health policy institute of ohio

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Health and **disabilities** basics

Part II: The health challenges facing Ohioans with disabilities

Introduction

People with disabilities face complex challenges to achieving optimal health and well-being. While this is true for many in the general population, some barriers are unique or more acute for people with disabilities. This brief explores some of these challenges, as well as the impact they have on health outcomes. The brief also examines current federal and state laws and policies designed to mitigate barriers to optimal health for those with disabilities. Broad recommendations for policies and strategies to address these barriers are also included. This brief is the second in a two-part series primarily focused on adults with disabilities.[1]

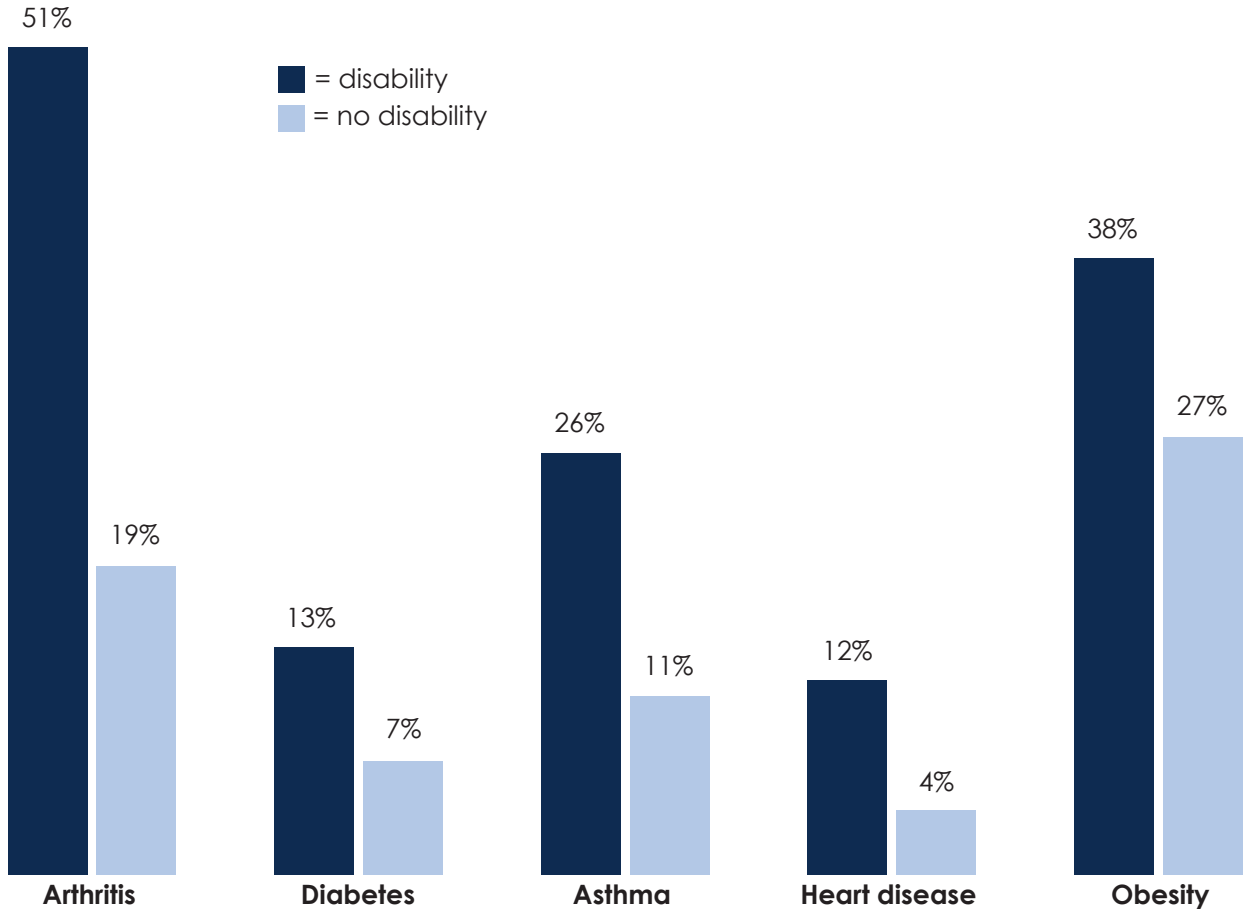
Who is considered 'disabled' according to federal law?

The Americans with Disabilities Act (ADA) defines someone with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activities.[2] This broad definition includes many types of disabilities, such as mobility impairments, speech and hearing impairments, visual impairments, mental illnesses and developmental or intellectual impairments.[3]

What is the health status of people with disabilities compared to people without disabilities?

Adults with disabilities, compared to adults without disabilities, are at increased risk of developing chronic health conditions.[4] As Figure 1 shows, rates of arthritis, diabetes, asthma, heart disease and obesity are all significantly higher among Ohioans with disabilities compared to those without disabilities.[5]

Figure 1. **Ohio adult chronic health conditions by disability status**



Source: 2011 Behavioral Risk Factor Surveillance System (BRFSS)

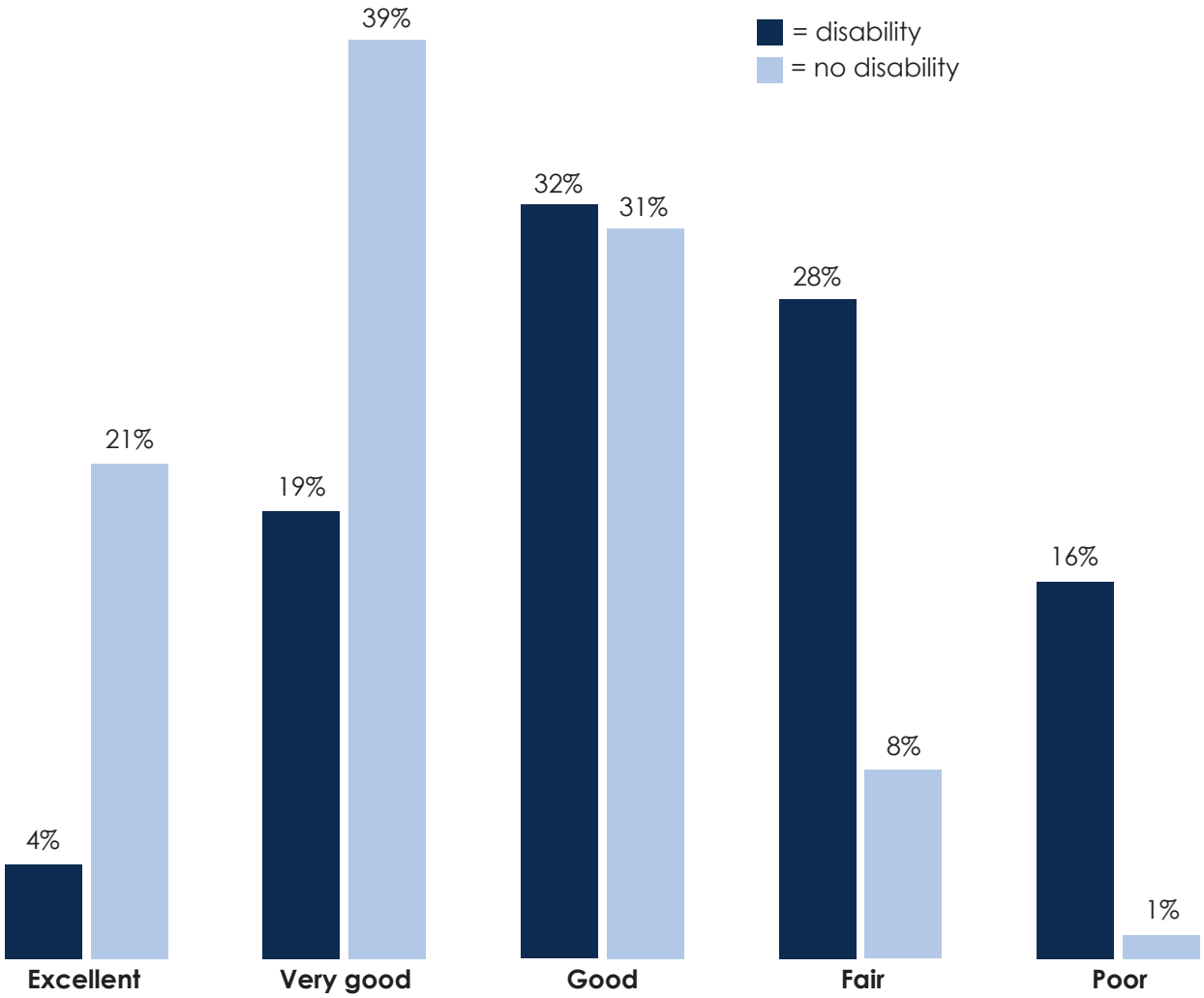
In addition, there are disparities in how individuals with disabilities view their own overall health. Twenty three percent of people with disabilities report having "very good" or "excellent" health, compared to 60 percent of people without disabilities. Furthermore, 44 percent of people with disabilities report having "fair" or "poor" health, compared to only 9 percent of people without disabilities (see Figure 2[6] below).

Evidence also suggests that there is an increased health risk both for and from mental health conditions among adults with disabilities. People with serious mental illness die, on average, 25 years younger than the general population. This is predominantly because of earlier onset of cardiovascular, pulmonary, respiratory, and infectious (e.g. AIDS/HIV) diseases, but also due to higher rates of suicide and injury.[7]

Research has found that emotional support protects against health problems, including heart disease and depression. However, people with disabilities have been shown to have significantly less emotional support.[8] The National Core Indicators Survey of 2011-12 found an estimated 31 percent of adults served by county boards of developmental disabilities had a co-occurring mental illness or psychiatric diagnosis, while 50 percent took medication for a "mood, behavior, anxiety or psychotic disorder."[9]

People with long-term disabilities, especially immobility, may experience early onset of conditions like coronary heart disease, diabetes and renal disease.[10] Researchers have also observed increases in preventable causes of disabling conditions. For example, the rates of obesity and Type 2 diabetes, which are contributors to heart disease, stroke and many other complications, have increased among people with disabilities.[11]

Figure 2. **Adult self-reported health status by disability status**



Source: 2011 Behavioral Risk Factor Surveillance System

To view the first part in our series on health and disabilities basics, titled "Health and disabilities basics: Overview of health coverage, programs and services," visit:

www.hpio.net/?p=1101

How do federal and state laws impact people with disabilities?

Changes in federal statutes over the past 30 years reflect recognition that people with disabilities have the right to accessible, high-quality clinical services and other health-related supports, and that such rights need to be protected and enforced. The following federal laws lay the groundwork for individuals with disabilities to enjoy equal access to opportunities for health and well-being. In some cases, states have enacted complementary laws in response to unique state circumstances, litigation and advocacy efforts.

Affordable Care Act of 2010

The Affordable Care Act (ACA) eliminated a barrier to private health insurance by guaranteeing that people with or without disabilities could not be denied coverage based on pre-existing conditions.

In addition, the ACA, along with the subsequent State of Ohio policy decision to expand Medicaid coverage to 138 percent of the federal poverty level (FPL), eliminated the need for many people with disabilities to "spend down" in order to qualify for Medicaid. Individuals with incomes between 138 percent of FPL and 400 percent of FPL are able to purchase private health insurance through the marketplace with financial assistance in the form of subsidies and cost sharing assistance. While these policy steps are helpful, affordability of private health insurance still may present a barrier to care for those with limited income.

Mental Health Parity and Addiction Equality Act of 2008

The Wellstone Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA) generally requires that group health insurance plans providing mental health and substance abuse benefits offer such benefits in a manner that is on par with medical/surgical benefits. Financial requirements, treatment limitations and network accessibility can be no more restrictive than for services traditionally called medical services. The ACA expands the MHPAEA requirements to the individual and small group markets as well, requiring that all individual and small-group plans, both inside and outside of the insurance marketplace, comply with essential health benefit requirements, including mental health and substance abuse treatment.

Notably, there has been no set or uniform standard for what parity compliance with MHPAEA looks like, which has impacted the implementation of the law. (Note: MHPAEA, along with implications created by ACA and state mental health parity laws, will be covered in more depth in a future HPIO brief.) The Final Rule to implement MHPAEA was issued on November 13, 2013, and all plans starting on or after July 1, 2014, must comply with the law and rule.[12] Ohio law has required coverage for biologically-based mental illness since 2006.[13] Similarly, state law mandates a certain level of treatment for alcoholism.[14]

Section 504 of the Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 protects qualified individuals from discrimination based on their disability. It prohibits such discrimination by federal agencies as well as by any entity or program that receives federal funds, including Medicaid, Medicare and federal block grant funding. Any recipient of federal funds cannot:

- Deny people with disabilities the opportunity to participate in or benefit from federally funded programs, services or other benefits, including healthcare services
- Deny people with disabilities access to programs, services, benefits or opportunities (including healthcare services) as a result of physical barriers
- Deny employment opportunities, including hiring, promoting, training and fringe benefits for which people with disabilities are otherwise entitled or qualified

Healthcare providers cannot give people with disabilities a healthcare service that is not as effective as what is offered to others. Section 504 requires healthcare providers to accommodate people with mental as well as physical disabilities to ensure equal access and opportunities. This not only includes physical access, but also includes accommodations for communication, such as sign language interpretation for people with hearing impairments.

The Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA), voted into law in 1990, deals with discrimination in employment (Title I) and discrimination in access (Titles II and III). Under both Titles, individuals with disabilities must have the same access and opportunities with a healthcare provider, and receive the same amount and quality of information and communication, as someone who does not have a disability. In addition, the law requires healthcare providers and other entities to modify their policies, practices and procedures to allow people with disabilities full and equal access to all services, unless the modification would fundamentally alter the healthcare service itself.

In *Olmstead v. L.C.* (1999), the United States Supreme Court construed Title II of the ADA to require states to eliminate unnecessary housing segregation based on mental or physical disability, requiring that states develop community-based housing and treatment options whenever possible.[15] Since that time, Ohio has expanded home and community-based options through Medicaid waivers. Total expenditures on home and community-based services waivers have grown from $85 million in 1997, just before the *Olmstead* decision, to $841.7 million in 2011.[16] At the same time, the need continues to be significant. A recent report commissioned by the Ohio Developmental Disabilities Council indicates that there are 41,260 unduplicated names on waiting lists for services. The median wait time is 6.4 years.[17]

In addition, in April 2014 with the landmark case *U.S. vs. Rhode Island*,[18] the U.S. Department of Justice's Civil Rights Division applied the *Olmstead* decision to segregated employment as a violation of employment rights for people with disabilities. The settlement mandates person-centered planning, including career planning, for transition-age youth and for adults served in sheltered workshops and day programs. It also sets specific quotas for defined populations and requires completion dates for these plans.

This decision may impact how Ohio serves people with developmental disabilities, as Ohio utilizes segregated employment settings. In Ohio, 32,009 people with intellectual/developmental disabilities are supported through segregated Adult Day Support or Vocational Habilitation services, while only 7,626 participate in integrated employment.[19] Only 13 percent of Ohioans with developmental disabilities surveyed in 2011-12 have community-based employment, while 54 percent report wanting it.[20]

Social inclusion and employment can be an important factor in health and well-being for people with severe mental illness. Assistance in employment, however, is largely an unmet need; only about 15 percent of people with severe mental illness are competitively employed at any given time.[21]

What are the barriers to optimal health?

Overall access to affordable, quality long-term services and supports

People with disabilities often need long-term services and supports to address their chronic health conditions, impaired mobility, impaired cognitive function and/or complex medical needs and to help them live as independently as possible. More than 42 percent of long-term care service beneficiaries are under the age of 65.[22] In addition, the lifetime probability of becoming disabled in at least two activities of daily living or of being cognitively impaired is 68 percent for people age 65 and older.[23] As the "Baby Boom" population continues to age, the need for long-term services is expected to increase significantly.[24]

Yet, according to the 2014 State Scorecard on Long-Term Services and Supports, many states, including Ohio, have room for improvement when it comes to five dimensions of long-term care: affordability and access, choice of setting and provider, quality of life and quality of care, support for family caregivers and effective transitions. Overall, Ohio ranks 44 out of 50 states and the District of Columbia, down from 35 in the 2011 scorecard.[25] Ohio scores in the bottom quartile for affordability and access as well as quality of life and quality of care. The state scores in the third quartile for choice of setting and provider, support for family caregivers and effective transitions.

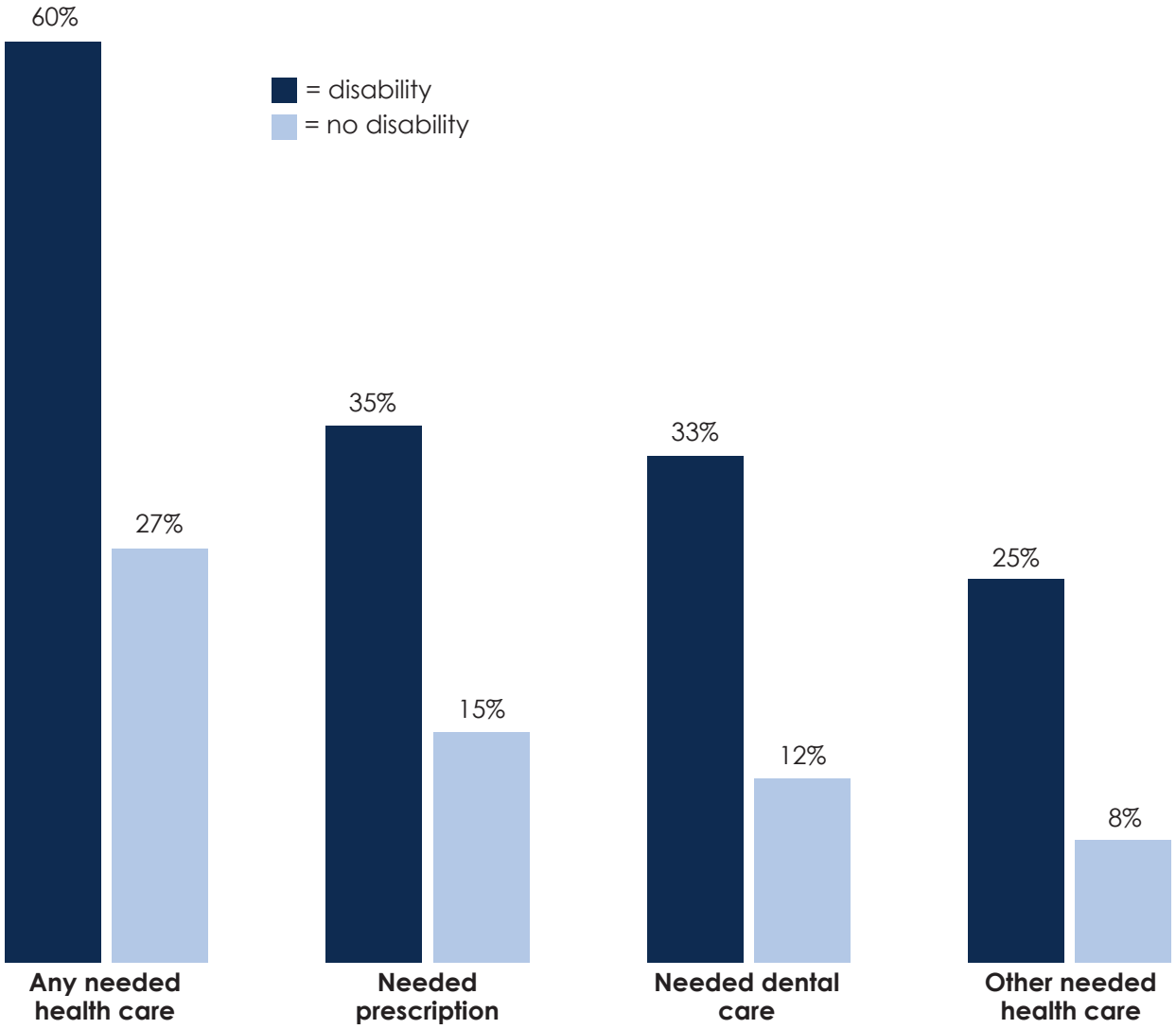
Access to appropriate, high-quality clinical care

People with disabilities face acute, and often unique, barriers to accessing appropriate, high-quality clinical services. Before the implementation of the ACA, one barrier to care was the inability of people with disabilities to obtain health insurance coverage. This is changing, though. While in 2011 the percentage of Ohioans with a disability who were uninsured was 1.8 percentage points higher than those without a disability. In 2012, that gap had dropped to .01 points.[26]

Despite federal laws aimed at improving access to health care and other supports for people with disabilities, adults with disabilities in Ohio are twice as likely to report not getting needed health care, prescriptions and dental care compared to those without disabilities (see Figure 3).[27] More specifically, Ohioans with disabilities are more than three times as likely as the general population to report not getting basic needs met, like medical exams, medical supplies and equipment (these services are included in the 'other needed health care' category of Figure 3). Ohio women with disabilities receive mammograms and pap smears at a lower rate than women without disabilities.

Stigma is also a significant barrier to accessing care, particularly for people with mental illness. According to the National Alliance on Mental Illness, "estimates indicate that nearly two-thirds of all people with a diagnosable mental illness do not seek treatment, especially people from diverse communities. Lack of knowledge, fear of disclosure, rejection of friends, and discrimination are a few reasons why people with mental illness don't seek help."[28]

Figure 3. **Ohio adult access to care — reported did not get needed care, by disability status**



Source: 2012 Ohio Medicaid Assessment Survey (OMAS)

Researchers also have noted that people with disabilities experience gaps in treatment even when services and coverage are available. They face barriers in plan restrictions such as number of sessions offered and other caps, or plans that cover medication only and not other services such as psychotherapy.[29] These obstacles leave individuals to either make do with inadequate services or forgo treatment altogether.

A review of research literature shows that access to clinical care is limited by several factors:

- **Limited availability of appropriate and accessible transportation.** The Rehabilitation Act of 1973 and the ADA require accessible transportation. For example, all public transport authorities that provide fixed route service must use accessible vehicles and also must provide 'para-transit services,' which are alternative modes of transportation that are not on a fixed route and are scheduled by individual users. In addition, Medicaid must cover non-emergency, medically necessary transportation. These services, though operational, are often limited due to budget constraints[30] and can be challenging to use. A study by Georgetown University and the National Rehabilitation Hospital Center for Health and Disability Research examined transportation barriers and found that public transportation often does not have stops close to providers or vendors.[31] Para-transit services may need to be scheduled as much as a week in advance, which is not conducive to the immediate nature of some health needs. Furthermore, the availability of such transport is unpredictable, due to multi-client usage and other factors.

- **Physical barriers to health care facilities and services.** Despite the fact that people with disabilities represent the most frequent consumers of health care,[32] they continue to report lack of accessible equipment and inadequately trained medical providers.[33] Physical barriers may include too few parking spaces close to entrances, poorly-placed ramps or curb cuts and doors that are too narrow and difficult to open to accommodate those with mobility issues. In addition, people with disabilities need access to medical service areas (e.g., reachable counters, spacious exam rooms, lowered exam tables and other diagnostic equipment) and materials (e.g., Braille, large print, or on-site interpreters).

- **The lack of disability competency training for healthcare practitioners.** Among nonelderly people with disabilities, 1 out of 4 reported that they had difficulty finding a healthcare professional who understood their disability.[34] Additionally, according to the National Council on Disability, healthcare providers often fail to treat a person's full range of health needs focusing instead primarily on the patient's disability.[35] Such an approach might result in the provider missing a patient's risk for the onset of secondary health conditions and/or providing appropriate preventive measures. Other dynamics come into play when considering mental health issues. In a phenomenon known as diagnostic overshadowing, medical professionals may over-attribute a patient's symptoms to a previously diagnosed psychiatric disorder or developmental disability, resulting in key co-morbid medical conditions being undiagnosed and untreated.[36]

Social determinants of health

In addition to access to clinical care, health policy experts recognize several other factors as key drivers of health outcomes for those with and without disabilities alike. A 2002 study estimated that behavioral patterns (40 percent), environmental exposures (5 percent), and social circumstances (15 percent) together contribute to more than half of the causes of premature death.[37] Taken together, these non-clinical factors are referred to as the *social determinants of health*. Behavioral patterns and social circumstances differ across groups; as a result, strategies to improve these areas for people with disabilities have complex implications.

Behavior patterns

Research has shown that by engaging in healthy behaviors, especially physical activity, people with disabilities can increase their overall mental and physical well-being. Barriers such as "transportation difficulties, inaccessible buildings or structures, [and] lack of staff knowledge on certain accommodations that are needed for managing physical, cognitive, or sensory impairments" likely impact people with disabilities in terms of limiting opportunities

to engage in health-promoting activities.[38] In Ohio, rates of smoking and physical inactivity among Ohioans with disabilities are significantly higher than for Ohioans without disabilities (see Figure 4). Poor nutrition and lack of mobility can contribute to obesity and the early onset of diabetes and has been noted as a particular health concern for people with disabilities.[39] Specialized programs to increase activity and improve nutritional choices have been shown to improve health among people with disabilities.[40]

These behavioral patterns highlight the need for more targeted health promotion efforts focusing on smoking cessation, physical activity and nutrition. Perhaps most importantly, engagement in physical activity can lower the risk of developing secondary conditions, including those that are disability-related such as loss of muscle tone, bone density and dexterity.[41]

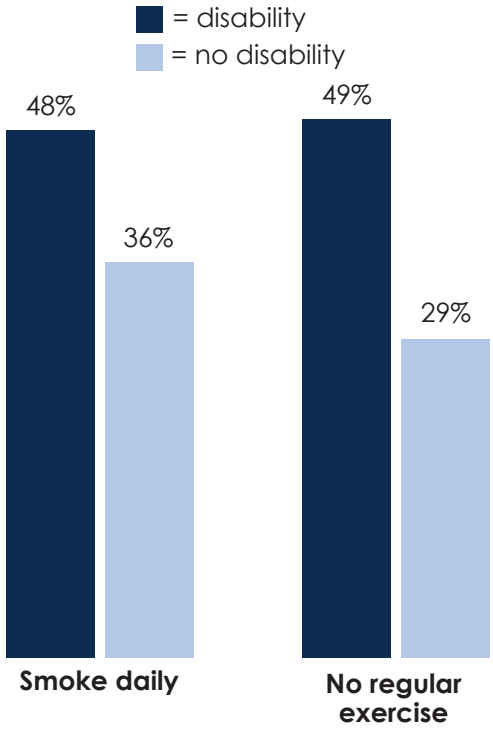
Social circumstances

People with disabilities face a number of societal challenges related to poverty, housing, employment and recreational opportunities, all of which directly or indirectly affect physical and mental health.

- **Poverty rates among people with disabilities are higher than for the general population.** Data from the American Community Survey (ACS) show that 32 percent of Ohioans with a disability were living in poverty in 2012, compared to just 12 percent of Ohioans without a disability.[42] Poverty worsens barriers to care and other supports, making it an underlying contributor to poor health. While the major components of the social welfare safety net discussed in the first brief (Medicare, Medicaid, Supplemental Security Income [SSI] and Social Security Disability Insurance [SSDI]) do much to alleviate abject poverty among Ohioans with disabilities, a sizable gap still divides Ohioans with and without disabilities.

- **Workforce participation and employment rates among Ohioans with disabilities are significantly lower than the general population** (See Figure 5[43]). Such underemployment contributes to poverty. Challenges to employment for adults with disabilities include lack of transportation to job sites, difficulty completing required applications, and, in some instances, discrimination and prejudice among employers. For some, disability may prove a barrier to acquiring needed job skills to participate in the workforce.

Figure 4. **Ohio adult health risk behaviors by disability status**



Source: 2012 OMAS

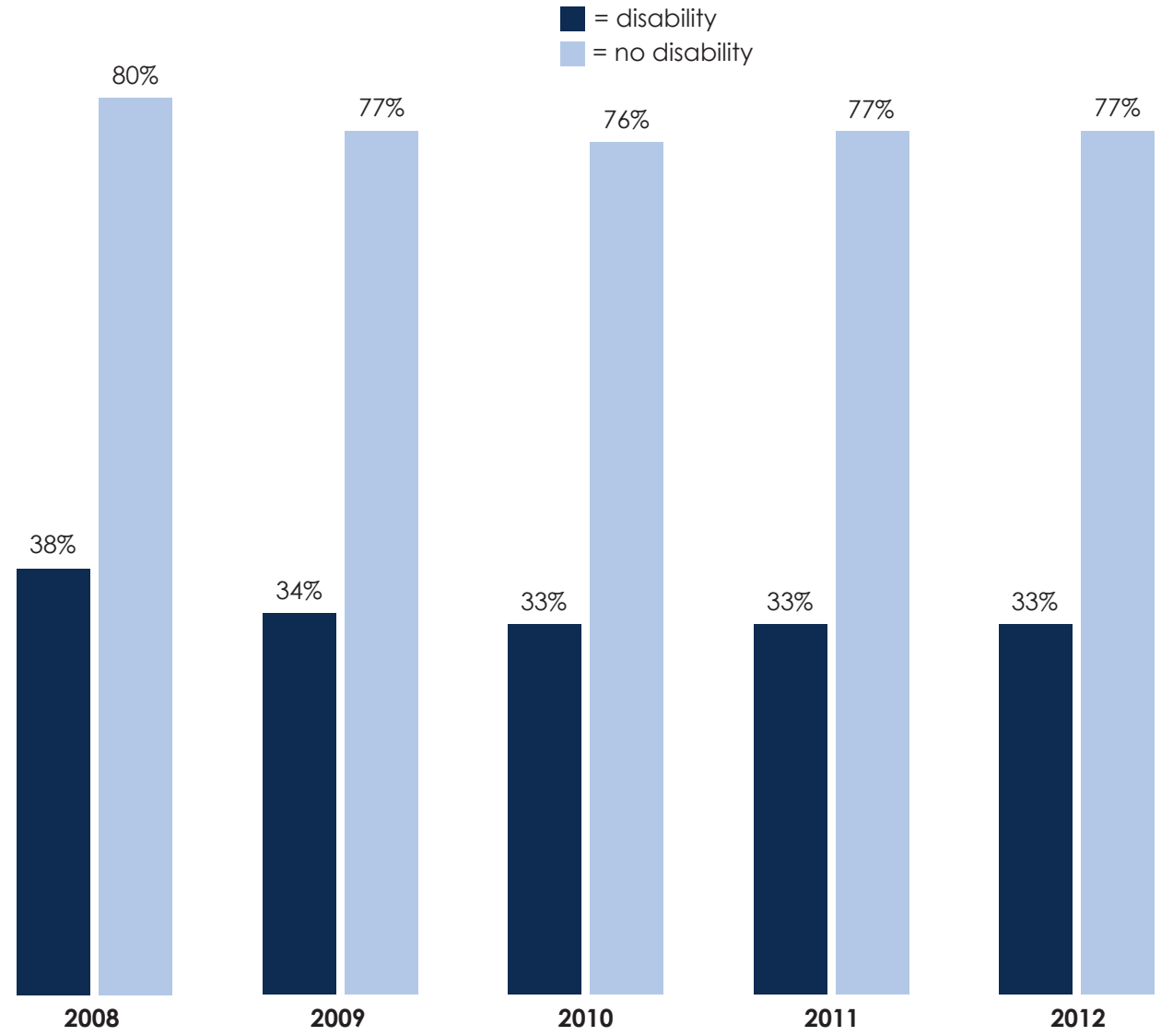
Although the ADA "prohibits private employers, state and local governments, employment agencies and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions and privileges of employment," some employers remain uncomfortable hiring people with disabilities.[44] A review of the literature shows that across disability groups, employer attitudes toward hiring people with disabilities are improving, thanks to greater exposure and access to programs supporting both the employer and employee.[45]

- **People with disabilities face challenges finding appropriate housing that meets their particular accessibility and affordability requirements**. An estimated 41 percent of all households with a member with a disability cannot afford their housing.[46] In Ohio, where 21 percent

of adults aged 21 to 64 with disabilities are dependent on SSI income, the cost of a one-bedroom apartment on the open market consumes, on average, 79 percent of the SSI benefit. This percentage ranges from a low of 67 percent in Allen County to a high of 86 percent in Union County,[47] leaving little money for food, transportation, and health care expenses. In addition, among homeless adults requiring shelter, 43 percent have a disability.[48]

- **Opportunities for social and recreational activities can be minimal for people with disabilities, often due to transportation barriers or physical inaccessibility**. Limited participation in community life and social activities has wide-ranging implications for health and well-being. Research indicates that social isolation is considered to be as potent a threat to health as high blood pressure, obesity, lack of exercise and smoking.[49] In addition, strong interpersonal relationships may buffer against depression and heart disease, shorten recovery from surgery, and improve breast cancer treatment outcomes.[50]

Figure 5. **Employment rates by disability status, ages 21 – 64**



Source: 2012 American Community Survey

What policies and strategies can address the challenges faced by people with disabilities?

- **Provide disability competency training to health care providers** as a requirement of practice and as a component of continuing education. Demonstrated competence in best practices for treating people with disabilities should be necessary for accreditation, licensure/certification, and/or receipt of state and federal funding for professional training of physicians, nurses and allied health providers.

- **Continue to evaluate and monitor the impact of federal and state parity legislation on access to mental health and addiction services among people with disabilities**. The Mental Health Parity and Addiction Equity Act of 2008 was enacted in 2008 and final rules to implement the law were issued in November 2013. Litigation is pending with focus on issues of provider reimbursements and network adequacy. This litigation, as well as other challenges, should be monitored and addressed to make sure that the law improves access as intended.[51]

- **Continue to evaluate the work of the federal Architectural and Transportation Barriers Compliance Board**. Established by the Rehabilitation Act of 1973, the Architectural and Transportation Barriers Compliance Board, or Access Board, sets the standard for access by developing and maintaining, "design criteria for the built environment, transit vehicles, telecommunications equipment, medical diagnostic equipment and information technology."[52] The Board also provides training and technical assistance in accessible design and acts as a coordinating body for federal agencies.

- **Explore and evaluate the use of telehealth** to deliver care to people with disabilities in their own homes and communities, thus removing transportation barriers and providing greater opportunity for family and caregiver support and participation.

- **Develop, support and evaluate targeted and accessible evidence-based prevention and health promotion programs for people with disabilities.** In general, the most successful health promotion programs for adults with developmental disabilities enlist their family members and other caregivers. Adults with other types of disabilities might benefit from health promotion programs available in the community with minimal accommodation (such as the Chronic Disease Self-Management program).[53]

- **Continue to develop and evaluate tools and programs that assist people with disabilities in locating affordable housing and homelessness assistance.** The Ohio Housing Locater (www.ohiohousinglocator.org), an interactive website for locating subsidized housing throughout the state, is one such tool; however, more vigilance is needed in keeping this and other tools updated. Homeless assistance (e.g. emergency shelter, educational provisions, etc.) provided through the federal McKinney-Vento Homeless Assistance Act of 1987 is another program worthy of ongoing evaluation.

- **Support, monitor and evaluate the work of the Access Board in developing and updating facility design guidelines known as the ADA Accessibility Guidelines (ADAAG)**. Published in 2002, these accessibility guidelines for new construction and alterations on recreational facilities include "scoping and technical provisions for amusement rides, boating facilities, fishing piers and platforms, golf courses, miniature golf, sports facilities, and swimming pools and spas." The guidelines ensure that newly constructed and altered recreation facilities meet ADA requirements and are readily accessible to and usable by individuals with disabilities.

- **Continue to tailor workforce development policies and programs to increase employment opportunities for people with disabilities.** In March 2012, Governor John Kasich signed an executive order making Ohio an "Employment First" state. This means that employment is the assumed goal when writing individual service plans for people with disabilities. The Ohio Department of Developmental Disabilities and Opportunities for Ohioans with Disabilities (formally the Rehabilitation Services Commission) are active partners in Ohio's Employment First Initiative. Federal support for these initiatives is provided through the Department of Labor's Office of Disability Employment Policy.[54]

- **Explore state policy best practices in long-term care and review state policies in place in those states that rank in the top quartile of the 2014 State Long-Term Services and Supports Scorecard.** There is great opportunity to learn from these states. Analyzing policies that work elsewhere in light of the particular needs of Ohioans can inform approaches to improving long-term services and supports.

Resources

ADA

- Illinois Legal Aid has developed a helpful resource called, "Disabilities Guidebook: Who Has a Disability under the ADA?" This resource can be found at: http://www.illinoislegalaid.org/index.cfm?fuseaction=home.dsp_content&contentID=167
- The U.S. Department of Justice hosts a website dedicated to rights protected under ADA, www.ada.gov. This website contains resources for physicians, explaining their obligations in access to services and to physical space. One particularly helpful guide is the "Access to Medical Care for Individuals with Mobility Disabilities."[55] This document deals with general requirements as well as specific parameters for the accessibility of the examination room and medical equipment used, such as the examination table.
- A federal website, www.disability.gov, contains information and tools to assist with everything from benefits and rights to employment and health.

Mental Health Parity

- The Centers for Medicare & Medicaid Services (CMS) has developed a Fact Sheet for the Mental Health Parity and Addiction Equality Act (MHPAEA). This Fact Sheet can be found at: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html#Introduction

Communication

- "Effective Communication for Health Care Providers: A guide to caring for people with disabilities," developed by the University of Delaware, Center for Disabilities Studies. This resource can be found at: http://www.gohdwd.org/documents/Effective_Communication.pdf

Housing

- Public Housing Authorities are the main outlet of federal funding for public housing for very low-income families, including individuals with disabilities. They are excellent resources for information on available public housing and housing choice voucher programs.
- The Ohio Housing Locater is an interactive website for locating subsidized housing anywhere in Ohio, another important resource for people with disabilities seeking affordable housing. The tool was developed by the Ohio Housing Finance Agency and the Ohio Department of Development with additional funding from the Ohio Developmental Disabilities Council. The Locator can be found at: www.ohiohousinglocator.org

Employment

- Ohio is an Employment First state. For more information and resources on Employment First initiatives in Ohio go to: http://www.ohioemploymentfirst.org
- Each county has an employment OhioMeansJobs site. For more information on disability related services through the OhioMeansJobs system see the Ohio Department of Job and Family Services' Fact Sheet: Disability Services for Job Seekers: http://jfs.ohio.gov/factsheets/disability.pdf. To find your One-Stop go to: http://jfs.ohio.gov/owd/wia/wiamap.stm
- OhioMeansJobs also contains listings of job fairs and workshops such as basic computer skills, resume writing, money management and more. See: http://ohiomeansjobs.com/omj/workshoplist.do?selectid=0
- OhioMeansInternships lists more than 1,000 opportunities around the state. See: www.ohiomeansinternships.com

Notes

1. Because of the breadth of the subject matter, this brief will focus on adults with disabilities, and not issues impacting children with disabilities.
2. 42 USC §12102(1)(A)-(C)
3. For more discussion on the various definitions of disability, including the definition used in federal law, see the first Brief in this series: Health Policy Institute of Ohio. "Health and Disabilities Basics: Overview of Health Coverage, Programs and Services." March 2014. http://www.healthpolicyohio.org/health-and-disabilities-basics-overview-of-health-coverage-programs-and-services. Also see: 42 USC 15001 § 102 (8).
4. Havercamp, Susan M., Donna Scandlin, and Marcia Roth. "Health disparities among adults with developmental disabilities, adults with other disabilities, and adults not reporting disability in North Carolina." Public Health Reports 119, no. 4 (2004): 418.
5. This data, from the CDC's Behavioral Risk Factor Surveillance System was analyzed and provided by the Ohio Disability Health Program at the Ohio State University Colleges of Medicine.
6. Ashmead, Robert, Tim Sahr, and Susan Havercamp. The Ohio Colleges of Medicine Government Resource Center and The Ohio State University Nisonger Center. 2013 Ohio Disability Data Report: Ohio Disability and Health Program. http://nisonger.osu.edu/media/odhp/OhioDisabilityDataReport_Ohio.pdf. This report draws from the Ohio Medicaid Assessment Survey, conducted in 2012, the Behavioral Risk Factor Surveillance System (BRFSS) in 2011, and the American Community Survey 3 year estimates.
7. Parks, J., D. Svendsen, P. Singer, M. Foti, and B. Mauer. "Morbidity and mortality in people with serious mental illness. National Association of State Mental Health Program Directors, 2006." (2009): 11. http://

www.nasmhpd.org/docs/publications/MDCdocs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf
8. Havercamp, et al. (2004), 424.
9. National Core Indicators, a collaboration of the National Association of State Directors of Developmental Disabilities Servcies and Human Services Research Institute. "NCI Adult Consumer Survey Outcomes: Ohio Report." 2011-2012. http://www.nationalcoreindicators.org/states/OH/.
10. Ashmead, et al., 267.
11. DeJong, Gerben, Susan E. Palsbo, and Phillip W. Beatty. "1. The organization and financing of health services for persons with disabilities." Milbank Quarterly 80, no. 2 (2002): 265-66.
12. United States Department of Labor. "Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program. November 13, 2013. http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=27169&AgencyId=8&DocumentType=2.
13. Ohio Revised Code 3923.281.
14. Ohio Revised Code 3923.29.
15. White House Press Release. "President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities." June 22, 2009. http://www.whitehouse.gov/the_press_office/President-Obama-Commemorates-Anniversary-of-Olmstead-and-Announces-New-Initiatives-to-Assist-Americans-with-Disabilities.
16. Braddock, D., Hemp, R., Rizzolo, M.C., Tanis, E.S., Haffer, L., Lulinski-Norris, A., & Wu, J. The State of the States in Developmental Disabilities 2013: The Great Recession and its Aftermath. Boulder: Department of Psychiatry and Coleman Institute, University of Colorado and Department of Disability and Human Development, University of Illinois at Chicago, 2013, p. 170. See other resources at www.stateofthestates.org. During the same period (1997 to 2011), spending in intermediate care facilities for intellectual disabilities grew from $507.9 million to $521.3 million, an increase of 2.6 percent.
17. "What are we Waiting For? Waiver Supported Services Needed by Individual and Their Caregivers." Report prepared by the Ohio Colleges of Medicine Government Resource Center for the Ohio Developmental Disabilities Council. February 2014. http://www.ddc.ohio.gov/pub/waiting-list-study-2-21-14.pdf.
18. United States Department of Justice, Civil Rights Division. Information and Technical Assistance on the Americans with Disabilities Act. "Olmstead Enforcement: U.S. v. Rhode Island – 1:14-cv-00175 – (D.R.I. 2014)." http://www.ada.gov/olmstead/olmstead_cases_list2.htm#ri-state.
19. This data is from the Ohio Department of Developmental Disabilities, Individual Data System, obtained through correspondence with the Employment First project on May 6, 2014.
20. National Core Indicators, a collaboration of the National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute. "NCI Adult Consumer Survey Outcomes: Ohio Report." 2011-2012. http://www.nationalcoreindicators.org/states/OH/.
21. Bond, Gary, and Kikuko Campbell. National Alliance on Mental Illness. "Supported Employment: An Evidence-Based Practice." http://www.nami.org/Content/ContentGroups/Other/Supported_Employment_An_Evidence_Based_Practice.htm.
22. Feder, Judith, Harriet L. Komisar, and Robert B. Friedland. Georgetown University Health Policy Institute. Long-Term Care Financing Project. "Long-Term Care Financing: Policy Options for the Future. June 2007. https://georgetown.box.com/shared/static/mhdbkd4vtklps9ntkskc.pdf
23. AARP. "Beyond 50.2003: A Report to the Nation on Independent Living and Disability." January 11, 2005.
24. U.S. Department of Health and Human Services. "Who Needs Care?" http://longtermcare.gov/the-basics/who-needs-care/.
25. Reinhard, Susan C., Enid Kassner, Ari Houser, Kathleen Ujvari, Robert Mollica, and Leslie Hendrickson. AARP Public Policy Institute. "Raising Expectations: A state scorecard on long-term services and supports for older adults, people with physical disabilities, and family caregivers." June 2014. http://www.longtermscorecard.org/2014-scorecard#.U6RGffldW8w.
26. Erickson, W., Lee, C., von Schrader, S. (2013). Disability Statistics from the 2011 American Community Survey (ACS). Ithaca, NY: Cornell University Employment and Disability Institute (EDI). Accessed June 16, 2014. www.disabilitystatistics.org.
27. Ashmead, Robert, Tim Sahr, and Susan Havercamp. (2013) p. 9 http://nisonger.osu.edu/media/odhp/OhioDisabilityDataReport_Ohio.pdf.
28. National Alliance on Mental Illness. "Facts about Stigma and Mental Illness in Diverse Communities." http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=5148.
29. Scheer, Jessica, Thilo Kroll, Melinda T. Neri, and Phillip Beatty. "Access Barriers for Persons with Disabilities The Consumer's Perspective." Journal of Disability Policy Studies 13, no. 4 (2003): 223-224.
30. The ARC. "Transportation Issues for People with Disabilities." http://www.thearc.org/what-we-do/public-policy/policy-issues/transportation.
31. Scheer, et al., 226.
32. DeJong, et al., 268-9. Researchers used functional limitations such as the use of a mobility devise as proxy for 'disability,' a potentially wide definition, in reviewing the 1996 Medical Expenditure Panel Survey. In doing so they found that people with 'disabilities' accounted for 46.3% of total health care expenditures.
33. Ibid., 271.
34. Hanson, Kristina W., Patricia Neuman, David Dutwin, and Judith D. Kasper. "Uncovering the health challenges facing people with disabilities: the role of health insurance." Health Affairs 22, no. 5 (2003): w552-65.http://content.healthaffairs.org/content/early/2003/11/19/hlthaff.w3.552.
35. National Council on Disability. "The Current State of Health Care for People with Disabilities." September 30, 2009. http://www.ncd.gov/rawmedia_repository/0d7c848f_3d97_43b3_bea5_36e1d97f973d?document.pdf.
36. Reiss, Steven, Grant W. Levitan, and Joseph Szyszko. "Emotional disturbance and mental retardation: Diagnostic overshadowing." American journal of mental deficiency 86, no 6 (1982): 567-574.
37. McGinnis, J. Michael, Pamela Williams-Russo, and James R. Knickman. "The Case for More Active Policy Attention to Health Promotion." Health Affairs 21, no. 2 (2002): 78-93.
38. Rimmer, James H., and Jennifer L. Rowland. "Health promotion for people with disabilities: Implications for empowering the person and promoting disability-friendly environments." American Journal of Lifestyle Medicine (2008): 409.
39. Heller, Tamar, Jeffrey A. McCubbin, Charles Drum, and Jana Peterson. "Physical activity and nutrition health promotion interventions: what is working for people with intellectual disabilities?." Intellectual and developmental disabilities 49, no. 1 (2011): 2.
40. Ravesloot, Craig, Tom Seekins, and Glen White. "Living Well With a Disability health promotion intervention: improved health status for consumers and lower costs for health care policymakers." Rehabilitation Psychology 50, no. 3 (2005): 239-245.
41. U.S. Department of Health and Human Services, Office of the Surgeon General. "The Surgeon General's Call To Action To Improve the Health and Wellness of Persons with Disabilities." 2005. http://www.ncbi.nlm.nih.gov/books/NBK44662/#healthandwellness.s1.
42. Erickson, W., Lee, C., von Schrader, S. Disability Statistics from the 2012 American Community Survey (ACS). Ithaca, NY: Cornell University Employment and Disability Institute (EDI). Accessed June 16, 2014. www.disabilitystatistics.org.
43. Ibid. Accessed April 30, 2014. www.disabilitystatistics.org.
44. United States Department of Justice, Civil Rights Division. Information and Technical Assistance on the Americans with Disabilities Act. "Employment: Title I." http://www.ada.gov/ada_title_I.htm.
45. Unger, Darlene D. "Employers' Attitudes Toward Persons with Disabilities in the Workforce Myths or Realities?." Focus on Autism and Other Developmental Disabilities 17, no. 1 (2002): 2-10
46. National Council on Disability. "The State of Housing in America in the 21st Century: A Disability Perspective." January 19, 2010. http://www.ncd.gov/publications/2010/Jan192010
47. Cooper, Emily, Ann O'Hara, Nikki Singer, and Andrew Zovistoski. "Priced Out in 2012: The Housing Crisis for People with Disabilities." Accessed April 1, 2014. http://www.tacinc.org/media/33368/PricedOut2012.pdf
48. National Council on Disability. "The State of Housing in America in the 21st Century: A Disability Perspective." January 19, 2010. http://www.ncd.gov/publications/2010/Jan192010
49. Achor, Shawn. The happiness advantage: The seven principles of positive psychology that fuel success and performance at work. New York: Random House, 2010, p. 177.
50. Ibid, p. 178.
51. For example, The American Psychiatric Association has been active in both advocacy and litigation regarding MHPAEA. See http://www.psychiatry.org/practice/parity.
52. United States Access Board. "About the U.S. Access Board." https://www.access-board.gov/the-board.
53. National Council on Aging. Chronic Disease Self-Management Program State Profiles. http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/cdsmp-state-profiles/cdsmp-state.html
54. United States Department of Labor, Office of Disability Employment Policy. "Disability Employment Policy Resources by Topic." http://www.dol.gov/odep/topics/EmploymentFirst.htm.
55. U.S. Department of Justice, Civil Rights Division, Disability Rights Section and U.S. Department of Health and Human Services, Office for Civil Rights. "Americans with Disabilities Act: Access to Medical Care For Individuals with mobility Disabilities." July 2010. http://www.ada.gov/medcare_mobility_ta/medcare_ta.htm.

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