



Needs assessment on accessing health services for the Michigan I/DD Community

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Executive summary

The Center for Social Work Research implemented the needs assessment for the Michigan Developmental Disabilities Institute (MI-DDI) from August 2021 to January 2022. The needs assessment team developed an online survey based on stakeholder conversations and review of survey questions used in years prior. Snowball sampling and social media ads were used to distribute the survey throughout the state. Three-hundred and seventy-nine (379) respondents participated in the survey. Group interviews were facilitated with stakeholders to gather additional input.

Survey respondents came from all over Michigan. Some regions were overrepresented, such as Oakland County. Others, such as Macomb County, were under-represented. Respondents ranged in age from 18 to 92 years-old; the average age was 46 years-old. In terms of race and gender, a large majority of respondents identified as White and female. Participants provided their relationship to the intellectual and developmental disabilities (I/DD) community; the majority were family members, followed by providers, advocates, and then people with I/DD.

Respondents were asked to rate amount of need for a list of ten areas of wellness and health care. The areas queried were: annual physicals, dental care, getting enough sleep, getting healthy food, having time to exercise, hearing checks, screenings for chronic conditions, vaccinations, vision checks and women’s health exams. Overall, dental care, getting healthy food, and screenings for chronic conditions were most frequently indicated as an area with “a lot of need”.

There was some variation in how different roles perceived needs (person with I/DD, family of person with I/DD, provider of services to people with I/DD and/or their family, and policymakers or advocates). People with I/DD agreed with overall participants that dental care and getting healthy food were top needs, but they saw more need in vaccinations, vision checks, and hearing checks than need for screenings for chronic conditions.

Reporting of a ‘a lot of need’ appears in all regions of the state but there is some variation. Consistently reported as areas of ‘a lot of need’ are dental care, getting healthy food, vision checks, screening for chronic conditions, women’s health exams and annual physicals with primary caregivers.

Overall, respondents gave a picture of a community in need. There are systemic barriers to helping those with I/DD get prevention including being limited to Medicaid insurance and reliance on others to get to services and secure health food. Efforts to address these needs should focus developing strategies to overcome the barriers, as well as advocacy for policy change.

Methodology

- The Center for Social Work Research implemented the needs assessment from **August 2021 – January 2022**.
- Initial stages involved **conversations** with stakeholder groups. Stakeholder groups included: MI-DDI Community Advisory Committee (CAC) and staff, City of Detroit Office of Disability Affairs, and SAM members and board members.
- A **survey was developed** in Spring 2021 based on these conversations and the previous 2016 MI-DDI Needs Assessment Survey. The survey was reviewed by the MI-DDI CAC and MI-DDI staff.
- Snowball sampling was utilized by emailing a link to the online survey. A second link led to a page on MI-DDI's website, which gave instructions on how to complete the survey online or over the phone with an interviewer.
- The link was emailed to email lists from MI-DDI. In addition, links to the survey were posted on the Facebook pages of organizations across Michigan. The Needs Assessment team made personal contact with individuals who had connections with the I/DD community.
- After some preliminary data analysis, targeted Facebook ads were utilized to gather responses from underrepresented areas.
- Survey participants had the option of enrolling in a drawing in which six \$50 Target gift cards will be awarded.

- The survey remained open from October 19 – January 31, 2022. 379 valid respondents participated in the survey.
- In December 2021 and January 2022, **forums** were hosted with SAM and MI-DDI CAC. Discussion questions were based on preliminary findings from the survey.

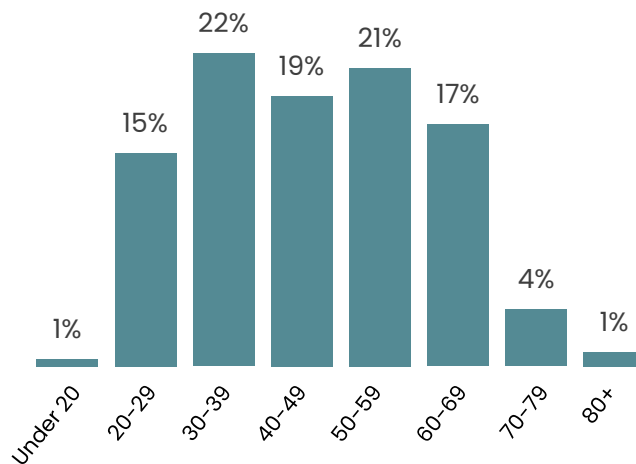
Demographics

Respondents were asked to provide their age, gender, race, and role in relationship to the I/DD community, and their zip Michigan workplace or residence zip code.

Age

Respondents were asked to provide their age. The average age of respondents was 46 and ranged from 18 to 92 years old. Examining **Figure 1** reveals the largest group of respondents fell between 30 and 39 years old (22%) with 50 to 59 and 40 to 49 coming close in second and third (21%; 19%). Few respondents were under 20 years old or 80 years old or more (2% total). The distribution of age among survey respondents was compared with the distribution of age of Michigan’s population. **Table 1** outlines the comparison. Most notably, the survey gathered more responses from 30 to 59 year olds (differences between 7% and 10%) when compared to Michigan’s population. To a lesser extent, the survey also gathered more responses from 20 to 29 year olds (1%) and 60 to 69 year olds (4%), and fewer responses from 70 to 79

Figure 1. Age Categories (N=297)



year olds (-4%) and 80 plus year olds (-3%). Note: the survey was available to individuals 18 years old and above. The State of Michigan does not provide data for population ages 18 to 20.

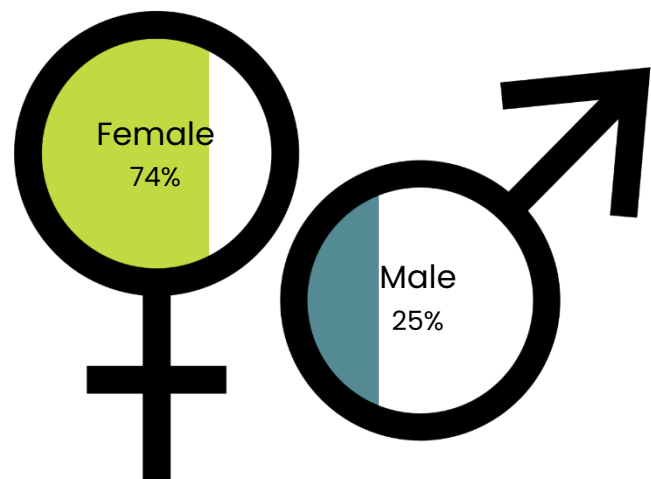
Table 1. Age comparisons between survey respondents and Michigan population

Age groups	Michigan population 2019 (N=9,986,857)	MI-DDI survey sample (N=297)	Diff. pop. & sample
Under 20	Not available*	1%	-
20 – 29	14%	15%	1%
30 – 39	12%	22%	10%
40 – 49	12%	19%	7%
50 – 59	13%	21%	8%
60 – 69	13%	17%	4%
70 – 79	8%	4%	-4%
80+	4%	1%	-3%
Total	100%*	100%	

Gender

Out of 300 survey respondents, the large majority identified as female (74%). On the flip side, less than one percent of respondents identified with each of the categories non-binary (.7%) and other unspecified (.3%), leaving 25% of respondents identifying as male. This is illustrated in **Figure 2** (note: non-binary and other unspecified are not included in Figure 2 due to their proportion not being large enough to visualize at such scale).

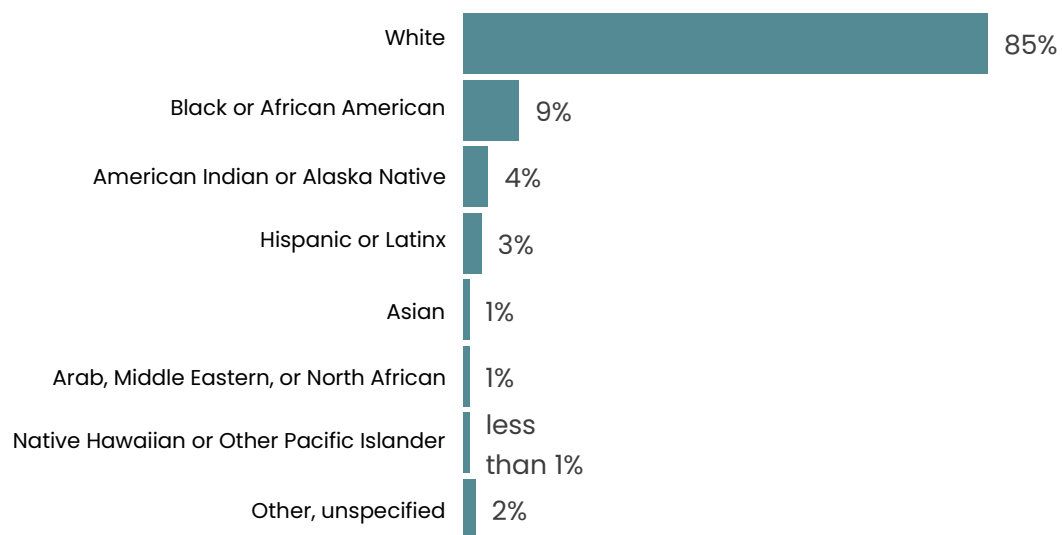
Figure 2: Binary gender (N=300)



The population of Michigan has almost an even split of individuals identifying as male or female (49%; 51%). Therefore, females were proportionately overrepresented in the survey sample. Note: The State of Michigan does not provide data for population identifying with a non-binary or other gender.

Race

Figure 3. Race categories
(N=302)*



*Multiple responses per person

The large majority of the survey sample identified as White (85%), followed by Black or African American (9%). Combined, the remaining groups comprise just over 10% of the respondents, as shown in **Figure 3**.

When compared to Michigan's population, the survey sample over represents individuals who identified as White by 10% and under represents individuals who identified as Black or African American by 5%. **Table 2** illustrates how the remaining races were evenly represented in the survey sample. Note: Survey respondents were asked to select one or more races.

Table 2. Race comparisons between survey respondents and Michigan population

Race (US Census categories)	Michigan population 2019 (N=9,986,857)	MI-DDI survey sample (N=316)	Diff. pop. & sample
White	75%	85%	10%
Black or African American	14%	9%	-5%
American Indian or Alaskan Native	1%	4%	3%
Hispanic or Latinx	5%	3%	-2%
Asian	3%	2%	-1%
Arab, Middle Eastern, or North African	Not available	1%	-
Native Hawaiian or Other Pacific Islander	0%	< 1%	< 1%
Other, unspecified	0%	2%	2%
Total	98%*	107%**	

*2% more than 1 race.

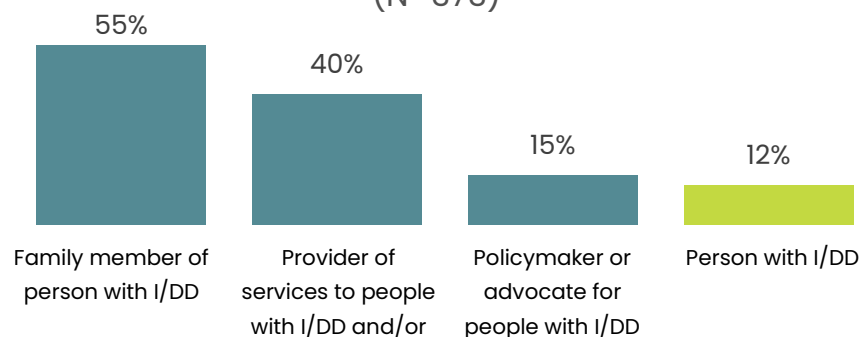
**Multiple responses per person

Role

Respondents were asked to provide their role in the I/DD community. Role options included a person with I/DD, a family member of a person with I/DD, a provider of services to people with I/DD and/or their families, or a policymaker or advocate for people with I/DD, and respondents were allowed to select more than one. The majority of respondents were family members of a person with I/DD (55%). **Figure 4** shows representation from each role.

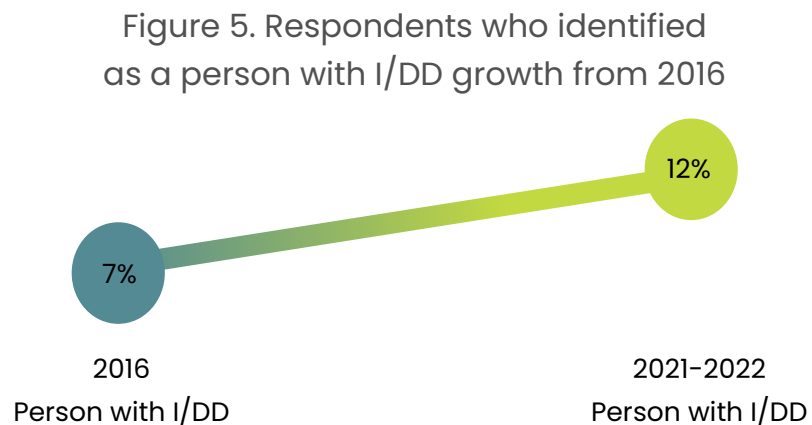
Figure 4. What is your relationship to the disability community?

(N=373)*



*Multiple responses per person

The goal was to increase the percentage of respondents with I/DD compared to that collected in the MI-DDI 2016 Needs Assessment, by any rate. In 2016, the rate

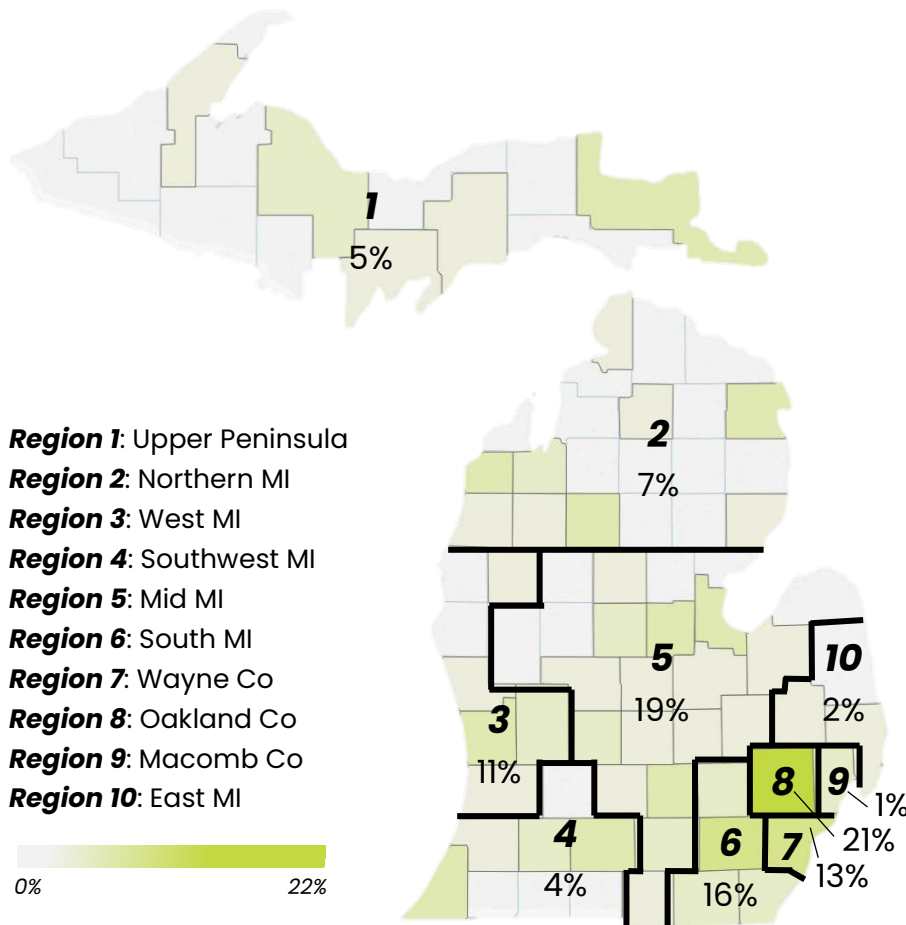


was 7% and in 2021-22, the rate went up to 12%, as shown in **Figure 5**. Efforts to reach this goal included continued outreach to self-advocacy groups and their networks, use of visual cues, attempts at setting reading level of survey below an 8th grade level, offering the survey via phone, and offering a small monetary incentive for survey facilitators. While exact impact of these efforts on the outcome is unknown, it is known that no individuals accessed the survey via phone and 29 surveys were facilitated by a secondary person.

Region

Respondents were asked to provide their Michigan zip code. Zip codes were mapped to determine where responses were coming from, then charted onto the Prepaid Inpatient Health Plan regions (PIHPs) devised by the Community Mental Health Association of Michigan (cite). PIHPs are “responsible for managing the Medicaid resources for behavioral health and intellectual/developmental disabilities services for Medicaid and Healthy Michigan enrollees” (Community Mental Health Association of Michigan, 2022). Response rate by county and region are mapped in **Figure 6**.

Figure 6. Responses by county and PIHP region (N=328)



Survey responses came from every PIHP region of the State. The majority of responses came from Region 8: Oakland County Community Mental Health Authority with Region 5: Mid-State Health Network close behind (21%; 19%).

Table 3 outlines response distribution from each region, as well as a comparison to Michigan’s population in each region. Overall, Region 6: Community Mental Health Partnership of Southeast Michigan and Region 8: Oakland County Community Mental Health Authority were most overrepresented (8% each), and Region 9: Macomb County Mental Health Services was most underrepresented (-8%) when compared to state population.

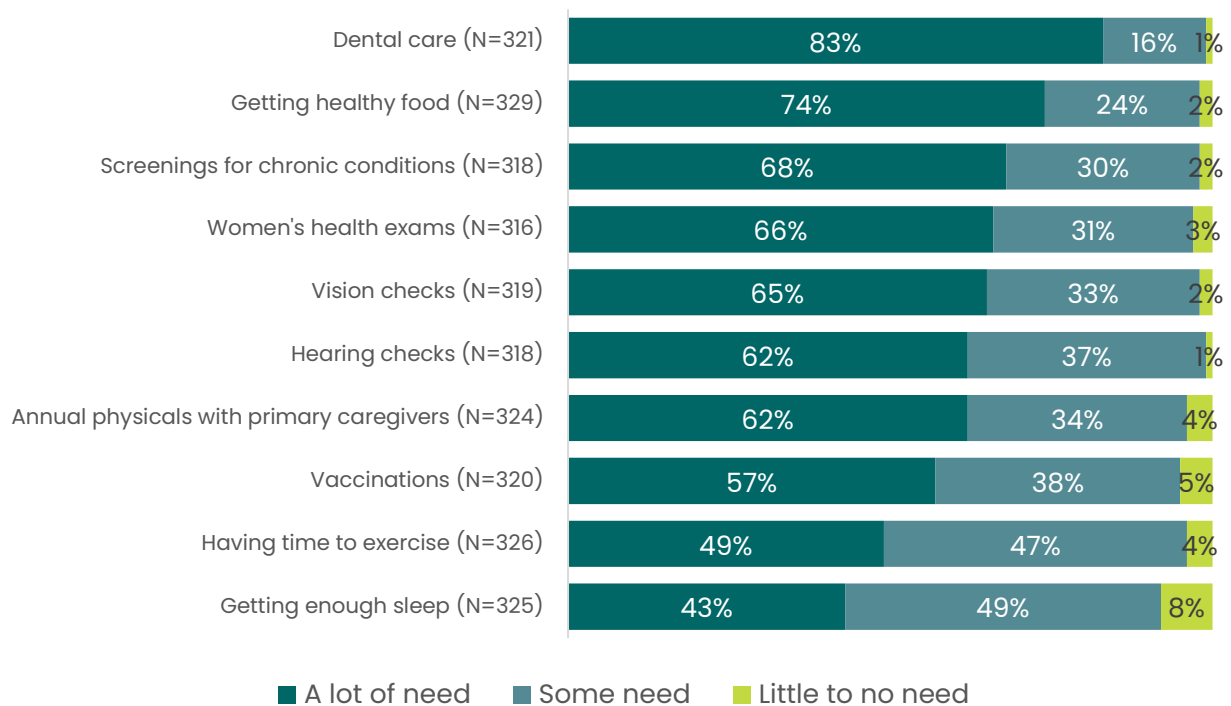
Table 3. Regional representation, comparison between survey respondents and Michigan population

PIHP Region	Michigan population 2019 (N=9,986,857)	MI-DDI survey sample (N=328)	Diff. pop. & sample
1: NorthCare Network	3%	5%	2%
2: Northern Michigan Regional Entity	5%	7%	2%
3: Lakeshore Regional Entity	13%	11%	-2%
4: Southwest Michigan Behavioral Health	8%	4%	-4%
5: Mid-State Health Network	16%	19%	3%
6: CMH Partnership of Southeast MI	8%	16%	8%
7: Detroit Wayne Mental Health Authority	18%	13%	-5%
8: Oakland County CMH Authority	13%	21%	8%
9: Macomb County Mental Health Services	9%	1%	-8%
10: Region 10	7%	2%	-5%
Total	100%	100%	

Areas of need

Respondents were asked to indicate how much need they thought people with I/DD have in different areas of wellness and health care services. **Figure 7** displays responses in order of greatest need. Eight out of the ten areas have over half of total responses indicating “a lot of need”. The top three areas of need were **dental care** (83%), **getting healthy food** (74%), and **screenings for chronic conditions** (68%). **Dental care** and **vision checks** had the greatest combined responses to “a lot of need” and “some need” (99%).

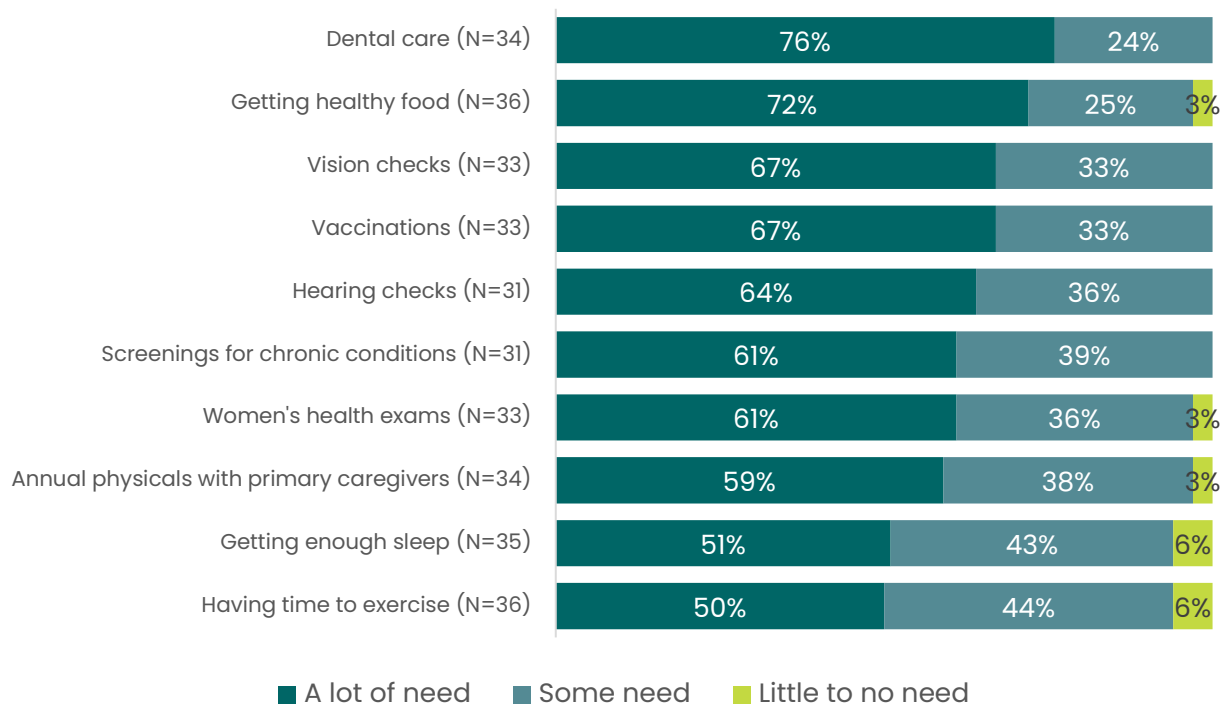
Figure 7. “How much need do you think people with I/DD have for the following wellness or health care areas?”



Areas of need for people with I/DD

Areas of need were analyzed by role in the I/DD community (person with I/DD, family member of a person with I/DD, provider of services to people with I/DD and/or their family, and/or policy maker or advocate for people with I/DD). Needs for people with I/DD are shown in **Figure 8**. Compared to participants overall, people with I/DD expressed greater need in different areas. While both participants overall and those with I/DD indicated **dental care** as the area with greatest need (83% overall, 76% people with I/DD) and **getting healthy food** as the area with second greatest need (74% overall, 72% people with I/DD), people with I/DD indicated **vision checks** and **vaccinations** as the areas with the next greatest need (67% each). **Dental care, vision checks, vaccinations, hearing checks, and screenings for chronic illnesses** had the greatest combined responses to “a lot of need” and “some need” (100%).

Figure 8. Role: People with I/DD
 “How much need do you think people with I/DD have for the following wellness or health care areas?”



Wellness areas

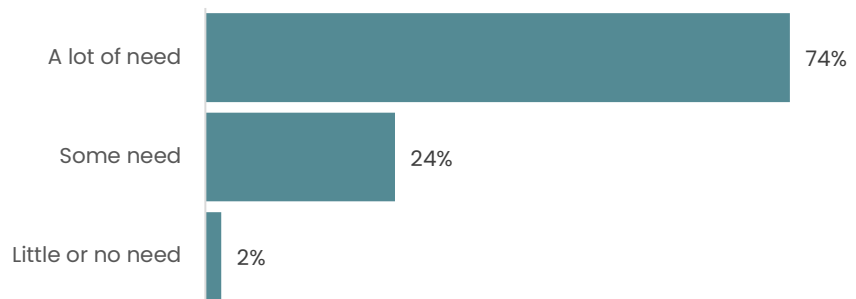
Survey participants were asked to indicate how much need they thought people with I/DD had for three different areas of wellness: Getting healthy food, having time to exercise, and getting enough sleep.

Getting healthy food

Figure 9 shows need related to the wellness area, **getting healthy food**.

A large majority of respondents saw “a lot of need” in this area (74%). Just 2% of respondents saw “little or no need”.

Figure 9. How much need do you think people with I/DD have for *getting healthy food*? (N=329)



Getting healthy food by role

When compared by role in the I/DD community, family members had the largest response rate in “a lot of need” (74%) and providers had the lowest (70%). Responses from people with I/DD were similar to those in other roles, as shown in **Table 4**.

Table 4. Need for getting healthy food by role in the I/DD community

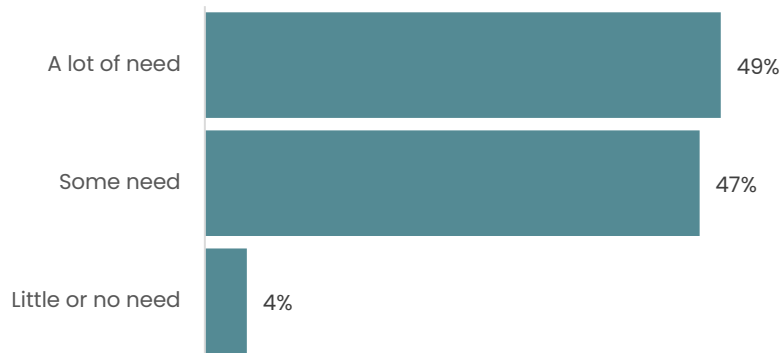
Role	A lot of need	Some need	Little or no need
Person with I/DD (N=36)	72%	25%	3%
Family of person with I/DD (N=181)	74%	25%	2%
Provider of services to people with I/DD and/or their family (N=133)	70%	28%	2%
Policymaker or advocate for people with I/DD (N=51)	71%	28%	2%

Having time to exercise

Figure 10 shows need related to **having time to exercise**.

Most respondents (49%) indicated “a lot of need” in this wellness area, though “some need” followed closely behind (47%). A small amount of respondents (4%) indicated “little or no need”.

Figure 10. How much need do you think people with I/DD have for *having time to exercise*? (N=326)



Having time to exercise by role

There was some variation in responses when looked at by role in the I/DD community, as shown in **Table 5**. Responses from people with I/DD, family, and advocates were similar with “a lot of need” ranging from 51% to 49%. However, providers saw less need in this area with only 40% of providers indicating “a lot of need” and “some need” receiving the largest response (55%).

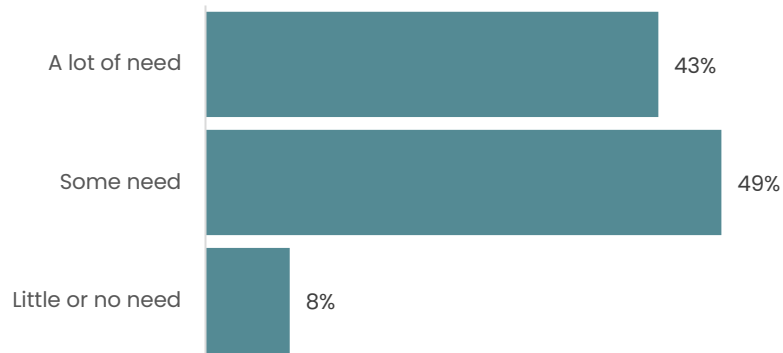
Table 5. Need for having time to exercise by role in the I/DD community

Role	A lot of need	Some need	Little or no need
Person with I/DD (N=36)	50%	44%	6%
Family of person with I/DD (N=178)	50%	45%	5%
Provider of services to people with I/DD and/or their family (N=134)	40%	55%	5%
Policymaker or advocate for people with I/DD (N=49)	49%	47%	4%

Getting enough sleep

Figure 11 shows need related to the wellness area, **getting enough sleep**. When compared to the other nine areas of health and wellness, this is the only area that sees “some need” with the highest response rate (49%), as opposed to “a lot of need” (43%) This category also had the highest rate of “little or no need” response (8%).

Figure 11. How much need do you think people with I/DD have for *getting enough sleep*? (N=325)



Getting enough sleep by role

Responses varied when split by role, as shown in **Table 6**. Compared to other roles, people with I/DD had the highest response rate in “a lot of need” (51%), followed by advocates (50%).

Table 6. Need for getting enough sleep by role in the I/DD community

Role	A lot of need	Some need	Little or no need
Person with I/DD (N=35)	51%	43%	6%
Family of person with I/DD (N=179)	41%	51%	8%
Provider of services to people with I/DD and/or their family (N=132)	37%	54%	9%
Policymaker or advocate for people with I/DD (N=50)	50%	40%	10%

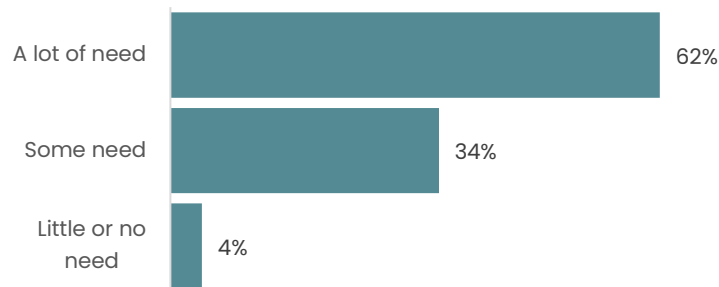
Health care services

Survey participants were asked to indicate how much need they thought people with I/DD had for seven health care services: Annual physicals with primary care provider, women’s health exams, dental care, vision checks, hearing checks, screenings for chronic conditions, and vaccinations.

Annual physicals with primary care provider

Figure 12 shows need related to **annual physicals with primary care provider**. Most respondents saw “a lot of need” in this area (62%) followed by “some need” (34%), then “little or no need” (4%).

Figure 12. How much need do you think people with I/DD have for *annual physicals with primary care provider?* (N=324)



Annual physicals with primary care providers by role

Table 7 shows variation in responses when split by role. Interestingly, family and advocates saw more need in this area (64% and 72% “a lot of need”, respectively) than people with I/DD and service providers saw less (59% and 57% “a lot of need”, respectively).

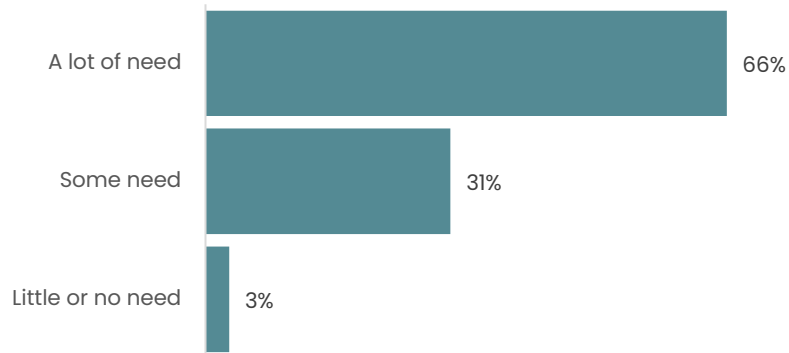
Table 7. Need for annual physical by primary care provider by role in the I/DD community

Role	A lot of need	Some need	Little or no need
Person with I/DD (N=34)	59%	38%	3%
Family of person with I/DD (N=179)	64%	32%	4%
Provider of services to people with I/DD and/or their family (N=132)	57%	38%	5%
Policymaker or advocate for people with I/DD (N=51)	72%	22%	6%

Women’s health exams

Figure 13 shows need related to **women’s health exams** (such as pelvic exams and breast screenings). Similar to other areas, the majority of respondents indicated “a lot of need” for women’s health exams. Just 3% of respondents indicated “little or no need”.

Figure 13. How much need do you think people with I/DD have for *women’s health exams*? (N=316)



Women’s health exams by role

Table 8 shows responses from people with I/DD, family, and service providers were similar with “a lot of need” ranging from 61% to 69%. Interestingly, a larger majority of advocates (82%) saw “a lot of need” for women’s health exams. However, responses of “little or no need” were similar in all roles, ranging from 2% to 4%.

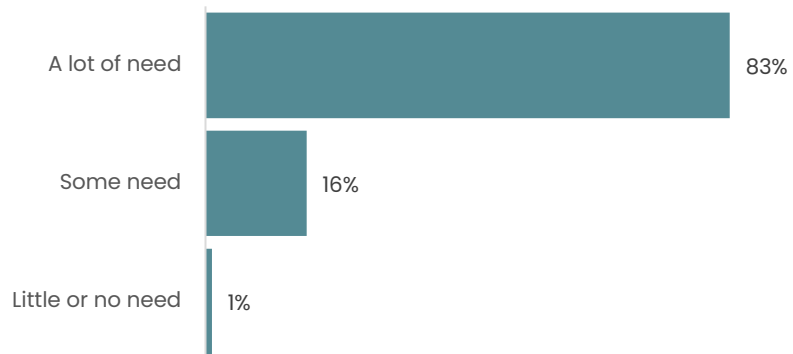
Table 8. Need for women’s health exams by role in the I/DD community

Role	A lot of need	Some need	Little or no need
Person with I/DD (N=33)	61%	36%	3%
Family of person with I/DD (N=173)	69%	27%	4%
Provider of services to people with I/DD and/or their family (N=131)	63%	34%	2%
Policymaker or advocate for people with I/DD (N=49)	82%	14%	4%

Dental care

Figure 14 shows need related to **dental care**. The majority of respondents saw “a lot of need” for this health care service (83%) with just 1% indicating “little or no need”. Amongst all health care and wellness areas, dental care had the highest “a lot of need” response.

Figure 14. How much need do you think people with I/DD have for *dental care*? (N=321)



Dental care by role

Table 9 shows responses to the need for dental care indicated by role. Only family members gave a response of “little or no need”, though it was just 1%. Compared to other roles, advocates thought there was the most need (88% “a lot of need”), followed by family members (84%), service providers (83%), then people with I/DD (76%).

Table 9. Need for dental care by role in the I/DD community

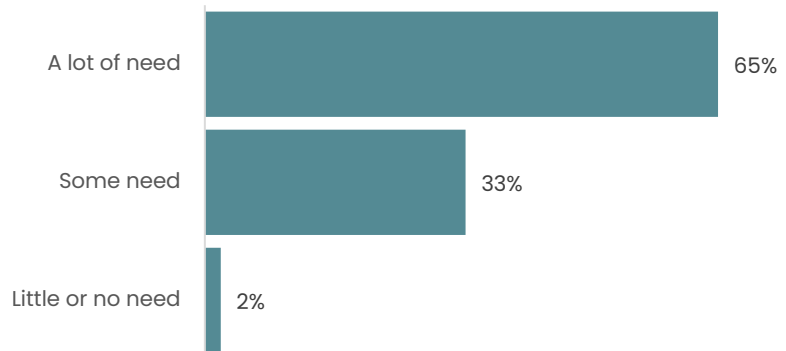
Role	A lot of need	Some need	Little or no need
Person with I/DD (N=34)	76%	24%	0%
Family of person with I/DD (N=176)	84%	15%	1%
Provider of services to people with I/DD and/or their family (N=132)	83%	17%	0%
Policymaker or advocate for people with I/DD	88%	12%	0%

Vision checks

Figure 15 shows need related to **vision checks**.

The majority of respondents indicated people with I/DD had “a lot of need” for this service (65%). Just 2% of respondents indicated “little or no need” for vision checks.

Figure 15. How much need do you think people with I/DD have for *vision checks*? (N=319)



Vision checks by role

Compared to the other roles in the in the I/DD community, people with I/DD were the only group to indicate a 100% combined response of “a lot of need” and “some need”, as shown in **Table 10**. However, family members had the highest “a lot of need” response (69%), followed by people with I/DD (67%), advocates (65%), then service providers (60%).

Table 10. Need for vision checks by role in the I/DD community

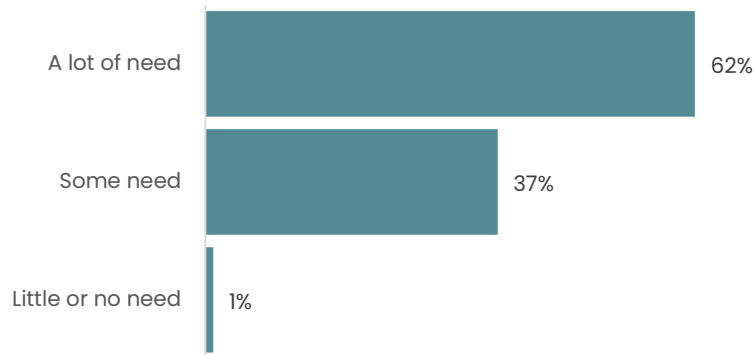
Role	A lot of need	Some need	Little or no need
Person with I/DD (N=33)	67%	33%	0%
Family of person with I/DD (N=176)	68%	30%	2%
Provider of services to people with I/DD and/or their family (N=131)	60%	36%	4%
Policymaker or advocate for people with I/DD (N=49)	65%	31%	4%

Hearing checks

Figure 16 shows need related to **hearing checks**.

Variation in distribution of responses was similar to that in other areas with “a lot of need” receiving 62% of responses and “little to no need” just 1% of responses.

Figure 16. How much need do you think people with I/DD have for *hearing checks*? (N=318)



Hearing checks by role

Similar to vision checks, compared to the other roles in the in the I/DD community, people with I/DD were the only group to indicate a 100% combined response of “a lot of need” and “some need”. **Table 11** shows people with I/DD and family members had the greatest response rate to “a lot of need” (64%), followed by advocates (61%), then service providers (57%).

Table 11. Need for hearing checks by role in the I/DD community

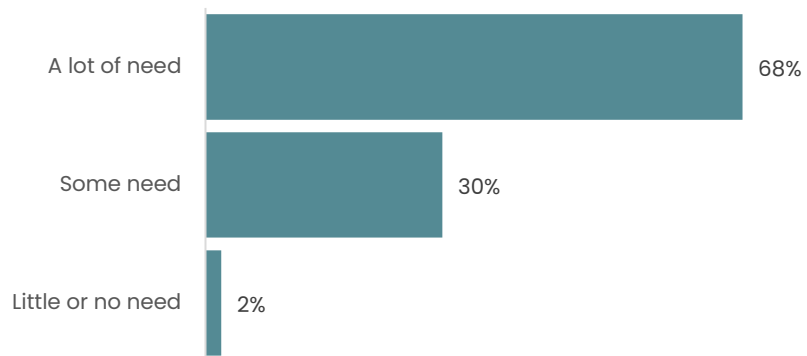
Role	A lot of need	Some need	Little or no need
Person with I/DD (N=31)	64%	36%	0%
Family of person with I/DD (N=177)	64%	35%	1%
Provider of services to people with I/DD and/or their family (N=130)	57%	40%	3%
Policymaker or advocate for people with I/DD (N=49)	61%	35%	4%

Screenings for chronic conditions

Figure 17 shows need related to **Screenings for chronic conditions**.

The majority of respondents (68%) indicated people with I/DD had “a lot of need” for this health care service, followed by “some need” (30%), and “little or no need (2%).

Figure 17. How much need do you think people with I/DD have for screenings for chronic conditions? (N=318)



Screenings for chronic conditions by role

Some variation in responses was seen when split by role in the I/DD community, as shown in **Table 12**. People with I/DD were the only group to indicate a 100% combined response of “a lot of need” and “some need”. However, advocates had the highest “a lot of need” response (74%) followed by family (69%), service providers (67%), then people with I/DD with the lowest “a lot of need” response (61%).

Table 12. Need for screenings for chronic conditions by role in the I/DD community

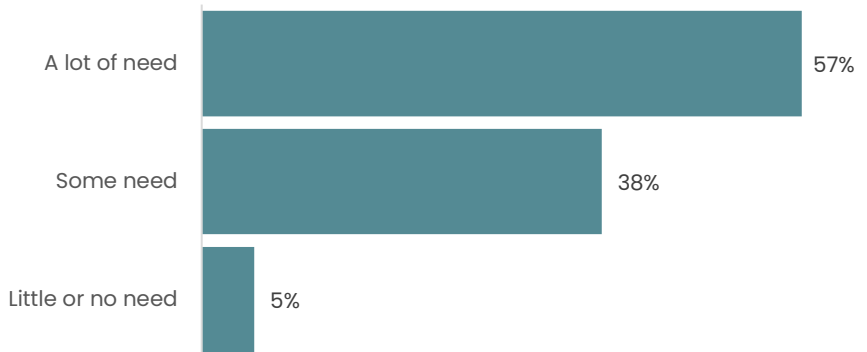
Role	A lot of need	Some need	Little or no need
Person with I/DD (N=31)	61%	39%	0%
Family of person with I/DD (N=176)	69%	29%	2%
Provider of services to people with I/DD and/or their family (N=131)	67%	31%	2%
Policymaker or advocate for people with I/DD (N=50)	74%	22%	4%

Vaccinations

Figure 18 shows need related to **vaccinations**.

This service had the second highest “little or no need” response compared to the nine other wellness areas and health care services (5%; getting enough sleep has the highest at 8%). Fifty-seven percent of respondents indicated “a lot of need” and 38% indicated “some need”.

Figure 18. How much need do you think people with I/DD have for *vaccinations*? (N=320)



Vaccinations by role

Table 13 shows some variation in responses when split by role. Similar to other categories, people with I/DD were the only group to indicate a 100% combined response of “a lot of need” and “some need”. In this case, they also had the highest rate of “a lot of need” responses (67%) followed closely by advocates (66%), family members (57%), then service providers (49%).

Table 13. Need for vaccinations by role in the I/DD community

Role	A lot of need	Some need	Little or no need
Person with I/DD (N=33)	67%	33%	0%
Family of person with I/DD (N=176)	57%	36%	6%
Provider of services to people with I/DD and/or their family (N=131)	49%	46%	5%
Policymaker or advocate for people with I/DD (N=50)	66%	28%	6%

Differences by region

Differences in perceived needs was examined by regions of the State of Michigan. For this analysis, regions were combined to make six different areas. Figures 19 through 24 present perception of need by grouped regions of the State of Michigan. Most areas are identified by many respondents as areas of a lot of need. The highest percentage of respondents in every region identified dental care as an area of a lot of need. This was followed by getting healthy food. Other areas where many respondents reported a lot of need include: vision checks, screening for chronic conditions, women’s health exams and annual physicals.

Figure 19 “How much need do you think people with I/DD have for the following wellness or health care areas?”

Northern MI and Upper Peninsula (PIHP regions 1 and 2)

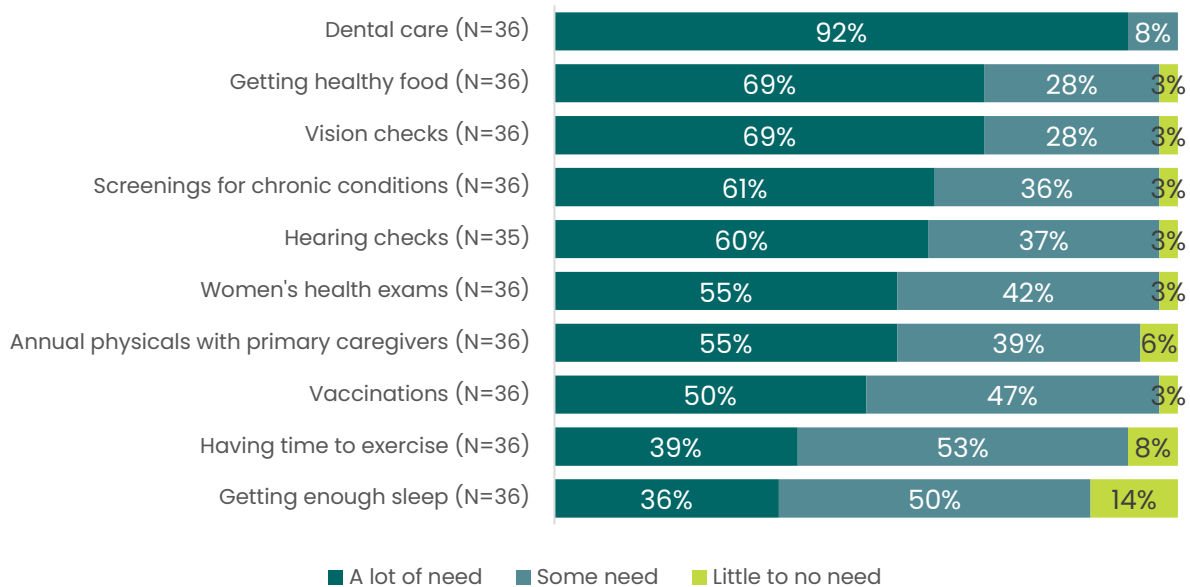


Figure 21. “How much need do you think people with I/DD have for the following wellness or health care areas?”

West MI (PIHP regions 3 and 4)

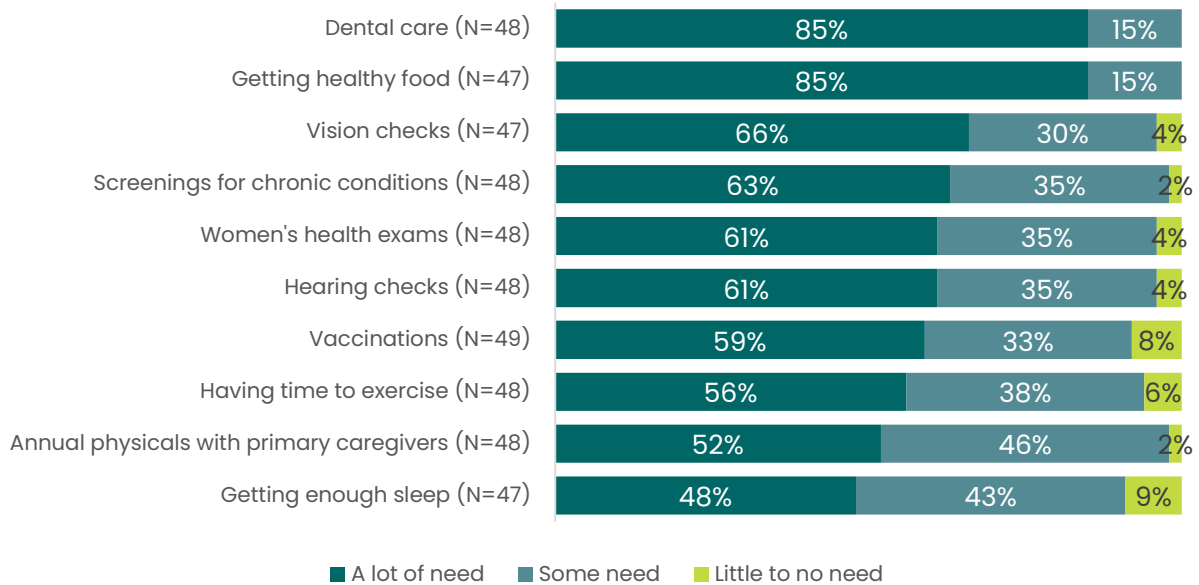


Figure 20. “How much need do you think people with I/DD have for the following wellness or health care areas?”

Middle MI (PIHP regions 5 and 10)

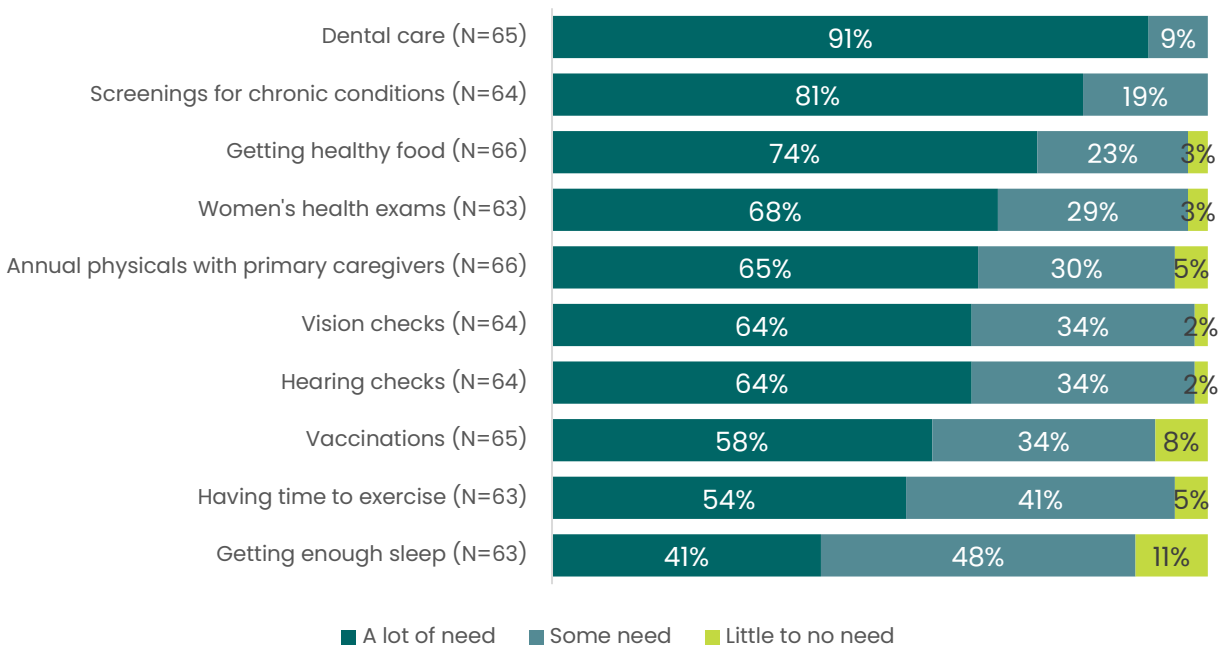


Figure 22. “How much need do you think people with I/DD have for the following wellness or health care areas?”

Wayne County, MI (PIHIP region 7)

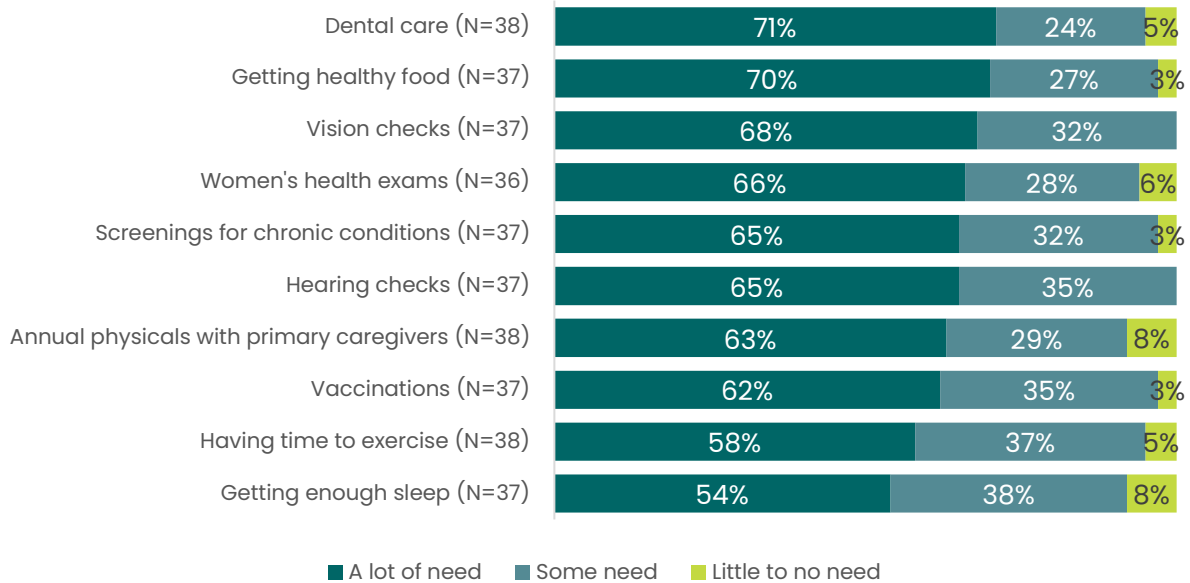


Figure 23. “How much need do you think people with I/DD have for the following wellness or health care areas?”

Oakland and Macomb counties, MI (PIHP regions 8 and 9)

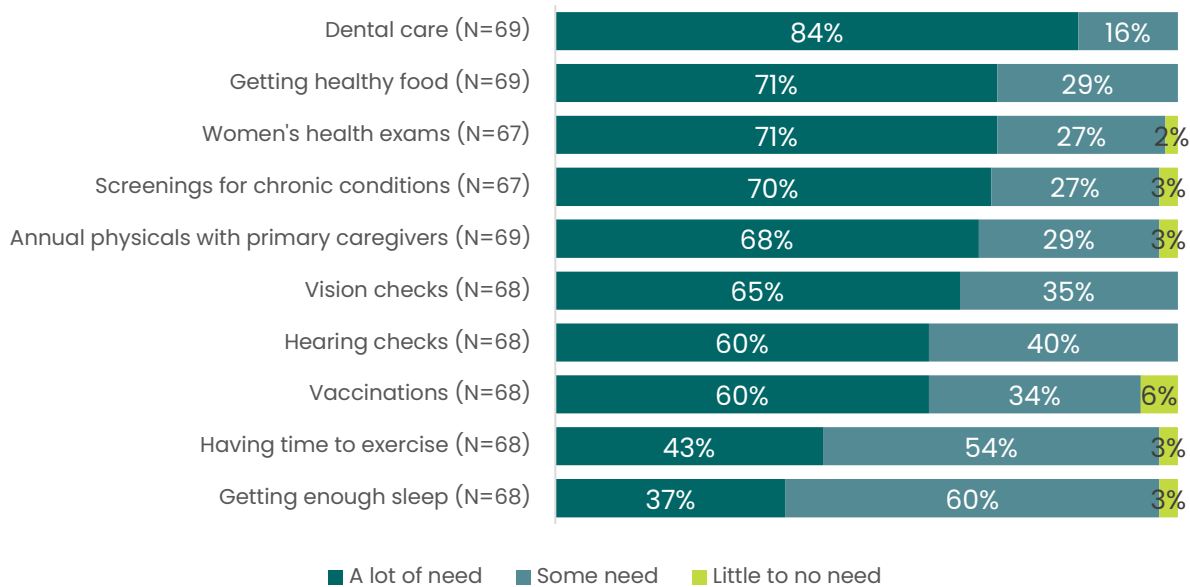
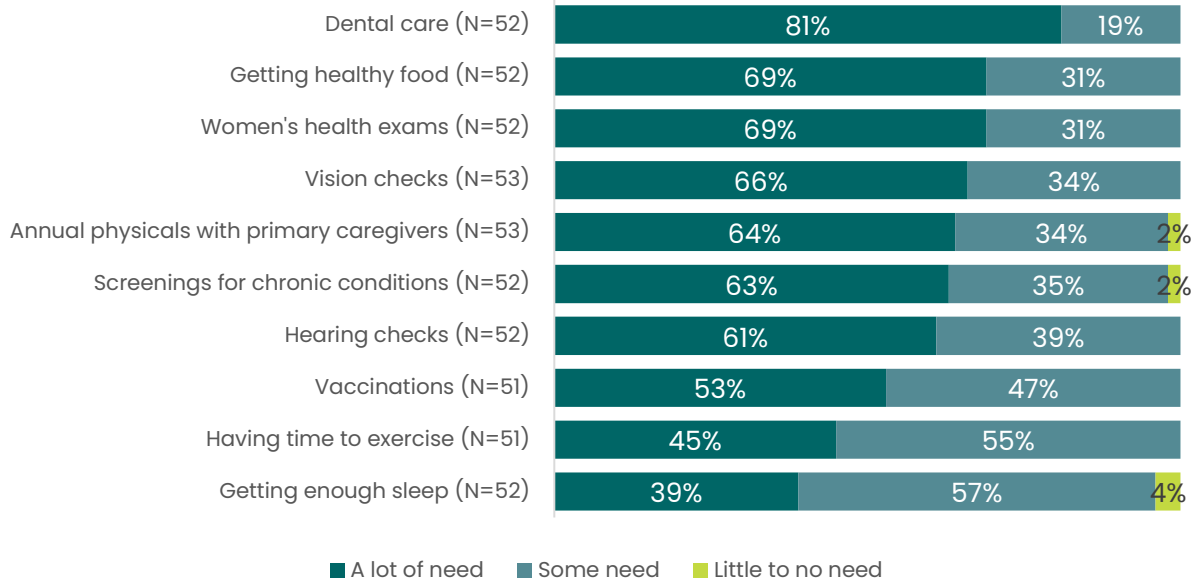


Figure 24. “How much need do you think people with I/DD have for the following wellness or health care areas?”

South MI (PIHP region 6)



Discussion

Areas of need were analyzed by role in the I/DD community (person with I/DD), family member or provider of services to people with I/DD or their family and/or policy maker or advocate for people with I/DD. This section of the report focused on the top priority health care needs identified by people with I/DD. Those included, dental care, vision checks, vaccinations, hearing checks, and screenings for chronic illnesses.

Dental care was identified as an area of great need by people with I/DD (76%). One explanation for this need is the well documented on-going issue of the lack of Michigan dentists that accept Medicaid for payment of services. Most people with I/DD have limited private insurance options and are relegated to Medicaid providers or private pay options. This results in long waiting lists for routine oral exams including teeth cleaning. There are only a few hospitals that offer sedation dentistry which is required for some people with I/DD for the treatment of dental conditions. People with Medicare insurance, have more provider choices, but can still incur high out of pocket costs. The lack of dental preventive care can result in other serious health care problems for people with I/DD including loss of teeth, periodontal disease and untreated infections. Because some individuals with I/DD cannot talk, or articulate the source of their pain, this lack of preventative care can result in more serious painful health conditions, which may have been avoided by regular, dental exams.

Access to healthy food was the second greatest identified area of need by people with I/DD. The MDHHS sponsors the MI-BRIDGES food stamps program for eligible Michigan residents. The Double Up program allows Bridge Card users to have their fruit and vegetable purchases matched dollar for dollar, up to \$20 a day. Double up can be used at grocery stores and farmer's markets and can increase healthy food options for Bridge card recipients.

Another issue with accessing healthy food is the reliance that people with I/DD have on other people to purchase and prepare their food. In addition to financial limitations and inflation, access to healthy food is further compounded by people with I/DD's inability to choose and prepare their own food.

Vision checks was also identified as a high area of health need by people with I/DD (67%). An explanation for this finding may be that many optometrists do not accept Medicaid for payment of their services. Locating an eye clinic that accepts Medicaid payment can be challenging and limited to geographic areas of the state. This results in waiting lists for people needing preventive screenings for corrective lenses and screening for eye disease, like glaucoma and diabetes.

Some progress may have been made since this survey was conducted in the area of vaccination availability for people with I/DD and chronic disease screening. The Michigan Vaccination Partners Project (MVP) led by the Michigan Developmental Disabilities Institute is sponsoring community events, to promote vaccinations, and preventative health screenings. These free events are a collaboration with the Wayne State University Medical School Mobile Health Unit, the Brain Injury Association of Michigan, the Autism Alliance of Michigan, and Disability Rights of Michigan. The goal of the project, sponsored by the MDHHS is to ensure that people with I/DD, their family and caregivers have access to free vaccinations and chronic health care screenings.

Hearing checks, like dental and vision care are rarely a Medicaid covered service. This means there are limited availability to audiologists who accept insurance most often carried by people with I/DD. Exacerbated by the fact that many people with I/DD have communication challenges, hearing loss can lead to social isolation, and quality of life outcomes.

People with I/DD and their caregivers need more information about MI-Bridges food stamp programs. People with I/DD are known to develop co-

morbidities related to lifestyle choices and dietary habits (Naaldenberg, et al, 2013). There is a 27% to 59% prevalence of obesity in adults with I/DD in the United States (Yamaki 2005; Rimmer and Yamake 2006; Hsieh et al 2014). Obesity is a risk factor for many health conditions including coronary heart disease, Type 2 diabetes, and high blood pressure (Centers for Disease control and Prevention, 2019). The MDHHS was recently selected by the Governor to be a pilot agency to promote a promising area of intervention with the Food Assistance Program to reduce disparities to Hispanics, and individuals with a visual disabilities. This pilot may also positively impact the food assistance programs used by people with I/DD and their caregivers.

Unfortunately, dental, vision, and hearing screening and treatment options are challenged by limited ability for people with I/DD to pay for these services. Medicaid has had long standing policies that prohibits or limits payment to cover these preventative health care services. Options, include locating service providers that will accept Medicaid, or providers that do a percentage of pro bono work in their communities. Access to these services at hospitals, is another option for people with IDD. There are waiting lists for these healthcare services, and it can take months for appointments.

Access to chronic health care screening and vaccinations may improve due to more community-based health care clinics because these programs meet people in the places where they live. Health promotion programs are a critical community service but especially important to people with I/DD. Health promotion is defined as the process of enabling people to increase control over the determinants of health and thereby improve their own health (WHO, 1998). It is important to build health promotion programs and services that are accessible to all people living in our communities. Health care prevention and improved access to health promotion services can mitigate serious health complications and even death.

Conclusion

Survey respondents reported an overall picture of a community in need of wellness and health care services. Almost all the areas were cited by many respondents as areas of ‘a lot of need’. Fifty percent or more of respondents with an I/DD reported a lot of need in every area queried.

Over two-thirds of respondents who identified as a person with I/DD identified the following as an area of ‘a lot of need’: dental care, getting health food, vision checks, vaccinations, and hearing checks. Well over half of them identified the following as an area of ‘a lot of need’: screening for chronic conditions, women’s health exams, and annual physicals with a primary caregiver. When we combine ‘a lot of need’ and ‘some’ need, almost all respondents with I/DD report needed access to the areas of healthcare on the survey.

There were not major differences with others in the I/DD community which included family members, service providers and policy makers. Greater than two-thirds of respondents in these other groups rated the following as areas of ‘a lot of need’: dental care, getting healthy food, screening for chronic conditions, and women’s health exams.

Reporting of a ‘a lot of need’ appears in all regions of the state but there is some variation. Consistently reported as areas of ‘a lot of need’ are dental care, getting healthy food, vision checks, screening for chronic conditions, women’s health exams and annual physicals with primary caregivers.

Overall, we are seeing areas of need particularly in the preventative services and actions. Dental care is consistently rated as an area of ‘a lot’ of need. Lack of wellness care and prevention services contribute to health disparities. From what the respondents have reported in this survey, many of these services are areas of high need.

Overall, the needs are great and are related to different ways that people with I/DD can engage in wellness and prevention care. The Michigan Department of Health and Human Services has plenty of opportunity to make a difference in these areas. Prioritizing efforts based on successful partnerships and expertise will likely contribute to success.

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