Background

• Health disparities are systematic, socially produced, and important differences in health between groups that are unnecessary and unjust. (Whitehead, 1992)

• Health disparities exist for racial and ethnic minorities, the poor, and other at-risk populations including people with disabilities.
Health Care Utilization

• People with intellectual and developmental disabilities (IDD) may be the most medically underserved (Public Health Services, 2002).
  – Similar risk of chronic health conditions (Shireman et al., 2010)
  – Low rates of primary health care visits despite insurance (Hall, Wood, Hou, & Zhang, 2007)
  – Low rates of specialty care (Tyler, et al., 2011)
  – Untreated medical conditions (Lennox & Kerr, 1997)
  – Lack of preventive care (Haveman et al, 2010)
Mental Health

• Stress impacts mental and physical health \( (Kessler, 1997; Craig & Brown, 1984) \)

• IDD may experience more stress \( (Hubert-Williams et al., 2011) \) and have fewer resources to cope \( (Lunsky & Havercamp, 1999) \)

• Social support may buffer the impact of stress on health \( (Lunsky & Benson, 2001) \)
Racial & Ethnic Disparities

- Disparities remain regardless of income, health insurance, and access to care
- Infant mortality, life expectancy, prevalence of chronic disease, and insurance coverage (Weinick, Zuvekas & Cohen, 2000)
- Disparities constant over time between Black and White and growing between White and Hispanic groups (Cook, McGuire & Zuvekas, 2009)
Measure

• National Core Indicators (NCI) is a Quality Management protocol for DD service delivery system
• HSRI and NASDDDS collaboration
• Standard instrument, interviewer training, and methodology (minimum random sample)
• Three sources of information: self-report, proxy (informant), and records (case file)
Study #1 Essence

- We explore factors predicting six different routine health care services and hypothesize that racial and ethnic minorities with IDD have a compounded risk of underutilization of health care services beyond the risk associated with IDD.
Study #1 Participants

• Combined NCI data from 2009-2010 and 2010-2011 cycles
• 20,395 adults randomly selected from state DD service registries
• 25 states were represented in this sample
  – A minimum of 400 adults from each state
• Participants self-identified as White, Black, or Hispanic
Access to 6 health services

- Prostate-Specific Antigen test (PSA)
- Pap test (Pap)
- Mammogram
- Routine physical exam
- Dentist visit
- Flu shot
Factors Predicting Lack of Health Care

- Older adults were generally more likely to use health care services
- Adults with more severe ID were more likely to get flu shots and physical exams
- Women with more severe ID were 2 times less likely to get mammogram (OR 2.0)
- Living with family predicted lowest utilization of health care
What about race/ethnicity?

- 6 regression models on routine health services
- Odds of *not receiving service* for each racial/ethnic group compared to White
- Covariates included age, level of ID, and place of residence
What about race/ethnicity?

- Minority race/ethnicity predicted lower odds of routine health care (dentist, physical exam, flu shot)
- Black participants were most likely to receive cancer screening
- Hispanic participants were least likely to receive cancer screening
NOT Using Health Care by Race and Ethnicity

- **PSA**
- **Pap**
- **Mammogram**
- **Routine Exam**
- **Dentist**
- **Flu Shot**

- **White**
- **Black**
- **Hispanic**
Conclusion

• Racial and ethnic minorities with IDD have a compound risk of underutilization of general care services

• Adults living with family were least likely to get health care
   Minorities were most likely to live with family
Policy implications

• **Training** health care providers
  – 90% practitioners found it difficult to provide quality care to patients with ID (Lennox, et al., 2000)
  – Implicit bias – cultural competence training

• **Insurance** reimbursement limits time available to patients with complex needs

• Additional **support for families** to promote health and access to health care
Study #2 Essence

• We explore the relationships between mental health, stress, and social support predicting that stress and lack of social support increase the risk to mental health and that lack of social support.
Study #2 Sample

- NCI data from 2009-2010
- Random sample of at least 400 adults with DD from 25 states
- N=10,627 adults with intellectual disability
- Not all participants completed the self-report section (social support items)
- Self-report sub-sample, N=6,604
NCI variables

• Mental Health
  – Mental illness (psychiatric diagnosis)
  – Behavior problem (self-injurious, disruptive, destructive)

• Stress (poor health, conflict, fear, change, dissatisfaction)

• Social Support (self-report only)

• Covariates = gender, residence, level of ID
Findings

• 36.6% had mental illness
• 45% had behavior problems
• These rates were lowest among adults living with family or independently
• Mental illness rates were highest at highest ID (least impaired) range
• Behavior problem rates were highest at lowest ID (most impaired) range

24% both
Hierarchical Regression

• **Stress** significantly predicted mental health
  – For each additional stressor reported, the likelihood of having mental illness increased by 20% and behavior problems by 19%

• Lack of **social support** was a significant predictor of mental health problems beyond stress and demographic covariates

• Similar patterns in both samples
Conclusion

• Stress is an important factor in mental health across ID levels
  – Should be routinely measured/discussed
  – Sensitivity is needed at stressful times
  – Teach coping skills

• Lack of social support is an unnecessary risk factor
  – Key planning consideration
  – Do we teach social reciprocity?
Sources


QUESTIONS?
References


References


