People with disabilities are not only a significant proportion of any health plan’s patient population but constitute a potential growth area for health plan market share. Over 54 million Americans have disabilities. One in five people live with at least one disability. With the aging of the baby boomer population, the number and proportion of people with disabilities will increase. Most Americans will experience a disability at some time during their lives. In addition, over 25 million family members provide personal assistance and care. Because of their affiliation with health plan members with disabilities, many of them could potentially become members. The Office of the Patient Advocate (OPA) is charged with providing consumer education to HMO enrollees and to develop written materials to assist consumers with navigating the managed care system. Additionally, OPA is charged with producing an annual Report Card. The HMO Report Card provides consumers, purchasers, advocates, and regulators with comparative information on the performance of California HMOs and medical groups using clinical and member/patient satisfaction data. Health Plans participate in the HMO Report Card process voluntarily. The HMO Report Card provides health plans with an opportunity to show their commitment to help patients make informed choices about their health care and the health plan that best fits their needs. Recognizing the tremendous impact the delivery of health care services has on the lives of people with disabilities, OPA examined health care service delivery for these consumers.


7. Ajamian, P.C. “Don't Turn a Deaf Ear; Patients with Vision Loss are Also More Likely to have Hearing Loss. As a Primary-care Doctor, Here's How You Can Help Them.” Review of Optometry 145.7 (2008): 81.


We describe how a Community-Based Participatory Research (CBPR) process was used to develop a means of discussing end-of-life care needs of Deaf seniors. This process identified a variety of communication issues to be addressed in working with this special population. We overview the unique linguistic and cultural characteristics of this community and their implications for working with Deaf individuals to provide information for making informed decisions about end-of-life care, including completion of health care directives. Our research and our work with members of the Deaf community strongly show that communication and presentation of information should be in American Sign Language, the language of Deaf citizens.


Blindness and visual impairment are among the 10 most common causes of disability in the United States and are associated with shorter life expectancy and lower quality of life. Previously, state-specific prevalences of visual impairment and eye disease were estimated from national prevalences. However, in 2005, five states (Iowa, Louisiana, Ohio, Tennessee, and Texas) provided state-specific estimates by using the new CDC Behavioral Risk Factor Surveillance System (BRFSS) vision module. CDC analyzed data from the module to determine the self-reported prevalence of visual impairment, eye disease, eye injury, and lack of eye-care insurance and eye examination among persons aged ≥50 years in each of these five states and among certain sociodemographic populations overall. This report describes the results of that analysis, which indicated variation in disease prevalence and use of eye care among individual states and also among racial/ethnic populations and age groups within the five states combined. The variability among state data suggests that state specific surveillance of visual impairment and eye care and investigation by states to identify influencing factors might lead to creation of vision programs better suited to individual state needs.

This letter investigates the barriers that people with disabilities face obtaining referrals and concludes that, “Physical disablement and doctors' perception of inability to perform exercise testing should not be a barrier to referral for diagnosis and risk assessment of cardiovascular disease.”

This article focuses on the biopsychosocial aspects of presbycusis and includes information on speechreading.

Promoting culturally sensitive and competent health care is one of the goals of
medical educators in guiding medical students and residents, as well as designing continuing education for family physicians. Working with minority communities is essential to meet that goal. This article introduces some of the sociocultural experiences of deafness and their relevance in health care settings.


   This article examines the association between age at onset of deafness and mortality using analyses of the National Health Interview Survey data from 1990 and 1991--the years the Hearing Supplement was administered--linked with National Death Index data for 1990-1995. The results showed that adults with postlingual onset of deafness were more likely to die in the given time frames than non-deaf adults. However, when analyses were also adjusted for health status, there was no difference between adults with postlingual onset of deafness and a control group of non-deaf adults. No differences in mortality were found between adults with prelingual onset of deafness and non-deaf adults. The authors concluded that adults with postlingual onset of deafness appear to have higher mortality than non-deaf adults, which may be attributable to their lower self-reported health status.


   The purpose of this study was to evaluate the utilization of health care by deaf adults in the U.S. according to the age at onset of deafness, which is an indicator of linguistic and sociocultural group affiliation. The study looked at a sample of adults who were deafened prelingually, postlingually and a control group pulled from the general population. The key measures were physician visits and preventative health care utilization. Compared with the general population, prelingually deafened adults had fewer physician visits and were less likely to have visited a physician in the preceding 2 years, whereas postlingually deafened adults had more physician visits and were more likely to have visited a physician in the preceding 2 years. Postlingually deafened women were less likely to have had a mammogram within the previous 2 years. In terms of health care utilization, the deaf population is heterogeneous. Prelingually deafened adults' use of health care is similar to that of other language minority groups. Postlingually deafened adults' use of health care services appears similar to people with chronic illness. Future studies must distinguish different groups of people with hearing loss in order to identify barriers and monitor improvements in health care services access.

The purpose of this study was to determine the prevalence of telephone ownership in different deaf populations and to explore its implications for telephone-based surveys. The authors used data from the National Health Interview Survey (NHIS) data from 1990 and 1991, the years in which the NHIS Hearing Supplement was administered. Results showed that prelingually deafened adults were less likely than members of the general population to own a telephone, whereas postlingually deafened adults were as likely as members of the general population to own one. The authors concluded that telephone surveys risk marginalizing prelingually deafened adults because of low telephone ownership and language barriers between the deaf and hearing communities.


This study investigated knowledge about HIV/AIDS and barriers to HIV/AIDS education and prevention among deaf and hard of hearing people. Focus groups and individual interviews were used to elicit information from various groups of people with a hearing loss in different regions of New York State. Themes elicited in the interviews suggested that deaf sign language users are less knowledgeable about HIV/AIDS than oral deaf and hard of hearing participants, and that deaf adolescents have more knowledge than deaf adults. These findings likely reflect differences in levels of education and English proficiency. In addition, participants living in urban areas and in sizeable deaf communities are more exposed to information about HIV/AIDS than other participants. All participants reported difficulties in communication with medical providers, limiting their access to health information and proper medical care. Recommendations for the design and dissemination of educational materials and greater access to services for deaf and hard of hearing people are provided.


Adults with learning disabilities frequently have unmet health needs. The causes are complex and may be related to difficulties in accessing usual primary care services. Health checks have been widely recommended as a solution to this need. This study examined the likelihood that a structured health check by the primary care team supported by appropriate education would identify and treat previously unrecognized morbidity in adults with intellectual disabilities.
The findings reflect a concern that current care delivery leaves adults with an intellectual disability at risk of both severe and milder illness going unrecognized. Health checks present one mechanism for identifying and treating such illness in primary care.


The objective of this study was to, “examine patterns of access to a variety of specific health care services among people with chronic or disabling conditions, focusing on factors that predict access to services.” The study concluded that people with chronic or disabling conditions often require a comprehensive array of health care services. Ensuring that health care is more responsive to those with the greatest service needs calls for increased payment rates and an improved service delivery structure.


The purpose of this study was to explore the reproductive health care experiences of women with physical disabilities and how reproductive health care experiences could be improved. The study used qualitative interviews with ten women, ages 28 to 47 years, with physical disabilities, including multiple sclerosis, cerebral palsy, and paralysis. Interviewees encountered numerous barriers to quality reproductive health care services, including inaccessible equipment and facilities, limited contraceptive options, health care providers' insensitivity and lack of knowledge about disabilities, and limited information tailored to their needs. Providers sometimes appeared surprised that such patients would be sexually active, and frequently did not ask about contraceptive use or assess for sexually transmitted diseases. Although most interviewees had private health insurance, some had problems seeing preferred providers. Accessing reproductive health care services is so difficult that some women avoid regular gynecologic visits.


This book investigates being deaf and its ramifications in society, and the relationship between thought processes and language, whether spoken or not. The sage perspective it offers will engender fresh insights about matters changed and unchanged for deaf persons today.

29. Berkwick, D.N. “Improving Patient Care: My Right Knee.” Annals of Internal Medi

A brief narrative description of the journal article, document, or resource. Little research has focused on tobacco use among deaf and hard of hearing youth. Findings are reported from a first-ever tobacco-related survey, completed by 226 California middle and high school students using either a written questionnaire or the Interactive Video Questionnaire, an interactive multimedia computer video technology. Rates for current smoking (3.1%), ever smoking (45.1%), and multiple types of tobacco use (10.6%) were found to be lower than among high school students generally; mainstreamed students were likelier to have ever tried smoking than their deaf school peers (57.8% vs. 31.8%). No statistically significant associations were found between ever smoking and race/ethnicity, gender, school performance, or prelingual vs. postlingual deafening; a quarter of the sample experienced occasional peer pressure to use tobacco products. Tobacco use covariates, exposure to cigarette marketing and anti-smoking programming, and tobacco education needs of deaf and hard of hearing youth are discussed.


The writers describe the development of a tobacco survey for youth who are deaf. The Interactive Video Questionnaire (IVQ), an interactive multimedia computer and video technology, was chosen as a strategy to overcome the barriers posed by traditional data-collection techniques among the deaf. A questionnaire was outlined by developing particular questions linked to key parts of deaf culture and identity. However, the questionnaire items had to be reshaped because the IVQ was unable to display a question and its possible response at the same time. The English language questionnaire was adapted for each language modality in the IVQ, although the original intent and content of each item was maintained. The IVQ survey represents an exciting step forward in the collection of much needed information on tobacco use among deaf youth, information that is crucial to adequate and timely public-health planning for this population.


This article offers guidelines for nurses working with women with disabilities in obstetrician/gynecological visits. It covers physical access barriers as well as the need to discuss issues of sexuality and child birth. The main focus of the
OBJECTIVES: This study assessed the effects of reducing fatal and nonfatal health conditions on the number of functionally limited older Americans in the coming decades. METHODS: Data from the 1990 census and the Longitudinal Study of Aging were used to project the number of functionally limited older Americans from 2001 to 2049, assuming 1% biennial reductions in five conditions that shorten life expectancy (coronary artery disease, stroke, cancer, diabetes, and confusion) and one condition that decreases functional ability (arthritis). RESULTS: Decreasing the prevalence of arthritis by 1% every 2 years would lead to a much greater reduction in functional limitation between 2001 and 2049 (4 million person-years) than would decreasing any of the other conditions by the same amount. Decreases in two fatal conditions (cancer and coronary artery disease) would lead to increases in functional limitation (0.9 and 0.1 million person-years, respectively). CONCLUSIONS: Advances against common nonfatal disabling conditions would be more effective than advances against fatal conditions in blunting the large increase in the functionally limited older population anticipated in the 21st century.


This article suggests that medicine often attaches negative characteristics to particular racial and ethnic groups, and physicians, for a variety of reasons, resort to these profiles in making individual treatment decisions. For example, African-American patients are understood to be less likely to survive invasive medical procedures, more likely to possess more virulent tumors, and less likely to respond to the standard course of treatment, because of presumed biological
differences. From a cultural perspective, African-American patients are understood to be less likely to adhere to risky and costly courses of treatment, and less likely to understand their medical condition.


Major shifts have occurred in the world of disability that have profound implications for health-service provision. Although health researchers and clinicians have begun to address the health needs of women with disabilities, representation of older women with intellectual disabilities in health research and health-care practice remains inadequate. As the visibility of this group continues to grow through policies that support greater community integration and longevity, they and their families, professionals, and advocates will require more information about their health concerns, and appropriate health services and options. This article provides an overview of major issues of women with developmental disabilities within the areas of primary health care, aging, access to health services, and future directions in research and practice.


This article focuses on embodied health movements, primarily in the US. These are unique in three ways: 1) they introduce the biological body to social movements, especially with regard to the embodied experience of people with the disease; 2) they typically include challenges to existing medical/scientific knowledge and practice; and 3) they often involve activists collaborating with scientists and health professionals in pursuing treatment, prevention, research and expanded funding. This article employs various elements of social movement theory to offer an approach to understanding embodied health movements, and provides a capsule example of one such movement, the environmental breast cancer movement.


Being active members of our local gym, as well as tech geeks from the AFB TECH product evaluation lab, we have a great personal interest in the barriers faced by people who are blind or have low vision who want to be physically fit. Hoping that AccessWorld readers share the same interest, we decided to discuss
some of the issues involved in working out at your local gym or fitness center, with an emphasis on the accessibility of various types of exercise equipment.


Disability may make it difficult to lie flat or abduct the arm to deliver radiation therapy, imposing a high risk for radiation-induced side effects or difficulty in positioning patients for mammography. The goal of this study was to determine the differences in treatment options experienced by women with physical disabilities compared with those without disabilities. The findings indicate that women with disabilities are less likely to undergo BCS and are less likely to receive neoadjuvant chemotherapy compared with women without disabilities, but the difference did not reach statistical significance. To the authors' knowledge, there are no data to support the hypothesis that disabled women are diagnosed at a more advanced stage of disease compared with women without disabilities.


This study assesses health insurance status and health-care access of young adults with disabilities attributable to a chronic condition. Authors analyzed data from the National Health Interview Survey from 1999 to 2002. Outcomes revealed delayed or unmet health needs owing to cost, no contact with a health professional in the prior year, and no usual source of care.


Health promotion interventions for adults who are visually impaired have received little attention. This article reports what is currently known about the health, overweight and obesity, and levels of physical activity reported by these adults. Conclusions about the need for health promotion activities based on this information are provided, and suggestions for implementing these activities or interventions are offered.

Health promotion and screening tests are important in persons with disability to avert secondary conditions that can lead to suboptimal functioning or premature death. Conversely, the existence of a primary disability can increase a person's susceptibility to secondary conditions. Cardiovascular disease (CVD) is the major cause of death in the United States, and its prevalence has been under-investigated in persons with disability. This descriptive study used survey research to compare the risk of CVD in samples of 100 physically disabled women with 50 nondisabled women in the community. Participants, recruited from health fairs, completed questionnaires that explored the participants' knowledge of CVD risk factors, possession of specific CVD risk factors, and experience with CVD preventive screening procedures. Data revealed that compared with women without disability, women with disability were less knowledgeable about CVD risk factors and experienced marked deficiencies in CVD preventive screening. Body weight measurement, baseline electrocardiograms, family history, and smoking queries were performed less often in women with disabilities than in women without disabilities of similar age. Physical inactivity and postmenopausal status were specific CVD risk factors found to be more prevalent in the sample of women with disability. These findings suggest that risk of CVD is under-recognized and under-assessed in women with a physical disability.


In 2002, an estimated 51.2 million persons in the United States (approximately 18.1% of the population) had a disability. Recent data suggest that substantial disparities in health behaviors and overall health status exist between persons with and without disabilities. Nonetheless, when they have access to adequate health care, persons with disabilities can lead healthy lives. The World Health Organization's International Classification of Functioning, Disability, and Health stresses the importance of environment (e.g., physical environment, attitudes of others, or policies) as either a barrier or facilitator in the daily activities of persons with disabilities. In addition, increasing access to health and wellness treatment programs for persons with disabilities and reducing the proportion of persons with disabilities who report environmental
Barriers to participation in daily activities are goals of Healthy People 2010 (objectives 6-10 and 6-12). However, few population-based studies have explored how environment affects the lives of those with disabilities. To determine the prevalence of disability among persons in Los Angeles County, California, and assess the effects of environmental barriers on these persons, residents were surveyed during 2002-2003. The results of that survey suggested that persons with physical or sensory disabilities experienced several environmental barriers and that the prevalence of barriers varied by demographic characteristics, household income, and severity of disability. To improve quality of life among persons with disabilities, public and private health agencies should implement measures to remove environmental barriers to health care and other services.


The U.S. Bureau of the Census and CDC analyzed data from the Survey of Income and Program Participation (SIPP) to determine national prevalence estimates of adults with disabilities and associated health conditions. This report summarizes findings of that analysis, which indicate that disability continues to be an important public health problem, even among working adults, and arthritis or rheumatism, back or spine problems, and heart trouble/hardening of the arteries remain the leading causes. Better health promotion and disease prevention may reduce the prevalence of disability-associated health conditions.


The article discusses the prevalence of arthritis and arthritis-attributable activity limitation in the adult U.S. population in 2003-2005, according to the National Health Interview Survey. Several disadvantages of arthritis include reduced quality of life and high health-care costs. Details of the methodology used in the study are offered.


The purpose of this study was to compare health maintenance procedure rates of Medicare patients with different levels of disability. Results indicated that compared to those without disabilities, the most severely disabled women reported fewer Pap smears and mammograms. In a controlled analysis, individuals with this high level of disability were 57% and 56% less likely to report receiving Pap smears and mammograms, respectively, compared with able-bodied women, regardless of their age, whether they were in an HMO, or whether they lived in a long-term care facility. Functional limitations were not a deterrent to receiving vaccinations. In general, patients in HMOs reported more procedures than those in fee-for-service, while those in long-term care facilities reported fewer procedures than those living in the community. The authors concluded that Disability among Medicare patients is a significant, independent risk factor for not receiving mammograms and Pap smears. Efforts should be made to identify the most severely disabled because they are at particular risk.

<http://www.healthwellness.org/training/sciconf/sciconf_briefs >.


Rapid advances in information technology have dramatically transformed the world during the past several decades. Access to computers and the World Wide Web is increasingly required for education and employment, as well as for many activities of daily living. Although these changes have improved society in many respects, they present an obstacle for visually disabled patients who may have significant difficulty processing the visual cues presented by modern graphical user interfaces. This article reviews the specific barriers to computer and Web access based by visually disabled patients, describes clinical evaluation method, summarizes traditional low vision methods as well as newer assistive computer technologies for universal accessibility, and discusses emerging technologies and future directions in this area.


This article gives an overview of the Agency for Healthcare Research and Quality’s (AHRQ) disability agenda and looks at opportunities for more health care and health services research. Then the article considers an agenda for future disability-related healthcare research.

This study examined barriers to hearing aid use among persons who were reported to have a hearing aid and among those reported to have hearing difficulties but no hearing aids.


This article discusses some issues for deaf and hard-of-hearing patients. It covers characteristics of deaf and hard-of-hearing patients, assessment of deaf and hard-of-hearing patients, practical suggestions for interviewing deaf and hard-of-hearing patients and organizations that offer support for deaf and hard-of-hearing persons. It also recommends reading for deaf and hard-of-hearing patients and their physicians.


OBJECTIVES: To estimate the cause-specific prevalence and distribution of blindness and low vision in the United States by age, race/ethnicity, and gender, and to estimate the change in these prevalence figures over the next 20 years.

METHODS: Summary prevalence estimates of blindness (both according to the US definition of < or =6/60 [< or =20/200] best-corrected visual acuity in the better-seeing eye and the World Health Organization standard of < 6/120 [< 20/400]) and low vision (< 6/12 [< 20/40] best-corrected vision in the better-seeing eye) were prepared separately for black, Hispanic, and white persons in 5-year age intervals starting at 40 years. The estimated prevalences were based on recent population-based studies in the United States, Australia, and Europe. These estimates were applied to 2000 US Census data, and to projected US population figures for 2020, to estimate the number of Americans with visual impairment. Cause-specific prevalences of blindness and low vision were also estimated for the different racial/ethnic groups. RESULTS: Based on demographics from the 2000 US Census, an estimated 937 000 (0.78%) Americans older than 40 years were blind (US definition). An additional 2.4 million Americans (1.98%) had low vision. The leading cause of blindness among white persons was age-related macular degeneration (54.4% of the cases), while among black persons, cataract and glaucoma accounted for more than 60% of blindness. Cataract was the leading cause of low vision, responsible for approximately 50% of bilateral vision worse than 6/12 (20/40) among white, black, and Hispanic persons. The number of blind persons in the US is projected to increase by 70% to 1.6 million by 2020, with a similar rise projected for low vision. CONCLUSIONS: Blindness or low vision affects approximately 1 in 28 Americans older than 40 years. The specific causes of visual impairment, and especially blindness, vary greatly by race/ethnicity. The prevalence of visual disabilities will increase markedly during the next 20 years, owing largely to the
aging of the US population.


Review of the literature concerning the relationship between deafness and psychiatric disorder reveals differences in the pattern of illness depending on the severity of deafness and the age of onset. In particular, the prevalence of schizophrenia in the prelingually deaf is similar to that found in the normal population, whereas the hard of hearing are over-represented among samples of patients suffering from paranoid psychoses in later life. Possible modes of action of long-standing hearing loss in the aetiology of paranoid illnesses are considered: the psychological and social consequences of deafness, the possible contribution of sensory deprivation phenomena, and the interference of hearing loss in attention, perception and communication. Finally, possible future lines of research are suggested.


The purpose of the consensus conference was to identify research priorities for physical activity and health among people with disabilities. Priorities were established by 30 participants, who were selected by the principal investigators to achieve balance in the areas of engineering, epidemiology, medicine, nutrition, exercise physiology, and psychology. The discovery process led the authors to conclude that exercise must be studied from the perspective of disease prevention while mitigating risk for injury. Five areas were identified as focal points for future work: epidemiological studies; effects of nutrition on health and ability to exercise; cardiovascular and pulmonary health; children with disabilities; and accessibility and safety of exercise programs. As people with disabilities live longer, the need for addressing long-term health issues and risk for secondary disability must receive greater attention. As a consequence of the consensus process, specific recommendations for future research regarding the impact of exercise on the health and quality of life of persons with disabilities were defined.


This study looked at the benefits of training health-care staff about mental health issues. The researchers tested workers before training and after training
and discovered that about one third of patients had mental illness that was not detected by staff. Four months after the delivery of training, significant improvements in knowledge, attitudes and referral decisions were observed. The authors concluded that brief training interventions may improve awareness of mental health problems, but further research is needed to understand the referral process and to demonstrate the role of training in influencing actual staff behavior.


This retrospective study used national survey data to examine multiple effects of nine comorbid conditions--breathing problems, depression risk, diabetes, heart problems, hearing impairment, hypertension, joint problems, low back pain, and stroke--on physical functioning, participation, and health status among older adults with visual impairments. Bivariate and multivariate procedures were used to compare older adults who had neither visual impairment nor these conditions with adults of similar age who had one of the nine conditions only, visual impairment only, or both visual impairment and the condition. Findings indicate that older adults with visual impairment frequently experience comorbid conditions, and that these conditions are associated with difficulties in walking and climbing steps, shopping, and socializing, and with significantly more self-reports of declining health. Results suggest that interventions by health care and mental health providers, as well as enhanced rehabilitation services, have the potential to reduce or prevent the deleterious effects of comorbid conditions.


This special issue of the Journal of Visual Impairment & Blindness is a first attempt to bridge the fields of vision rehabilitation and public health. As such, it has a dual audience and a dual purpose: 1) to persuade members of the vision rehabilitation field that collaborating with the public health community will help to meet the needs of people with visual impairments, and 2) to convince those in public health that their mission to serve the public will be more fully realized if they include people with disabilities within their conception of health and ensure accessibility throughout their programs and services. As obvious as this type of mutual benefit may sound to some, it has been questioned, and certainly has not yet had a chance to develop in practice.

Objectives. We investigated the health, activity, and social participation of people aged 70 years or older with vision impairment, hearing loss, or both.

Methods. We examined the 1994 Second Supplement on Aging to determine the health and activities of these 3 groups compared with those without sensory loss. We calculated odds ratios and classified variables according to the International Classification of Functioning, Disability and Health framework.

Results. Older people with only hearing loss reported disparities in health, activities, and social roles; those with only vision impairment reported greater disparities; and those with both reported the greatest disparities.

Conclusions. A hierarchical pattern emerged as impairments predicted consistent disparities in activities and social participation. This population’s patterns of health and activities have public health implications.


This primer is on Medicaid's role as the major provider of health coverage for non-elderly persons with disabilities and on the policy challenges that lie ahead. It also provides short profiles of people with disabilities from across the country.


Despite the disproportionate health care needs and expenditures of many—though not all—individuals with disabilities, the mainstream health services research community has largely neglected them. This article outlines the most pressing health service research issues in addressing the health care needs of individuals with disabilities.

83. DeJong G.; Palsbo S.E.; Beatty P.W.; Jones G.C.; Kroll T. and Neri, M.T. “The

In this article, the authors present the results of a series of focus groups with people with disabilities, in which they took a cross-disability, lifespan perspective of disability. Consumers were asked about a broad set of barriers, such as problems with communication, transportation, and insurance, as well as about barriers related to physical accessibility. Barriers were categorized as structural, financial, or personal/cultural. Results suggest that individuals with disabilities experience multiple barriers to obtaining health care and that these barriers are more pronounced for some types of health care than others. In addition, regardless of disability type, consumers consistently spoke about similar barriers. The results underscore the importance of taking a broad perspective when making policy decisions and the need for continued change and improvement in this area.


This article suggests that a 21st century public health perspective on community needs and resource mobilization in vision impairment be grounded in a holistic concept of the community. This perspective should recognize the nature and magnitude of blindness and visual impairment within the significant technological, demographic, political, and socio cultural changes that characterize today's complex community structures. These changing community dynamics are linked with strategies for organizing and mobilizing resources. The article concludes with three propositions and a call for political action to transform our currently fragmented system of providing services into an integrated strategy for the 21st century.


In previous articles, AccessWorld has documented the fact that only one
currently available blood glucose monitor uses modern technology and is accessible, but it comes at a price 10 times more than the inaccessible monitors. There are only two home blood pressure monitors for sale that have speech output. This article discusses an informal survey of diabetes educators and highlights their lack of knowledge on how to instruct patients who are blind or visually impaired to independently monitor and manage their health.


The authors investigated differences in the development of disability in activities of daily living among non-Hispanic Whites, African Americans, Hispanics interviewed in Spanish, and Hispanics interviewed in English. The risk for developing disability among Hispanics interviewed in English was similar to that among Whites but was substantially higher among African Americans and Hispanics interviewed in Spanish. Adjustment for demographics, health, and socioeconomic status reduced a large portion of those disparities. The authors concluded that higher risks for developing disability among older African Americans, and Hispanics interviewed in Spanish compared with Whites were largely attenuated by health and socioeconomic differences. Language- and culture-specific programs to increase physical activity and promote weight maintenance may reduce rates of disability in activities of daily living and reduce racial/ethnic disparities in disability.


Physicians were surveyed regarding prior contacts with deaf patients and with deaf people outside the medical setting, and regarding their knowledge and beliefs concerning methods of communicating with deaf people. Physicians were asked to estimate the fraction of encounters in which they communicated with deaf patients by lipreading, writing, translation by a relative or friend, a sign language interpreter, or other methods. Results showed that writing was the method used most frequently in communicating with deaf patients. Although 63% of physicians knew that signing should be the initial method of communicating with deaf patients who sign, only 22% used sign language interpreters more frequently than other methods in their practices. Past contact with deaf people, belief that communication by signing was the best means of communication and knowledge of the inefficiency of lipreading were predictors of the use of sign language interpreters for deaf patients. Physicians who used sign language interpreters more frequently than other methods believed that
much more time and effort were involved in caring for deaf than for hearing patients compared with those who used interpreters less frequently. Greater recognition of the advantages of signing over other methods and greater availability of sign language interpreters should lead to more effective communication between deaf patients and physicians.


People hold many simultaneous cultural associations, and each have implications for the care process. The "culture of disability" is something physicians should be well-versed in to ensure appropriate, culturally sensitive care to persons with congenital or acquired disabilities. Cultural competencies include communicating with patients who have deficits in verbal communication and avoidance of infantilizing speech; understanding the values and needs of persons with disabilities; the ability to encourage self-advocacy skills of patients and families; acknowledging the core values of disability culture including the emphasis on interdependence rather than independence; and feeling comfortable with patients with complex disabilities. Medical schools have programs to facilitate development of competencies with respect to patients with disabilities. The culture of disability should be included as one of the many cultures addressed in cultural competence initiatives in medical school and residency curricula.


The objective of the study was to better understand the perceptions and needs of multigenerational Deaf adults related to mental health services. A survey sampled participants who were between 20 and 85 years old and Deaf. Questions were developed to identify the perspectives of Deaf adults related to the availability of mental health services, preferences for these services, and current utilization of services. Participants were grouped into age (years) categories: young adult (18-34), middle adult (35-54), older adult (55-65), and oldest (66-). Category response trends were examined using chi-square analysis. The analysis showed significant differences in the preferences and utilization of mental health care. These data also suggested preferences for service delivery. These data indicate areas of importance related to the development of programs and services for Deaf adults and to indicate where funding for services would be best utilized.

This review was conducted to identify health care needs and the availability and accessibility of health care services for people with MR.

OBJECTIVES: This article presents survey data about the health and behavioral characteristics of a randomly selected sample of 629 adults with mental retardation (MR) living in Massachusetts in 2000. The goals of this analysis were to: describe the health, behavioral, and functional characteristics of the sample; examine relationships between consumer health, behavior problems, and functioning; and analyze variations in health and behavior problems by type of residential setting (parent/relative home, community residence, or institutional setting). METHODS: The authors analyzed data obtained from interviews with proxies (relatives, guardians, advocates, or program staff) on behalf of consumers and from state agency records. Chi-square analyses were conducted to examine the relationships between health, behavioral, and functional characteristics of consumers and differences in health and behaviors by type of residence. RESULTS: More than 80% of consumers were reported to have either "excellent" or "good" health. Overall health status did not significantly vary by residential type, but was significantly related to the presence of additional disabilities and some functional limitations. Several health and behavioral measures varied significantly by residential type: recent physical, dental, and ob/gyn exams; medication usage; problem behaviors; and functional level. CONCLUSIONS: As large numbers of individuals with MR reach adulthood and old age, public health and medical professionals face the challenges of addressing the health and behavioral needs of this population, preventing secondary health conditions, and improving environmental conditions that may influence health and mental health.


As reported, the plaintiff sued her doctor under the ADA, Section 504, and New Jersey’s Law Against Discrimination for refusing to provide her with an interpreter over the course of 20 visits over 20 months during her treatment for lupus. The defendant had claimed that, as a solo practitioner, the estimated
The interpreter’s cost of $150–$200 per visit would be an undue hardship when he was only being reimbursed $49 per visit by plaintiff’s insurer, but the plaintiff’s attorney introduced tax returns showing that defendant provider earned over $400,000 a year. The three-week trial took place in New Jersey Superior Court, and the jury ultimately found that the defendant violated the law by failing to provide the plaintiff with an interpreter and retaliating against her for requesting one.


The purpose of this study was to investigate differences in health service use and pregnancy outcomes among women enrolled in Medicaid under eligibility categories for the blind and disabled and those enrolled under other eligibility categories. The authors found that women with disabilities were more likely than women without disabilities to have had continuous Medicaid coverage from preconception through the postnatal period. Women with disabilities were equally or less likely to have received adequate prenatal care compared to women without disabilities in the two study states with these data. They were also more likely to have had emergency room visits, hospital admissions during pregnancy, cesarean deliveries, and readmissions within 3 months of delivery in all study states. Also, women with disabilities were more likely to deliver preterm and low birth weight infants. Results suggest that opportunities exist to improve access to prenatal care among women with disabilities enrolled in Medicaid under blind and disabled eligibility categories who become pregnant.


Quantitative research is designed to test well-specified hypotheses, determine whether an intervention did more harm than good, and find out how much a risk factor
predisposes persons to disease. Equally important, qualitative research offers insight into emotional and experiential phenomena in health care to determine what, how, and why. There are 4 essential aspects of qualitative analysis. First, the participant selection must be well reasoned and their inclusion must be relevant to the research question. Second, the data collection methods must be appropriate for the research objectives and setting. Third, the data collection process, which includes field observation, interviews, and document analysis, must be comprehensive enough to support rich and robust descriptions of the observed events. Fourth, the data must be appropriately analyzed and the findings adequately corroborated by using multiple sources of information, more than 1 investigator to collect and analyze the raw data, member checking to establish whether the participants' viewpoints were adequately interpreted, or by comparison with existing social science theories. Qualitative studies offer an alternative when insight into the research is not well established or when conventional theories seem inadequate.


People with disabilities have more dental disease, more missing teeth, and more difficulty receiving dental care than other members of the general population. Because of the deinstitutionalization movement during the later 20th century, many formerly institutionalized people now reside in community settings, which lack oral health services. Even individuals who were not institutionalized have barriers to oral health services. These realities underscore the importance of preventing dental disease in people with special needs by establishing preventive dental disease protocols.


Marking the 10th anniversary of the landmark Americans with Disabilities Act, advocates sued Kaiser Permanente of California Wednesday, alleging that the health care giant fails to provide equal and adequate care for the physically disabled. The lawsuit, filed on behalf of three people who rely on wheelchairs, contends that the disabled face pervasive barriers at scores of Kaiser facilities statewide, including exam rooms, counters and restrooms, as well as a lack of specially equipped exam tables and weight scales.


Provides an overview of chemical dependency, assessment issues, and considerations unique to the deaf and hard-of-hearing population. A chemical-dependency assessment tool developed by the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals is described and a case study illustrating application of this assessment process is provided.


Few data exist describing Medicaid's success in providing health care services to people with abilities. The access to care survey from the Medicaid Expenditures Panel Survey was used to collect access data from 502 individuals with disabilities in Central Missouri receiving Medicaid under fee for service reimbursement. Nearly all of the respondents had a usual source of care, but two thirds reported difficulties obtaining a needed health care service. Dental, optometric, and personal assistance services were the most difficult to obtain. Provider nonparticipation, non-coverage of a service, and coverage restrictions were the most frequently cited barriers to obtaining care. Results suggest that people with disabilities have difficulty accessing needed health care services through the Missouri Medicaid fee-for-service program.


This study assessed the impact of transition from Medicaid drug coverage to Medicare Part D on a sample of dually eligible adults younger than age 65 years with disabilities. A telephone survey was conducted of employed adults participating in the Kansas Medicaid Buy-In program, Working Healthy, about their experiences in accessing medications after their transition to Part D. A total of 328 (55%) individuals from a random sample of 600 agreed to participate in a
survey administered by a university-based research unit during February and March 2006, which included 18 questions with yes/no, multiple choice, and open-ended responses. Participants resembled other Kansas dual eligibles demographically and medically, other than having slightly higher rates of mental illness and lower rates of mental retardation and some physical conditions. Participants' 2004 Medicare and Medicaid claims data were analyzed to obtain an overview of their comorbidities and previous prescription use. Twenty percent of participants reported difficulty obtaining medications, including drugs in Part D-protected classes; 13% were required to switch medications; and 8% stopped taking at least 1 medication. More than half did not know they could change plans monthly, potentially improving their access to medications. The high incidence of access problems despite Centers for Medicare & Medicaid Services (CMS) safeguards points to the need for ongoing monitoring of Part D. If the problems persist, CMS must be willing to modify the program and/or better enforce the rules already in place to avoid adverse outcomes for beneficiaries with disabilities.


This review presents a literature overview of global health policy for ID with the intent to focus specifically on the policy and treatment within Israel. The methodology involved sites visits to care centers, discussions with stakeholders in health policy, and a literature review. Authors believe that Israel is in a unique position between a developed and developing culture. In particular, the distinct problems faced by the Arab and Bedouin community in terms of ID must be formally accounted for in Israel's future policies. The global approach in this presentation led to certain policy recommendations that take into account the uniqueness of Israel's position from a social, economic, religious, and demographic perspective. It is the hope that this paper will lead to an increased awareness of the challenges faced by persons with ID and their providers in all sectors of Israeli society and that the necessary policy recommendations will ultimately be adopted.


Adults living with disabilities face considerable challenges in the health-care system. Those interviewed for this survey have wide-ranging disabling conditions and substantial health-care needs, along with high rates of functional
and cognitive limitations. For many, these needs are compounded by low or modest incomes that often translate into financial barriers to the medical care and supports they need. Although most people with disabilities do have some form of health insurance coverage, those who are both uninsured and disabled are at a particular disadvantage in the current health-care system. They are more likely than others to forgo or delay getting necessary care, including the prescription drugs and preventive services that would reduce their future need for health-care services. These findings underscore the importance of additional research that identifies those who fall within this group in terms of their health-care needs, income levels, and employment status, while also suggesting the need to provide health insurance coverage for small, but particularly vulnerable subsets of adults with disabilities.


   Due to complex individual, interpersonal, and systemic factors, deaf and hard of hearing (d/hoh) individuals often receive inadequate, inappropriate, and unethical health care. This article begins with a review of the relevant socioeconomic and legal issues and the health status of d/hoh individuals. I then review health care starting with the patient's knowledge base, personal experiences, and understanding of health care relationships. I discuss the Deaf community's perspectives, providers' views about disability, communication between providers and deaf patients, and barriers encountered in health care delivery. The article concludes by assessing these factors' effects on health care delivery to d/hoh people, reviewing the ethical implications, and making recommendations for change.


   The purpose of this paper is to examine the information on the population with disabilities in a nationally representative survey conducted by the National Center on Health Statistics called the National Health Interview Survey (NHIS). The paper provides a description of the disability information available in the NHIS and how the data may be used to assess the employment, economic well being and health of the population. Descriptive statistics from the 2002 NHIS public use files are used to illustrate the type of analysis that will be useful to researchers and policymakers.


The purposes of this study were to identify disparities between adults with developmental disabilities and non-disabled adults in health and medical care, and to compare this pattern of disparities to the pattern of disparities between adults with other disabilities and adults without disabilities. Results indicated that adults with developmental disabilities were more likely to lead sedentary lifestyles and seven times as likely to report inadequate emotional support, compared with adults without disabilities. Adults with disabilities and developmental disabilities were significantly more likely to report being in fair or poor health than adults without disabilities. Similar rates of tobacco use and overweight/obesity were reported. Adults with developmental disabilities had a similar or greater risk of having four of five chronic health conditions compared with non-disabled adults. Significant medical care utilization disparities were found for breast and cervical cancer screening as well as for oral health care. Adults with developmental disabilities presented a unique risk for inadequate emotional support and low utilization of breast and cervical cancer screenings.


This study reviews the challenges of Medicaid managed care organizations that serve blind and disabled members. Beneficiary satisfaction and access to care are assessed, and access problems are identified and resolved or minimized to the greatest degree possible. Survey responses showed that beneficiaries had limited experience with managed care and were generally satisfied with access to primary care. The healthcare system used the study findings to develop focused training programs and materials, to initiate a special needs liaison program, and to revise guidelines to simplify and standardize authorization procedures for obtaining medical supplies and repairing equipment. Factors found to be associated with the success of a Medicaid managed care program serving blind and disabled beneficiaries include educating the members and providers for better understanding of managed care, incorporating collaborative service improvement activities, and documenting trends.


The article describes the development of an interview tool to collect standardized health-related information from deaf adults via face-to-face interviews in American Sign Language (ASL). There were 139 questions on the survey. A total of 203 interviews were conducted between November 2002 and March 2003. A standardized interview survey administered in ASL proved an effective and well-accepted means of collecting health-related information from a diverse sample of deaf individuals. Several challenges were encountered throughout the process, and the resulting lessons will be useful to future research efforts.

Hendershot, G.E. “Session on Deaf Respondents in Health Interview Surveys.” Presented at the American Public Health Association Annual Meeting, Chicago, IL (November 10, 1999), pages 312-313.

Henry J. Kaiser Family Foundation, “Fact Sheet: Medicare and the Cognitively Disabled.”


The study examined the prevalence and characteristics of community-dwelling Medicare beneficiaries reporting a communication disability and the relationship between that disability and dissatisfaction with medical care. A total of 12,769 Medicare Current Beneficiary Survey respondents age 65 and older in 2001 were categorized by level of communication disability. Sampling weights were used to make inferences about the entire Medicare population. Over 16 million beneficiaries reported a communication disability. Hearing problems were most commonly reported (41.99%). The association between dissatisfaction and communication disability was statistically significant (p .05) for 8 of 10 items. Prevalence of dissatisfaction among those with a communication disability varied, ranging from 3.43% to 19.34%. Respondents with a communication disability reported much more dissatisfaction when compared with those respondents without a communication disability.


The purpose of this study was to update the projected prevalence of self-reported, doctor-diagnosed arthritis and arthritis-attributable activity limitations among US adults ages 18 years and older from 2005 through 2030. The prevalence of self-reported, doctor-diagnosed arthritis is projected to increase from 47.8 million in 2005 to nearly 67 million by 2030 (25% of the adult population). By 2030, 25 million (9.3% of the adult population) are projected to report arthritis-attributable activity limitations. In 2030, >50% of arthritis cases will be among adults older than age 65 years. However, working-age adults (45–64 years) will account for almost one-third of cases. By 2030, the number of US adults with arthritis and its associated activity limitation is expected to increase substantially, resulting in a large impact on individuals, the health care system, and society in general. The growing epidemic of obesity may also significantly contribute to the future burden of arthritis. Improving access and availability of current clinical and public health interventions aimed at improving quality of life among persons with arthritis through lifestyle changes and disease self-management may help lessen the long-term impact.


This study examines racial separation in long-term care. Authors surveyed a stratified sample of 181 residential care/assisted living facilities and 39 nursing homes in four states. Most African Americans resided in nursing homes and smaller facilities intended to be concentrated in a few predominantly African-American facilities, whereas the vast majority of whites resided in predominantly white facilities. Facilities housing, African Americans tended to be located in rural nonpoor African American communities to admit individuals with mental retardation and difficulty in ambulating and to have lower ratings of cleanliness, maintenance and lighting. Be racial disparities may result from economic factors, exclusionary practices, or resident choice. Whether separation relates to inequities in care is undetermined.

The field of health promotion has yet to acknowledge the unique needs of women with disabilities, a population representing approximately 1 of 5 women in the United States. Compared with women without disabilities, women with disabilities have critical needs for evidence-based health promotion services. Women with disabilities face a lack of access to multitudinous opportunities for maintaining and improving their overall health. Inaccessible exercise equipment and other disability-related barriers discourage women with physical disabilities from engaging in health-promoting behaviors. This article identifies 10 essential elements for achieving effective health promotion research and interventions for women in this population.


The concepts of wellness and its complement, health promotion, have popularized the notion that health itself is more than simply the absence of disease. Furthermore, the wellness concept has advanced the idea of the importance of engaging in certain health promoting behaviors within healthy environments, not simply for the purpose of preventing or better managing a disease, but also to enhance one's well-being and quality of life (Green & Kreuter, 1991; Mullen, 1986). Encouraging this emphasis on wellness is Healthy People 2010 (U.S. Department of Health and Human Services, 2000), a national ten-year plan intended to increase quality and years of life and eliminate disparities which features a new area that recognizes the importance of health promotion and disease prevention in the lives of people with disabilities. Increasingly, the value of promoting wellness--including for people with disabilities--is being recognized (Rimmer & Braddock, 2002).


The purpose of this study was to investigate the influence of parental disability on children's healthcare as measured by the timely receipt of childhood immunizations. Results of the project indicate that children living with a parent who is unable to provide his or her own personal care are 65% less likely to be immunized on time than children who live with parent(s) who do not have a disability. Children of parents who are limited in their personal care, and children of parents who have work limitations, are not less likely than children of non-disabled parents to receive immunizations on time. The impact of a parent's severe disability extends to the health care of dependent children. These findings argue for research to investigate the full scope of the effects of parental
disability on children's health and for policies that address this impact.


This article deals with the validity of studying health care issues for people with disabilities using administrative data. It covers issues with defining disability, examining the health care experiences of people with disabilities and assessing the outcome of their care.


A book about how mobility problems affect people's lives and how health care and other policies help or hinder their independence, published by University of California Press in 2003. Authors found that about 19 million adults who live outside nursing homes or other institutions say they have at least some difficulty walking or use a mobility aid. Mobility difficulties are not exclusively conditions of old age and people with mobility difficulties are more likely to have health insurance than those without such problems. Medicare and health insurers often have coverage policies that prevent people with disabilities from obtaining assistive devices and regaining their independence. The most common causes of mobility problems are arthritis and other joint problems, back problems, accidental falls, heart disease, motor vehicle accidents, and chronic lung disease. People with mobility problems are more likely to be obese. Many people who use wheelchairs or scooters do not view themselves as disabled. Whether to start using a wheelchair or scooter is a critical decision for people who have progressive difficulty in walking. Primary care physicians are generally poorly trained to recognize physical disabilities and to refer patients to appropriate rehabilitation specialists and assistive technology, and they carry misconceptions about the role a wheelchair might play in patients' lives. People with mobility problems face barriers getting into and around health care settings.

The purpose of this study was to determine whether those persons whose sensory or physical functioning improved or worsened over one year are more or less satisfied with their health care. The authors found that worsened functioning was strongly associated with older age, low income, and low educational attainment. Improved functioning was rarely significantly associated with satisfaction; an exception involved substantially lower rates of dissatisfaction with “ease and convenience” of getting to physicians. Worsened functioning was often statistically significantly associated with dissatisfaction, always with adjusted odds ratios >1.0. Across all five functional categories, persons whose functioning worsened displayed significantly greater dissatisfaction with overall quality, ease, and costs or care. Persons whose functioning improved rarely reported better satisfaction than did those whose functioning did not improve, while those whose functioning worsened expressed more systematic reservations about their care.


This study examined whether persons who are blind or have low vision, who are deaf or hard of hearing, or who have mobility impairments or manual dexterity problems are satisfied with the technical and interpersonal aspects of their care. The authors concluded that persons with disabilities generally reported positive views of their care, although they were significantly more likely to report poor communication and lack of thorough care. These findings held regardless of the disabling condition. Thoughtful systematic approaches are required to improve communication and to reduce time pressures that might compromise the health care experiences of people with disabilities.


The purpose of this study was to compare satisfaction with health care between persons with and without disabling conditions. The quality domains generating the greatest dissatisfaction were anticipated, given the nature of disabling conditions. Improving these areas requires attention inside and outside the health care system. Redesigning practice settings and procedures, and changing payment policies offer the only solutions to some problems.


144. Iezzoni, L.I.; McCarthy, E.P.; Davis, R.B.; Harris-David, L. and O'Day, B. "Use of Screening and Preventive Services Among Women with Disabilities." American Journal
This study used the 1994-1995 National Health Interview Survey (NHIS), with Disability, Family Resources, and Healthy People 2000 supplements, to examine screening and preventive service use for adult women with disabilities living in the community—about 18.4% of women (estimated 18.28 million). Disability was associated with higher age-adjusted rates of: poverty; living alone; low education; inability to work; obesity; and being frequently depressed or anxious. Disabled women generally reported screening and preventive services at rates comparable to all women. Women with major lower extremity mobility difficulties had much lower adjusted odds of Papanicolaou smears, mammograms, and smoking queries. Various approaches exist to improve access for disabled women to health care services.


The objective of this study was to assess the national prevalence of mobility difficulties among non-institutionalized adults and to examine associations with demographic characteristics and other physical and mental health problems. The authors concluded that reports of mobility difficulties are common, including among middle-aged adults. Associations with poor performance of daily activities, depression, anxiety, and poverty highlight the need for comprehensive care for persons with mobility problems.


Primary care for people with disabilities often concentrates on underlying debilitating disorders to the exclusion of preventive health concerns. This study examined use of screening and preventive services among adults with mobility problems (difficulty walking, climbing stairs, or standing for extended periods).


The objective of this study was to examine perceptions of disability among people with lower-extremity mobility difficulties. The results showed that 3.1% of respondents reported major mobility difficulties, including 3.7% of self-respondents and 2.7% of those with proxy respondents. Among persons with major mobility problems, 70.8% perceived themselves as disabled, whereas
64.8% thought other people see them as disabled. Also, 80.5% of manual wheelchair users saw themselves as disabled. Proxies were somewhat more likely to perceive disability than self-respondents, although differences were not generally statistically significant. In multivariable regressions, mobility level was the strongest predictor of self-perceived disability, followed by general health status.


This book examines the barriers that people with disabilities face when attempting to access health care services. It looks at health insurance policies and current barriers to health care. The authors conclude the book with proposals to overcome the hurdles.


The objective of this study was to understand perceptions of health care experiences and suggestions for improving care among deaf or hard-of-hearing individuals. The authors concluded that as the population ages, physicians will encounter many more persons with hearing limitations. Physicians are not reimbursed for making some accommodations, such as hiring sign language interpreters. However, ensuring effective communication is essential to safe, timely, efficient, and patient-centered care.

150. Iezzoni, L.I.; Killeen, M. B. and O'Day, B. L. “Rural Residents with Disabilities Confront Substantial Barriers to Obtaining Primary Care.” Health Services Research 41.4.1: 1258-75.

The purpose of the study was to learn about the health care experiences of rural residents with disabilities in Massachusetts and Virginia. Local centers for independent living recruited 35 adults with sensory, physical, or psychiatric disabilities to participate in four focus group interviews. Interviewees described the many well-recognized impediments to health care in rural America; disability appears to exacerbate these barriers. Interviewees reported substantial difficulties finding physicians who understand their disabilities and sometimes feel that they must teach their local doctors about their underlying conditions. Interviewees described needing to travel periodically to large medical centers to get necessary specialty care. Many are poor and are either uninsured or have Medicaid coverage, complicating their searches for willing primary care physicians. Because many cannot drive, they face great difficulties getting to their local doctor and especially making long trips to urban centers. Available public transportation often is inaccessible and unreliable. Physicians' offices are sometimes located in old buildings that do not have accessible entrances or equipment. Based on their personal experiences, interviewees perceive that rural
areas are generally less sensitive to disability access issues than urban areas. Meeting the health care needs of rural residents with disabilities will require interventions beyond health care, involving transportation and access issues more broadly.


Persons with major mental illness often have chronic diseases and poor physical health. Therefore, all practicing physicians should learn about communicating effectively with these patients. Few efforts to teach medical students communication skills have specifically targeted patients with major mental illness. Indeed, most of the limited literature on this topic is decades old, predating significant scientific advances in cognitive neuroscience and psychiatric therapeutics and changes in social policies regarding major mental illness. To gather preliminary insight into training needs, we interviewed 13 final-year students from 2 Boston medical schools. Students' observations coalesced around 4 themes: fears and anxieties about interacting with persons with major mental illness; residents “protecting” students from patients with major mental illness; lack of clinical maturity; and barriers to learning during psychiatry rotations. Educational researchers must explore ways to better prepare young physicians to communicate effectively with patients with major mental illness.


Health disparities work is at the research and development stage. Unequal Treatment produced a shift in disparities discourse toward the role of racism in health care. No effort to reduce disparities could succeed without the goal of eliminating racist health care. However, the resulting attention to race is, for now, overshadowing the role of other socially constructed contributors to unequal health care, and no effort to reduce disparities can succeed without intervening in the operation of those contributors as well. Neither the disparities research agenda nor the discourse has solidified. The federal government published its ambitious public health agenda, Healthy People 2010, five years ago. The goal of eliminating “health disparities among segments of the
population, including differences that occur by gender, race or ethnicity, education to income, geographic location, or sexual orientation,” is only five years away. We may not eliminate disparities by 2010, but we can make serious progress if we take seriously the goal of using a multi-axis approach. Using critical cultural inquiry to hone the legal interventions produced by structuralist analysis, stepping up political pressure to eliminate all forms of unequal health care, and questioning the most basic concepts for ideological content can help expand the agenda.


Disability in America presents a five-prong strategy for reducing the incidence and prevalence of disability as well as its personal, social, and economic consequences. Although the preferred goal is to avoid potentially disabling conditions, the authoring committee focuses on the need to prevent or reverse the progression that leads to disability and reduced quality of life in persons with potentially disabling conditions. Calling for a coherent national program to focus on prevention, the committee sets forth specific recommendations for federal agencies, state and local programs, and the private sector. This comprehensive agenda addresses the need for improved methods for collecting disability data, specific research questions, directions for university training, reform in insurance coverage, prenatal care, vocational training, and a host of other arenas for action.


Women with spina bifida have unique health care concerns and as the life expectancy of this population increases, they are transitioning from adolescence to womanhood and entering their reproductive years with little information about what to expect. Likewise, their health care providers do not have the benefit of evidence-based research that comprehensively addresses the issues these women may face related to reproduction or aging. Few studies have focused on the effects that spina bifida may have on these women's reproductive systems, nor has attention been paid to the effects that possible reproductive endocrine changes may have on their disability. Needless to say, concerns about
sexuality, sexual function, and pregnancy are just as important to these women as they are to their able-bodied counterparts.


The Chartbook on Women and Disability in the United States describes the current status of women with disabilities, relative to other women and men with and without disabilities, in a number of different aspects of life. By identifying the specific barriers and discrimination faced by girls and women, the chartbook paves the way for policy and attitudinal changes to ensure equal opportunity. The chartbook also highlights gaps in the research on both disability and gender. Hopefully, this information will stimulate further thoughtful discourse and the creation of policy innovations that will provide more and better opportunities for girls and women with disabilities.


The importance of an informational outreach program focused on eye health and visual impairment is underscored by surveys showing that the vast majority of Americans have misperceptions about or have never heard of low vision. This article uses the National Eye Institute's Low Vision Education Program as a model for the development, implementation, and evaluation of a public health education initiative. The components of an effective public education program are outlined in the context of what people know, don't know, and want to know about vision loss.


Deaf persons’ access the health-related information is limited by barriers to spoken or written language: they cannot overhear information; they have limited access to television, radio, and other channels for public information; and average reading level of Deaf adults is at a third to fourth grade level. However, literature searches revealed no published reports of community analysis focusing specifically on health education priorities in Arizona Deaf communities A seven-step community analysis was conducted to learn the health education
priorities in Arizona Deaf communities and to inform development of culturally relevant health education interventions in Deaf communities.


The purpose of this quasi-experimental, pre-post-test study was to test the effectiveness of the Deaf Heart Health Intervention (DHHI) in increasing self-efficacy for health-related behaviors among culturally deaf adults. The DHHI targets modifiable risk factors for cardiovascular disease. A sample of 84 participants completed time-1 and time-2 data collection. The sign language version of the Self-Rated Abilities Scale for Health Practices (SRAHP) was used to measure self-efficacy for nutrition, psychological well-being/stress management, physical activity/exercise, and responsible health practices. Total self-efficacy scores were significantly higher in the intervention group than in the comparison group at time-2, controlling for scores at baseline (F [1, 81] = 26.02, p < .001). Results support the development of interventions specifically tailored for culturally deaf adults to increase their self-efficacy for health behaviors.


The purpose of this study was to test the effectiveness of the Deaf Heart Health Intervention (DHHI) in increasing self-efficacy for health-related behaviors among culturally deaf adults. The DHHI targets modifiable risk factors for cardiovascular disease. The sign language version of the Self-Rated Abilities Scale for Health Practices (SRAHP) was used to measure self-efficacy for nutrition, psychological well-being/stress management, physical activity/exercise, and responsible health practices. Total self-efficacy scores were significantly higher in the intervention group than in the comparison group at time-2, controlling for scores at baseline. Results support the development of interventions specifically tailored for culturally deaf adults to increase their self-efficacy for health behaviors.


This fact sheet describes the characteristics of the uninsured population, the difference health insurance makes, and why there is a large uninsured population.

People with disabilities are at risk in the health-care system because of their wide-ranging health-care needs, their relatively heavy use of prescription drugs, health-care and support services, and typically low incomes. This survey of people with permanent mental and/or physical disabilities explores their health-care experiences and challenges in accessing and paying for care.

This short article briefly discusses six barriers to health care that people with disabilities experience: array of services; prevention and maintenance; access and accommodation; information on managing disabilities; procedures, finances, and transportation; and practitioner knowledge and expertise. Policy change recommendations addressing a number of federal and state statutes and regulations were developed that combined the opinions of people with disabilities who are not working in disability-related fields as well as disability professionals, academics, advocates, and disability health policy experts with and without disabilities.

For this study a prostate cancer education program was adapted for deaf men with the goal of creating a single program that could meet the educational needs of this diverse community. The program was evaluated using baseline, post-test, and two-month follow-up surveys, plus focus group discussions. Overall, baseline knowledge about prostate cancer and awareness of the screening options for the early detection of prostate cancer increased significantly at post-test and this gain was maintained at the two-month follow-up. While prostate-specific antigen (PSA) screening and digital rectal exams also increased among men 50 and older, the increase was not statistically significant, possibly a consequence of the small sample size. Participants’ reported their preferred methods of communication. Greater knowledge gains were demonstrated among those who preferred communications via American Sign Language (ASL).
versus English-based communications. The authors concluded that clinicians and health educators can help raise the deaf community's health awareness through programs such as this one, which ultimately evolved into the Internet accessible ASL video: Prostate Cancer: Know Your Options.

Abstract

Introduction: A review of the scientific literature yielded no examples of programs that were designed to give deaf men access to information about prostate cancer, early detection, and treatment. The community's diverse linguistic abilities, multiple preferences for receiving information, and the small size of the community, create additional challenges for health educators.

Materials and methods: A prostate cancer education program was adapted for deaf men (N=121), with the goal of creating a single program that could meet the educational needs of this diverse community. The program was evaluated using baseline, post-test, and two-month follow-up surveys, plus focus group discussions.

Results: Overall, baseline knowledge about prostate cancer and awareness of the screening options for the early detection of prostate cancer increased significantly at post-test and this gain was maintained at the two-month follow-up. While prostate-specific antigen (PSA) screening and digital rectal exams also increased among men 50 and older, the increase was not statistically significant, possibly a consequence of the small sample size. Participants’ reported their preferred methods of communication. Greater knowledge gains were demonstrated among those who preferred communications via American Sign Language (ASL) versus English-based communications. Conclusion: Cancer education programs offered in ASL can help address health knowledge disparities and that in turn can contribute to alleviating these disparities. Clinicians and health educators can help raise the deaf community's health awareness through programs such as this one, which ultimately evolved into the Internet accessible ASL video: Prostate Cancer: Know Your Options.


This report presents data in text and graphs on the situation of people with disabilities in the United States in the context of requirements of the Americans with Disabilities Act. An introduction identifies four reasons for the observed slow pace to compliance with disability-rights laws: (1) ignorance about what constitutes accessibility and reasonable accommodation and the achievability of these objectives; (2) serious defects in federal laws and policies which hamper social integration of Americans with disabilities; (3) failure by local authorities to enforce legal requirements for access and accommodations; and (4) continuing prejudice against people with disabilities. The sections following the introduction provide data concerning demographics, employment, social integration, barriers to independence, and transportation. Individual sections provide key points, an analysis of the data, illustrative graphs, and a comparison/contrast of myths and facts. Data sources are provided at the end of each section. A concluding section notes progress, but also outlines continuing
needs, including job training, changes in employer attitudes, elimination of physical barriers in schools and businesses, an increase in the amount of accessible housing, an increase in accessible transportation, and a decrease in the segregation of people with disabilities, particularly the elderly and those with mental retardation or developmental disabilities.


The potential benefits to the vision rehabilitation field and the people it serves of an ongoing collaboration with public health are highlighted. This article focuses on the current phase of the long-term federal Healthy People initiative, and suggests that the inclusion in Healthy People 2010 of a section devoted to people with disabilities and another that specifically targets vision and hearing loss make this an especially propitious time for an alliance between fields that have historically operated on separate tracks. Formation of such an alliance faces a number of obstacles, however, and action on the part of those working in vision rehabilitation and special education is called for, lest they lose a significant opportunity to enlist professionals in public health in the cause of people with visual impairments.


Discusses the need for agencies which provide services to people with visual
impairments to collect statistics about race and ethnicity to estimate prevalence of visual impairments, create accountability, and design appropriate programs. Current statistics on the racial and ethnic diversity of individuals with visual impairments are provided.


Three cases are presented that demonstrate substandard care for patients with disabilities, yet they occurred recently at US tertiary care medical centers with the latest technologies and well-qualified physicians. These failures resulted from basic, "low-tech" structural deficiencies—lack of accessible call systems, diagnostic equipment, and examination tables.


This article extracts principles from two Surgeon General reports, Closing the Gap: A National Blueprint to Improve the Health of Persons with Mental Retardation (2002) and Call to Action to Improve the Health and Wellness of Persons with Disabilities (2005), and combines them with the Objectives from Chapter 6 of Healthy People 2010 to create a policy framework. This framework is used to review literature from the past decade on access to health care and health promotion for persons with intellectual and developmental disabilities (IDD). Review of the literature indicates an emerging evidence base for health promotion programs for persons with IDD. Research in health care and health promotion access requires improvements in surveillance and measurement of quality of life, as well as increased participation of persons with IDD and their families in its implementation. While international guidelines for primary health care have been developed for people with IDD, US guidelines are specialty focused and address specific conditions. Despite its recognized importance, there is surprisingly little information on training programs for health care providers to improve care of persons with IDD. Financing of health care continues to threaten access to comprehensive care for persons with IDD.
particularly regarding coordination of care and availability of providers who accept Medicaid patients. Community-based sources of health care have been slow to emerge, and there is clear need for assumption of responsibility for providing care to persons with IDD. Future US policy should include consideration of environmental factors in health care access.


Research in substance abuse (SA) treatment has demonstrated that persons with disabilities (PWDs) are at substantially higher risk for SA than persons without disabilities. Despite their higher risk, PWDs access SA treatment at a much lower rate than persons without disabilities. Using the Behavioral Model for Vulnerable Populations as a research framework, we identified reasons for differences in access to SA treatment for Medicaid-eligible adults with disabilities in Oregon through a multiphase study. Analyses of demographic and referral source data, along with interviews with key state agency representatives, adults with disabilities, and treatment program personnel, helped identify barriers to SA treatment access. These barriers are reflected as attributes of PWDs, contextual variables that enable or impede access, recognition of the need for SA treatment, and characteristics of treatment services. The findings suggest needed policy and practice changes to increase access rates for PWDs. They provide direction for future research.


This article presents recent conceptualizations that begin to disentangle health from disability, summarizes the literature from 1999 to 2005 in terms of the cascade of disparities, reviews intervention issues and promising practices, and provides recommendations for future action and research. The reconceptualization of health and disability examines health disparity in terms of the determinants of health (genetic, social circumstances, environment, individual behaviors, health care access) and types of health conditions (associated, comorbid, secondary). The literature is summarized in terms of a cascade of disparities experienced by people with ID, including a higher prevalence of adverse conditions, inadequate attention to care needs, inadequate focus on health promotion, and inadequate access to quality health care services. Promising practices are reviewed from the perspective of persons with ID, providers of care and services, and policies that influence systems of care. Recommendations across multiple countries and organizations are synthesized as guidelines to direct future action. They call for promoting principles of early identification, inclusion, and self-determination of people with ID; reducing the occurrence and impact of associated, comorbid, and secondary conditions;
empowering caregivers and family members; promoting healthy behaviors in people with ID; and ensuring equitable access to quality health care by people with ID. Their broadscale implementations would begin to reduce the health disparity experienced by people with ID. MRDD Research Reviews.


A brief narrative description of the journal article, document, or resource. Analysis of a national survey indicates that more than a third of children with autism, a fifth with mental retardation, and a fifth with other types of special health care needs had problems obtaining needed care from specialty doctors in the preceding year. The most common problems included getting referrals and finding providers with appropriate training


Individuals with physical disabilities are less likely to utilize primary preventive healthcare services than the general population. At the same time they are at greater risk for secondary conditions and as likely as the general population to engage in health risk behaviors. This qualitative exploratory study had two principal objectives: (1) to investigate access barriers to obtaining preventive healthcare services for adults with physical disabilities and (2) to identify strategies to increase access to these services. We conducted five focus group interviews with adults (median age: 46) with various physically disabling conditions. Most participants were male Caucasians residing in Virginia, USA. Study participants reported a variety of barriers that prevented them from receiving the primary preventive services commonly recommended by the US Preventive Services Task Force. We used a health services framework to distinguish structural-environmental (to include inaccessible facilities and examination equipment) or process barriers (to include a lack of disability-related provider knowledge, respect, and skilled assistance during office visits). Participants suggested a range of strategies to address these barriers including disability-specific continuing education for providers, the development of
accessible prevention-focused information portals for people with physical disabilities, and consumer self-education, and assertiveness in requesting recommended services. Study findings point to the need for a more responsive healthcare system to effectively meet the primary prevention needs of people with physical disabilities. The authors propose the development of a consumer-and provider-focused resource and information kit that reflects the strategies that were suggested by study participants.


This article describes the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system that Medicaid programs can use to make health-based capitated payments for TANF and disabled Medicaid beneficiaries. The authors describe the diversity of diagnoses and different burdens of illness among disabled and AFDC Medicaid beneficiaries. Claims from seven States are analyzed, and payment weights are provided that States can use when adjusting HMO payments. The authors also compare the taxonomy and statistical performance of CDPS to other leading diagnostic classification systems and find that the new model performs better in a number of respects.


This study reviewed the current health services literature related to quality of care for persons with disabilities and highlighted the need for a unique framework for conceptualizing quality and patient safety issues for this population. The study concluded that health care providers need to embrace a multidisciplinary approach to quality to meet the needs of persons with disabilities. Funders and purchasers need to provide flexibility in funding to enable a comprehensive primary care approach, while health service researchers need to adopt a broad view of quality to capture issues of importance for persons with disabilities.

Canada prides itself on being an inclusive society with policies that promote equity in provision of health care services. But some groups of people miss out. People with developmental disabilities (DD) are one of these groups, and unlike other groups with serious unmet health needs, they receive virtually no attention in popular or medical literature. People with DD appear at times to be almost invisible to society and health services. Why is this so? Perhaps they are too few in number. But at 1% to 3% of the population (325000 to 975000 Canadians), they are relatively numerous. The indifference is due to society’s negative attitude, and more specifically with health care, the negative attitude of medical practitioners, toward patients with DD. Those of us who care for patients with DD find that some of our colleagues have little interest in our patients with DD.


This report presents health statistics from the 2002 National Health Interview Survey (NHIS) for the civilian noninstitutionalized adult population, classified by sex, age, race and Hispanic origin, education, income, poverty status, health insurance coverage, marital status, place of residence, and region of residence for chronic condition prevalence, health status, functional limitations, health care access and utilization, health behaviors, and human immunodeficiency virus testing. The presentation of percentages and percent distributions in both age-adjusted and unadjusted versions is new this year. SOURCE OF DATA: The NHIS is a household, multistage probability sample survey conducted annually by interviewers of the U.S. Census Bureau for the Centers for Disease Control and Prevention's National Center for Health Statistics. In 2002, data were collected for 31,044 adults for the Sample Adult questionnaire. The conditional response rate was 84.4%, and the final response rate was 74.4%. The health information for adults in this report was obtained from one randomly selected adult per family. HIGHLIGHTS: In 2002, 62% of adults 18 years of age or over reported excellent or very good health. Fifty-nine percent of adults never participated in any type of vigorous leisure-time physical activity, and 14% of adults did not have a usual place of health care. Eleven percent of adults had been told by a doctor or health professional that they had heart disease, and 21% had been told on two or more visits that they had hypertension. Twenty-two percent of all adults were current smokers, and 23% were former smokers. Based on their body mass index, 35% of adults were overweight, and 23% were obese.


196. Lewis, M.A.; Lewis, C.E.; Leake, B.; King, B.H. and Lindemann, R. “The Quality of

The purpose of this study was to determine the health status of adults with developmental disabilities residing in community settings and the quality of the preventive, medical, dental, and psychiatric services they receive. Data were collected on a sample of 353 adults residing in Los Angeles, California, in 1997. Historical data were obtained from study subjects or caregivers, physical and dental examinations were performed, blood was drawn for analysis, and a psychiatrist reviewed medical records for reports of psychiatric diagnoses and consultations. Health markers, such as rates of obesity, and laboratory test results were within normal limits for an adult population. However, preventive services were notably lacking, especially for individuals living at home. Fewer than half of the study subjects had received influenza vaccine; only a third of those living alone or with family or friends had received this vaccination. Chart audits revealed that about a third received psychotropic medications, but only 24% of these individuals had psychiatric consultations noted in their record. Further, 36% of this medicated group received psychotropic drugs without any identifiable diagnosis, and simultaneous receipt of two or more antipsychotics was not uncommon. Given that the U.S. health care system fails to ensure the provision of preventive services for all people, including the developmentally disabled, a systematic overhaul is necessary to establish an effective quality assurance program that will provide preventive medical, dental, and psychiatric services for people with developmental disabilities.


Discusses the history of coverage of vision-related rehabilitation by health insurance and identifies opportunities for expanded coverage within the rapidly changing health care environment. Reviews strategies for persuading health insurance plans to fund vision-related rehabilitation, including educating the public, reconfiguring service delivery, and measuring outcomes.


Nurses play a pivotal role in promoting access to culturally competent health care services for those who experience linguistic and cultural barriers. Nursing strategies to facilitate and enhance the Deaf community's access to health care services are provided.

To evaluate the perceptions of families of children with developmental disabilities regarding their primary care physicians and to determine if differences exist for different conditions.

Despite the prevalence of disabilities among persons living in rural areas, scarce data exist on their health care needs. While rural residents generally experience barriers to access to primary health care, these problems are further exacerbated for people with disabilities. This article summarizes findings from the published literature on access to primary health care among people with disabilities living in rural locations. A comprehensive computerized literature search revealed 86 articles meeting the study criteria focused on the following rural populations affected by disabilities: children and adolescents, working age adults, the elderly, people who are mentally ill, and people with AIDS. For each of these populations, substantial problems in accessing appropriate health care have been documented. The literature consistently emphasizes the failure of local healthcare systems in non-metropolitan areas to adequately address the complex medical and related needs of individuals with disabilities.

A survey of 204 secondary students with deafness or hearing impairment suggested that adolescents had a general idea about what human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) are and the potential impact of the disease. However, they demonstrated gaps in knowledge of how the disease is transmitted and prevented and who can get AIDS.
Deaf gay men represent a subpopulation of the gay male community at particularly high risk for HIV/AIDS due to numerous barriers including language, stigma, and inequitable access to health services. The participants in this exploratory pilot study (N = 5) struggled with the ongoing threat of HIV infection and the pervasive nature of AIDS-related debilitation, death, and grief. Whether HIV infected or not, they described living at the intersection of multiple communities—the deaf, gay, and hearing—each characterized by unique communication styles, cultural expectations, and a propensity to marginalize outsiders. Health care providers were perceived as lacking compassion and largely ignorant to the needs of deaf persons, in general, and deaf gay men, in particular. Printed HIV materials were considered culturally inappropriate, incomprehensible, and ineffective. These findings suggest an extraordinary risk for adverse mental and physical health outcomes if care is not appropriately designed for this vulnerable population.


This article is about a comprehensive health survey of Deaf adults with questions on CVD knowledge. Questions assessed knowledge of heart attack and stroke symptoms, risk factors, and emergency response. Forty percent of respondents could not list any symptoms of a heart attack, while over 60% could not list any symptoms of a stroke. Less than half of respondents identified chest pain/pressure as a symptom of a heart attack. Only 61% reported that they would call 911 in response to cardiovascular disease symptoms. The median number of risk factors correctly identified by respondents was 3 of 6. Conclusions: Knowledge of cardiovascular disease among Deaf respondents is low, and considerably lower than that of the general hearing population. The need to develop health education materials and programs for Deaf individuals is evident. Health care providers should be educated on Deaf culture and barriers in communication. Finally, efforts need to be made to assure that 911 is deaf-accessible.


This study was designed to determine if the incidence of some common health conditions was higher among 770 women with a disability compared with 1097 women without a disability and 679 men with a disability in the same primary care medical practices. The results showed that diabetes, hypertension, and obesity, three important predictors of morbidity and mortality, were not significantly more likely to occur in women with disabilities compared with others in the same medical practice. Dementia had higher hazard ratios (HRs) for women with sensory, developmental, and trauma disability. However, women with trauma disability had a significantly lower (HR) for dementia compared with men with the same disability. Women with sensory disability were at higher risk for transient ischemic attack (TIA) compared with women in the same practice without disability, and there was no difference in HRs compared with men with disability. Women with disability related to trauma were at higher risk for depression compared with women in the same practice without disability and compared with men with the same disability. Some conditions, such as congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD), have opportunities for prevention, as they are associated with smoking, physical inactivity, and diet.


Although the study focused on breast cancer screening services, women also describe financial, architectural, environmental, and attitudinal barriers that affected all of their healthcare services. Women described for transportation, heavy doors, and inaccessible exam tables and bathrooms. They felt devalued by their providers and believed that their symptoms are often overlooked. Women with physical disabilities face both financial and nonfinancial barriers to access that may result in delayed detection and increased risk of poor outcomes from breast cancer.


Recent advances within molecular genetics to identify the genes for deafness mean that it is now possible for genetic-counseling services to offer genetic testing for deafness to certain families. The purpose of this study is to document the attitudes of deaf adults toward genetic testing for deafness. A structured, self-completion questionnaire was given to delegates at an international conference on the "Deaf Nation," held at the University of Central Lancashire in 1997. The conference was aimed at well-educated people, with an emphasis on Deaf culture issues. Eighty-seven deaf delegates from the United Kingdom returned completed questionnaires. The questionnaire had been designed to quantitatively assess attitudes toward genetics, interest in prenatal diagnosis (PND) for deafness, and preference for having deaf or hearing children. The results from this study provide evidence of a predominantly negative attitude toward genetics and its impact on deaf people, in a population for whom genetic-counseling services are relevant. Fifty-five percent of the sample thought that genetic testing would do more harm than good, 46% thought that its potential use devalued deaf people, and 49% were concerned about new discoveries in genetics. When asked about testing in pregnancy, 16% of participants said that they would consider having PND, and, of these, 29% said that they would prefer to have deaf children. Geneticists need to appreciate that some deaf persons may prefer to have deaf children and may consider the use of genetic technology to achieve this. Any genetic-counseling service set up for families with deafness can only be effective and appropriate if clinicians and counselors take into consideration the beliefs and values of the deaf community at large.


City, Middle-Aged African Americans have Excess Frank and Subclinical Disability.”
The Journals of Gerontology Series A: Biological Sciences and Medical Sciences 60.2 (2005): 207-12.


Despite the best efforts of the Centers for Medicare and Medicaid Services (CMS) with regard to the field of visual impairment and blindness, and despite the concerted efforts of the members of the field to make the most of the Medicare Low Vision Rehabilitation Demonstration Project, there are intrinsic flaws in scope and design of the project that preclude its successful implementation and may even undermine the services that have been extended by Medicare to beneficiaries with visual impairments in the last decade. To set the stage and provide a context for this argument, we begin with some background information and a review of events leading up to the April 1, 2006 initiation of the five-year demonstration project.


The objective of this study was to estimate the prevalence of obesity and diabetes among US adults in 2001. The authors found that in 2001 the prevalence of obesity (BMI =30) was 20.9% vs 19.8% in 2000, an increase of 5.6%. The prevalence of diabetes increased to 7.9% vs 7.3% in 2000, an increase of 8.2%. The prevalence of BMI of 40 or higher in 2001 was 2.3%. Overweight and obesity were significantly associated with diabetes, high blood pressure, high cholesterol, asthma, arthritis, and poor health status. They concluded that Increases in obesity and diabetes among US adults continue in both sexes, all ages, all races, all educational levels, and all smoking levels. Obesity is strongly associated with several major health risk factors.


The purpose of this study is to explore the scope and nature of the consequences that adults with disabilities perceive as the result of inappropriate access to health care services; the variability of these consequences by demographic attributes such as disability type, gender, and health insurance type; and the inter-relatedness and multidimensionality of these consequences. The authors concluded that health insurers and providers need a better understanding of the multiple consequences of access barriers. Based on this knowledge, detrimental and costly effects of inappropriate service delivery could be more effectively prevented. Implications for health care services and policy are discussed.


This article reports findings from the National Study of Women with Physical Disabilities about rates of screening for breast and cervical cancer and factors associated with regular screening in a large sample of women with a variety of physical disabilities and a comparison group of women without disabilities. The results of the study indicate that women with disabilities tend to be less likely than women without disabilities to receive pelvic exams on a regular basis, and women with more severe functional limitations are significantly less likely to do so. No significant difference was found between women with and without disabilities, regardless of severity of functional limitation, in receiving mammograms within the past 2 years. Perceived control emerged as a significant enhancement factor for mammograms and marginally for pelvic exams. Severity of disability was a significant risk factor for noncompliance with recommended pelvic exams, but not mammograms. Race was a significant risk factor for not receiving pelvic exams, but not mammograms. Household income and age did not reach significance as risk factors in either analysis.


Persons who are blind or have low vision face special challenges in obtaining care that is safe, effective, timely, and patient centered. To explore perceptions of care and recommendations for improvements, the authors conducted 8 interviews with experts and 2 focus groups with 19 persons, all of whom are blind or have low vision. Interviewees perceived that they confront special barriers to care because of being blind or having low vision. Barriers fell into four broad categories: basic respect, including concerns about physicians thinking they cannot participate fully in their own care; communication barriers, including difficulties interacting with physicians and office staff; physical access barriers, including difficulties getting to and around physicians' offices; and information barriers, including receiving written materials in inaccessible formats (eg, not in Braille, large print, or audiotape). Using common courtesy and individualized communication techniques, physicians and office staff could improve health care experiences of blind and low-vision patients.

This study examined the barriers that 16 locus group participants with psychiatric disabilities confront in obtaining primary care services and their recommendations on improving quality of care. They cited a) difficulty identifying a primary care physician with good empathic and communication skills, b) physicians' misunderstanding of the nature of psychiatric disability, c) inadequate information about the side effects of psychotropic medications, and d) costs due to inadequate insurance coverage. In addition to suggestions for improving patient-physician communication and expanding physician knowledge, participants emphasized strategies to become empowered in their relationships with physicians and to obtain personal support.

The objective of this study was to provide current estimates of the prevalence and trends of overweight in children and adolescents and obesity in adults. Results showed that in 2003-2004, 17.1% of US children and adolescents were overweight and 32.2% of adults were obese. Tests for trend were significant for male and female children and adolescents, indicating an increase in the prevalence of overweight in female children and adolescents from 13.8% in 1999-2000 to 16.0% in 2003-2004 and an increase in the prevalence of overweight in male children and adolescents from 14.0% to 18.2%. Among men, the prevalence of obesity increased significantly between 1999-2000 (27.5%) and 2003-2004 (31.1%). Among women, no significant increase in obesity was observed between 1999-2000 (33.4%) and 2003-2004 (33.2%). The prevalence of extreme obesity (body mass index 40) in 2003-2004 was 2.8% in men and 6.9% in women. In 2003-2004, significant differences in obesity prevalence remained by race/ethnicity and by age.


BACKGROUND AND OBJECTIVES: The quality of communication between physician and patient is a major contributor to patient satisfaction and treatment adherence. Deaf patients who use American Sign Language experience significant communication barriers in most medical settings. This study investigated factors impacting deaf patients' satisfaction with prenatal care and prenatal care disparities between deaf and hearing women. METHODS: Questionnaires modified from Omar and Schiffman's prenatal satisfaction measure were administered to 23 deaf and 32 hearing women. RESULTS: Deaf women were less satisfied than hearing women with physician communication and less satisfied with overall care. Deaf women's expectations about provision of interpreter services being met or exceeded was significantly associated with overall satisfaction. Hearing women had more prenatal care appointments and reported receiving more information from their doctors. CONCLUSIONS: Maximizing communication effectiveness with deaf patients results in better prenatal care and improved patient satisfaction. Good communication includes conveying concern and making efforts to ensure that whatever communication methods used are effective.


Background: Previous studies show that Deaf persons tend to have lower health status, lack health knowledge, have differing health attitudes, and decreased health care utilization when compared to the general population. The authors sought to examine knowledge, attitudes, and behaviors surrounding age- and gender-specific cancer screening tests amongst a sample of Deaf adults who were patients of Deaf-friendly medical organizations. The authors also sought to compare age- and gender-specific cancer screening rates amongst this sample to that of the general US population. Methods: A sample of 203 adult Deaf patients participated in a comprehensive, face-to-face health survey conducted between November 2002 and March 2003. The survey was administered in American Sign Language by Deaf interviewers and included age- and gender-specific cancer knowledge, attitude, and behavior questions. Results: Knowledge pertaining to Pap smear among females was low, while the proportion having ever had a Pap smear was comparable to the general population. Mammography knowledge amongst females age 50 and older was comparatively higher, although it remained lower than the proportion of females in this age group who reported ever receiving a mammogram. Overall, screening rates for breast, cervical, and colorectal cancer were similar to rates in the general US population. Attitudes toward specific cancer screening tests were also favorable. Conclusions: Persons within the Deaf community can have cancer screening rates similar to those of the general US population. However, utilization in the absence of knowledge regarding these tests is worrisome and brings about ethical, health care quality and health education concerns.


Information can be empowering if it is accessible. While a number of known information access barriers have been reported for the broader group of people with disabilities, specific information issues for people with complex communication needs have not been previously reported. In this consumer-focused study, the accessibility of information design and dissemination practices were discussed by 17 people with complex communication needs; by eight parents, advocates, therapists, and agency representatives in focus groups; and by seven individuals in individual interviews. Participants explored issues and made recommendations for content, including language, visual and audio supports; print accessibility; physical access; and human support for information access. Consumer-generated accessibility guidelines were an outcome of this study.


This study compares potential and realized use of health care for a national sample of working-age women with cognitive disabilities. Using data from the Medical Expenditure Panel Survey for 2000 and 2002, we compared potential and realized use of health care for a national sample of working-age women with cognitive disabilities. Despite having similar likelihoods of potential access to health care as compared to nondisabled women, they had markedly worse rates of receiving cervical cancer and breast cancer screenings, similar rates of routine check-ups, and yet had better rates of receipt of influenza shots. They were also less likely to be satisfied with their medical care than were nondisabled women. Policy recommendations are suggested to address the disability-based disparities in reproductive health care for women with cognitive limitations.


Little is known about the health care received by women with disabilities, who comprise a substantial subset of the population. This article describes the health care of a national sample of low-income female Medicaid recipients. Despite having similar potential for care (health insurance, usual source of care, and having a physician as a usual source of care) as compared to nondisabled women, women with disabilities had substantially worse rates of receiving medical care and medication when they were needed and of cervical cancer screenings. Women with disabilities were also much less likely to be satisfied with their care than were nondisabled women. These results support calls to mandate quality-based reimbursement incentives within Medicaid, specifically for women with disabilities.


Despite having similar or better potential access to health care, women with

Ramps to Solve the Crisis in Healthcare for People with Disabilities Rehabilitation Institute of Chicago: Chicago. 2004.
disabilities experience worse health care and worse preventive care than non-disabled women. This study examined the health care of a national probability sample of 8,721 disabled and 45,522 non-disabled women living in the United States. Logistic regression models, adjusted for age and household income, were estimated for eight measures of health care, including three measures of potential access to care, two measures of receipt of preventive services, and postponement of care. Findings signal potentially serious consequences for women with disabilities, who require care at higher rates than their non-disabled counterparts and are at increased risk of developing secondary conditions if their care needs are not met.


There is an impending crisis in long-term care for people with developmental disabilities. The demand for care will likely outpace the supply for decades to come. Factors, such as limited existing long-term care resources, increased life expectancy for people with developmental disabilities, changing family demographics, legal actions, and competition for resources with the elderly population are driving the crisis. Virtually every domain of social work practice will face challenges in this area. This article argues for an immediate response from the social work community in several areas. The profession needs to provide social workers with expanded training in family-centered approaches to working with people with developmental disabilities, develop new interventions, create new organizational supports, and practice assertive advocacy.


Using data from the Medical Expenditure Panel Survey for 2000 and 2002, we compared potential and realized use of health care for a national sample of working-age women with cognitive disabilities. Despite having similar likelihoods of potential access to health care as compared to nondisabled women, they had markedly worse rates of receiving cervical cancer and breast cancer screenings, similar rates of routine check-ups, and yet had better rates of receipt of influenza shots. They were also less likely to be satisfied with their medical care than were nondisabled women. Policy recommendations are suggested to address the disability-based disparities in reproductive health care for women with cognitive limitations.


Focuses on HIV education for the deaf and argues that this population is particularly
vulnerable because of language barriers, unique culture and the scarcity of community services.


Women with disabilities experience a variety of unique health needs from adolescence to older age. They require compassionate and comprehensive health care services to manage their physical disabilities and to prevent secondary conditions. Unfortunately, many women with disabilities encounter attitudinal, informational, environmental, and geographic barriers as they seek access to health care. A variety of measures can be implemented to overcome these barriers and to improve the quality of health care that women with disabilities receive.


OBJECTIVES: This report presents health statistics from the 2006 National Health Interview Survey for the civilian noninstitutionalized adult population, classified by sex, age, race and ethnicity, education, family income, poverty status, health insurance coverage, marital status, and place and region of residence. Estimates are presented for selected chronic conditions and mental health characteristics, functional limitations, health status, health behaviors, health care access and utilization, and human immunodeficiency virus testing. Percentages and percent distributions are presented in both age-adjusted and unadjusted versions. SOURCE OF DATA: NHIS is a household, multistage probability sample survey conducted annually by interviewers of the U.S. Census Bureau for the Centers for Disease Control and Prevention's National Center for Health Statistics. In 2006, data were collected for 24,275 adults for the Sample Adult questionnaire. The conditional response rate was 81.4%, and the final response rate was 70.8%. The health information for adults in this
report was obtained from one randomly selected adult per family. In very rare instances where the sample adult was not able to respond for him or herself, a proxy was allowed. HIGHLIGHTS: In 2006, 61% of adults 18 years of age or over reported excellent or very good health. Sixty-two percent of adults never participated in any type of vigorous leisure-time physical activity, and 16% of adults did not have a usual place of health care. Eleven percent of adults had been told by a doctor or health professional that they had heart disease, and 23% had been told on two or more visits that they had hypertension. Twenty-one percent of all adults were current smokers and 21% were former smokers. Based on estimates of body mass index, 35% of adults were overweight and 26% were obese.


Discusses the application of contemporary cross-cultural ethical principles and practices in deafness research, including the relevance of framing some deafness research as cross-cultural. A gradient is defined where cultural bearing varies from low to high, depending on a study's topic and design. It is concluded that scientists should employ contemporary cross-cultural ethical practices when their studies have cultural bearing. The evolution and nature of these special ethical practices are detailed. They extend research protections beyond the individual participant to the host community as a collective entity, and address relations with the heterogeneous host community, the research agenda and design, the participation of host community scientists, and publication foci and channels. Specific applications of these principles and practices to deafness research are described.


Describes the use of a regional consensus planning approach to addressing the longstanding difficulties deaf and hard-of-hearing residents in New York have in securing access to and competence in public mental health services. The nominal group technique was used to bring together individuals who plan, fund, manage, and render public mental health services and individuals who are specifically knowledgeable about deaf and hard-of-hearing people and their mental health care needs. Conference planning is discussed, including preliminary efforts, committee structure and activities, the goal statement, attendee selection and preparation, barrier statements, and final preparations. The conference itself is described, including setting and maintaining its tone, small and large group consensus, the impact-likelihood matrix, cluster groups, wrap-up, and evaluations. The aftermath of the conference is also considered.

269. Pollard, R.Q. "Public Mental Health Service and Diagnostic Trends Regarding
From a pool of 84,437 public mental health case records in Rochester, NY, 544 pertained to deaf or hard of hearing (DHH) patients. Proportional comparisons of demographic, service, and diagnostic patterns revealed significant differences between DHH and comparison samples. Women, children, and non-Caucasians were underrepresented in the DHH sample; male and elderly DHH patients were overrepresented. DHH patients were overrepresented in 4 small but communicatively accessible programs that provided a limited range of services. When served by community services, DHH patients received fewer clinical services and more continuing treatment and case management services. Axis II diagnoses of mental retardation were more frequent in the DHH sample, and clinicians were less able to rule out Axis II pathology. It is suggested that observed differences reflect service accessibility and clinician expertise problems rather than clinical distinctions.


with Developmental Disabilities from Minority Backgrounds.” Mental Retardation 42.6 (2004): 459-70.

This project examined access to health care by individuals with developmental disabilities in Kansas from low income populations and from minority backgrounds. Four criteria for determining access were employed: availability, accessibility, affordability, and appropriateness of care. Factors that pose barriers and that facilitate access are described and recommendations are set out with particular reference to the 2002 Report of the Surgeon General of the United States.


More than 50 million Americans have a disability. Beef people face enormous physical, social, and attitudinal barriers toward their participation in physical and recreational activities that they need to maintain their health and wellness. Furthermore, the concept of being "healthy” and “disabled” or “physically active” and “disabled” is not a common visualization in the mainstream media. This paper calls for a more inclusive vision within public health messages that target physical activity participation among its citizens, especially those with disability who are at greater risk for developing health problems associated with sedentary living.


Physical activity is universally recommended for the maintenance of good health. Unfortunately, for people with disabilities, including those with vision loss, options for exercise may be limited by the built environment, as well as by inaccessibility of programs, equipment, and services offered in community recreation facilities.


OBJECTIVE: To determine if the type of insurance arrangement, specifically health maintenance organization (HMO) vs fee-for-service (FFS), affects cancer outcomes for Medicare beneficiaries with disabilities. STUDY DESIGN: Retrospective cohort. METHODS: We used the Surveillance, Epidemiology, and End Results-Medicare linked dataset to identify beneficiaries older and younger than 65 years entitled to Medicare benefits because of disability (Social Security Disability Insurance) who subsequently were diagnosed as having breast cancer (n = 6839) or non-small cell lung cancer (n = 10,229) from 1988 through 1999. We categorized persons according to Medicare insurance arrangement (continuous FFS, continuous HMO, or mixed FFS/HMO) during the periods 12 months before diagnosis and 6 months after diagnosis. Using a retrospective cohort design, we examined stage at diagnosis, cancer-directed treatments, and survival. RESULTS: Women with continuous HMO insurance had earlier-stage breast cancer diagnosis (adjusted relative risk, 0.77; 95% confidence interval, 0.65-0.91) and were more likely to receive radiation therapy following breast-conserving surgery (adjusted relative risk, 1.11; 95% confidence interval, 1.03-1.19). Women having continuous HMO insurance had better breast cancer survival, primarily resulting from earlier-stage diagnosis. Among persons with non-small cell lung cancer, those having mixed FFS/HMO insurance were more likely to receive definitive surgery for early-stage disease (adjusted odds ratio, 1.23; 95% confidence interval, 1.02-1.49) and to have better overall survival but not significantly better lung cancer survival. CONCLUSION: When diagnosed as having breast cancer or non-small cell lung cancer, some Medicare beneficiaries with disabilities fare better with managed care compared with FFS insurance plans.


The objective of this study was to determine to what degree chiropractic clinics are complying with the Americans with Disabilities Act (ADA), which mandates that health care clinics be accessible to the disabled. METHODS: A survey was developed and mailed to 200 chiropractic clinics in Orange and Los Angeles counties. The survey asked about the essential necessities for health care clinics to be accessible to the wheelchair-bound, the blind, and the deaf. It also sought to discover how many disabled patients these clinics were treating and the attitudes of practitioners and staff toward this population. Results indicated that accessibility for the wheelchair-bound was high. Accessibility for the blind was limited by a lack of Braille signs. Accessibility to the deaf was limited by lack of telecommunications device for the deaf or use of sign language interpreters. Most clinics were treating few or no disabled patients and
did not perceive a need to become more accessible.


Among people aged 18 to 44, the prevalence of vision impairments is about 5.7 percent, while the rate is approximately 21.7 percent among people who are 75 years of age or older.


BACKGROUND: The Deaf community reports limited access to health promotion information and care. Literature review, key informant interviews, and focus groups generated a clearer understanding of the community. Health care providers, educators, and policymakers could improve medical care to the Deaf community by: 1) better understanding its culture and language; 2) creating more health education programs specifically for the Deaf community; 3) developing opportunities for more deaf people and American Sign Language (ASL) users to enter the health professions; and 4) creating incentives for hearing health care providers to become ASL proficient.


This article examines the access barriers to primary, specialist, and rehabilitative care, and their consequences for individuals’ health, functioning, well-being, and health services utilization. The findings are based on an in-depth analysis of 30 qualitative interviews. Access problems are grouped into environmental, structural, and process barriers. The findings highlight the complex nature of access barriers for people with disabilities and underscore the importance of disability literacy in the health service delivery process.


Hearing status is based on the question "Which statement best describes your hearing without a hearing aid: good, a little trouble, a lot of trouble, deaf?"

The purpose of this study was to investigate the effects of a women's health clinic that was established to meet the needs of women with SCI and other disabilities. Specifically, this study examined the effect of clinic participation upon the rate of preventive gynecologic health care behaviors and assessed the relationship between physical and emotional functioning in women with SCI and other disabilities. Results indicated a trend towards increased frequency of breast self-exam three months after initial participation in the clinic. Other rates of health promoting behaviors (exercise, diet and mammography) did not increase. Results also indicated that although physical functioning and life satisfaction were not related, women in this study did experience moderate to high levels of psychological distress.


The goal of the study was to assess the barriers to gynecologic care for adolescents with disability in this state. 136 providers of gynecologic care in Utah were surveyed to assess existing conditions, attitudes, and comfort levels regarding this population. A comfort level among surveyed clinicians in providing gynecological care to disabled adolescence was relatively low, even for routine screening. Respondents identified the following as barriers to providing this care: time, reimbursement, inadequate knowledge, and disability related issues, (office access and preference to not serve the population). Suggested solutions included: continuing education programs, consultation to practices on serving both youth and individuals with disability, and better billing mechanisms.


   The objective of this study was to compare insurance coverage, access to care and unmet health needs of children with and without chronic conditions in a national probability sample of the US population and to examine the role of poverty status in any demonstrated differences between the 2 groups. The authors concluded that despite higher levels of insurance coverage and greater access to regular providers of medical and routine care compared with healthy peers, children with chronic conditions are reported by their parents to be less likely than other children to receive the full range of needed health services. The magnitudes of the differences are small, yet the pattern of disadvantage in meeting health care needs among children with conditions compared with healthy peers is consistent across many different variables and it exists across income levels.


   The purpose of this study was to gain insight into the perceptions of women
with mobility and sensory limitations about several healthcare issues that may affect them: barriers to obtaining care, sources of information about health issues, ways to improve access to care, and ways to help hard-to-reach women overcome barriers to health care and health information. Seven themes are discussed in this article: communication barriers; lack of knowledge and awareness among healthcare providers; access issues; working the system; system issues; outreach to healthcare providers; and reaching hard-to-reach women. The findings of this study can provide direction to development of more effective outreach to hard-to-reach women with disabilities, resulting in better integration of healthcare services for this population.


No studies to date have examined access to insurance coverage or medical care for a broadly defined population of uninsured nonelderly adults with disabilities. This analysis uses the 2002 National Survey of America's Families to examine access to coverage, access to care, and service use for a large sample of adults with disabilities, with a focus on the uninsured. All disabled groups reported unmet need and service use greater than their nondisabled counterparts with the same insured status. Access to coverage was most problematic for low-income adults with work limitations but no other indication of disability, with over one-third uninsured. This group deserves greater policy attention.


In this article the authors discuss accommodating active medical school faculty with disabilities, drawing on University of Pennsylvania School of Medicine initiatives exploring the concerns of faculty with sensory and physical disabilities. Anecdotal reports suggest that many faculty, fearing reprisals, resist seeking job accommodations such as those mandated in the 1990 Americans with Disabilities Act (ADA). Although some faculty with disabilities have found
supportive academic mentors, others report that lax institutional enforcement of ADA requirements, including physical access problems, demonstrates a tepid commitment to disabled staff. Potentially useful job accommodations include adjusting timelines for promotion decisions; reassessing promotions requirements that inherently require extensive travel; improving physical access to teaching, research, and clinical sites; and modifying clinical and teaching schedules. Faculty with disabilities bring identical intellectual and collegial benefits to medical schools as their nondisabled counterparts. In addition, they may offer special insights into how chronic illness and impairments affect daily life.


The authors investigated knowledge, attitudes, and beliefs about mental illness and providers held by a group of deaf adults. Method: The American Sign Language interviews of 54 deaf adults were analyzed. Results: Recurrent themes included mistrust of providers, communication difficulty as a primary cause of mental health problems, profound concern with communication in therapy, and widespread ignorance about how to obtain services. Conclusions: Deaf consumers' views need due consideration in service delivery planning. Outreach regarding existing programs is essential.


The authors investigated the knowledge, attitudes, and healthcare experiences of Deaf women. They found that a lack of health knowledge was evident, including little understanding of the meaning or value of cancer screening, mammography, or Pap smears; purposes of prescribed medications, such as hormone replacement therapy (HRT); or necessity for other medical or surgical interventions. Negative experiences and avoidance or nonuse of health services were reported, largely due to the lack of a common language with healthcare providers. Insensitive behaviors were also described. Positive experiences and increased access to health information were reported with practitioners who used qualified interpreters. Providers who demonstrated minimal signing skills, a willingness to use paper and pen, and sensitivity to improving communication were appreciated.

310. Stineman, M.G.; Ross, R.N.; Maislin, G. and Iezzoni, L.I. “Estimating Health-Related Quality of Life in Populations through Cross-Sectional Surveys.” Medical Care 42
Obtaining evidence on the effectiveness of public health interventions is a critical first step in selecting those interventions most likely to improve population health or prevent disease. However, in addition to knowing “What works and what is the size of the impact?” policymakers need other information to answer the question “What is the best choice of interventions for our program?” Public health decision makers, faced with limited resources, must routinely make decisions about how to prioritize public health problems and related interventions and choose among several alternatives. In making such choices, decision makers can benefit by knowing the financial resources required to implement each effective intervention and how dollars invested compare to outcomes achieved. Economic evaluations provide this information by comparing the costs and consequences of public health interventions (policies, programs, and other activities) (see Table 11–1). This chapter addresses the rationale and value of systematic reviews of economic evaluations, describes the methods used by the Community Guide to conduct such reviews, and provides information to help decision makers interpret review findings.

In this study the authors use data from the Health and Retirement Study to estimate the association between obesity and disability, and combine these data with trend estimates of obesity rates from the Behavioral Risk Factor Surveillance Survey. If current trends in obesity continue, disability rates will increase by 1 percent per year more in the 50-69 age group than if there were no further weight gain.

The objective of this study was to develop practical Canadian guidelines for primary health care providers based on the best available evidence for addressing health issues in adults with developmental disabilities (DD).
with DD have complex health issues, some differing from those of the general population. Adequate primary health care is necessary to identify these issues and to prevent morbidity and premature death. Physical, behavioral, and mental health difficulties should be addressed, and primary health care providers should be particularly attentive to the interactions of biological, psychological, and social factors contributing to health, since these interactions can easily be overlooked in adults with DD. Attention must also be paid to such ethical issues as informed consent and avoidance of harm. Developmental disabilities are not grounds for care providers to withhold or to withdraw medically indicated interventions, and decisions concerning such interventions should be based on patients' best interests.


OBJECTIVE: To investigate the unique health care issues of deaf and hard-of-hearing (D&HH) persons by studying their attitudes, beliefs, and behaviors toward preventive medicine. DESIGN: A self-administered, cross-sectional survey, written in a format comprehensible to persons whose primary language is American Sign Language. POPULATION: One hundred forty D&HH persons recruited from southeastern Michigan, Chicago, Ill, and Rochester, NY, and 76 hearing subjects from southeastern Michigan and Rochester. RESULTS: No significant differences existed between D&HH or hearing persons from different states. However, numerous differences existed between D&HH and hearing persons. Deaf and hard-of-hearing persons were less likely to report receiving preventive information from physicians or the media, and more likely to report receiving it from a Deaf club. They rated the following physician-initiated procedures as less important than hearing persons: discussion of alcohol consumption, smoking, depression, and diet, plus screening for hypertension, hearing loss, and cancer. Deaf and hard-of-hearing persons often considered a preventive procedure important if it was reported performed at their last health maintenance examination. They were less likely to report being asked about alcohol consumption and smoking, or to having been examined for hypertension, cancer, height, and weight. They were more likely to report receiving a hearing examination, mammogram, and Papanicolaou smear. Deaf and hard-of-hearing persons were less likely to report believing that smoking less, exercising regularly, maintaining ideal weight, and regular physical examinations improve health. Differences existed within the D&HH cohort depending on the respondent's preferred language (oral English vs American Sign Language); our sample size was too small for a complete assessment of these differences. CONCLUSIONS: Deaf and hard-of-hearing persons appear to have unique knowledge, attitudes, and behaviors regarding preventive medicine, and their attitudes are influenced by their personal experiences with physicians. Preventive practices addressed during health visits may differ between D&HH and hearing patients. Further research is needed to clarify the reasons for these
differences, including within D&HH subgroups, and to develop effective mechanisms to improve the health care of all D&HH persons.


OBJECTIVES: To estimate the cause-specific prevalence and distribution of blindness and low vision in the United States by age, race/ethnicity, and gender, and to estimate the change in these prevalence figures over the next 20 years. METHODS: Summary prevalence estimates of blindness (both according to the US definition of < or =6/60 [< or =20/200] best-corrected visual acuity in the better-seeing eye and the World Health Organization standard of < 6/120 [< 20/400]) and low vision (< 6/12 [< 20/40] best-corrected vision in the better-seeing eye) were prepared separately for black, Hispanic, and white persons in 5-year age intervals starting at 40 years. The estimated prevalences were based on recent population-based studies in the United States, Australia, and Europe. These estimates were applied to 2000 US Census data, and to projected US population figures for 2020, to estimate the number of Americans with visual impairment. Cause-specific prevalences of blindness and low vision were also estimated for the different racial/ethnic groups. RESULTS: Based on demographics from the 2000 US Census, an estimated 937 000 (0.78%) Americans older than 40 years were blind (US definition). An additional 2.4 million Americans (1.98%) had low vision. The leading cause of blindness among white persons was age-related macular degeneration (54.4% of the cases), while among black persons, cataract and glaucoma accounted for more than 60% of blindness. Cataract was the leading cause of low vision, responsible for approximately 50% of bilateral vision worse than 6/12 (20/40) among white, black, and Hispanic persons. The number of blind persons in the US is projected to increase by 70% to 1.6 million by 2020, with a similar rise projected for low vision. CONCLUSIONS: Blindness or low vision affects approximately 1 in 28 Americans older than 40 years. The specific causes of visual impairment, and especially blindness, vary greatly by race/ethnicity. The prevalence of visual disabilities will increase markedly during the next 20 years, owing largely to the aging of the US population.


This report presents key findings from what we believe is the most comprehensive health survey ever conducted with Deaf adults. Participants were Deaf patients of two Chicago-based health care systems, both offering special
health care programs aimed at deaf and hard of hearing persons. A plethora of useful information pertaining to health status, health care experiences, communication styles, barriers to accessing health care, health knowledge, attitudes and behaviors was collected via standardized, face-to-face interviews conducted in American Sign Language (ASL). The findings presented herein are based on 203 interviews with culturally Deaf adults. A description of the process followed in developing a standardized interview tool to be administered in a visual-manual (i.e., ASL) rather than a written language, and a description of the unique challenges such a process presents are also presented within the report. Finally, the report concludes with recommendations of steps that can be taken to improve health service delivery to Deaf individuals.


U.S. Surgeon General Richard H. Carmona, M.D., M.P.H., FACS, today released "The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities," appealing to all Americans to help increase the quality of life for people with disabilities through better health care and understanding. This first-ever Surgeon General's Call to Action on disability is being issued on the 15th anniversary of the Americans with Disabilities Act. "This Call to Action is a call to caring. Every life has value and every person has promise," Surgeon General Carmona said. "The reality is that for too long we provided lesser care to people with disabilities. Today, we must redouble our efforts so that people with disabilities achieve full access to disease prevention and health promotion services." Developed by the Surgeon General in collaboration with the HHS Office on Disability, the Call to Action describes the particular challenges to health and well being faced by persons of all ages with disabilities and identifies four goals that, together, can help people with disabilities experience full, rewarding and above all healthy lives as contributing members of their communities.


The Cheshire Deaf Women's Health Project undertook a research study to assess the access to healthcare of women who are deaf in Cheshire, UK. The data revealed inequities in access to healthcare. For example, women who are deaf face a lack of awareness by health staff of how to communicate with them. The survey confirmed that these problems are of major importance to the majority of women who are deaf. For example, fewer than one in 10 deaf women said that they usually fully understand what the doctor says to them when they visit the doctor on their own. There are many other difficulties faced by women who are deaf, leading to inequalities when they are compared with hearing people. Almost half the respondents said that they would be more likely to use health services if help and/or services for deaf women were available. The introduction of various relatively simple measures would greatly help to reduce the inequalities of access to healthcare faced by deaf women. Under the terms of the Disability Discrimination Act 1995, such action is essential if providers are to avoid facing possible legal action.
The goal of our research is measurable improvements in health care in America, gauged in terms of improved quality of life and patient outcomes, lives saved, and value gained for what we spend. To achieve its goals, the Agency is committed to organizational excellence, the use of efficient and responsive business processes to maximize the Agency’s resources and the effectiveness of its programs. Our overall focus is: Safety and quality: Reduce the risk of harm by promoting delivery of the best possible health care. Effectiveness: Improve health care outcomes by encouraging the use of evidence to make informed health care decisions. Efficiency: Transform research into practice to facilitate wider access to effective health care services and reduce unnecessary costs.

The Maternal and Child Health (MCH) Services Block Grant (Title V of the Social Security Act) has operated as a federal-state partnership since the Social Security Act was passed in 1935. Through Title V, the federal government pledged its support of state efforts to extend health and welfare services for mothers and children. Title V has been frequently amended in ensuing years to reflect changing national approaches to maternal and child health and welfare issues. This booklet provides an overview of Title V for those new to the Block Grant program and a compact guide for those familiar with Title V programs. For each portion of the law, a short synopsis is provided and relevant criteria explained. In addition, citations for the pertinent sections of Title V are included so that those interested in more detailed information can refer to the Title itself.


Vision: The NCMHD envisions an America in which all populations will have an equal opportunity to live long, healthy and productive lives. Mission: The mission of the
National Center on Minority Health and Health Disparities (NCMHD) is to promote minority health and to lead, coordinate, support, and assess the NIH effort to reduce and ultimately eliminate health disparities. In this effort NCMHD will conduct and support basic, clinical, social, and behavioral research, promote research infrastructure and training, foster emerging programs, disseminate information, and reach out to minority and other health disparity communities.


Dental school graduates do not gain the necessary expertise to treat patients with MR/DD. The results of a national study in the US and Canada carried out in the late 1990’s showed actual decreases in the time for training students.


Addressing health disparities has been a national challenge for decades. The National Institutes of Health-sponsored Centers for Population Health and Health Disparities are the first federal initiative to support transdisciplinary multilevel research on the determinants of health disparities. Their novel research approach combines population, clinical, and basic science to elucidate the complex determinants of health disparities. The centers are partnering with community-based, public, and quasi-public organizations to disseminate scientific findings and guide clinical practice in communities. In turn, communities and public health agents are shaping the research. The relationships forged through these complex collaborations increase the likelihood that the centers' scientific findings will be relevant to communities and contribute to reductions in health disparities.


The purpose of this study was to explore the status of clinical preventative services for women with disabilities. Results showed that overall, 23% of the
women in the study (n = 835) were disabled. Disabled women, however, were less likely to receive mammography and Pap smears within the recommended intervals. However, disabled women were more likely to receive influenza immunization, cholesterol screening, and colorectal screening within the recommended intervals. Among the disabled, usual source of care and health insurance remained significant predictors of receipt of clinical preventive services across all types.


The objective of this study was to determine the prevalence of obesity in adults with physical and sensory limitations and serious mental illness. Results indicated that among adults with disabilities, 24.9% were obese vs 15.1% of those without disabilities. After adjusting for sociodemographic factors, adults with a disability were more likely to be obese. The highest risk occurred among adults with some or severe lower extremity mobility difficulties. After further adjustment for comorbid conditions, adults with disabilities were as likely to attempt weight loss as those without disabilities, except for adults with severe lower extremity mobility difficulties, who were less likely and adults with mental illness, who were more likely. Physician exercise counseling was reported less often among adults with severe lower extremity) and upper extremity mobility difficulties


Approximately ten percent of the world's population has a disability. In the United States, it is estimated that there are 43 million disabled people and roughly 30% of them are women. There is often limited physical and structural access to health care for disabled women. As young girls, women with disabilities are often told that marriage is not a possibility, which can lead to feelings of asexuality. Barriers to contraception for women with disabilities may be twofold; attitudinal as well as knowledge based. Sexually transmitted disease detection and prompt management interventions may be hampered by a number of factors. Women with disabilities that become pregnant have identical issues in many ways as compared with nondisabled women. Fertility and sexuality are closely intertwined. As a woman with a disability undergoes an infertility evaluation, her sexuality as well as identity as a woman may be threatened. Disabled women are living longer and are reaching the age of menopause while remaining active and involved in their family life, social life, and in the workforce.

The purpose of this study was to address issues regarding the treatment of women with disabilities and to suggest ways in which the patient and the provider can work together for a positive outcome. Results showed that the treatment of STDs in women with disabling conditions presents diagnostic and therapeutic challenges to clinicians, because symptoms may be confusing and may mimic manifestations of underlying disorders. Women with spinal cord injury may be at risk for the development of autonomic activation as a sign of STDs. The author concluded that to enhance compliance with medication regimens, the limitations of the patient should be considered. Furthermore, women with disabilities are at high risk for sexual abuse; therefore, the presence of an STD may be of special concern. Developing good communication with the patient will enable the clinician to work with her to sort out symptoms, design therapeutic regimens, and to help protect her from abuse.

This study looks at adults with disabilities and their susceptibility to secondary health problems because of factors not directly related to their disability.
This study was conducted to identify accessibility and related psychosocial issues in diabetes care and education for visually impaired adults who have diabetes. Two focus groups of adults with visual impairment and diabetes were conducted; data were recorded and analyzed. The 3 main issues identified were lack of access to up-to-date diabetes information in an accessible format, lack of understanding by healthcare providers of the needs and competencies of people with both visual impairment and diabetes, and lack of access to nonvisual diabetes self-management equipment.


Adult aging is accompanied by declines in many areas of cognitive functioning, including reduced memory for new information. Potential sources of these declines are well established and include slowed processing, diminished working-memory capacity, and a reduced ability to inhibit interference. In addition, older adults often experience sensory decline, including decreased hearing acuity for high-frequency sounds and deficits in frequency and temporal resolution. These changes add to the challenge faced by older adults in comprehension and memory for everyday rapid speech. Use of contextual information and added perceptual and cognitive effort can partially offset the deleterious effects of these sensory declines. This may, however, come at a cost to resources that might otherwise be available for “downstream” operations such as encoding the speech content in memory. We argue that future research should focus not only on sensory and cognitive functioning as separate domains but also on the dynamics of their interaction.


BACKGROUND: Approximately 10% of the US population has some degree of hearing loss, and 2 million Americans are deaf. Most medical school curricula and major textbooks characterize deafness as pathologic condition only, which is at odds with the movement to understand the Deaf population as a minority group with a unique language and cultural tradition. Physicians might therefore be unprepared to meet the needs of deaf patients effectively and sensitively. This study seeks to understand the health care experiences of elderly Deaf adults in Richmond, Va. METHODS: The authors conducted focus groups of elderly Deaf persons. Real-time voice-interpretation of the sign language communication allowed for tape recording and full transcription. The authors independently analyzed the transcripts using an editing style, and incorporated feedback on their interpretation from participants. RESULTS: Participants
experienced many practical barriers to effective health care, including problems with scheduling appointments and communicating with providers. They believed that providers are ill-prepared to care for them and worried that prejudice might be a more subtle obstacle. Participants seemed resigned to these circumstances. CONCLUSIONS: The authors suggest a possible explanation for this perspective, and make specific recommendations for three levels of competency in caring for deaf patients. When the provider and the office staff provide methods to communicate with deaf patients using telephone-assisted communication, qualified interpreters, and some basic knowledge of lipreading or sign language, the care of deaf patients is greatly enhanced and the physician-patient relationship improved. This study seeks to understand the health care experiences of elderly Deaf adults in Richmond, Va. The authors conducted focus groups of elderly Deaf persons. Real-time voice-interpretation of the sign language communication allowed for tape recording and full transcription. The authors independently analyzed the transcripts using an editing style, and incorporated feedback on their interpretation from participants. Participants experienced many practical barriers to effective health care, including problems with scheduling appointments and communicating with providers. They believed that providers are ill-prepared to care for them and worried that prejudice might be a more subtle obstacle. Participants seemed resigned to these circumstances.


The authors investigated whether the public information being dispensed about Acquired Immunodeficiency Syndrome (AIDS) reaches Deaf and Hard of Hearing (D&HH) persons to the same extent as the rest of the American population. Using a self-administered written survey, modified so that D&HH persons whose primary language is American Sign Language (ASL) could understand the questions, the authors studied 40 D&HH and 37 hearing persons in southeast Michigan. There were no significant demographic differences between the two populations, but there were differences regarding attitudes towards and knowledge about AIDS. D&HH persons were less likely to associate sexual contact with drug users and number of sexual partners as high risk sexual behaviors, were more likely to believe that storing blood for future personal use lowers their chances of contracting AIDS, and believed that using public restrooms, kisses on the cheek and visiting an AIDS patients increased their chances of contracting AIDS. Furthermore, they were more likely to believe they did not need to change their sexual behavior as a result of the AIDS epidemic. D&HH persons also reported different attitudes towards AIDS patients, such as they were not important to their community, dentists with AIDS should not be allowed to continue working, and landlords should be able to evict people with AIDS. Our findings suggest differences in receiving, trusting, and/or being exposed to current information about AIDS by the Deaf
community, consistent with the fact that they are a minority population with distinct knowledge and cultural traditions.


Recent policy debates in the US over access to mental health care have raised several philosophically complex ethical and conceptual issues. The defeat of mental health parity legislation in the US Congress has brought new urgency and relevance to theoretical and empirical investigations into the nature of mental illness and its relation to other forms of sickness and disability. Manifold, nebulous, and often competing conceptions of mental illness make the creation of coherent public policy exceedingly difficult. Referencing a variety of approaches to ethical reflection on health care, and drawing from the empirical literature on therapeutic efficacy and economic efficiency, we argue that differential rationing, 'disparity,' is unjustifiable.


The ICF is WHO's framework for measuring health and disability at both individual and population levels. The ICF was officially endorsed by 191 WHO Member States in the Fifty-fourth World Health Assembly on 22 May 2001 (resolution WHA 54.21). Unlike its predecessor, which was endorsed for use in Member States as the international standard to describe and measure health and disability.


The objective of this study was to investigate the relationship between varying levels of cognitive function and dental care utilization. The authors found that the level of cognitive function was associated with dental care utilization. At a higher level of cognitive functioning, individuals were more likely to have had more frequent dental visits. In addition, a higher level of socioeconomic status, healthy lifestyle, and worse self-rated oral health–related symptoms were more likely to indicate a higher frequency of dental care utilization. By contrast, poorer oral health status as determined by clinical examinations was negatively associated with frequency of dental visits.


371. Zazove, P.; Niemann, L.C.; Gorenflo, D.W.; Carmack, C.; Mehr, D.; Coyne, J.C and

OBJECTIVE: To evaluate whether health habits, self-reported health status, and communication with physicians play a role in the known altered health care utilization patterns of deaf and hard-of-hearing persons. DESIGN: A cross-sectional survey. Respondents were given the choice of completing either a self-administered written survey or an American Sign Language interview-administered survey. POPULATION: Eighty-seven deaf and hard-of-hearing members of various organizations serving this population in southeastern Michigan and 88 hearing patients from a family practice clinic in the same area. RESULTS: Deaf and hard-of-hearing persons visit physicians more frequently (P = .01), have a lower incidence of ever smoking tobacco (P < .0006) and of alcohol use (P = .04), have more difficulties communicating with physicians (P < .001), have trouble understanding physicians (P < .001), and feel less comfortable with physicians (P < .001). Lower current tobacco use among deaf and hard-of-hearing persons was only seen in persons who were not educated beyond high school. Increased frequency of physician visits for deaf and hard-of-hearing persons was especially noticeable in the group of persons 60 years of age and older. Our finding that use of interpreters is associated with increased utilization and decreased understanding suggests deaf and hard-of-hearing patients presenting with interpreters warrant more focused attention from physicians. Reasons for seeing physicians did not explain the difference in frequency of physician visits between the two groups. CONCLUSIONS: Deaf and hard-of-hearing persons report a lower subjective health status and higher physician utilization, as well as substantial communication difficulties with physicians. They also report better health-related behaviors, namely less use of tobacco and alcohol. The use of interpreters did not decrease physician utilization or improve the understanding of physicians by these persons. Overall, our results underscore the fact that deaf and hard-of-hearing persons constitute a minority population that experiences considerable difficulties in the patient-physician relationship.


Updated November 2009