported limitations, those reporting non-ADL/IADL limitations, and those reporting ADL/IADL limitations. Logistic regression models were applied to pooled annual data from the 2002-2004 Medical Expenditure Panel Survey to examine relationships between any ER use and access to medical care and prescription medications. After controlling for socio-demographic factors, resources, and number of acute conditions, lack of or delayed access to medical care and prescription medications were significantly related to ER use. In addition, more adults with limitations reported difficulty accessing necessary medical care and prescription medications (17%, 14% respectively) compared to ACHCN without limitations (7%, 5%) or adults without chronic health care needs (3%, 1%). This suggests the need for improved access to and coordination of primary care for adults with chronic health care needs, especially those with limitations.

8. Tool for Accessing Usability of Outpatient Health Clinics

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Background and Importance

Accessible health care facilities are a foundation for good health among people with disabilities. In fact, the Americans with Disabilities Act requires that health care facilities be accessible. While the ADA Accessibility Guidelines (ADAAG) contain over 700 specifications for accessible facilities, more concise tools can serve as a useful first step in improving accessibility. This presentation describes the development of a valid, reliable, and practical tool for assessing the "usability" of outpatient health clinics.

Methods & Results

Content Validity Ratios (CVR) were used to determine the items in the tool. Three focus groups of people with sensory, cognitive, or mobility disabilities prioritized items from the ADAAG. Items receiving a minimal CVR of .20 received further review. A panel of ADA experts reviewed each item to determine if it was essential to establish a health care facility as "useable." Items receiving a CVR of .80 were retained.

Inter-rater reliability was established with both trained and untrained raters assessing 20 clinics. Inter-rater reliability of the 158 items was strong, with an average Kappa coefficient of 0.89. Assessments revealed a number of barriers to usability, e.g., 93% of clinics had no means of weighing a wheelchair user, and 80% had no adjustable-height exam tables. Practicality was judged based on length of time required to assess a clinic (<2 hours) and training requirements.

Conclusions

The OHCUP provides reliable data on key barriers for people with disabilities attempting to use outpatient clinics, and a practical beginning point for full accessibility determinations.