

2016  
data



# Adults with Disabilities

IN THE COACHELLA VALLEY: A SPECIAL REPORT



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## EXECUTIVE SUMMARY

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HARC, Inc. is a 501(c)(3) nonprofit organization that provides community research and evaluation. HARC (Health Assessment and Research for Communities, formerly called Health Assessment Resource Center) was founded in 2006 to serve the Coachella Valley community by providing regular community surveys. HARC has conducted this survey four times to date: 2007, 2010, 2013, and 2016. The results of the most recent survey, from 2016, were released on January 31, 2017. That report, known as the Executive Report, described the entire community. This report analyzes the same data in a different manner to examine the health of adults with disabilities.

This report uses the 2016 data to provide an in-depth look at adults with disabilities in the Coachella Valley. For purposes of this report, “adults with disabilities” are defined operationally as those who answered “yes” to the question, “Are you limited in any way in any activities because of physical, mental, or emotional problems?”. For reference, data for adults without disabilities (those who answered “no” to the same question) are provided alongside the disabilities data.

This report was funded by the Grace Helen Spearman Foundation. HARC would not have been able to put out this report without the Grace Helen Spearman Foundation grant, and is deeply grateful for the opportunity to provide this information to the community.

### ***Demographics***

Participants were asked, “Are you limited in any way in any activities because of physical, mental, or emotional problems?” Results indicate that 22.1% of Coachella Valley adults, or 67,462 people, have a disability by this definition. This is the definition that is used throughout the report to compare adults with disabilities (those who answered “yes”) to those without disabilities (those who answered “no”).

Disabilities disproportionately affect the older population in the Coachella Valley. Specifically, the average age of a Coachella Valley adult with disabilities is 58, while the average age of a Coachella Valley adult without disabilities is 48.

Local adults with disabilities have significantly lower income levels than their counterparts without disabilities. Adults with disabilities are significantly more likely to be in the lowest income bracket (\$0 to \$19,999 per year) and significantly less likely to be in the highest income bracket (\$100,000 or more per year). There are more than 16,130 local adults with disabilities who live below the poverty line.

Adults with disabilities are significantly less likely to be employed when compared to their counterparts without disabilities (23% versus 54%), and significantly more likely to be unable to work (22% versus 2%).

Participants were asked, “Are you a caregiver that provides unpaid care or assistance to a family member or friend with a health condition, long-term illness or disability?” Results showed that 18% of adults with disabilities (11,820 people) were acting as a caregiver to another person.

More than 9,860 local adults with disabilities are veterans. In fact, local adults with disabilities are significantly more likely to have served active duty (15%) compared to adults without disabilities (8%). It is possible that some of these people received their disability while in the service, thus accounting for the high numbers.

### ***Disability Specifics***

About 21% of adults with disabilities (14,252 people) are deaf or have difficulty hearing, and about 17% (11,114 people) are blind or have serious difficulty seeing, even when wearing glasses.

Approximately 15% of adults with disabilities need assistance with activities of daily living (ADLs), such as eating, bathing, toileting, walking, dressing, or grooming. This is approximately 9,987 people with disabilities who need such assistance. Approximately 11% of those who need help (more than 1,070 local adults with disabilities) are unable to get it.

Results indicate that 22% of local adults with disabilities—14,827 people—need assistance with instrumental activities of daily living (IADLs), such as meal preparation, shopping, medication management, money management, housework, transportation, etc. Approximately 14% of those who need help (more than 2,080 people with disabilities) are unable to get it.

Approximately 39% of local adults with disabilities (more than 26,120 people) have a health problem that requires them to use special equipment such as a cane, wheelchair, special bed, or special telephone. Most local adults with disabilities who need such equipment were able to get it; however, 14%, or 3,636 people with disabilities, were not able to get what they needed.

### ***Healthcare Access and Utilization***

The vast majority of local adults with disabilities (95%) have health insurance coverage. However, approximately 3,265 people with disabilities are uninsured, and may have trouble getting the treatment they need.

Many people with disabilities had difficulty receiving necessary healthcare in the past year due to difficulty understanding what is covered by their insurance (24%), transportation issues (21%), and the hours that healthcare providers are open to see patients (19%). Local adults with disabilities are significantly more likely to have trouble with transportation than their counterparts without disabilities (21% versus 6%, respectively).

### ***General Health Status***

Nearly half of local adults with disabilities (48%, 32,383 people) rate their health as “fair” or “poor”. This is a startling contrast to adults without disabilities, only 11.8% of whom rate their health as “fair” or “poor”. Less than 10% of adults with disabilities rate their health as “excellent”.

Adults who rated their health as “fair” or “poor” were asked why they gave their health that rating; the most common reasons listed by adults with disabilities were chronic illness (32% of those who rated their health as “fair” or “poor”) and physical disabilities (27%).

### ***Major Disease***

Participants were asked if they had ever been diagnosed by a doctor or other healthcare provider with a series of chronic illnesses/major diseases. The most common major diseases for local adults with disabilities include arthritis (affecting 56% of adults with disabilities, more than 37,400 people), high blood pressure (53%, 35,719 people), and high blood cholesterol (40%, or 26,907 people). Adults with disabilities have significantly higher rates of major disease diagnoses when compared to adults without disabilities.

### ***Mental Health***

Participants were asked if they had ever been diagnosed by a doctor or other healthcare provider with a series of mental health disorders. Results show that 44% of adults with disabilities—approximately 29,480 people—have been diagnosed with one or more mental health disorders. This is significantly higher than the rate for adults without disabilities (16%).

The most common mental disorder diagnoses among adults with disabilities include depressive disorders (30%), generalized anxiety disorder (20%), and post-traumatic stress disorder (17%).

About 8% of adults with disabilities—more than 6,500 people—have seriously considered attempting suicide in the past year. This is more than triple the rate of suicidal ideation for adults without disabilities (8% versus 3%, respectively).

Approximately 19% of Coachella Valley adults with disabilities needed mental health care in the past year and could not get it. This equates to more than 7,000 people in need, and is significantly higher than the rate for adults without disabilities.

Similarly, 15% of Coachella Valley adults with disabilities needed mental health medication in the past year and could not get it. This is more than 5,600 people, and once again, is significantly higher than the rate for adults without disabilities.

### ***Weight and Fitness***

Most Coachella Valley adults with disabilities are either overweight (30.3%) or obese (31.2%). This mirrors the trends for all adults in the Valley; that is, Coachella Valley adults are equally likely to be overweight or obese; it does not vary based on disability. About 30% of local adults with disabilities (more than 19,980 people) did no aerobic exercise in the past week. People with disabilities exercise significantly less than those without disabilities.

### ***Food Insecurity and Other Unmet Needs***

In the past year, approximately 14% of those with disabilities had to cut the size of their meals or skip meals because there wasn't enough money for food; this equates to more than 9,360 people with disabilities. This rate is significantly higher than for those without disabilities (14% versus 8%, respectively).

Those who had to cut the size of meals or skip meals due to lack of money were then asked how often this happened. For the majority of food insecure adults with disabilities—61%, or 5,600 people—this happened almost every month.

Results show that 7% of Coachella Valley adults with disabilities have gone without eating for a whole day sometime in the past year due to a lack of money for food. This is more than 4,940 local adults with disabilities who have gone hungry for an entire day. This is significantly higher than the rate for adults without disabilities (7% versus 2%, respectively).

To assess some basic needs, participants were asked, “Have you needed help with any of the following in the past 12 months?” Results indicate that the most common needs for assistance for people with disabilities include transportation assistance (21%), utility assistance (20%), and food assistance (19%).

#### ***Senior-Specific Information***

Approximately 7% of local seniors with disabilities (2,600 seniors) have been physically or mentally mistreated or neglected in the past year. The rate of elder abuse for seniors with disabilities is significantly higher than the rate for seniors without disabilities (7% versus 2%, respectively).

In the Coachella Valley, approximately 25% of seniors with disabilities—more than 10,150 people—have fallen one or more times in the past three months. Falls are significantly more common for seniors with disabilities than seniors without disabilities.

#### ***Conclusion***

It is HARC’s goal that this report will highlight the areas where people with disabilities have greater needs, and allow service providers and caregivers to respond to those needs. From this report, it is clear that our Valley needs to have low-to-no-cost resources for people with disabilities, including transportation services, mental health services, and emergency food sources, among others.

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## INTRODUCTION

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### About HARC

HARC, Inc. is a 501(c)(3) nonprofit organization that provides community research and evaluation. HARC (Health Assessment and Research for Communities, formerly called Health Assessment Resource Center) was founded in 2006 to serve the Coachella Valley community.

The Coachella Valley is a unique community located within Riverside County in Inland Southern California. As such, local organizations found that County-level data, while available, did not adequately tell the story of the health needs of those living in the Coachella Valley. Service providers in the region struggled for years to identify health disparities, inequities, unhealthy behaviors and trends. HARC emerged to fill this gap and provide objective, reliable Coachella Valley-specific data.

### About the Coachella Valley Community Health Survey

In 2007, HARC was able to conduct the first survey of health in the region, provided by a random-digit-dial telephone survey. This survey provided vital information about health and quality of life in the region, and covered topics such as healthcare access, utilization, health behaviors, major disease, mental health, and more. It was determined that the survey would be revised and repeated every three years in order to measure progress and provide up-to-date data.

To date, the survey has been conducted four times: 2007, 2010, 2013, and 2016. This report summarizes the findings from the 2016 survey. The survey focuses on the health status of the Coachella Valley, a geographically isolated area of Riverside County in Southern California. The Coachella Valley is comprised of nine major cities (Cathedral City, Coachella, Desert Hot Springs, Indian Wells, Indio, La Quinta, Palm Desert, Palm Springs, and Rancho Mirage) as well as several unincorporated areas (such as Bermuda Dunes, Mecca, Thermal, and Thousand Palms, among others). Tribal areas within the Coachella Valley include the reservations of the Agua Caliente Band of Cahuilla Indians, the Augustine Band of Mission Indians, the Cahuilla Band of Mission Indians, and the Torres-Martinez Desert Cahuilla Indians.

### About this Special Report on Adults with Disabilities

This report uses the 2016 data to provide an in-depth look at adults with disabilities in the Coachella Valley. For purposes of this report, “adults with disabilities” are defined operationally as those who answered “yes” to the question, “Are you limited in any way in any activities because of physical, mental, or emotional problems?”. For reference, data for adults without disabilities (those who answered “no” to the same question) are provided alongside the disabilities data.

This report was funded by the Grace Helen Spearman Foundation. HARC would not have been able to put out this report without the Grace Helen Spearman Foundation grant, and is deeply grateful for the opportunity to provide this information to the community.

## About Disabilities

A disability can be characterized under two broad domains including physical and mental limitations. These various types of physical and mental limitations can affect people from any demographic background and at varying points throughout their lifespan. In other words, some people are born with a disability (or more than one disability) while others acquire a disability at a later point in time. For example, a disability can begin as early as birth as a result of gene and chromosomal disorders, or prenatal exposure to toxic substances.<sup>1</sup> Other disability conditions are developmental and become apparent in the childhood years. Moreover, other disability conditions can be the result of an injury or a chronic health condition.<sup>2</sup> Either way, these limitations can interfere with one's quality of life due to a lack of mobility, a lack of independence, health problems (acute and chronic), and social stigma and inequality. Over a tenth of the nation (12.8%) lives with some form of a disability.<sup>3</sup>

The American Disability Association's legal definition of a person with a disability is "a person who has a physical or mental impairment that substantially limits one or more major life activity".<sup>4</sup>

The World Health Organization (WHO) further recognizes three dimensions of living with disabilities, which include impairment, activity limitation, and participation restriction.<sup>5</sup> In other words, there may be impairments in body function, difficulty in activities, and difficulty with being involved in daily activities. The extent of a disability and its associated health outcomes is dependent upon the severity of the impairment, social, political, and cultural influences/expectations, natural surroundings, assistive technology, and family or community support/engagement.<sup>6</sup> Because of these various influences and support systems, people with the same types of disabilities will be affected in different ways.

Under these definitions, it is clear that a disability can assume many different forms. For that reason, when HARC conducted data collection for the Coachella Valley Community Health Survey of 2016, gauging whether the respondent had a disability was assessed with the question, "Are you limited in any way in any activities because of physical, mental, or emotional problems?", which aligns closely with the ADA's legal definition.

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<sup>1</sup> Disability Overview. (2017). Centers for Disease Control and Prevention. <https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html>

<sup>2</sup> Ibid.

<sup>3</sup> American Community Survey One-Year Estimates. (2016). U.S. Census Bureau.

[https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_16\\_1YR\\_S1810&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S1810&prodType=table)

<sup>4</sup> What is the definition of disability under the ADA? ADA National Network. <https://adata.org/faq/what-definition-disability-under-ada>

<sup>5</sup> Disabilities. World Health Organization. <http://www.who.int/topics/disabilities/en/>

<sup>6</sup> Disability Inclusion. (2017). Centers for Disease Control and Prevention. <https://www.cdc.gov/ncbddd/disabilityandhealth/disability-inclusion.html>

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## METHODS

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HARC's Coachella Valley Community Health Survey was initially developed in 2006 by survey experts and a steering committee of local leaders (nonprofits, healthcare providers, businesses, local government, etc.). The survey is adapted each cycle based on both practical experience (e.g., removing survey questions that are not producing valid information) and input from the steering committee on what new data needs have emerged in the intervening years.

The survey instruments were modeled after the well-respected Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS) and the California Health Interview Survey (CHIS). The instruments assessed topics such as access to and utilization of, health status indicators, health insurance coverage, and health related behaviors, among others.

HARC contracted with the Kent State University Survey Research Lab to conduct the 2016 survey. Data were collected by telephone survey with randomly selected adults. Surveys were restricted to private residences (such as apartments, houses, mobile homes) within the geographic area of Coachella Valley with landlines and/or cell phones. As such, this survey does not include people who are homeless, those who live in group home settings (such as nursing homes, group homes, etc.), or those who do not have a landline *or* a cell phone (which is an estimated 3% of the population, according to the National Health Interview Survey's 2016 figures).<sup>1</sup>

Data collection began on February 2 and concluded on October 8, 2016. Data collection included 2,532 fully completed surveys: 2,022 in the adult sample and 510 in the child sample. The question regarding disability was only asked on the adult survey, and thus, only the adult sample is used in this report.

Nearly 60% of this year's completed surveys were conducted on a cell phone, which is an incredibly strong showing compared to HARC's history and other nationally known population health surveys. By including a large proportion of cell phone users, the data is more representative of the community, especially those who are younger, lower income, and/or Hispanic.<sup>2</sup> Approximately 21% of the completed surveys were done in Spanish, according to the preferences of the participants.

Once data collection was complete, statisticians at Kent State University weighted the sample data to most accurately represent the entire population living in the Coachella Valley. The post-stratification weighting used the Centers for Disease Control and Prevention (CDC) raking protocol (CDC 2011). The data was weighted based on the U.S. Census Bureau's American Community Survey's five-year estimates (2009 to 2014). The weights were raked to age, sex, race, and ethnicity. Weighting the data is essential to ensure that the 2,532 survey respondents represent the 400,000+ people living in the Coachella Valley.

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<sup>1</sup> National Center for Health Statistics (2016). Wireless substitution: Early release of estimates from the National Health Interview Survey, January – June 2016. Available online at <https://www.cdc.gov/nchs/data/nhis/earlyrelease/wireless201612.pdf>

<sup>2</sup> Ibid.

It is worth noting that in prior survey cycles, the weighting procedure included weighting to the seasonal residents or “snowbirds”. Because of the climate and relatively low cost of living, many people have chosen to make the Coachella Valley their home for the winter months. In the past, HARC weighted the data to represent these seasonal residents based on the 2009 Wheeler’s Report. However, this cycle, HARC staff chose not to weight the snowbird data because of the relative age of the reference data (the 2009 Wheeler’s Report has not been updated since). Given the lack of weighting for snowbirds, as well as the slight shift in data collection months (including summer months when snowbirds are not in residence), this data represents far fewer snowbirds than prior years. HARC staff chose to make this operational decision to strengthen the reliability of the data so that the 2016 data could be as robust as possible.

Specifically, in 2013, snowbirds made up about 12% of the raw data. When weights were applied, this became approximately 25%. In 2016, snowbirds made up about 6% of the raw data. Without weighting the snowbird data specifically, snowbirds remained about 6% in the final weighted dataset. As a result, this year’s data focuses more heavily on year-round residents of the Coachella Valley, with less emphasis on snowbirds than in prior cycles. As such, readers should be cautious about making comparisons to prior years.

All data and data collection methods have strengths and weaknesses. The strengths of telephone surveys are that they typically have higher response rates than mailed surveys, can reach households with unlisted as well as listed phone numbers, allow respondents to ask questions about the survey and obtain immediate answers, and allow interviewers to probe for additional information if survey responses are unclear. One weakness is that telephone surveys cannot reach households without telephones, homeless populations, those who are incarcerated, or the institutionalized.

Differences reported in the text are “statistically significant”, which means that the differences are 95% sure to be “real” differences in the entire population of the Coachella Valley (and not just a fluke of HARC’s sample of Coachella Valley residents). This means that there is a 95% likelihood that the differences described here are true differences, not just due to chance.

Aggregate data as described in this report are not designed, nor should they be used, to give valid information about any one individual or subset of individuals. For example, just because seniors in general have a higher income level than younger adults, we cannot say with any degree of confidence that a particular senior in our community has a high income.

This report frequently includes statements such as, “60% of adults live in households with an annual income below \$50,000.” Given that these are self-report data, it might be more appropriate to write, “60% of adults *report* that they live in households with an annual income below \$50,000.” For parsimony and readability, we have omitted reference to “reporting.”

HARC enthusiastically supports the responsible use of statistics. If you have any questions on how to interpret this data, or how to cite the data accurately, please don’t hesitate to contact us at 760-404-1945, or via email at [staff@HARCdata.org](mailto:staff@HARCdata.org).

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## RESULTS

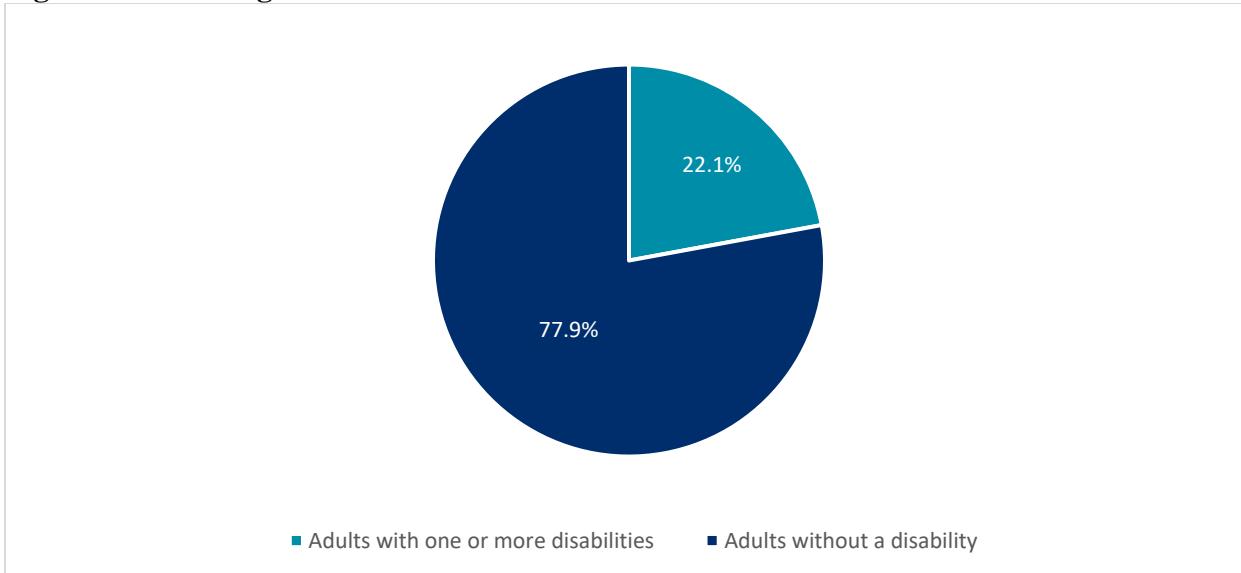
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## Section 1: Demographic Profile

Participants were asked, “Are you limited in any way in any activities because of physical, mental, or emotional problems?” Results indicate that 22.1% of Coachella Valley adults, or 67,462 people, have a disability by this definition, as illustrated in Figure 1.

**Figure 1. Percentage of Adults with Disabilities**



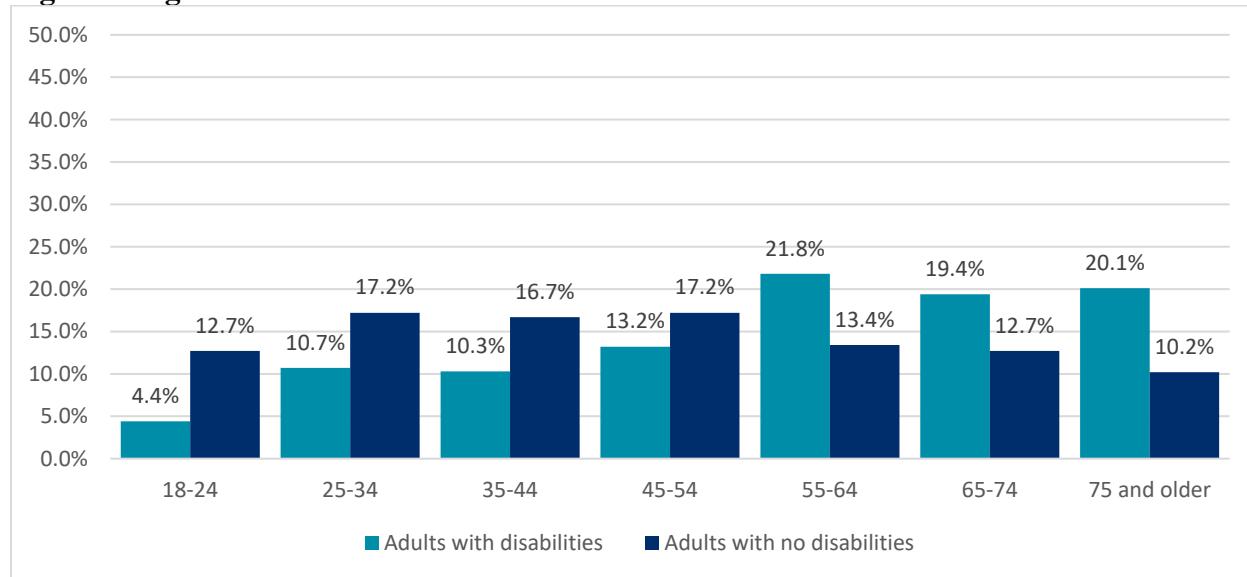
Throughout this report, individuals who answered “yes” to this question will be called “adults with disabilities”, while those who answered “no” to this question will be called “adults without disabilities”. This is not a perfect definition; for example, someone may identify as a person with a disability but have answered “no” to this question because they do not feel limited by their condition. However, it should capture most of those who have a disability for the purposes of this report.

The remainder of this report will compare those with disabilities, using this definition, to those without. The goal of this comparison is to identify what health issues disproportionately affect local adults with disabilities, and thus, deserve increased attention and resources to address.

## Age

Disabilities disproportionately affect the older population in the Coachella Valley, as illustrated in Figure 2. Specifically, the average age of a Coachella Valley adult with disabilities is 58, while the average age of a Coachella Valley adult without disabilities is 48. More than half of adults with disabilities (61.3%) are among the senior (55+) population.

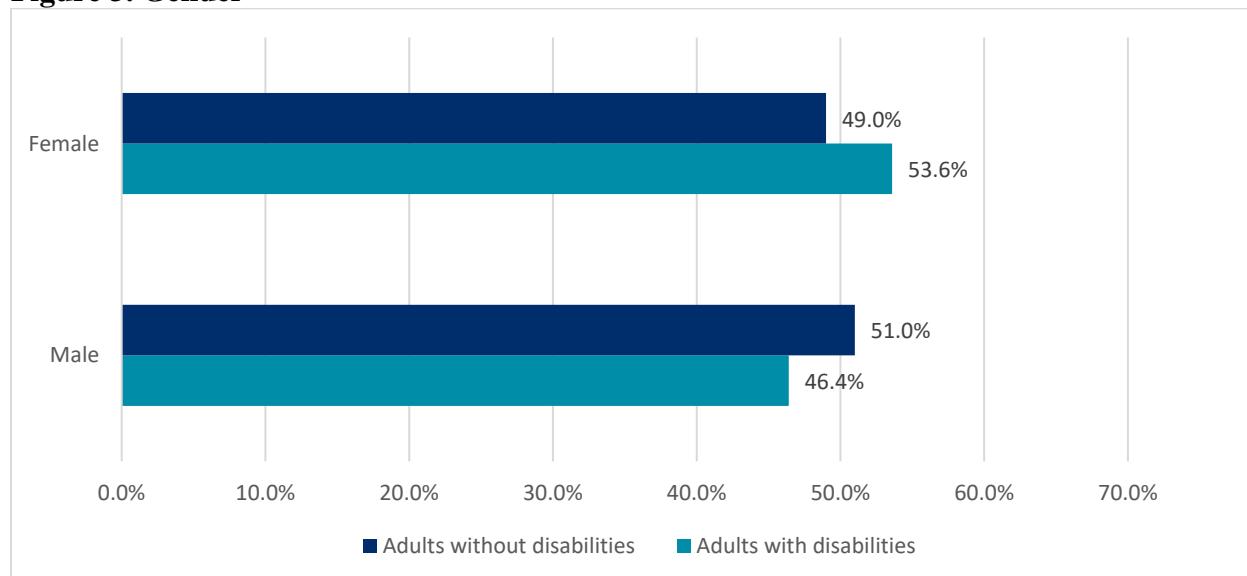
**Figure 2. Age**



## Gender

As illustrated in Figure 3, disabilities affect men and women similarly in the Coachella Valley. That is, there is no significant difference in disability based on gender.

**Figure 3. Gender**

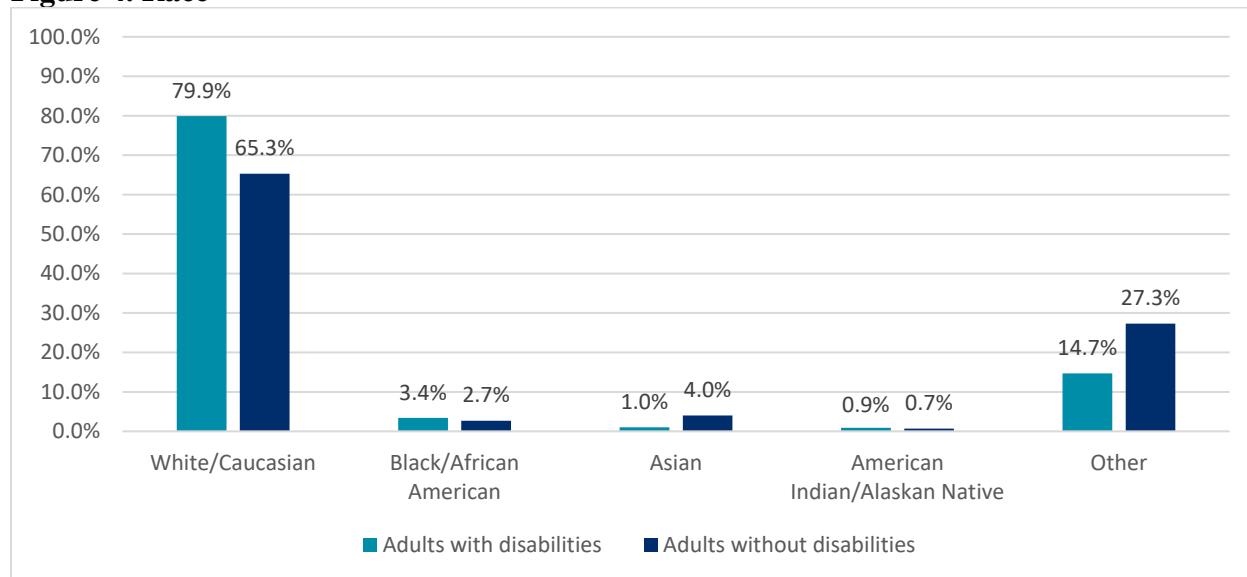


## Race

Participants were asked to report on their race and ethnicity in two questions, using the protocol that is utilized by the U.S. Census Bureau. To assess race, participants were asked, “Which one of these groups best represents your race? For the purposes of this question, Hispanic/Latino is not a race.”

Most local adults with disabilities identify as White/Caucasian, as illustrated in Figure 4. There are more than 12,800 local adults with disabilities who identify their race as Black/African American, Asian, American Indian/Alaska Native, or “other”. Overall, local adults with disabilities are less racially diverse than their counterparts without disabilities.

**Figure 4. Race**



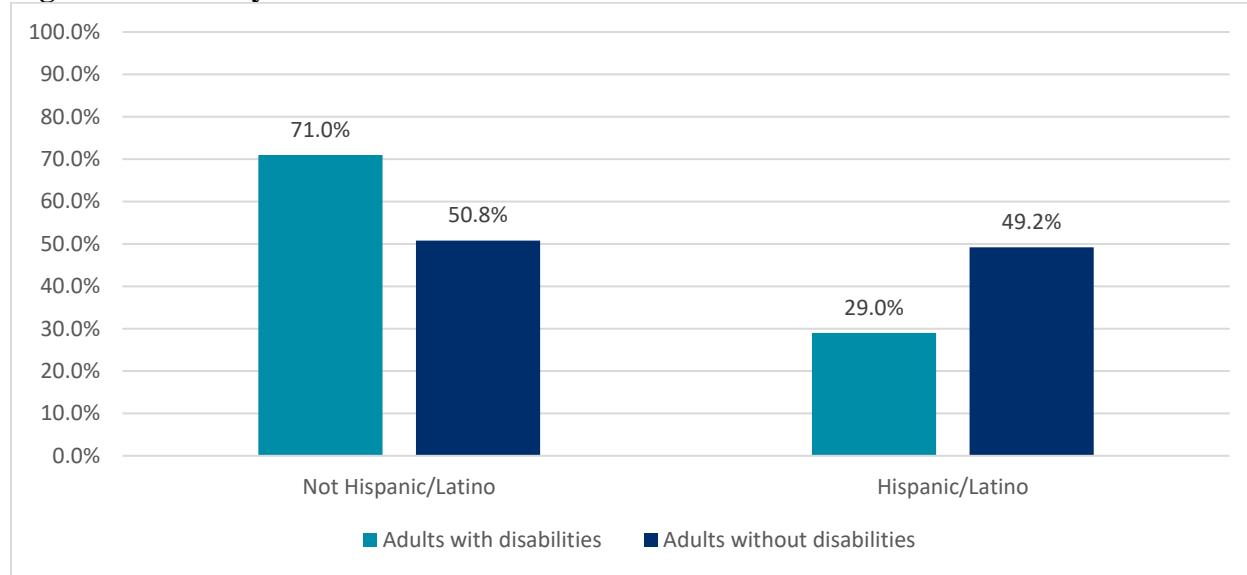
## Ethnicity

To assess ethnicity, participants were asked, “Are you of Hispanic, Latino, or Spanish origin?”

Most local adults with disabilities (71.0%, or 47,542 people) are not Hispanic; approximately 29.0% are Hispanic/Latino, which equates to more than 19,420 Hispanic/Latino adults with disabilities.

Adults with disabilities are less likely to be Hispanic/Latino than their counterparts without disabilities, as illustrated in Figure 5.

**Figure 5. Ethnicity**



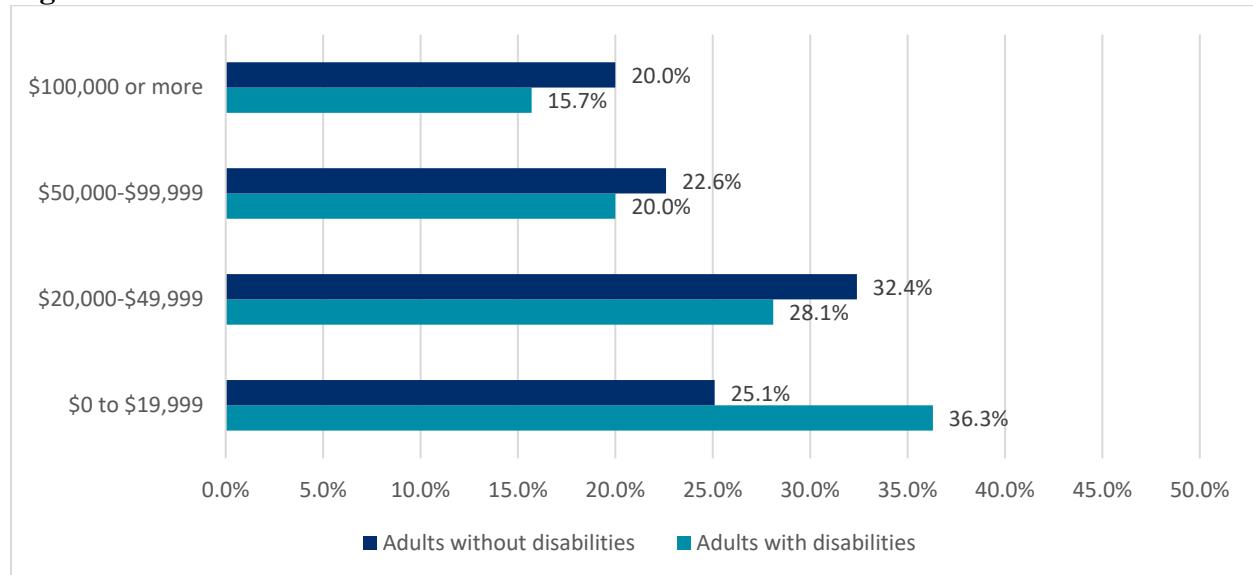
## Socioeconomic Status (SES)

Socioeconomic status (SES) can be assessed through many indicators; here we cover income, poverty level, perceived income adequacy, education, and employment. It is important to assess SES as people with lower levels of SES are less likely to receive healthcare, acquire a well-paying job, and/or be able to take advantage of healthful opportunities.<sup>1</sup>

### ***Income***

Local adults with disabilities have significantly lower income levels than their counterparts without disabilities. As illustrated in Figure 6, adults with disabilities are significantly more likely to be in the lowest income bracket (\$0 to \$19,999 per year) and significantly less likely to be in the highest income bracket (\$100,000 or more per year).

**Figure 6. Income**



<sup>1</sup> Factors That Contribute to Health Disparities in Cancer. (2014). Centers for Disease Control and Prevention. [http://www.cdc.gov/cancer/healthdisparities/basic\\_info/challenges.htm](http://www.cdc.gov/cancer/healthdisparities/basic_info/challenges.htm)

## **Poverty**

In addition to household income, participants were also asked to report the number of people residing within their household. This information was used to calculate poverty levels per the Department of Health and Human Services' guidelines for poverty in 2016, as illustrated in Table 1. For example, for a single person, the poverty guideline is \$11,880 per year, while for a family of four, it is \$24,300 per year.

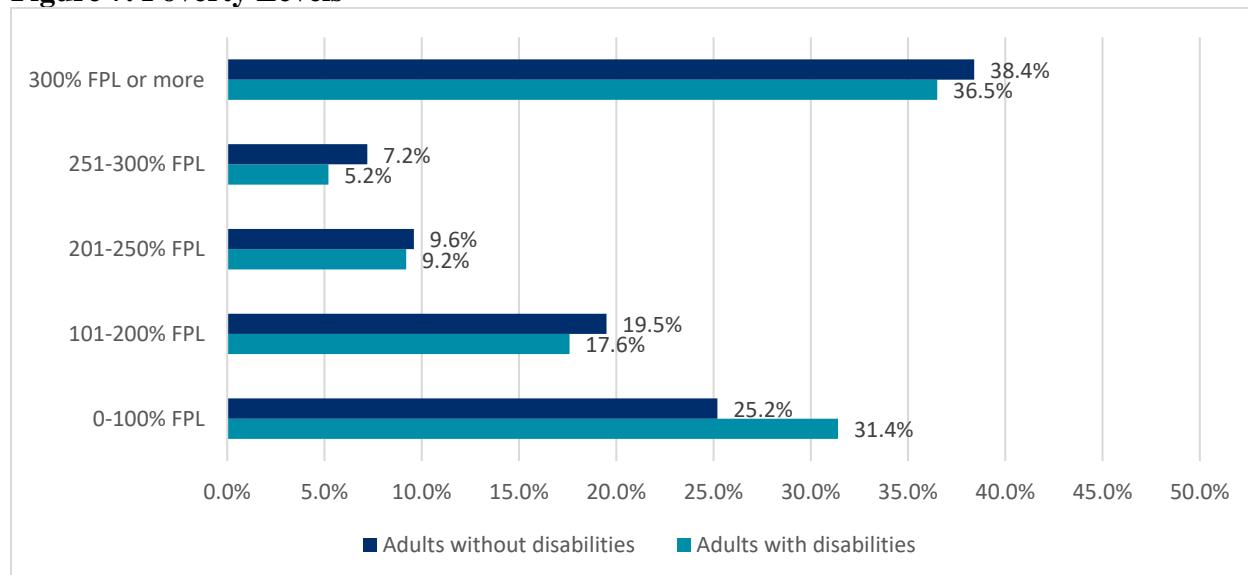
**Table 1. Poverty Guideline Reference**

Number of People in Household	Annual Income Guideline for Poverty
1	\$11,880
2	\$16,020
3	\$20,160
4	\$24,300
5	\$28,440
6	\$32,580
7	\$36,730
8	\$40,890

*Note:* Guidelines are from the U.S. Department of Health and Human Services for the year of 2016. For families or households with more than 8 persons, add \$4,160 for each additional person.

There are more than 16,130 local adults with disabilities who live below the poverty line, as illustrated in Figure 7. This is not significantly different than the rates for adults without disabilities; that is, adults with and without disabilities are equally likely to be living in poverty.

**Figure 7. Poverty Levels**



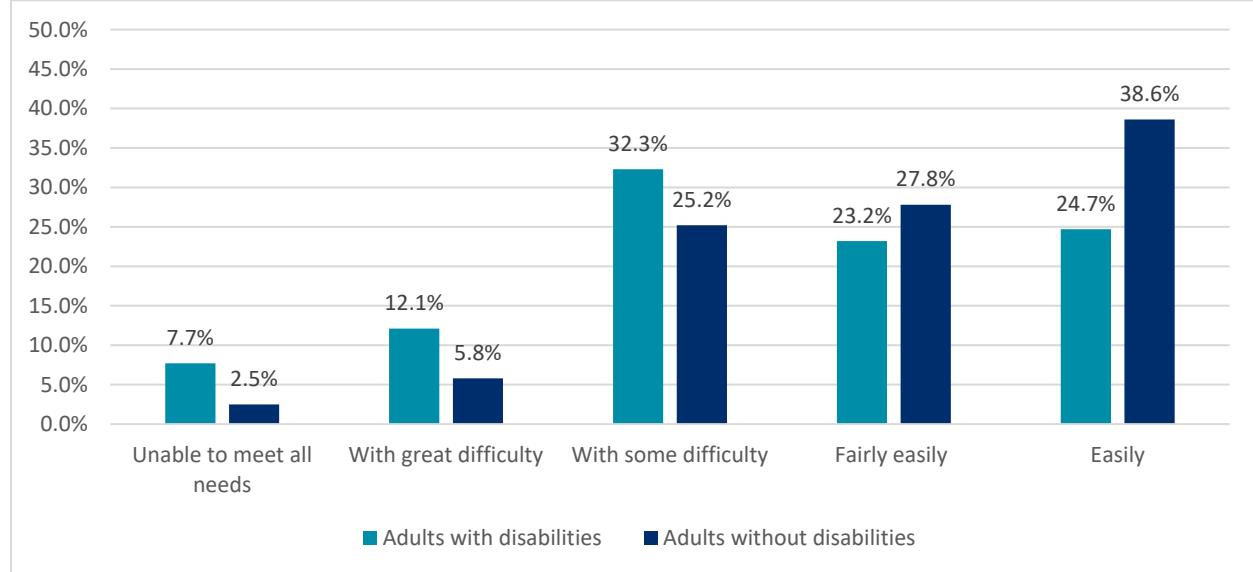
## ***Perceived Income Adequacy***

Participants were asked to rate how well their household's total monthly income takes care of their needs. This is known as "perceived income adequacy".

Results indicated that 7.7% of local adults with disabilities—which equates to more than 3,950 people—are unable to meet their needs based on their income. This is significantly higher than the rate for their counterparts without disabilities (2.5%), as illustrated in Figure 8.

This discrepancy in perceived income adequacy was consistent throughout. At the other end of the scale, less than a quarter of adults with disabilities said they could easily meet all their needs with their income, compared to nearly 40% of adults without disabilities, as illustrated in Figure 8. This may be because people with disabilities have higher levels of need than those without disabilities, and many of these everyday needs—such as assistive technology, medication, or continuing treatment—are associated with an additional expense. Thus, an income level that may be adequate for meeting all needs in a household without disabilities falls short when you factor in the need to pay for these extra services.

**Figure 8. Income Adequacy**

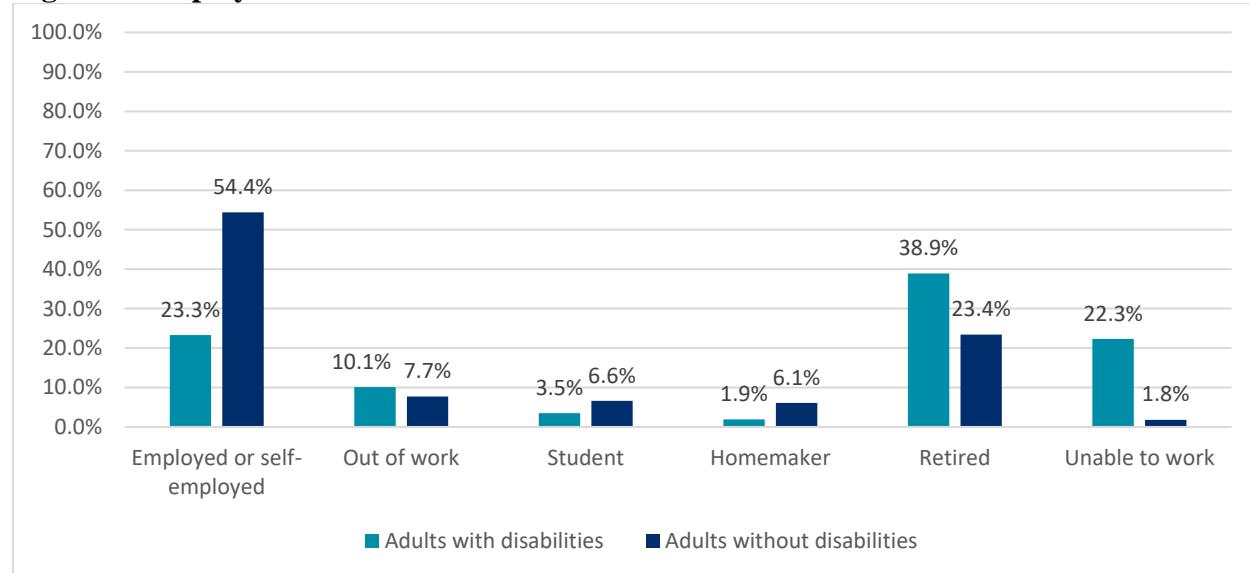


## ***Employment Status***

Most local adults with disabilities are retired (26,122 people), employed (15,662 people), or unable to work (14,931 people).

Adults with disabilities are significantly less likely to be employed when compared to their counterparts without disabilities (23.3% versus 54.4%, as illustrated in Figure 9). In contrast, they are more likely to be unable to work (22.3% versus 1.8%, as illustrated in Figure 9).

**Figure 9. Employment Status**

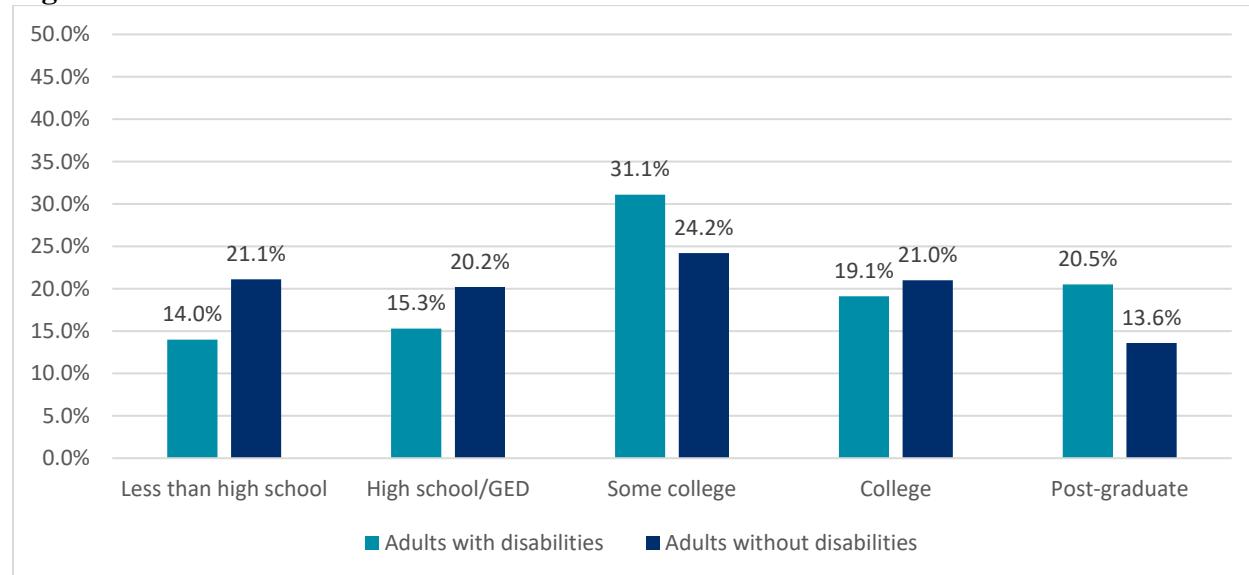


## ***Education Level***

Although local adults with disabilities are significantly more likely to be unable to work, as illustrated in Figure 9, they have approximately the same educational attainment as their counterparts without disabilities, as illustrated in Figure 10.

Most local adults with disabilities (70.7%) have at least some college experience, as illustrated in Figure 10. Rates of education did not differ significantly based on disability status.

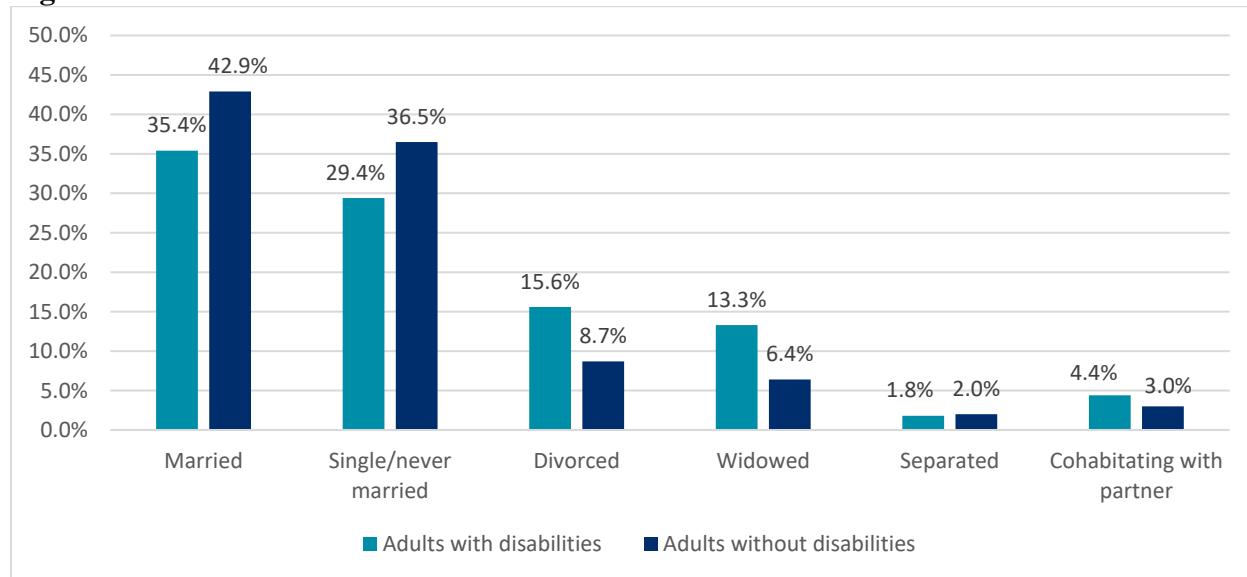
**Figure 10. Educational Attainment**



## Marital Status

Adults with disabilities are significantly more likely to be divorced (15.6%) compared to adults without disabilities (8.7%). Further, adults with disabilities are significantly more likely to be widowed (13.3%) compared to adults without disabilities (6.4%), as illustrated in Figure 11. The difference in widowed status likely reflects the 10 year age difference between those with disabilities and those without.

**Figure 11. Marital Status**

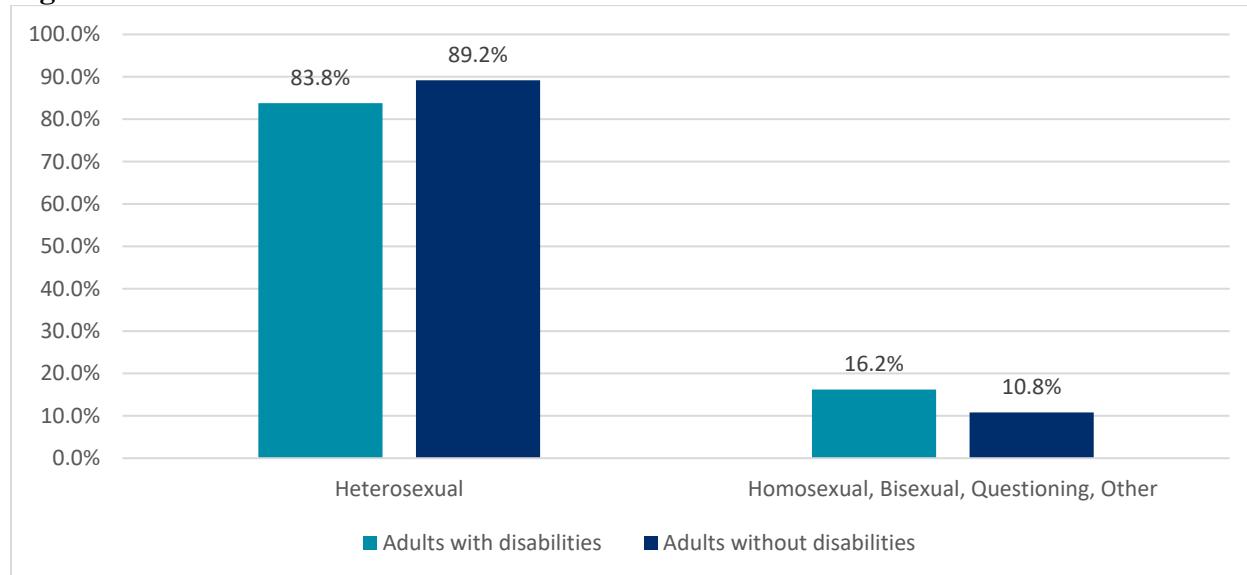


## Sexual Orientation

To identify sexual orientation, participants were asked if they considered themselves to be heterosexual, homosexual, bisexual, transgender, questioning, or “other”.

Approximately 16.2% of local adults with disabilities identify their sexual orientation as homosexual, bisexual, questioning, or “other”, as illustrated in Figure 12. This equates to more than 10,600 people who have a disability and are members of the LGBQ community.

**Figure 12. Sexual Orientation**

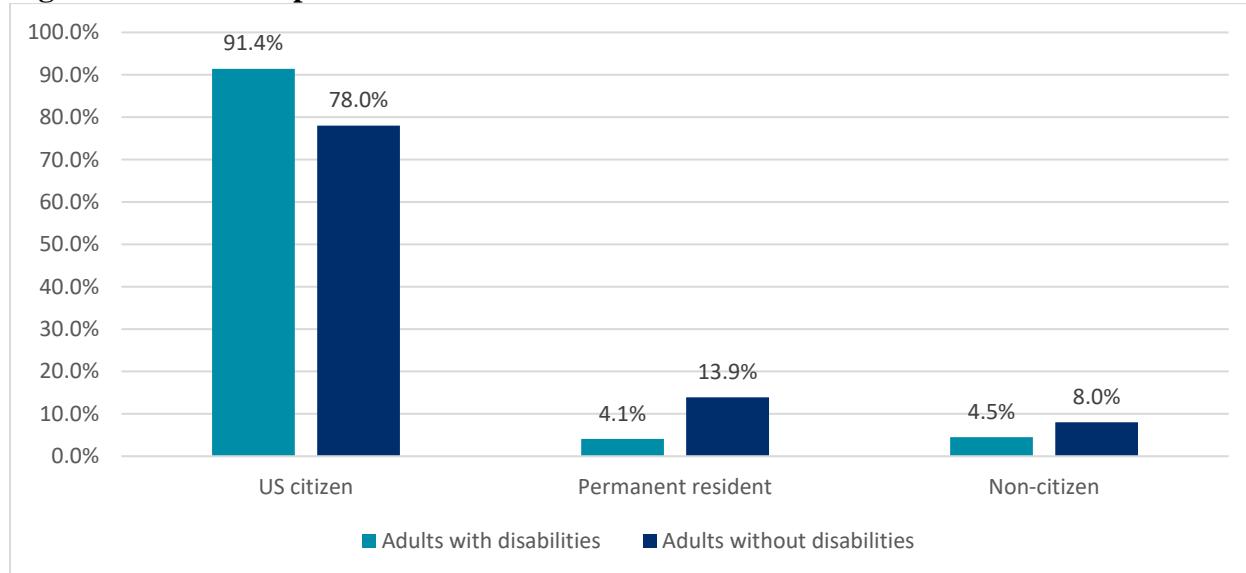


## Citizenship and Residency

Participants were asked to report whether they were a U.S. citizen. Some people who are not citizens may be hesitant to admit their lack of citizenship for fear of legal repercussions, including deportation. To encourage participation, these questions were prefaced with the statement, “The following questions are on citizenship and immigration. Your answers are confidential and will not be reported to any government agency.”

Most local adults with disabilities are U.S. citizens, as illustrated in Figure 13. In fact, they are significantly more likely to be U.S. citizens when compared to local adults without disabilities. There are approximately 3,030 local adults with disabilities who are not citizens and not permanent residents; these individuals likely lack the safety net services provided to U.S. citizens (such as Medicare or Medicaid), and may have poorer health as a result.

**Figure 13. Citizenship Status**

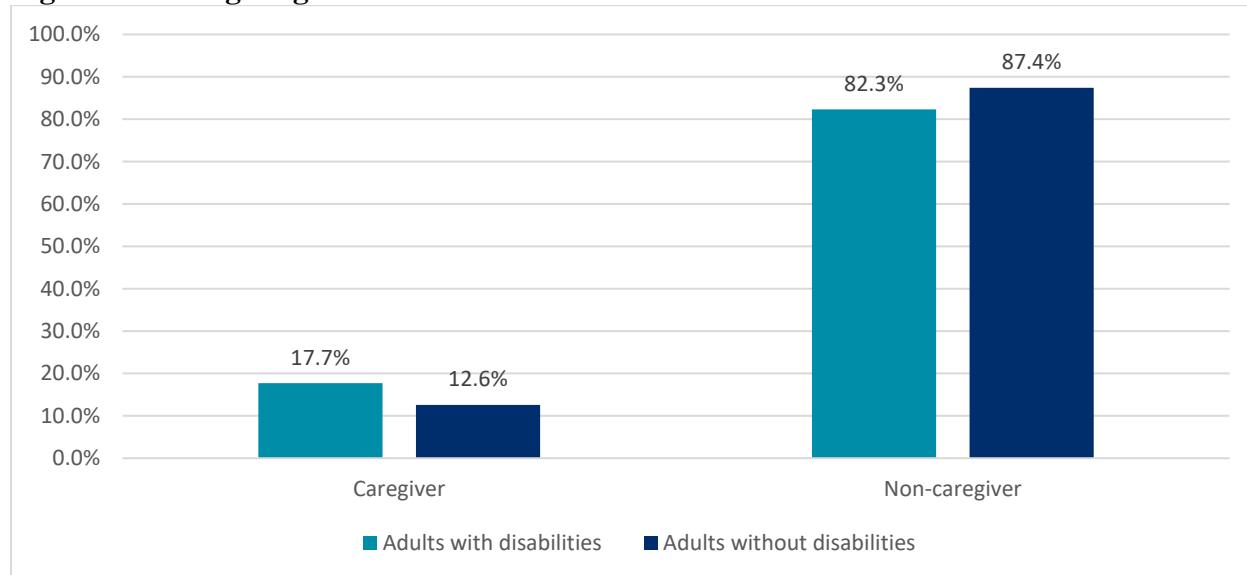


## Caregiving

Participants were asked, “Are you a caregiver that provides unpaid care or assistance to a family member or friend with a health condition, long-term illness or disability?”

Results showed that about 17.7% of local adults with disabilities were acting as a caregiver to another person, as illustrated in Figure 14. This equates to more than 11,820 local adults with a disability who are also caring for another person (who may have a disability).

**Figure 14. Caregiving Status**

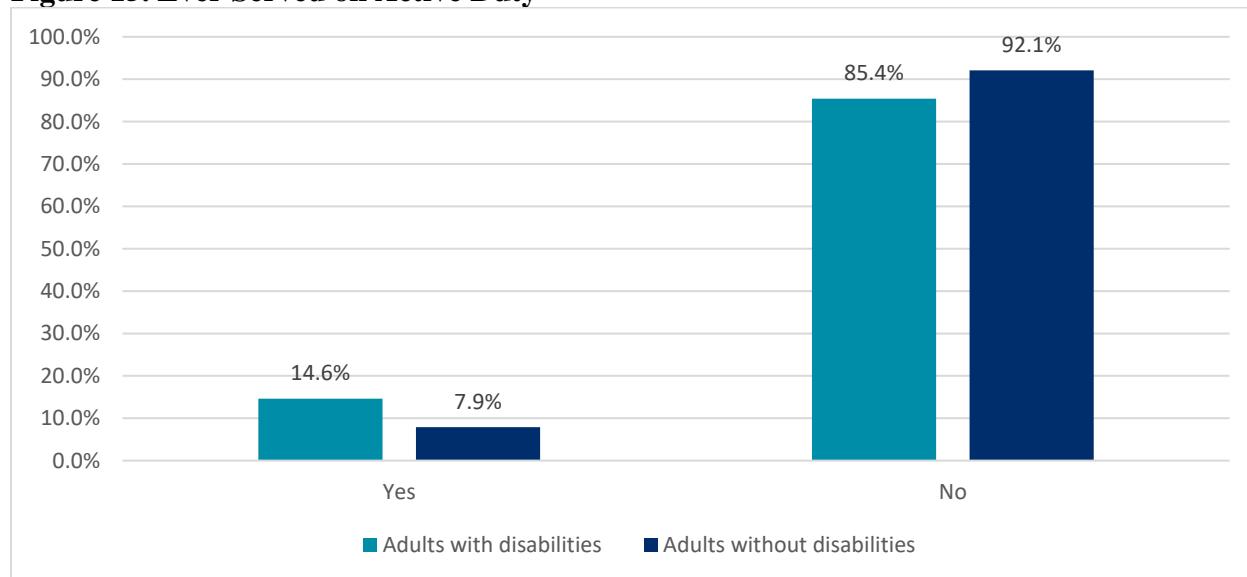


## Military Service

Participants were asked to report if they had ever served on active duty in the U.S. Armed Forces. Results indicate that approximately 14.6% of local adults with disabilities are veterans, as illustrated in Figure 15. This equates to more than 9,860 veterans with disabilities.

Local adults with disabilities are significantly more likely to have served active duty (14.6%) compared to adults without disabilities (7.9%). It is possible that some of these people received their disability while in the service, thus accounting for the high numbers. Combat veterans are especially vulnerable to issues such as traumatic brain injury, post-traumatic stress disorder (PTSD), and physical injuries such as amputations necessitated by improvised explosive devices.

**Figure 15. Ever Served on Active Duty**



## Section 2: Disability Specifics

Participants who indicated that they had a disability were not asked to describe what that disability was, or how it limited their activities. However, a series of additional questions help us to understand the nature of those disabilities.

It is worth noting that some of the people who answered “no” to the question “Are you limited in any way in any activities because of physical, mental, or emotional problems?” (i.e., those who are called “people without disabilities”) answered “yes” to the subsequent questions about sensory limitations, needing assistance with activities of daily living, and needing assistive technology. The “yes” responses for these people without disabilities are always significantly lower than the “yes” responses for people with disabilities, but they do exist. This is likely because these people have limitations, but don’t feel that they are limited in their activities as a result.

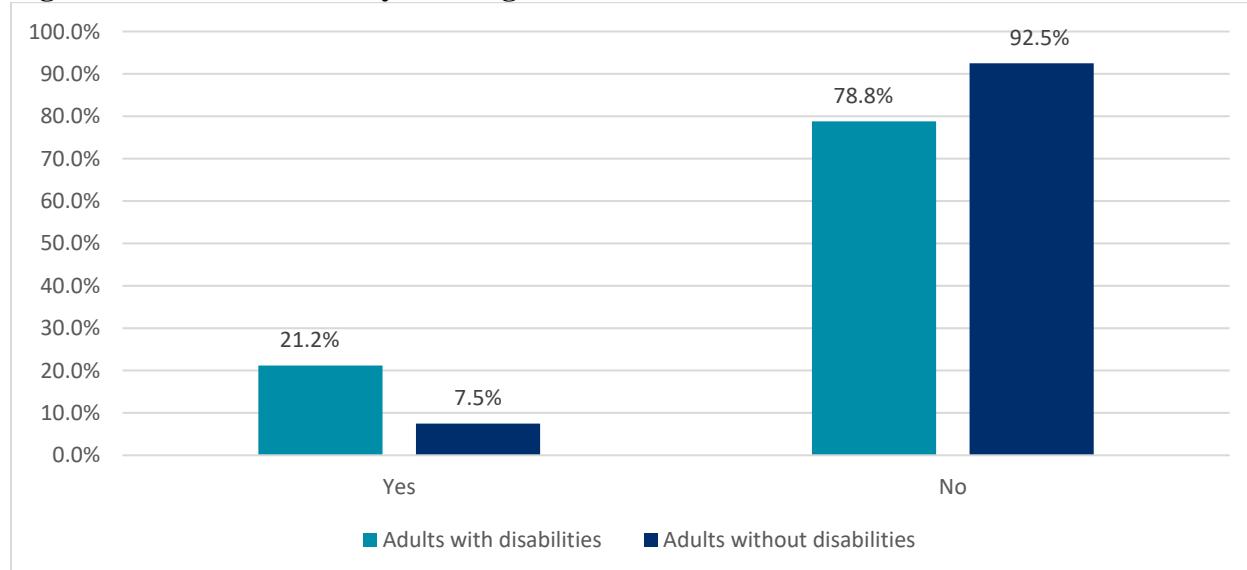
### Sensory Limitations

Two common types of disability include vision and hearing deficits. Having visual or hearing problems can prevent or hinder daily activities from being performed.

#### *Hearing Difficulties*

Participants were asked, “Are you deaf or do you have serious difficulty hearing?” About 21.2% of adults with disabilities are deaf or have difficulty hearing, which equates to approximately 14,252 people. As illustrated in Figure 16, about 7.5% of adults without disabilities answered “yes” to the question “are you deaf or do you have serious difficulty hearing?”

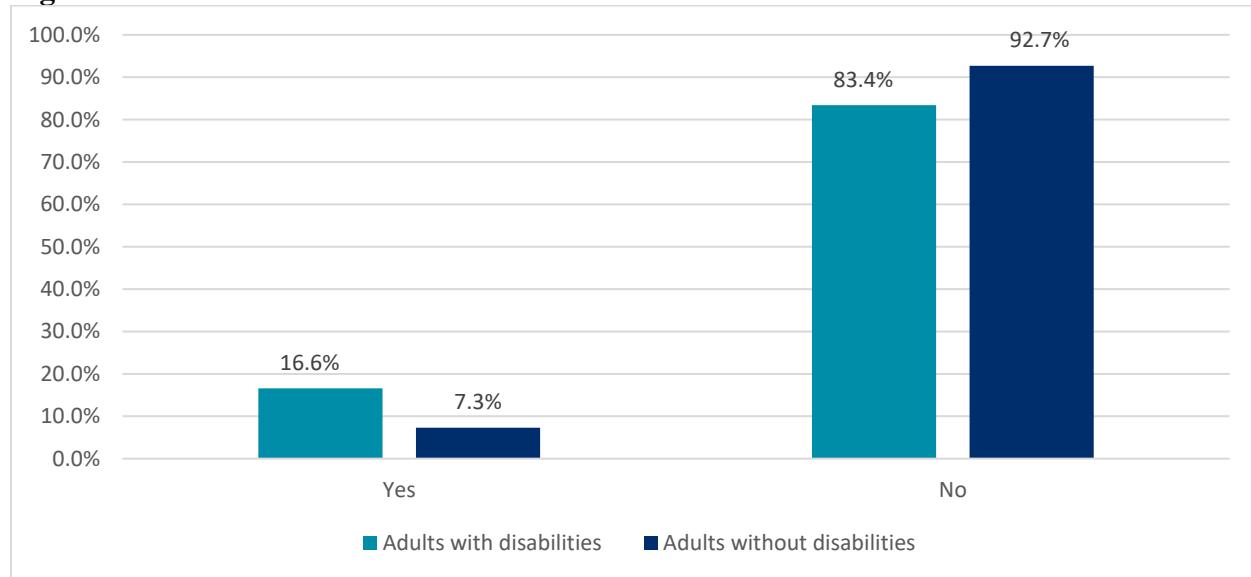
**Figure 16. Deaf or Difficulty Hearing**



## **Vision Difficulties**

Participants were asked, “Are you blind or do you have serious difficulty seeing, even when wearing glasses?” As illustrated in Figure 17, approximately 16.6% of adults with disabilities (approximately 11,114 people) are blind or have serious difficulty seeing. Approximately 7.3% of people without disabilities have a similar issue.

**Figure 17. Vision Difficulties**



## Assistance with Activities of Daily Living

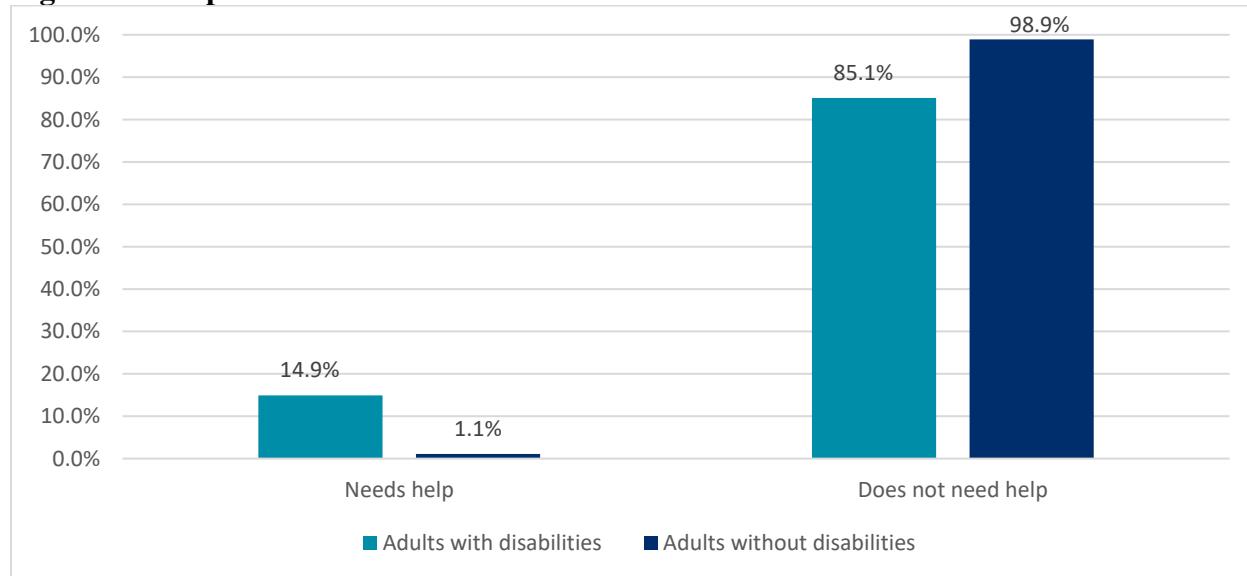
Activities of daily living (ADLs) are the basic tasks of everyday life such as eating, bathing, dressing, toileting, and transferring oneself from place to place. Inability to perform the ADLs is a significant predictor of increased use of physician services, formal paid home care services, inpatient hospital services, and changes in living arrangements.

To measure the need for assistance with ADLs, participants were asked, “Because of a disability, health problem, or frailty due to age, do you need help from another person for any of the following activities of daily living: eating, bathing, toileting, transfers (getting in and out of bed, bath tub, toilet, car, etc.), walking, dressing, or grooming?”

As illustrated in Figure 18, approximately 14.9% of adults with disabilities need assistance with ADLs. This is approximately 9,987 people.

Approximately 1.1% of adults without disabilities also need assistance with ADLs.

**Figure 18. Help with ADLs**



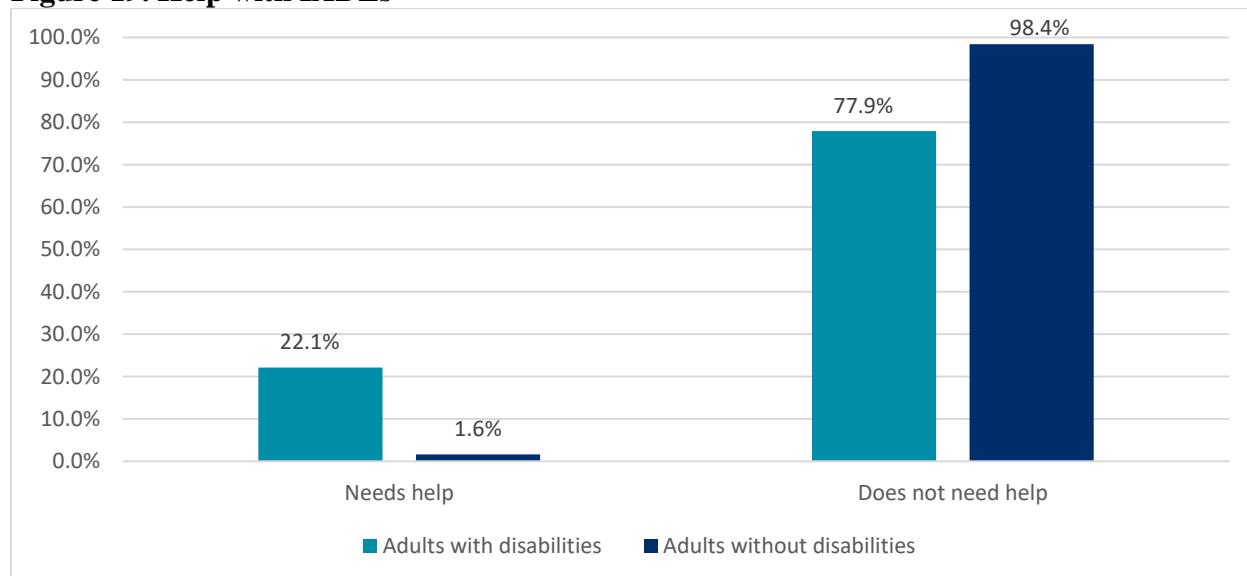
Those adults with disabilities who need assistance with ADLs were asked, “When you need help, is there someone to assist you?” Fortunately, 89.3% said “yes” in response to this follow-up question. However, 10.7% said “no”, indicating that there are more than 1,070 local adults with disabilities who need help with ADLs and have no one to assist them.

In contrast to ADLs, independent activities of daily living (IADLs) are more complex social activities. IADLs include using the telephone, preparing meals, managing medications, and shopping, among others.

To assess the need for assistance with IADLs, participants were asked, “Because of a disability, health problem, or frailty due to age, are you prevented from living independently because you need help from another person for any of the following activities: meal preparation, shopping, medication management, money management, using the telephone, housework, transportation, climbing stairs, indoor or outdoor mobility, or doing laundry?”

Results indicate that 22.1% of local adults with disabilities—14,827 people—need assistance with IADLs, as do 1.6% of adults without disabilities.

**Figure 19. Help with IADLs**



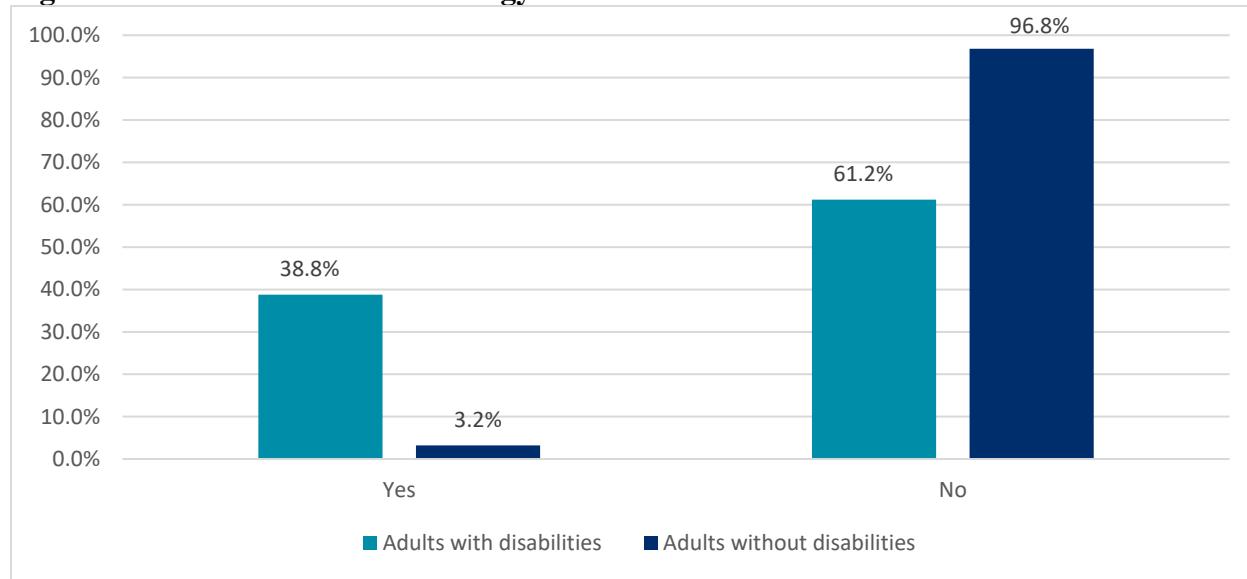
Those adults with disabilities who need assistance with IADLs were asked, “When you need help, is there someone to assist you?” Fortunately, 85.8% said “yes” in response to this follow-up question. However, 14.2% said “no”, indicating that there are more than 2,080 local adults with disabilities who need help with IADLs and have no one to assist them.

## Assistive Technology

To measure assistive technology use, participants were asked, “Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?”

Approximately 38.8% of local adults with disabilities require some assistive technology, as illustrated in Figure 20. This equates to more than 26,120 people. Additionally, approximately 3.2% of adults without disabilities need assistive technology.

**Figure 20. Needs Assistive Technology**



Participants who answered “yes” to this question were then asked, “Are you able to get the equipment that you need?” Most local adults with disabilities who need assistive technology (85.8%) were able to get it. However, 14.2%, or 3,636 people with disabilities, were not able to get what they needed.

## Section 3: Healthcare Access and Utilization

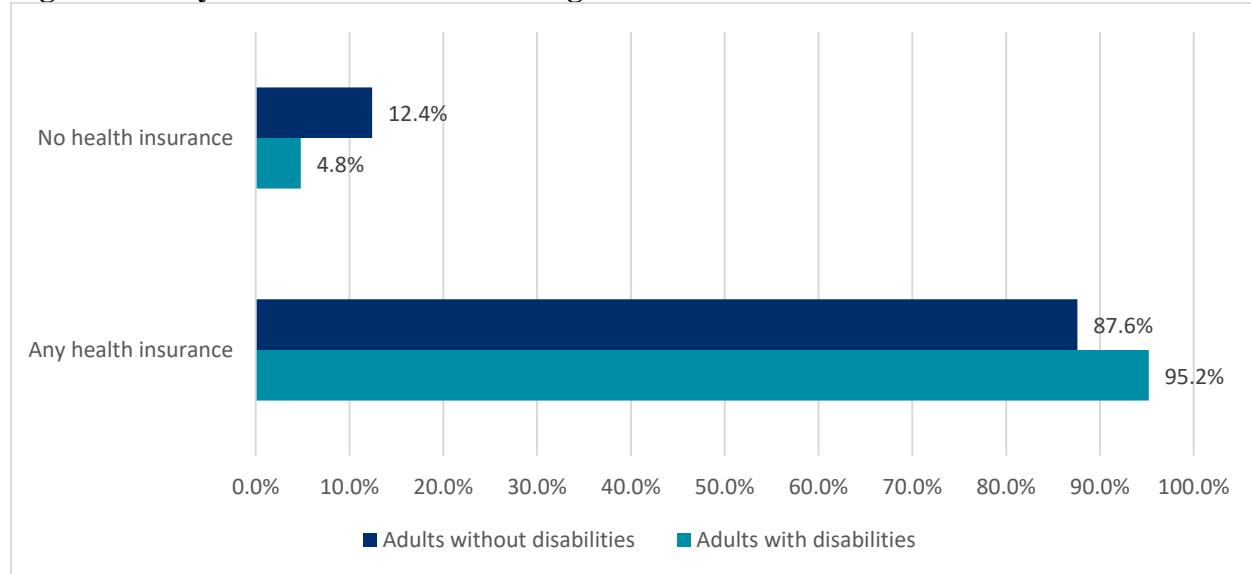
Access to good, high-quality healthcare not only helps people recover from illness and injury, but also aids in the prevention of disease and maintenance of good health. This is especially important for people with disabilities, which may need on-going care and treatment.

### Health Insurance Coverage

The vast majority of local adults with disabilities (95.2%) have health insurance coverage. Local adults with disabilities are significantly more likely to have health insurance than their counterparts without disabilities (95.2% versus 87.6%, respectively). This may be because certain disabilities can make an individual Medicare eligible who would not otherwise be eligible, thereby allowing them to have health insurance.

However, as illustrated in Figure 21, approximately 4.8% of local adults with disabilities do not have health insurance. This means that approximately 3,265 people are coping with a disability without insurance coverage, and may not be getting the care they need as a result.

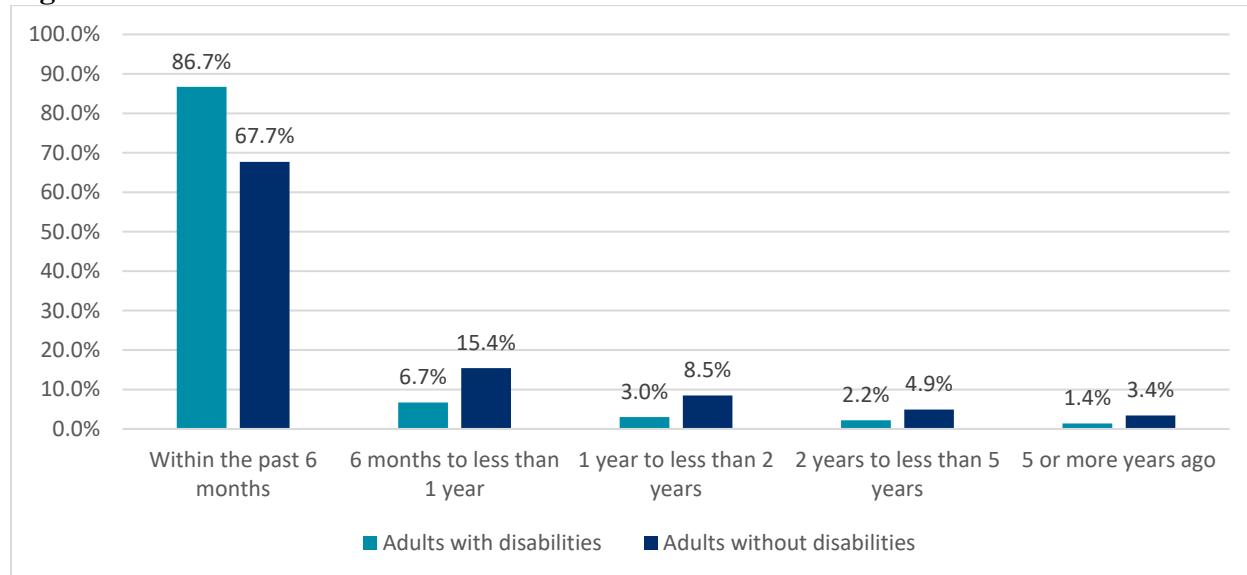
**Figure 21. Any Health Insurance Coverage**



## Recent Use

Participants were asked, “About how long has it been since you last visited a healthcare provider?” As illustrated in Figure 22, the vast majority of adults with disabilities (93.4%) have visited a healthcare provider in the past year. In fact, adults with disabilities are significantly more likely to have visited a healthcare provider recently than those without disabilities. However, approximately 930 adults with disabilities have not been to a provider in the last five years, and may be struggling to manage their disability as a result.

**Figure 22. Most Recent Visit to a Healthcare Provider**

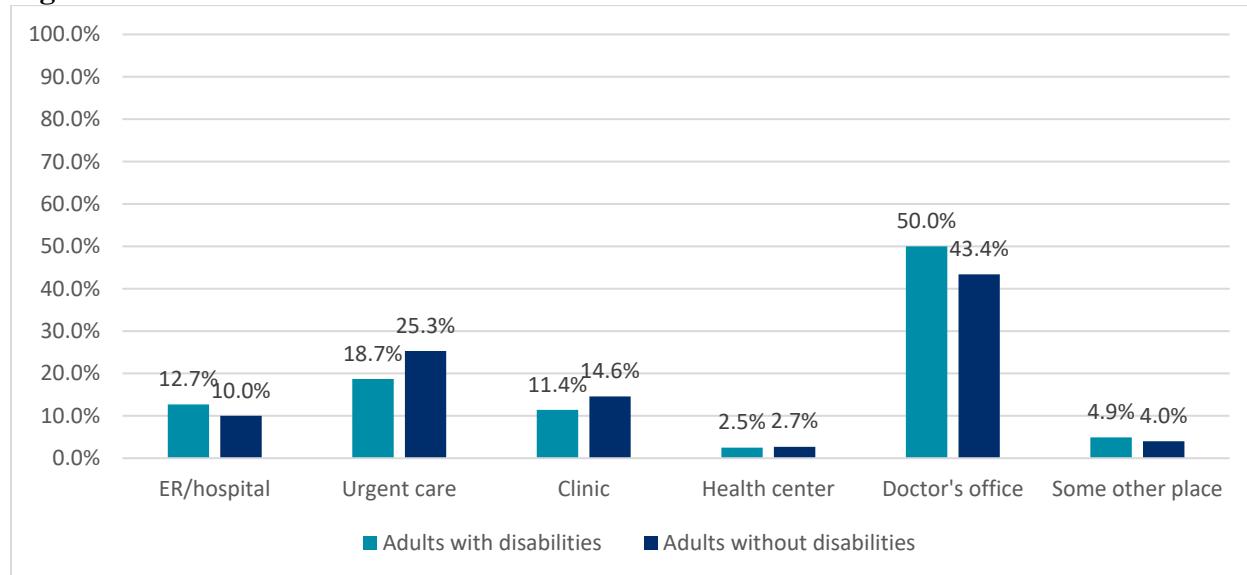


## Usual Source of Care

To assess usual source of care, participants were asked, “When you are sick or in need of health care, where do you usually go?”

The usual sources of care for adults with disabilities most commonly include the doctor’s office (50.0%) and urgent care (18.7%). A similar pattern exists for those without disabilities as 43.4% go to the doctor’s office, and another 25.3% go to urgent care. See Figure 23 for details.

**Figure 23. Usual Source of Care**



## Barriers to Receiving Care

To assess barriers to care, participants were asked, “Please tell me if any of the following has consistently made it very difficult or prevented you from receiving health care when you needed it in the past 12 months?”

As illustrated in Table 3, the three most common barriers to receiving care for adults with disabilities include understanding what is covered by their insurance (24.3%), transportation (20.7%), and the hours that healthcare providers are open to see patients (19.0%).

Adults with disabilities are significantly more likely to have trouble understanding what is covered by their insurance than their counterparts without disabilities (24.3% versus 16.4%, respectively). This may be because they are seeking treatment for their disability or needing specialty care rather than simple preventative care or regular check-ups. Adults with disabilities are also significantly more likely to have trouble with transportation (20.7% versus 5.7%, respectively), as illustrated in Table 2.

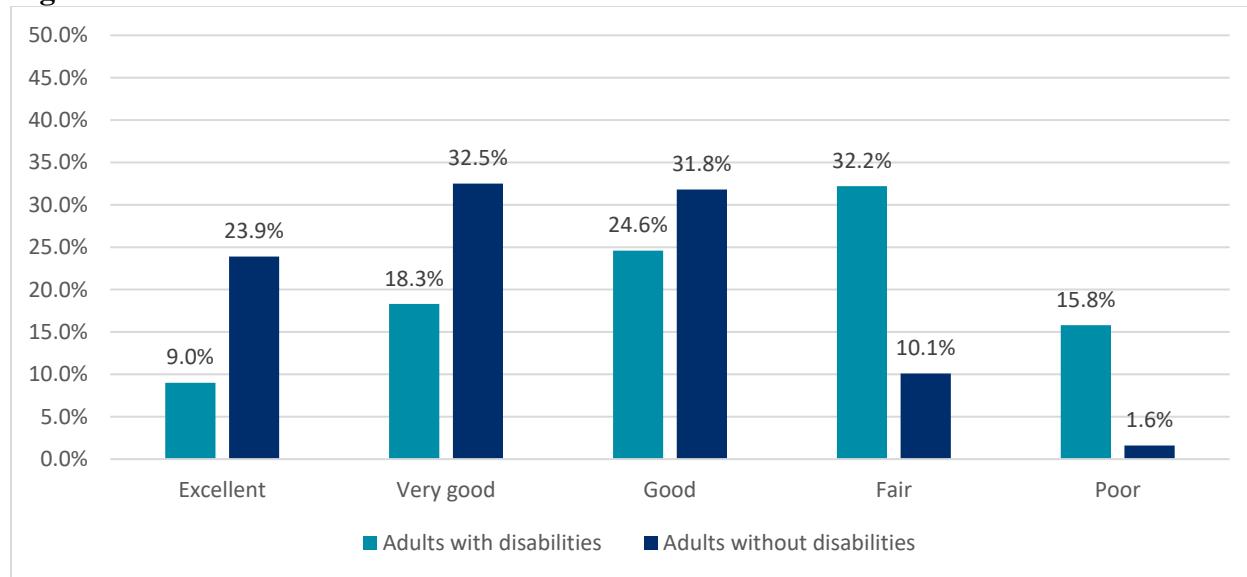
**Table 2. Barriers to Receiving Care**

Barriers	Adults with disabilities		Adults without disabilities	
	Weighted Percent	Population Estimate	Weighted Percent	Population Estimate
Understanding what is covered by your plan	24.3%	16,246	16.4%	38,382
Transportation	20.7%	13,995	5.7%	13,531
Hours that the healthcare provider is open to see patients	19.0%	12,737	17.0%	39,991
Not having authorization from an HMO	17.0%	11,007	10.1%	22,530
Finding a doctor of the sex, age, ethnicity, or sexual orientation that is comfortable for you	12.4%	8,227	7.5%	17,774
Taking time off work	8.7%	5,815	12.7%	30,132
Language barriers/problems	6.3%	4,240	6.1%	14,403
Unable to find childcare or homecare	3.6%	2,412	2.3%	5,421

## Section 4: General Health Status

Nearly half of local adults with disabilities (48.0%, 32,383 people) rate their health as “fair” or “poor”. This is a startling contrast to adults without disabilities, only 11.8% of whom rate their health as “fair” or “poor”. As illustrated in Figure 24, less than 10% of adults with disabilities rate their health as “excellent”, compared to nearly a quarter of adults without disabilities.

**Figure 24. Perceived Health Status**



Adults who rated their health as “fair” or “poor” were asked why they gave their health that rating; the most common reasons listed by adults with disabilities were chronic illness (31.8% of those who rated their health as “fair” or “poor”) and physical disabilities (27.1%).

## Section 5: Major Disease

Chronic illnesses – the leading cause of death and disability in the nation – are diseases that generally take years or decades to progress, are persistent, and can last for long periods of time. These illnesses are the cause for 7 out of 10 deaths in the U.S., and approximately 117 million Americans have at least one chronic illness.<sup>1</sup> These conditions diminish one's quality of life and often result in continuous health care costs.

### Chronic Illness and Major Disease

Participants were asked if they had ever been diagnosed by a doctor or other healthcare provider with a series of chronic illnesses/major diseases. The most common major diseases for local adults with disabilities include arthritis (affecting 56.2% of adults with disabilities, more than 37,400 people), high blood pressure (53.3%, 35,719 people), and high blood cholesterol (40.4%, or 26, 907 people).

Adults with disabilities have significantly higher rates of every type of major disease listed in Table 3, compared to adults without disabilities. Part of this may be due to the age difference (on average, adults with disabilities are 10 years older than adults without disabilities), as many of these major diseases are more common among older adults. It also may be that certain major diseases, such as arthritis, are the cause of the disability.

**Table 3. Major Disease Diagnoses**

Disease	Adults with Disabilities		Adults without disabilities	
	Weighted Percent	Population Estimate	Weighted Percent	Population Estimate
Arthritis	56.2%	37,409	19.5%	46,130
High blood pressure	53.3%	35,719	28.8%	68,060
High blood cholesterol	40.4%	26,907	23.7%	55,601
Cancer	20.8%	13,934	8.1%	19,181
Diabetes	20.8%	13,855	10.6%	25,185
Bone disease	17.5%	11,612	4.7%	11,074
Asthma	16.5%	11,063	9.4%	22,304
Heart disease	13.7%	9,144	4.4%	10,312
Other respiratory disease	11.9%	7,974	2.6%	6,272
Heart attack	9.0%	6,055	2.4%	5,801
Stroke	7.1%	4,734	1.8%	4,366
Liver disease	4.3%	2,869	1.0%	2,422

<sup>1</sup> Chronic Disease Overview. (2017). Centers for Disease Control and Prevention. <http://www.cdc.gov/chronicdisease/overview/>

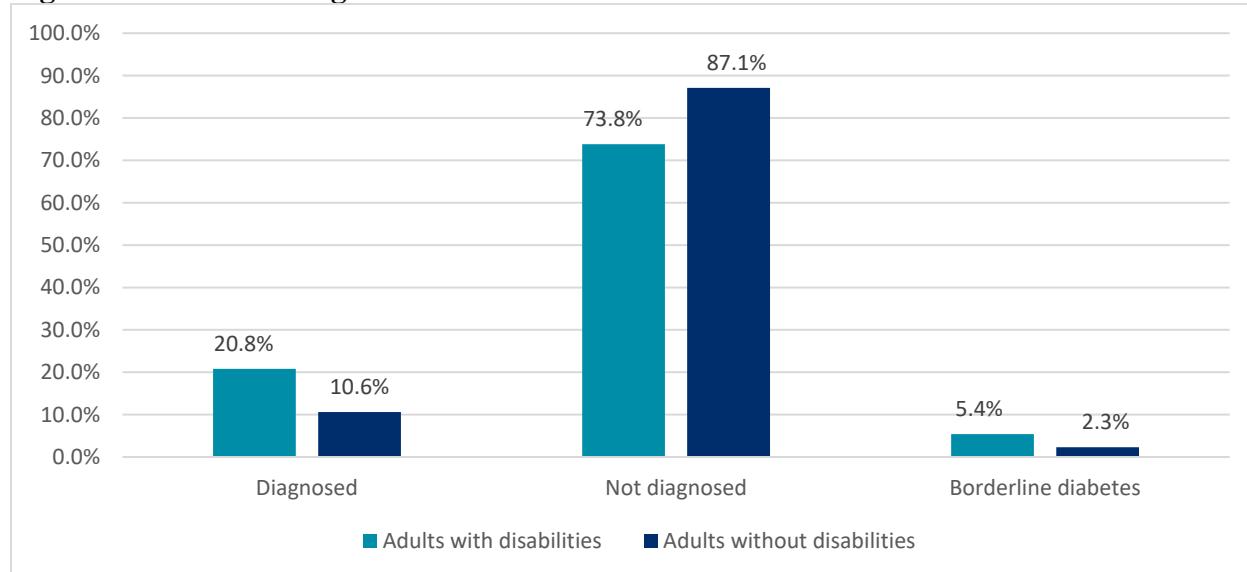
## Diabetes

Diabetes mellitus is a group of chronic diseases in which the body has exceedingly high levels of blood glucose resulting from a lack of insulin production, insulin action, or both. When untreated or not properly managed, diabetes can lead to serious health complications, such as heart disease, blindness, kidney failure, lower extremity amputations, and premature death. There are three types of diabetes: Type 1, Type 2, and gestational diabetes.

Diabetes is very common in people with disabilities, as illustrated in Figure 25. In fact, approximately 1 in 4 Coachella Valley adults with disabilities has been diagnosed with diabetes or pre-diabetes (also known as borderline diabetes).

These rates are significantly higher than the rates for adults without disabilities, as illustrated in Figure 25.

**Figure 25. Diabetes Diagnoses**



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## Section 6: Mental Health

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Mental health is a state of psychological well-being in which an individual can enjoy life and can cope with everyday situations and stressors. It is not simply the lack of a mental disorder, but also the presence of positive mental health. One's mental health can be affected by environmental, genetic, and/or psychological factors.

### Mental Health Disorders

Participants were asked if they had ever been diagnosed by a doctor or other healthcare provider with a series of mental health disorders. Results show that 43.9% of adults with disabilities—approximately 29,480 people—have been diagnosed with one or more mental health disorders. This is significantly higher than the rate for adults without disabilities (16.1%).

It is important to remember that the mental health disorder may be the source of the disability (e.g., someone is limited in their activities because of their anxiety disorder), or may be the result of their disability (e.g., someone becomes depressed after an injury limits their mobility and related activities).

The most common mental disorder diagnoses among adults with disabilities include depressive disorders (30.0%), generalized anxiety disorder (20.0%), and post-traumatic stress disorder (17.3%), as illustrated in Table 4. Adults with disabilities are significantly more likely to have any of the listed mental disorder diagnoses compared to adults without disabilities.

**Table 4. Mental Health Disorder Diagnoses**

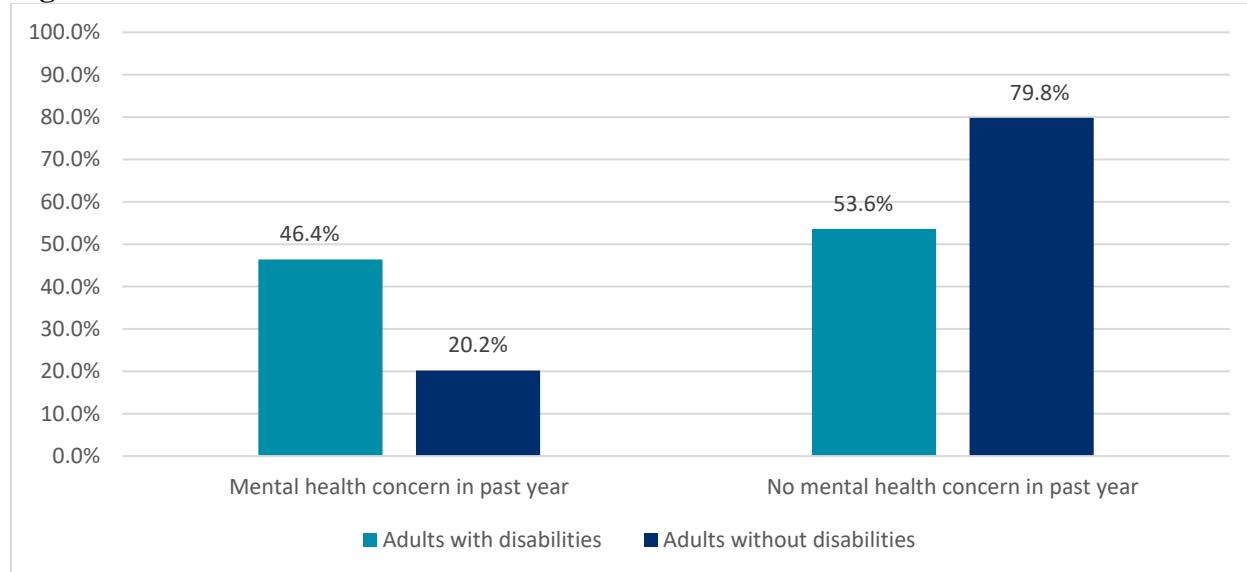
Disorder	Adults with disabilities		Adults without disabilities	
	Weighted Percent	Population Estimate	Weighted Percent	Population Estimate
Depressive disorders	30.0%	19,969	7.7%	18,204
Generalized anxiety disorder	20.0%	13,341	6.3%	14,952
Post-traumatic disorder	17.3%	11,481	1.9%	4,588
Panic disorder	12.7%	8,419	2.5%	5,969
Phobia	10.7%	7,153	3.2%	7,493
Bipolar disorder	8.5%	5,632	1.5%	3,470
Obsessive compulsive disorder	8.0%	5,343	1.5%	3,460
Other mental health condition	7.4%	4,929	1.5%	3,547

About 9.7% of adults with disabilities—more than 6,500 people—have seriously considered attempting suicide in the past year. This is more than triple the rate of suicidal ideation for adults without disabilities (9.7% versus 3.0%, respectively).

Not all mental health concerns have been formally diagnosed by a mental health professional or other healthcare provider. In order to capture potential undiagnosed mental health issues, participants were asked, “Have you had any emotional, mental, and behavioral problems such as stress, anxiety, or depression that concerned you during the past 12 months?”

Results showed that nearly half of local adults with disabilities (46.4%, or 31,112 people) had such a concern in the past year. This rate is significantly higher than the rate for adults without disabilities, as illustrated in Figure 26.

**Figure 26. Mental Health Concern in Past Year**



Those who had a mental health concern in the past year were subsequently asked, “Did you consider any of these problems severe enough that you felt you needed professional help?” Results show that 68.1% of adults with disabilities (20,164 people) felt that they needed professional help. This was significantly higher than the rate for adults without disabilities; 47.8% of these adults felt their problems required professional help.

Finally, participants were asked, “Are you still bothered or concerned about your emotional, mental or behavioral problem?” Results showed that 63.2% of adults with disabilities (19,417 people) were still concerned about their issues. Once again, this was significantly higher than the rate for adults without disabilities (37.1%).

In short, local adults with disabilities are significantly more likely to have an emotional, mental, or behavioral problem that concerned them in the past year; significantly more likely to need professional help for that problem, and significantly more likely to still be concerned by the problem.

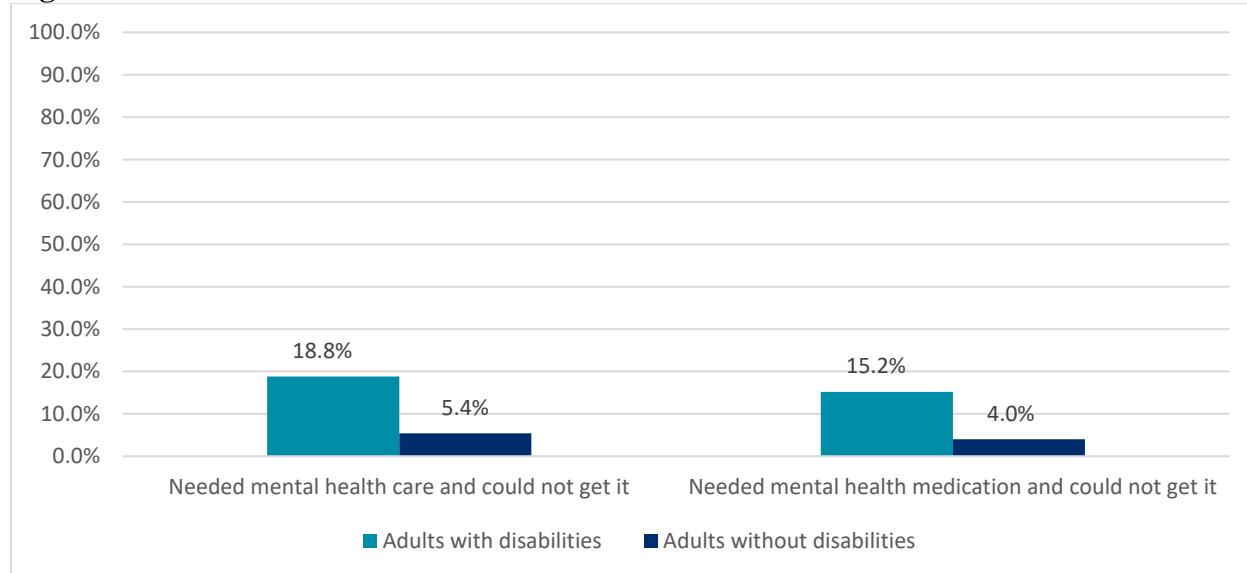
## Mental Health Treatment

Participants who had emotional, mental, or behavioral problem that concerned them in the past year or a diagnosed mental health disorder were subsequently asked several questions about treatment.

Approximately 18.8% of Coachella Valley adults with disabilities needed mental health care in the past year and could not get it. This equates to more than 7,000 people in need, and is significantly higher than the rate for adults without disabilities.

Similarly, as illustrated in Figure 27, 15.2% of Coachella Valley adults with disabilities needed mental health medication in the past year and could not get it. This is more than 5,600 people, and once again, is significantly higher than the rate for adults without disabilities.

**Figure 27. Mental Health Treatment Needs**



## Section 7: Obesity and Exercise

Weight regulation, exercise and proper nutrition are important for maintaining good health among all groups of people.

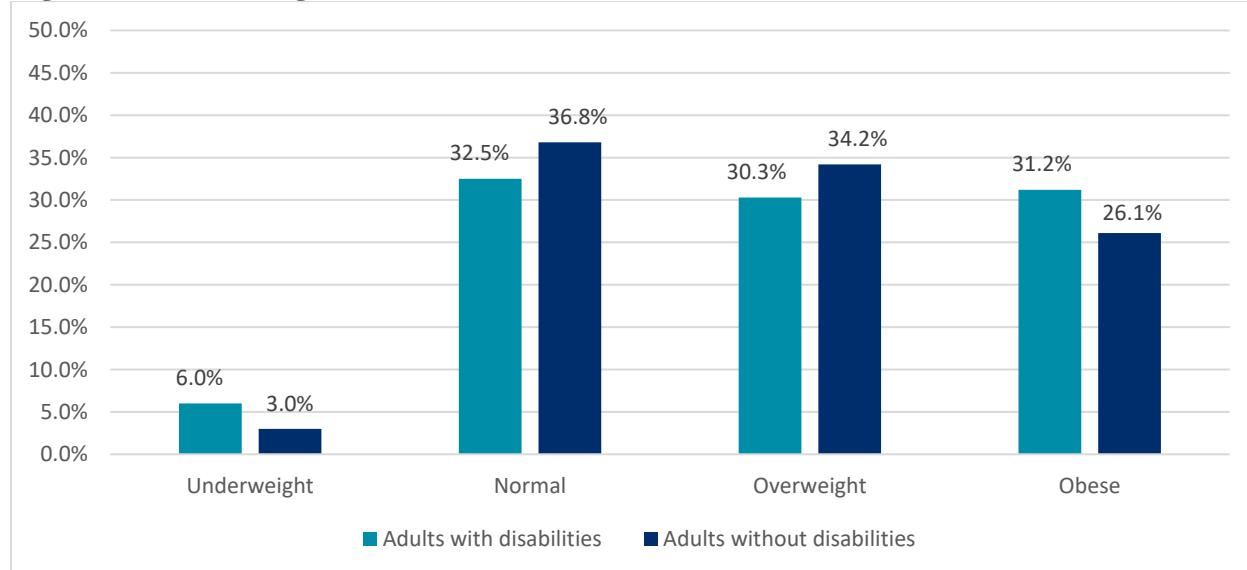
### BMI and Obesity

Body mass index (BMI) is a calculated value based on the height and weight of a person. A high BMI can be an indicator of a high body fat percentage.<sup>1</sup> For adults over the age of 20, BMI scores are interpreted as follows: Underweight (below 18.5), normal weight (18.5-24.9), overweight (25.0-29.9), and obese (30.0 and above).<sup>2</sup>

Obesity is often directly caused by a combination of two factors: poor nutrition and a lack of physical activity. Some of the leading causes of preventable death are associated with having obesity and include heart disease, stroke, type 2 diabetes, and some types of cancer.<sup>3</sup>

HARC calculated BMI for participants based on their self-reported height and weight. As illustrated in Figure 28, most Coachella Valley adults with disabilities are either overweight (30.3%) or obese (31.2%). This mirrors the trends for all adults in the Valley; that is, Coachella Valley adults are equally likely to be overweight or obese; it does not vary based on disability.

**Figure 28. BMI Categories**



<sup>1</sup> Body Mass Index (BMI). (2015). Centers for Disease Control and Prevention. <https://www.cdc.gov/healthyweight/assessing/bmi/index.html>

<sup>2</sup> About Adult BMI. (2017). Centers for Disease Control and Prevention. [https://www.cdc.gov/healthyweight/assessing/adult\\_bmi/index.html](https://www.cdc.gov/healthyweight/assessing/adult_bmi/index.html)

<sup>3</sup> Adult Obesity Facts. (2017). Centers for Disease Control and Prevention. <http://www.cdc.gov/obesity/data/adult.html>

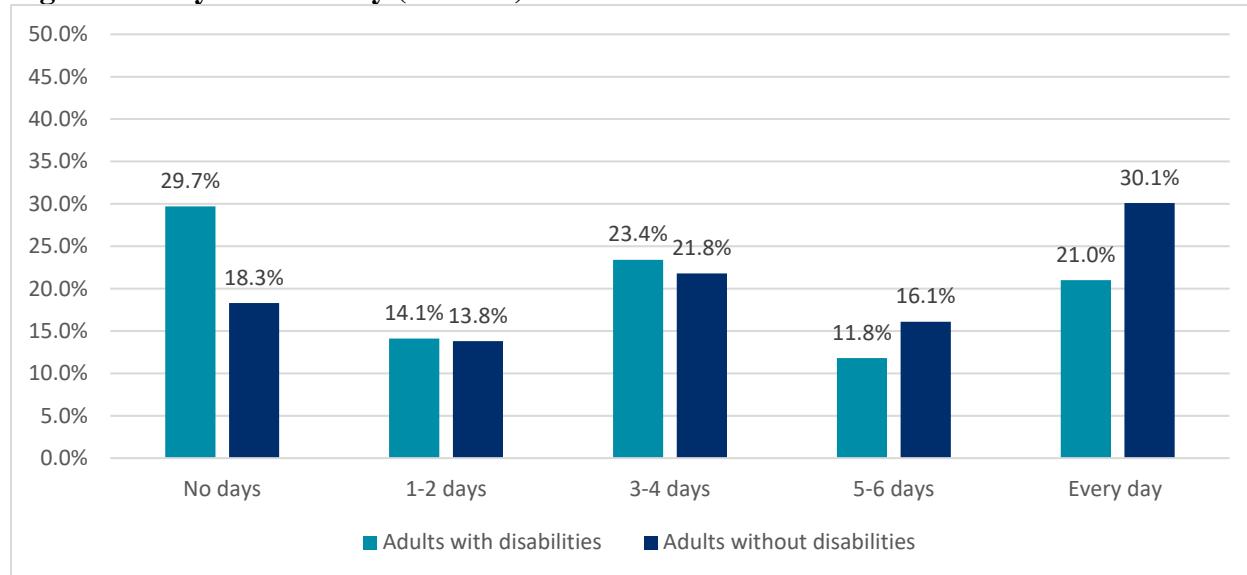
## Physical Activity

Physical activity is important for maintaining good health and a necessary part of a healthy lifestyle. Engaging in regular physical activity lowers one's risk of premature death and decreases the risk for heart disease, diabetes, high blood pressure, depression, anxiety, and colon cancer. Physical activity facilitates weight control, improves mood, and reduces the risk of falling.

The U.S. Department of Health and Human Services recommends that adults get at least 150 minutes of moderate-intensity aerobic activity each week, as well as 2 or more days per week of muscle-strengthening activities for all major muscle groups.<sup>1</sup> As estimated by the CDC, only 20.5% of adults in the U.S. meet these criteria for physical activity.<sup>2</sup>

About 29.7% of local adults with disabilities did no aerobic exercise in the past week, as illustrated in Figure 29. This means more than 19,980 people with disabilities got no exercise in the past week, and likely have poorer health because of it. People with disabilities exercise significantly less than those without disabilities.

**Figure 29. Physical Activity (Aerobic) in Past Week**

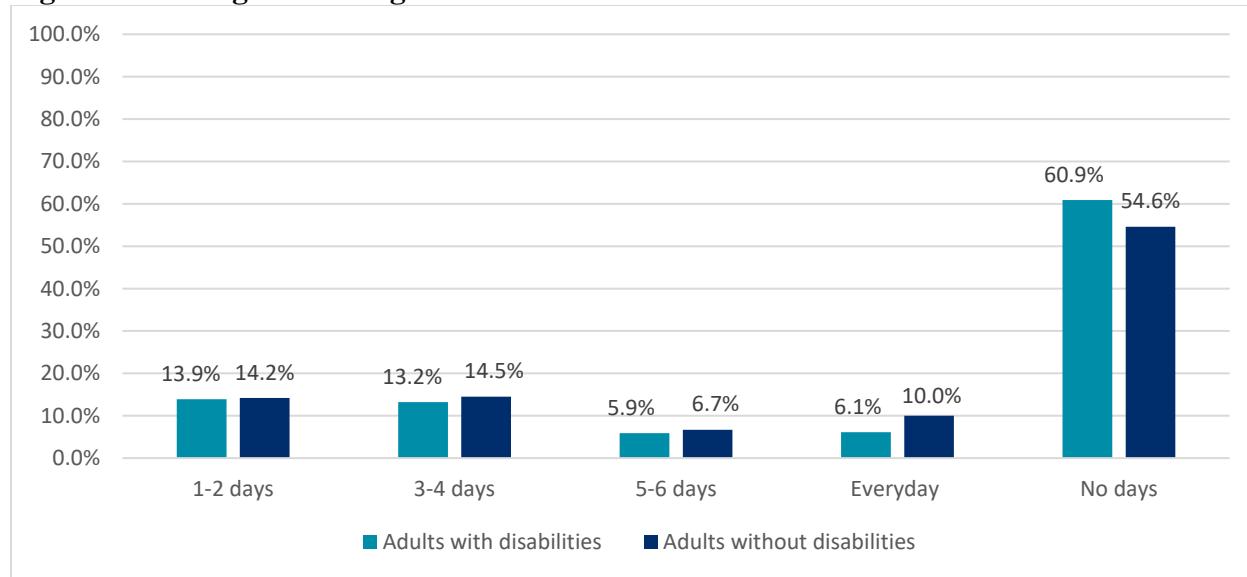


<sup>1</sup> 2015–2020 Dietary Guidelines for Americans. 8th Edition. (2015). U.S. Department of Health and Human Services. [http://health.gov/dietaryguidelines/2015/resources/2015-2020\\_Dietary\\_Guidelines.pdf](http://health.gov/dietaryguidelines/2015/resources/2015-2020_Dietary_Guidelines.pdf)

<sup>2</sup> Nutrition, Physical Activity, and Obesity: Data, Trends and Maps. (2015). Centers for Disease Control and Prevention. <https://www.cdc.gov/nccdphp/dnpao/data-trends-maps/index.html>

Strength-training is relatively rare among all Coachella Valley adults, as illustrated in Figure 30. That is, the majority of adults with disabilities (60.9%) and the majority of those without disabilities (54.6%) have not done any strength training in the past week.

**Figure 30. Strength Training in Past Week**



## Section 8: Food Insecurity and Unmet Needs

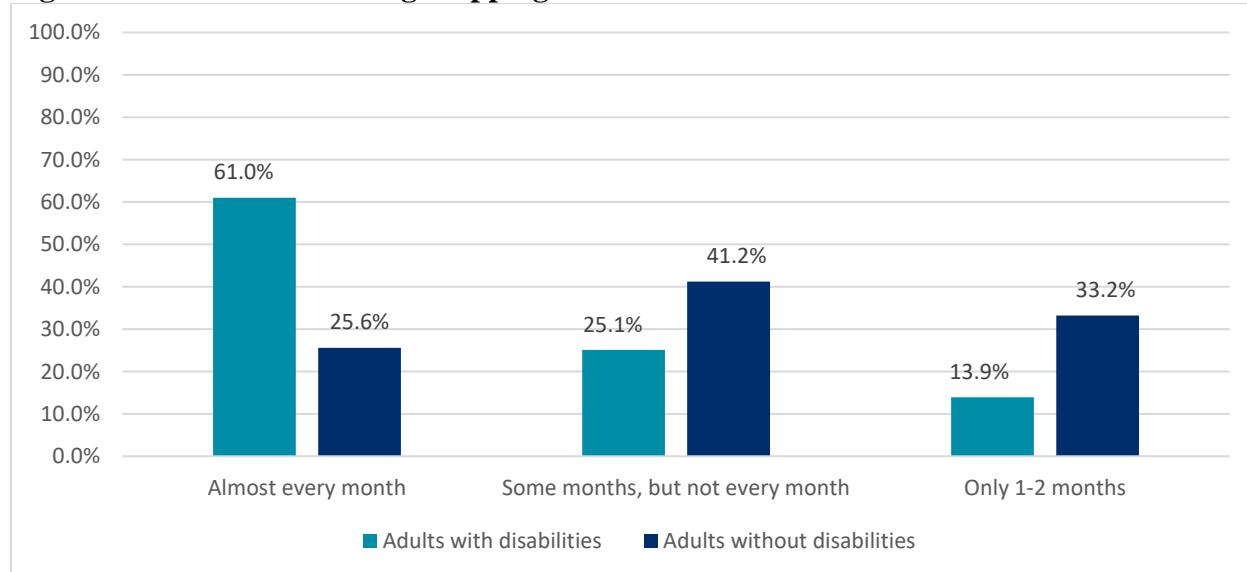
### Food Insecurity

Food insecurity is defined by the U.S. Department of Agriculture Economic Research Service as “limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.”<sup>1</sup> Food insecurity in the United States was roughly 12.3%, about 15.6 million households in 2016.<sup>2</sup> The estimate of food insecure households includes both those that have low food security (7.4%) and those households with very low food security (4.9%).<sup>3</sup>

In the past year, approximately 14.0% of those with disabilities had to cut the size of their meals or skip meals because there wasn’t enough money for food; this equates to more than 9,360 people with disabilities. This rate is significantly higher than for those without disabilities (14.0% versus 8.3%, respectively).

Those who had to cut the size of meals or skip meals due to lack of money were then asked how often this happened. For the majority of food insecure adults with disabilities—61.0%, or 5,600 people—this happened almost every month. As illustrated in Figure 31, this is significantly higher than the rate for people without disabilities.

**Figure 31. Amount of Cutting/Skipping Meals**



<sup>1</sup> Measurement. (2017). United States Department of Agriculture and Economic Research Service. <http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/measurement.aspx>

<sup>2</sup> Key Statistics and Graphs. (2015). United States Department of Agriculture and Economic Research Service. <http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx#trends>

<sup>3</sup> Ibid.

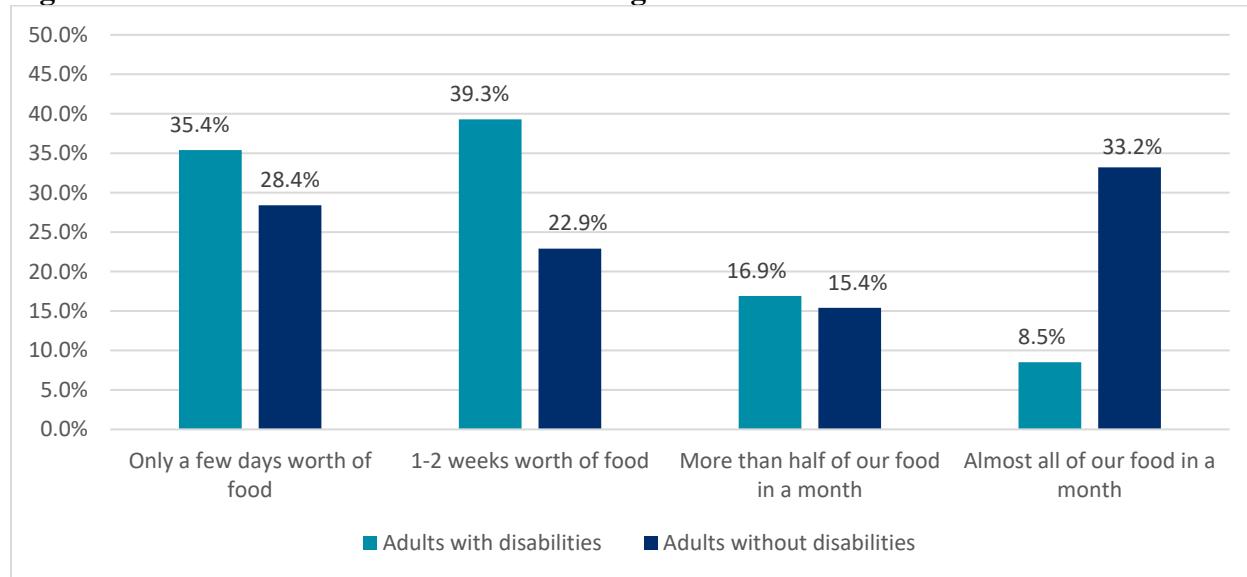
Beyond cutting the size of meals and/or skipping meals is going for a whole day without eating. Results show that 7.3% of Coachella Valley adults with disabilities have gone without eating for a whole day sometime in the past year due to a lack of money for food. This is more than 4,940 local adults with disabilities who have gone hungry for an entire day. This is significantly higher than the rate for adults without disabilities (7.3% versus 2.4%, respectively).

Within the past year, approximately 21.3% of adults with disabilities worried about running out of food before they got money to buy more. This represents a financial stress on more than 14,300 local people with disabilities. It is also significantly higher than the rate for adults without disabilities, which is 13.6%.

In the past month, approximately 12.1% of adults with disabilities received emergency food from a food assistance program. This is approximately 8,060 local adults with disabilities who utilized such emergency food services. It is also significantly higher than the rate for adults without disabilities (6.2%).

The participants who accessed emergency food sources in the past month were then asked how much of their food came from the food assistance program. Most adults with disabilities who received food from a food assistance program relied on the program for less than half of their food during the month, as illustrated in Figure 32.

**Figure 32. Amount from Food Assistance Programs**



## **Other Unmet Needs**

Many adults—of all ages—need assistance with the basic components of a healthy lifestyle. In order to be truly healthy, individuals need shelter, food, and basic utilities at a bare minimum. If people are unable to obtain these needs, health is severely threatened. Ideally, those who need assistance in these areas would have programs and people they could rely on for help. However, for those who have unmet needs in these areas, interventions are needed to provide these important services.

To assess some basic needs, participants were asked, “Have you needed help with any of the following in the past 12 months?” Results indicate that the most common needs for assistance for people with disabilities include transportation assistance (21.3%), utility assistance (20.2%), and food assistance (18.8%), as illustrated in Table 5.

There is a significant difference in the level of need between people with disabilities and those without disabilities; the need is higher for people with disabilities on every one of the categories presented in Table 5.

**Table 5. Need for Assistance**

Needs	Adults with disabilities		Adults without disabilities	
	Weighted Percent	Population Estimate	Weighted Percent	Population Estimate
Transportation assistance	21.3%	14,299	5.5%	13,156
Utility assistance	20.2%	13,556	5.1%	12,151
Food assistance	18.8%	12,691	8.6%	20,509
Home health care assistance	16.9%	11,393	2.4%	5,668
Financial assistance	16.1%	10,856	6.6%	15,626
Housing assistance	7.8%	5,209	3.2%	7,622
Rental assistance	7.5%	5,050	2.7%	6,469

## Section 9: Senior-Specific Information

Food insecurity is defined by the U.S. Department of Agriculture Economic Research Service as Seniors, as a population of interest, have several health issues that affect them disproportionately. To this end, a section of the survey was directed only at participants aged 55 and older. Thus, for this next section, these questions were not asked of younger adults (ages 18-54).

### Elder Abuse

Under California Law, abuse of an elder or a dependent adult includes physical or mental abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm, pain, or mental suffering. The consequences of elder abuse include numerous physical and psychological ailments. Physically, elders who endure abuse are likely to have wounds, injuries, nutrition deficits, increased susceptibility to illnesses, and increased risks for premature death. Psychologically, there is increased distress, depression, anxiety, PTSD, and feelings of helplessness.<sup>1</sup>

Every year, hundreds of thousands of elderly people are abused physically, sexually, emotionally, financially, or through neglect and abandonment. According to the CDC, one out of every ten elders are abused in their own home.<sup>2</sup> Unfortunately, this estimate is likely higher due to the fear of speaking out or the inability to seek help.

Approximately 6.5% of local seniors with disabilities have been physically or mentally mistreated or neglected in the past year, as illustrated in Table 6. This is more than 2,600 Coachella Valley seniors with disabilities who have reported the abuse—the actual numbers are likely higher. The rate of elder abuse for seniors with disabilities is significantly higher than the rate for seniors without disabilities (6.5% versus 1.7%, respectively).

Approximately 7.5% of local seniors with disabilities have been taken advantage of financially in the past year, as have 3.8% of seniors without disabilities, as illustrated in Table 6.

**Table 6. Elder Abuse**

Type of Abuse	Seniors with Disabilities		Seniors without disabilities	
	Weighted Percent	Population Estimate	Weighted Percent	Population Estimate
Physically or mentally mistreated or neglected in the past year	6.5%	2,648	1.7%	1,419
Taken advantage of financially in the past year	7.5%	3,053	3.8%	3,271

<sup>1</sup> Elder Abuse: Consequences. (2017). Centers for Disease Control and Prevention.

<http://www.cdc.gov/violenceprevention/elderabuse/consequences.html>

<sup>2</sup> Elderly Abuse Prevention. (2017). Centers for Disease Control and Prevention. <http://www.cdc.gov/features/elderabuse/>

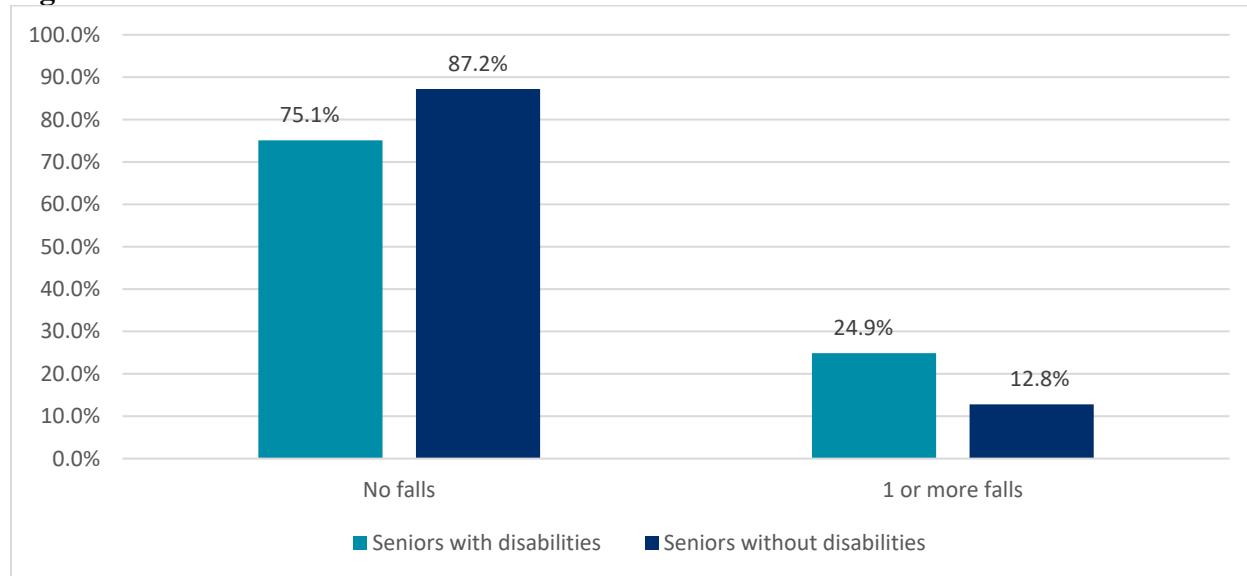
## Senior Mobility

One of the greatest challenges seniors face is the battle to remain mobile. The American Journal of Preventive Medicine listed mobility as a key factor affecting the quality of life of older Americans.<sup>1</sup> Some conditions that make seniors more likely to fall include lower body weaknesses, vitamin D deficiency, difficulties with walking and balance, usage of depressants, vision problems, foot pain or poor footwear, and home hazards (uneven steps, throw rugs, clutter).<sup>2</sup>

Nationally, falling is a serious concern for seniors and is the leading cause of unintentional death for those aged 65 and above.<sup>3</sup> Falling is very common, with one out of every four elders falling annually.<sup>4</sup>

In the Coachella Valley, approximately 24.9% of seniors with disabilities—more than 10,150 people—have fallen one or more times in the past three months. Falls are significantly more common for seniors with disabilities than seniors without disabilities, as illustrated in Figure 33.

**Figure 33. Number of Falls in Past Three Months**



More than half of local seniors with disabilities (54.7%, more than 22,255 people) have a concern or fear that they may fall, which may inhibit their mobility as much as an actual fall. This is significantly higher than the rate for seniors without disabilities; 21.6% of whom fear falling.

<sup>1</sup> Midlife Physical Activity and Mobility in Older Age. (2006). American Journal of Preventive Medicine, Volume 31, Issue 3. [http://www.ajpmonline.org/article/S0749-3797\(06\)00201-7/abstract](http://www.ajpmonline.org/article/S0749-3797(06)00201-7/abstract)

<sup>2</sup> Important Facts About Falls. (2017). Centers for Disease Control and Prevention. <https://www.cdc.gov/homeandrecreationsafety/falls/adultfalls.html>

<sup>3</sup> 10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States-2015. (2015). Centers for Disease Control and Prevention. [https://www.cdc.gov/injury/images/lc-charts/leading\\_causes\\_of\\_injury\\_deaths\\_unintentional\\_injury\\_2015\\_1050w760h.gif](https://www.cdc.gov/injury/images/lc-charts/leading_causes_of_injury_deaths_unintentional_injury_2015_1050w760h.gif)

<sup>4</sup> Important Facts About Falls. (2017). Centers for Disease Control and Prevention. <https://www.cdc.gov/homeandrecreationsafety/falls/adultfalls.html>

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## CONCLUSION

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With more than 67,460 local adults who are limited due to a physical, mental, and/or emotional problem in our Valley, we cannot ignore the issue of disability.

People with disabilities in the Coachella Valley have significantly lower income than those without, and are less able to meet their needs with the income they do have. Similarly, adults with disabilities are less likely to be able to work than their counterparts without disabilities. Thus, financial assistance is likely needed for many individuals with disabilities. Many of the access issues described below need to be offered for free or very low cost so that low-income people with disabilities can afford to utilize the services.

Accommodations need to be made for the thousands of local adults who are deaf/hard of hearing and/or blind/low vision. For example, when creating online content, local businesses should ensure that their websites are compatible with screen readers so that the content can be automatically read out loud to those who are blind/low-vision, and that any videos they post/share have captions for those who are deaf/hard of hearing. Organizations and businesses must be equipped to deal with these limitations, or risk missing thousands of local community members.

Results show that more than 1,070 local adults with disabilities need assistance with activities of daily living and are unable to get such assistance, and more than 2,080 are unable to get the help they need with instrumental activities of daily living. Nonprofits or healthcare organizations that can provide this assistance at low-or-no-cost will be important to closing this gap and getting everyone the help they need. Similarly, more than 3,630 local adults with disabilities are unable to get the special equipment that they need; systems to provide these equipment items would be very beneficial. Some local nonprofits already have informal systems, such as soliciting wheelchair donations and then distributing them to a waiting list of members who need one, but a more widespread and well-known program would be beneficial.

People with disabilities have significantly more difficulty with transportation than their counterparts without disabilities. In fact, transportation issues have made it difficult or impossible to receive necessary healthcare for nearly 14,000 people with disabilities in the past year. Programs and services that provide transportation for people with disabilities are crucial in our Valley. While some great options currently exist, such as SunLine Transportation's SunDial program, expanded transportation services are clearly needed to address this barrier.

Care providers working with people with disabilities must be prepared to deal with major disease issues, as people with disabilities are significantly more likely than people without disabilities to have been diagnosed with chronic illnesses. Some of these chronic illnesses, like arthritis, may cause disability, while others, like high blood pressure, may be caused by disabling conditions and/or the medication used to treat them.

Mental health issues disproportionately impact people with disabilities. It is important to note that some mental health issues may be the cause of disability (such as being limited in daily activities due to anxiety disorder) or the result of the disability (such as becoming depressed after

losing physical mobility). Regardless of the cause-and-effect, disability and mental health are closely intertwined, and anyone caring for and/or working with people with disabilities needs to be prepared to address mental health issues.

Nearly 1 in 3 adults with disabilities has been diagnosed with a depressive disorder, and more than 6,500 people with disabilities have seriously considered suicide in the past year. More than 7,000 adults with disabilities needed mental health care in the past year and could not get it. Thus, programs that provide low-to-no-cost mental health care and are specifically aimed at people living with disabilities would be very welcome. Additionally, given the transportation issues already mentioned, any efforts to bring such treatment to the person rather than requiring them to leave their home, such as telemedicine, would be welcomed.

Food insecurity is also more common for people with disabilities than those without—in fact, nearly 5,000 local adults with disabilities had to go for a whole day without eating due to lack of money to buy food in the past year. Thus, it is clear that food distribution programs, such as the senior markets offered by Hidden Harvest and the “Meals on Wheels” programs delivering meals to homebound seniors are critically important to addressing this need.

It is important to remember that sometimes disabilities can make an individual vulnerable to abuse. The rate of elder abuse for seniors with disabilities is significantly higher than the rate for seniors without disabilities. Caregivers, friends, neighbors, and relatives should be on the lookout for such issues among seniors who are living with a disability.

In sum, this report has highlighted many areas where people with disabilities have higher needs than people without disabilities. It is our hope that caregivers and service providers will take note of these disparities and be able to respond to them, given this information.