



**LEGISLATION AND PUBLIC POLICY COMMITTEE (LPPC)  
MEETING NOTICE/AGENDA**

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PARTICIPANT CODE:**

**1-800-839-9416  
8610332**

**DATE:** July 14, 2016  
**TIME:** 12:00 p.m. - to 4:00 p.m.  
**LOCATION:** State Council on Developmental Disabilities  
1507 21<sup>st</sup> Street, Suite 210  
Sacramento, CA 95811  
(916) 322-8481

**TELECONFERENCE SITE(S):**

**SCDD Silicon Valley-Monterey Office**  
2580 North First Street, Suite 240  
San Jose, CA 95131  
(408) 324-2106

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**AGENDA**

	<b><u>PAGE</u></b>
1. CALL TO ORDER	J. Lewis
2. ESTABLISH QUORUM	J. Lewis
3. WELCOME/INTRODUCTIONS	J. Lewis

For additional information regarding this agenda, please contact Michael Brett, 1507 21<sup>st</sup> Street, Ste. 210 Sacramento, CA 95811, (916) 322-8481.

Documents for an agenda item should be turned into SCDD no later than 12:00 p.m. the day before the meeting to give members time to review the material. The fax number is (916) 443-4957.

**4. MEMBER REPORTS**

Members

*This item is for committee members to provide a report on their legislative and/or public policy activities related to the agency or group they represent. Each person will be afforded up to three minutes to speak.*

**5. APPROVAL OF MAY 24, 2016 MINUTES**

J. Lewis

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**6. PUBLIC COMMENTS**

*This item is for members of the public only to provide comments and/or present information to the Council on matters **not** on the agenda. Each person will be afforded up to three minutes to speak. Written requests, if any, will be considered first.*

**7. NEW BUSINESS**

a. Discussion of Proposed 2017 SCDD Legislative Platform J. Lewis/All 12

b. New Bills G. Giovati/All

**8. OLD BUSINESS (Standing Items)**

a. Bills Discussed at Last Meeting, 5/24/16 G. Giovati/ J. Lewis/All 17

- 1) AB 1553 (Irwin) Qualified ABLE program
- 2) AB 1715 (Holden) Behavior Analysis
- 3) AB 1821 (Maienschein) Sex Offenses
- 4) AB 1824 (Chang) Service Animals
- 5) AB 2091 (Lopez) IEP Translation Services
- 6) AB 2212 (Harper) Bullying
- 7) AB 2231 (Calderon) Care Facilities
- 8) AB 2582 (Maienschein) Income Taxes
- 9) SB 884 (Beall) Special Education
- 10) SB 982 (McGuire) Developmental Centers
- 11) SB 1034 (Mitchell) Health Care: Autism
- 12) SB 1072 (Mendoza) School Bus Alarms
- 13) SB 1221 (Hertzberg) Firefighters Interaction

b. IHSS/CMS Updates/Overtime Discussion/DC Closures J. Lewis/All

c. Self-Determination J. Lewis/A. Lopez/C. Lapin/All

1) Statewide SDP Committee

d. Disparity Issues All 19

9. **ADJOURN** J. Lewis



**5. APPROVAL OF  
MAY 24, 2016 MINUTES**





**DRAFT**

**LPPC Committee Meeting Minutes**

**DATE: May 24, 2016**

**Attending Members**

Janelle Lewis (FA)  
April Lopez (FA)  
David Forderer (SA)  
Sandra Aldana (SA)  
Connie Lapin (FA)  
Evelyn Abouhassan

**Members Absent**

Lisa Davidson (FA)  
Jennifer Allen (SA)

**Others Attending**

Bob Giovati  
Michael Brett  
Nelly Nieblas  
Deborah Doctor  
Wayne Glusker

**1. CALL TO ORDER**

Chairperson Janelle Lewis (FA) called the meeting to order at 12:11 p.m.

**2. ESTABLISH QUORUM**

A quorum was established.

**3. WELCOME/INTRODUCTIONS**

Members and others introduced themselves as indicated.

**4. MEMBER REPORTS**

**Dr. April Lopez (FA):** Briefed on the following:

- SB 1072 involvement.
- As a result of Dr. Lopez (FA) participating in a press conference on SB 1072, Kern County (Transportation) invited her to give a keynote speech on her personal story/SB 1072.
- Gave accolades to Chairperson Lewis (FA)/staff on coordination of SB 1072 interviews/hearings.

- For one of these SB 1072 hearings, Dr. Lopez' (FA) daughter, Ava, gave a moving speech.

**Connie Lapin (FA):** Briefed the following:

- Since the last LPPC meeting, various meetings took place:
  - DS Taskforce: April 13, 2016.
  - HCBS: April 29, 2016.
  - Workgroup: May 17, 2016.
  - Self Determination: May 25, 2016.
- HCBS and Self-Determination waivers: Mrs. Lapin (FA) would like the committee to discuss possible safety nets to these waivers. Chairperson Lewis (FA) suggested the committee incorporate these safety nets throughout the Council's Legislative Platform.

**Sandra Aldana (SA):** Briefed the following:

- It has been determined that the SCDD Silicon Valley-Monterey Bay Office will be representing Ms. Aldana's (SA) area.
- Working on voter registration with the FCRA.

**David Forderer (SA):** Briefed the following:

- Discussed Self-Determination stressing the importance of reaching self advocates.

**Evelyn Abouhassan:** Briefed the following:

- Budget Hearing is taking place, today, May 24, 2016:
  - Voting on Trailer Bill Language (TBL).
  - Handed out the TBL points to the committee. To view this handout, please click on the link below:

<http://www.scdd.ca.gov/res/docs/pdf/LPPC/2016/LPPC%20Additional%20Handouts%205.24.16.pdf>

- Update on DRC sponsored bills:
  - AB 2837: DRC would like the Council to draft a letter to get it out of appropriations.
  - AB 488: Is in the Senate.

**Chairperson Lewis (FA):** No report.

## 5. APPROVAL OF THE MARCH 17, 2016 MEETING MINUTES

It was moved/seconded (Forderer)(SA), (Lapin)(FA) and carried to approve the March 17, 2016 meeting minutes with corrections. There were no abstentions.

(See attendance list for voting members)

Corrections made to the LPPC Packet Meeting Minutes:

- Change Arch to ARC. This is from Mrs. Lapin's (FA) member report located on page 4.
- Remove Dr. from Sandra Aldana's (SA) name. This is located on page 6.

## 6. PUBLIC COMMENTS

There were no public comments.

## 7. OLD BUSINESS ( Standing Items)

### a. Budget Update

Bob Giovati, Deputy Director of Policy and Planning, gave a briefing. He discussed that he and Aaron Carruthers, Executive Director, attended the Budget Sub 3 Hearing. A handout was also passed out to the committee giving an overview of the May Revise. To view this handout, please click on the link below which is located on the State Council's website.

<http://www.sccd.ca.gov/res/docs/pdf/LPPC/2016/LPPC%20Additional%20Handouts%205.24.16.pdf>

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Legend:

SA = Self-Advocate  
FA = Family Advocate

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b. **IHSS/CMS Updates/Overtime Discussion/DC Closures**

The committee invited Debra Doctor, who is a lobbyist from DRC, to give a briefing on IHSS/Overtime. Ms. Doctor has been doing this work for many years. She briefed the committee on the history of IHSS and what is currently taking place with the overtime rules. She also explained the workings of the program.

Ms. Doctor went over the following areas:

- Training/Certifying.
- Must be on Medicare to receive IHSS.
- Timesheets.
- Labor rules effecting consumers
- Overtime Rules.
- Overtime effective dates.
- DRC Manual.
- Claiming provider hours.
- Prior to February 1, 2016: Overtime was not claimed. There were no controls in place on provider hours worked.
- Different scenarios of provider work hours.
- Calculations for number of hours.
- Hour limits.
- Exceptions and violations.
- New family exceptions/federal policies.
- Exemption rejections.
- Different types of exemptions.
- Violations took effect May 1, 2016.

- Publications on CDSS Website explaining new system.
- Supportive Living Services/IHSS.

During this session, committee/staff held a discussion and asked questions.

For more detailed information regarding the above material, please refer to the handouts from Ms. Doctor. To view these handouts, click on the link below which is located on the SCDD Website:

<http://www.scdd.ca.gov/res/docs/pdf/LPPC/2016/LPPC%20Handouts%205%2024%2016.pdf>

Committee and Staff held a discussion on the Sonoma Developmental Closure (DC).

Staff recommended mentioning DC Closures in the Council's Legislative Platform.

Chairperson Lewis (FA) mentioned that the next Council meeting, taking place 5.26.16, will be conducting a PowerPoint Presentation on CMS Rules. To see this presentation, refer to the Council packet dated 5.26.16. This packet is located on the SCDD Website.

**c. Federal and State Legislation Updates/Council Update on LPPC Bill Package and Other Bills.**

Deputy Director Giovati briefed the committee on the following bills which are being supported by the Council:

- 1) AB 1553 (Irwin) Qualified ABLE program:
  - *Out of the Assembly and in the Senate.*
- 2) AB 2091 (Lopez) IEP Translation Services:
  - *Is currently on Appropriation suspense.*
- 3) SB 1221 (Hertzberg) Firefighters Interaction:
  - *In the Assembly.*
- 4) SB 1252 (Stone) Patient Notification:
  - *Dead.*

5) SB 1072 (Mendoza) School Bus Safety Alarms:

- *Out of the Senate and in the Assembly. Double referred to Transportation and Education committees.*
- *Staff feels this bill may be amended but should ultimately pass and be signed by the Governor.*

Chairperson Lewis (FA) requested staff to explain to the committee what suspense, appropriations, and dead mean. Deputy Director Giovati then explained the legislative process.

d. **Self-Determination**

Mrs. Lapin (FA)/committee gave the following update:

- Letter the Council wrote.
- It is important for Self-Advocates to get involved in Self-Determination.
- Gave updates on different meetings attended regarding Self-Determination/Local Advisory Committees.
- Westside Regional Center's agenda.

i. **Statewide SDP Committee**

Committee discussed coordination on the next SDP committee.

e. **Disparity Issues**

Committee held a discussion on disparity issues. Various reports were discussed on these concerns. To view these important reports, please see pages 13 – 157 of the LPPC Packet.

Click on the link below to get to the packet which is located on the Council's website:

<http://www.scdd.ca.gov/res/docs/pdf/LPPC/2016/LPPC%20Packet%20Part%201%20pgs%204%20to%20157%205.24.16.pdf>

8. **NEW BUSINESS**

Deputy Director Giovati and the committee held a discussion on all these bills and determined the following:

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Legend:  
SA = Self-Advocate  
FA = Family Advocate

**a. Detail Sheets/Bill Review**

- 1) AB 1715 (Holden) Behavior Analysis:
  - *This bill is currently on Suspense.*
  - *Committee is watching.*
  
- 2) AB 1821 (Maienschein) Sex Offenses:
  - *This bill is currently on Suspense.*
  - *Committee is watching.*
  
- 3) AB 1824 (Chang) Service Animals:
  - *This bill is in the Senate.*
  - *Committee is watching.*
  
- 4) AB 2212 (Harper) Bullying:
  - *Bill is moving forward.*
  - *Committee gave the following motion to support:*

It was moved/seconded (Forderer)(SA), (Lopez)(FA) to recommend support on AB 2212 with an abstention from Evelyn Abouhassan.

(See attendance list for voting members)

- 5) AB 2231(Calderon) Care Facilities:
  - *Committee is watching.*
  
- 6) AB 2582 (Maienschein) Income Taxes:
  - *Committee is watching.*

The above bill information was given to the committee as a handout. To view this language, refer to the SCDD Website under “Additional Bills” which is located at the link below:

<http://www.scdd.ca.gov/res/docs/pdf/LPPC/2016/Addtional%20Bills%2005%2024%2016.pdf>

- 7) SB 884 (Beall) Special Education:
  - *Committee is watching.*

The above bill information was given to the committee as a handout. To view this language, refer to the SCDD Website under “Additional Bills” which is located at the link below:

<http://www.scdd.ca.gov/res/docs/pdf/LPPC/2016/Addtional%20Bills%205%2024%2016.pdf>

8) SB 982 (McGuire) Developmental Centers:

- *Committee is watching.*

9) SB 1034 (Mitchell) Health Care: Autism:

*Committee is watching.*

For more information on the above bills, with the exception of AB 2582 and SB 884, please see pages 158 – 275 of the LPPC Packet.

Click on the link below to get to the packet which is located on the Council's website:

<http://www.scdd.ca.gov/res/docs/pdf/LPPC/2016/LPPC%20Packet%20Part%202%20pgs%20158%20to%20289%205.24.16.pdf>

**b. Muscular Dystrophy Proclamation**

Deputy Director Giovati briefed the committee that an individual from the state of Florida requested a Governor's Proclamation declaring a particular month as Muscular Dystrophy Month. Committee held a discussion and decided not to move forward with this proclamation.

For more information on this proclamation, please see pages 276 – 279 of the LPPC Packet.

Click on the link below to get to the packet which is located on the Council's website:

<http://www.scdd.ca.gov/res/docs/pdf/LPPC/2016/LPPC%20Packet%20Part%202%20pgs%20158%20to%20289%205.24.16.pdf>

**c. Discussion of Council Legislative Platform**

Chairperson Lewis (FA) has asked the committee to bring their ideas to the next LPPC regarding the Council Legislative Platform. For example, updates on HCBS/Transition Plan/Transportation.

**9. ADJOURN**

Meeting adjourned at 4:14 p.m. Next meeting is planned for July 2016.

**7a. DISCUSSION OF  
PROPOSED 2017 SCDD  
LEGISLATIVE PLATFORM**





LEGISLATIVE  
and Public Policy  
Platform

Approved 2014



## SELF-DETERMINATION

Individuals with IDD and their families must be given the option to control their service dollars and their services through Self-Determination. With the support of those they choose and trust, people with IDD and their families are best suited to understand their own unique needs, develop their own life goals, and construct those services and supports most appropriate to reach their full potential. Self-Determination gives individuals the tools and the basic human right to pursue life, liberty, and happiness in the ways that they choose.



## HEALTH CARE

Individuals must be reimbursed for insurance co-pays, co-insurance, and deductibles, when their health insurance covers therapies that are on their IPPs.

California has an obligation to assure that individuals with disabilities have continuity of care, a full continuum of health care services and equipment, and access to plain language information and supports to make informed decisions about their health care options.

California has an obligation to support the health care of individuals with IDD. This includes people with multiple health care needs, those who require routine preventative care, mental health treatment, dental care, durable medical equipment, and those with gender specific health issues.



## EDUCATION

Schools must implement the goals of the Individuals with Disabilities Education Act (IDEA) to provide children with disabilities with free appropriate public education and prepare them for post-secondary education, employment, and independent living. Students with disabilities will be educated alongside their non-disabled peers in the least restrictive environment. School districts and other educational authorities need to be held accountable for implementing the letter and the intent of IDEA, in all aspects, including measureable postsecondary goals.

## HOUSING

Community integrated living options for individuals with IDD must be increased and enhanced through access to housing subsidy programs and neighborhood education to reduce discrimination. Permanent, affordable, accessible, and sustained housing options must be continually developed to meet both current and future needs.

## **RATES FOR SERVICES**

The state must restore rates to adequately support the availability of quality services for people with all disabilities in all the systems that serve them. A planned and systematic approach to rate adjustments must prioritize and incentivize services and supports that best promotes self-determination, independence, employment, and inclusion in all aspects of community life.

## **VICTIMS OF CRIME**

All people have a right to be safe; however, individuals with IDD experience a much greater rate of victimization, and a far lower rate of prosecution for crimes against them, than does the general public. The same level of due process protections must be provided to all people. Individuals with IDD need to be trained in personal safety, how to protect themselves against becoming victims of crime, and how their participation in identification and prosecution can make a difference. Law enforcement personnel must be trained in how to work with people with IDD who they interact with during the course of their duties, including those who are victims of crimes.



## **QUALITY OF SERVICES AND SUPPORTS**

The State of California must ensure that funding is used to achieve positive outcomes for individuals with IDD and their families. The state must streamline burdensome and duplicative regulations and processes that do not lead to positive outcomes for people with IDD and their families. Quality assessment and oversight must be provided by the state; it must measure what matters, be administered in a culturally competent manner, and the results made public and used to improve the system of services and supports.



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**8a. BILLS DISCUSSED AT  
LAST MEETING, 5/24/16**



## Assembly Bill 1715 authored by Assemblymember Chris Holden (D-Pasadena)

Date: 6/20/2016



On behalf of the Board of Directors of CalABA, we wanted you to be among the first to know that we have decided not to move forward this year with our legislation to license behavior analysts, Assembly Bill 1715 authored by Assemblymember Chris Holden (D-Pasadena).

We have made this difficult decision despite our great success earlier this year moving the legislation through the Assembly. AB 1715 won approval from the Business & Professions Committee (14-0), the Assembly Appropriations Committee (15-1), and the full Assembly (74-1). These votes were major steps toward ensuring that consumers of ABA services benefit from the work of qualified individuals. Despite our best efforts, it appeared the legislation would be amended to include language that would hurt – rather than help – our profession and consumers. As a result, after consulting with multiple stakeholders and the bill author, we have decided to withdraw the bill from further consideration by the legislature this year.

Like you, we are saddened and disappointed by this action. It was necessary, however, to ensure the integrity of our profession and to protect consumers.

But all is not lost. In the coming months, we will be meeting with our opponents to educate them further on the purpose and scope of the legislation in the hope they will withdraw their opposition. We are confident that we will ultimately win support for a licensure bill if key players are made fully aware that it would license only professional practitioners of ABA, not providers of other types of behavioral health services.

Passing legislation of this nature in California is typically a difficult and drawn-out process. Our bill is no different.

Thank you for your support of our efforts during this legislative session. We look forward to working closely together in the near future on this critical issue for our profession. We welcome your questions, thoughts, and feedback at [info@calaba.org](mailto:info@calaba.org)

## 8d. DISPARITY ISSUES



# People with disabilities experience unrecognized health disparities

02/26/2015

CORVALLIS, Ore. – People with disabilities have unmet medical needs and poorer overall health throughout their lives, and as a result should be recognized as a health disparity group so more attention can be directed to improving their quality of life, a team of policy researchers has found.

“Many of the health concerns of people with disabilities, including diabetes, heart disease and obesity, are largely preventive and unrelated to the disability,” said [Gloria Krahn](#) of Oregon State University’s [College of Public Health and Human Sciences](#). Krahn is lead author on a new paper advocating the recognition.

“There’s no overt reason, based on the diagnosed condition, that people with disabilities should have higher rates of these diseases,” said Krahn, the Barbara E. Knudson Endowed Chair in Family Policy and a professor of practice in public health at OSU. “There may always be some disparity in health because of a person’s disability, but people can have disabilities and also be healthy.”

The researchers’ findings were published this month in an article in the [“American Journal of Public Health.”](#) Co-authors are Deborah Klein Walker of Abt Associates and Rosaly Correa-de-Araujo of the National Institutes of Health. The article was based on research conducted primarily while Krahn was working at the Centers for Disease Control and Prevention.

People with significant disabilities – defined federally as functional limitations of movement, vision, hearing or problem-solving – make up about 12 percent of the U.S. population. Reducing the incidence of preventable diseases in this population could lead to improved quality of life as well as significant reductions in health care costs, Krahn said.

Race and ethnicity are used to define health disparity populations by state and federal governments. Disability is not recognized as a disparity population, even though people with disabilities are, on average, in poorer health than the rest of the population. Adults with disabilities are 2.5 times more likely to report skipping or delaying health care because of costs and they have higher rates of chronic disease than the general population, for example.

Establishing disability as a health disparity group is a way of bringing attention to a group that clearly has unmet needs, Krahn said.

The researchers suggest that recognizing people with disabilities as a health disparity population could lead to:

- Improved access to health care and human services for the disabled;
- Increased data on the disabled population, aiding in policy-making;
- Added training for health care providers, strengthening the workforce and improving care for the disabled;
- Improved public health programs that are designed to be inclusive of people with disabilities;
- Enhanced emergency-preparedness; people with disabilities can be especially vulnerable in emergency or disaster situations.

A focus on the health disparity could lead to creation of health promotion materials that are accessible to people with disabilities; development of weight-loss or smoking cessation programs to serve the disabled; and emergency evacuation and shelter training for people with disabilities, Krahn suggested.

“To say that disability is a health disparity will mark a significant shift in approach toward health care of people with disabilities,” Krahn said. “It would influence public health practice, research and policy.”

### College of Public Health and Human Sciences

**About the OSU College of Public Health and Human Sciences:** The only accredited college of public health in Oregon, the college creates connections in teaching, research and community outreach while advancing knowledge, policies and practices that improve population health in communities across the state and beyond.

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# Racial and Ethnic Disparities among Adults with Intellectual and Developmental Disabilities

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Sandra Magaña<sup>1</sup>, Susan Parish<sup>2</sup>, Miguel A. Morales<sup>1</sup>, Henan Li<sup>2</sup> and Glenn T. Fujiura<sup>1</sup>

## Overview

This study investigated the extent of racial and ethnic disparities in the health of adults with intellectual and developmental disabilities. Analyzing data from the 2002-2011 Medical Expenditure Panel Survey and the 2000-2010 National Health Interview Survey, we found that Black and Latino adults with intellectual and developmental disabilities have markedly worse health in contrast to their white peers with intellectual and developmental disabilities.

\*\*\*\*\*

Decades of research has clearly established that people of Black, Latino and American Indian descent living in the United States receive worse health care and have worse health outcomes in contrast to white people. These disparities are a persistent, pervasive public health problem. Emerging research indicates there are health disparities between people with intellectual and developmental disabilities compared to the general population. However, little is known about the extent of racial and ethnic health disparities among adults with intellectual and developmental disabilities.

Recent research shows that adults with intellectual and developmental disabilities also experience health disparities compared to those without disabilities. For example, compared to other adults, adults with intellectual and developmental disabilities are more likely to have fair or poor health (Haverkamp & Scott, 2015), obesity (Hsieh, Rimmer, & Heller) and diabetes (Balogh et al., 2015).

We analyzed data from the 2002-2011 Medical Expenditure Panel Survey and 2000-2010 National Health Interview Survey datasets. The total sample size was 972,099 adults, including 1,131 adults with intellectual and developmental disabilities. The adults in our sample lived in community, and not institutional, settings. The outcome variables were 1) perceived health, 2) perceived mental health 3) obesity, and 4) diabetes. Statistical analyses controlled for age, sex, income, urban living status, education and insurance status.



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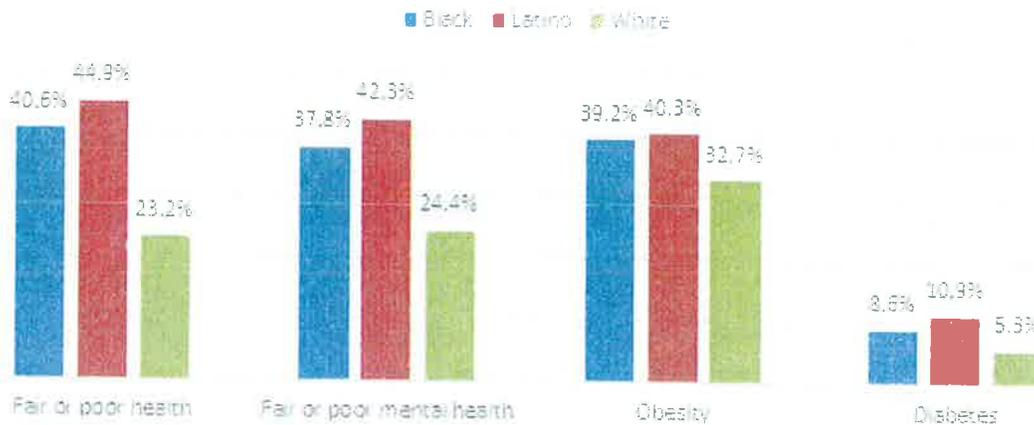
1 Department of Disability and Human Development, University of Illinois at Chicago

2 Lurie Institute for Disability Policy, The Heller School for Social Policy and Management, Brandeis University

## Findings

When comparing Latino, Black and White adults with intellectual and developmental disabilities on demographic variables, we found that Latino adults in our sample were younger, 32 years on average compared to 35 for White adults and 37 for Black adults. Notably, we found that Latino and Black adults with intellectual and developmental disabilities had lower levels of income and education than White adults with intellectual and developmental disabilities. Furthermore, Latino adults with intellectual and developmental disabilities were less likely to be insured all year than their Black and White counterparts. **Consistent with long-standing evidence of racial and ethnic differences in the general population, Black and Latino adults with intellectual and developmental disabilities were significantly more likely to be in fair or poor health and mental health than White adults with intellectual and developmental disabilities (See Figure 1).** We found marginal differences between Latino and White adults with intellectual and developmental disabilities related to obesity and diabetes in which Latino adults were more likely to be obese and to have diabetes than their White peers. All of these findings were robust, and persisted after controlling for a range of demographic characteristics that typically influence health care and health, including age, sex, income, urban living status, education and insurance status.

Figure 1: Percentages of Health Outcomes by Ethnicity among Adults with IDD



We also examined the extent of disability-based disparities between adults with and without intellectual and developmental disabilities within the larger Black and Latino subsets of the population. Black and Latino adults with intellectual and developmental disabilities were significantly more likely to report fair or poor health and mental health than those without intellectual and developmental disabilities. Figures 2 and 3 show that these differences are quite stark.

Among Latino adults (Figure 3), those with intellectual and developmental disabilities were more likely to be obese and have diabetes. Statistically significant differences in the likelihood of diabetes and obesity were not found between Black adults with and without intellectual and developmental disabilities (Figure 2).

Figure 2: Percentages of Health Outcomes between Black Adults with and without IDD

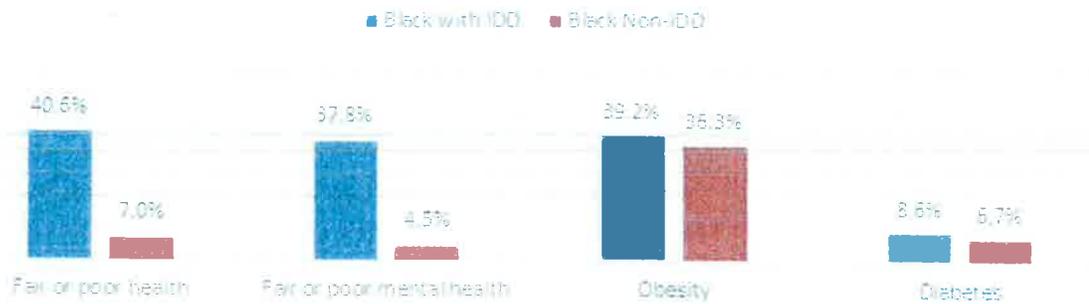
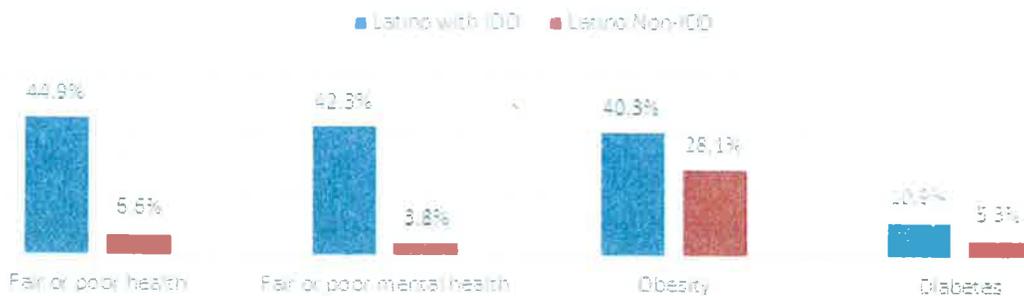


Figure 3: Percentages of Health Outcomes between Latino Adults with and without IDD



These findings suggest that Black and Latino adults with intellectual and developmental disabilities have markedly worse health status than both their white counterparts with intellectual and developmental disabilities, and nondisabled adults within their racial and ethnic groups.

Overall, the results indicate that racial and ethnic health disparities are significant problems for adults with intellectual and developmental disabilities. The substantial body of evidence synthesized in the 2002 Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* found that racial and ethnic disparities in health and health care persist and constitute a major, costly public health problem that should be eliminated. These disparities continue to affect racial and ethnic minorities despite national initiatives to address this problem. Likewise, the Surgeon General’s “Closing the Gap Report”, also issued in 2002, argued for aggressive measures to improve the health and well-being of adults with intellectual disabilities. Our findings indicate that troubling gaps in health persist for adults with intellectual and developmental disabilities.

Further research is needed to understand the costs of the impact of these social determinants of poor health. It is clear that the existing federal initiatives to address racial- and disability-based health disparities have fallen far short of their targets. Innovative and aggressive new measures are urgently needed to address these disparities.

## Policy Opportunities

Ben Jackson and Adriane Griffen<sup>3</sup>

### Health Disparities

Cultural competence is widely seen as a foundational pillar for reducing disparities through culturally sensitive and unbiased quality care. Culturally competent care is defined as care that respects diversity in the patient population and cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviors. Accessibility in this context refers to the “ability to access” the functionality and possibly benefit from a system giving it the ability to be utilized by as many people as possible. Current legislation and initiatives must be amended to be culturally (and linguistically) competent, as well as accessible, and better able to be delivered in community-based settings. This would reduce health disparities in racial and ethnic minorities with intellectual disabilities.

To remedy the problem of health disparities, laws and regulations need to be focused on providing universal access to participants. It is not enough that the Department of Health and Human Services (HHS) declared the intent to have “a nation free of disparities in health and healthcare,” as stated in the 2010 Disparities Action Plan. This “Disparities Action Plan” needs to be accessible to incorporate individuals with intellectual disabilities within that population. This combination of concepts would greatly benefit racial and ethnic minorities with intellectual disabilities. For health outcome areas that have not yet addressed, it would be beneficial to design measures based on that critical combination.

### Obesity

Obesity is more prevalent in adults with intellectual disabilities than in the general population, and has been shown to contribute to their reduced life expectancy and increased health needs.

There is a need to adjust to the needs of especially vulnerable populations. Current legislation is proposed to remedy the obesity healthcare crisis in America, the *Treat and Reduce Obesity Act* of 2015. The existing bill makes no mention of disability or the intersection of race and ethnicity. Additionally, while many population-level policy changes may be equally effective for everyone, such as making healthy choices the default option, disability-specific policy initiatives are critical and necessary.

Emerging research shows evidence for tailoring and adjusting weight loss approaches for people with intellectual disabilities. The result of having few research studies and minimal evidence is that evidence-based federal initiatives have then overlooked people with disabilities. Few disability resources are highlighted in the “Guide to Community Preventive Services” and the “Common Community Measures Project for Obesity Prevention,” two evidence-based federal initiatives that provide recommendations for public health efforts on effective intervention approaches for obesity prevention and weight management.

Relatively few studies have examined the effectiveness of weight loss interventions for adults with intellectual disabilities. However, there is evidence to support interventions that take into account the context of the lives of adults with intellectual disabilities, including career involvement in interventions. The population this study surveyed focused solely on individuals living in the community. To reduce the health inequalities experienced by adults with intellectual disabilities, there is a clear need to develop accessible, evidence-based clinical weight management services.

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