AUDIENCE PROFILE: PEOPLE WITH DISABILITIES

71%

71% of people with disabilities – have non-visible disabilities such as a learning or cognitive disability.

56.7M

Persons with disabilities make up 19% of the nation's total population.

States with the highest percentages of people with disabilities are in the southern U.S. and Maine and Oregon.

In order to successfully engage your target audience, you must have a clear understanding of their culture, beliefs and barriers to health. This audience profile includes information about the nuances that need to be considered when reaching people with disabilities, based on the review of various research studies and also taking into consideration lessons learned through past experiences working with this group. This document is not an in-depth research report or analysis, as it is meant to help you have a general understanding of different factors that may affect your audience's availability, interest and/or commitment to your program. Use the questions listed at the end of this profile to validate and expand on the information provided for your local program's market.

Understanding People With Disabilities

According to the U.S. Census, in 2010, about 56.7 million people — 19 percent of the population — had a disability, according to a broad definition of disability. People with disabilities include individuals of all ages, genders, ethnicities, geography, education, employment and income levels.

There are three key pieces of disability regulation that support people with disabilities:

- Americans with Disabilities Act – ADA (2008/1990)
- Individuals with Disabilities Educational Act – IDEA (2004/1975)
- The Rehabilitation Act (1973)

Statistics

Census data added that more than half of the audience with disabilities reported having a disability that was severe. The report shows that 41 percent of those age 21 to 64 with any disability were employed, compared with 79 percent of those with no disability. Along with the lower likelihood of having a job came the higher likelihood of experiencing persistent poverty; that is, continuous poverty over a 24-month period. Among people age 15 to 64 with severe disabilities, 10.8 percent experienced persistent poverty; the same was true for 4.9 percent of those with a non-severe disability and 3.8 percent of those with no disability. (1)

According to the American Community Survey (ACS), the percent of people with disabilities varies greatly by state, as do levels of people with disabilities in employment, poverty, earnings, and health behaviors. (2)

For adults ages 18-64, the ACS reports that the highest percentages of people with disabilities were in states in the southern US from Oklahoma to West Virginia, and also Maine and Oregon. The percentage was lowest in Hawaii and New Jersey (7.7 percent) and more than twice as high in West Virginia (16.9 percent). (2)

Visit SharePoint to access research studies about people with disabilities.

Types of Disability

The ACS asks about six types of disability: vision, hearing, cognitive, ambulatory, self-care, and independent living:

- **Hearing difficulty:** deaf or having serious difficulty hearing
- **Vision difficulty:** blind or having serious difficulty seeing, even when wearing glasses
- **Cognitive difficulty:** Because of a physical, mental, or emotional problem, having difficulty remembering, concentrating, or making decisions
- **Ambulatory difficulty:** Having serious difficulty walking or climbing stairs
- **Self-care difficulty:** Having difficulty bathing or dressing
- **Independent living difficulty:** Because of a physical, mental, or emotional problem, having difficulty doing errands alone such as visiting a doctor's office or shopping

From 2008 to 2015, the percentages of people with each type of disability have remained relatively unchanged. (2)

Characteristics and Cultural Understanding

When talking about people with disabilities we do not refer exclusively to wheelchair users, Braille readers and sign language gurus. Individuals with visible disabilities constitute fewer than 29 percent of people with disabilities. The vast majority – 71 percent of people with disabilities – have non-visible disabilities such as a learning or cognitive disability. Those with visible disabilities and those with non-visible disabilities have different identities depending on whether their disability is readily evident. (4)

Each person is unique—even if he or she identifies with a disability category. A person who may become blind at age 40 will not have the same life experience and perspectives as someone who was born without sight. You must recognize each person's individual journey. Similarly, each person relates to their disability differently than others. Some may relate more to their gender, ethnicity or age—over their disability.

Disability begins with identity. An individual with a learning disability may not be deemed 'medically disabled', but having to develop alternative methods for interacting with the external environment may cause them to develop an internal identity as having a disability. The 'tag' of disability, rooted in medical terms for the last two centuries, is a matter of self-perception. Identity is key, as it impacts the relationship between individuals, brands and organizations as customers and employees. (4)

Over the last few decades, we have seen people with disabilities move from a marginalized and isolated population to one that is more engaged through education, employment and access. The Americans with Disabilities Act of 1990 improved access even more, as it prohibits discrimination on the basis of disability in employment, State and local government programs, public accommodations, transportation and communication. It also set minimum standards for accessibility of the built environment. The definition of disability has seen an evolution as well with the rise of what is known as the Social Model of Disability. Rather than identifying disability as something internal to an individual, this identifies it as something that takes place when an environment does not support an individual's limited function.

In terms of socioeconomic status, individuals with disabilities are less likely to be employed, more likely to have low household incomes, and more likely to be dependent on federal and state-funded health insurance programs such as Medicare and Medicaid than those without disabilities. (5)

Companies that understand the needs of people with disabilities; are inclusive in messaging, images and actions; and organizations that are authentic in their approach win the regular and repeated business of people with disabilities and their networks.

It is important to keep in mind that people with disabilities can still be healthy, as long as they are in the right environment and have the right resources and programs at their disposal.

Economic Implications

Employment and Income

In 2015, 34.9 percent of people with disabilities in the US ages 18-64 living in the community were employed compared to 76.0 percent for people without disabilities - a gap of 41.1 percentage points. The employment gap between those with a disability and those without has widened steadily over the past 8 years from 38.8 to 41.1 percentage points. There is state variation in the rates of employment for people with disabilities, from a high of 57.1 percent in Wyoming to a low of 25.4 percent in West Virginia; for

people without disabilities, state employment rates ranged from a high of 83.8 percent in Minnesota to a low of 70.1 percent in Mississippi. (2)

Employment rates vary by type of disability. Employment rates are highest for people with hearing (51.0 percent) and vision disabilities (41.8 percent) and lowest for people with self-care (15.6 percent) and independent living disabilities (16.4 percent). (2)

Employment and employability affects the annual earning for people with disabilities. More than one in five (21.2 percent) US civilians with disabilities of working-age in 2015 were living in poverty. For US civilians of working-age without disabilities, the national poverty rate was 13.8 percent. (2)

Health Implications

In 2015, the US obesity rate for people with disabilities was 39.9 percent. For people without disabilities, the obesity rate was 25.4 percent. 2015 showed the first year-to-year drop in obesity gap since 2009 between the percentages of obesity for people with and without disabilities. (2)

Smoking and binge drinking also are of great concern and prevalent within the disability community—often as a result of isolationism and boredom.

People with disabilities report fewer healthy days than the general population and lower rates of health promoting behaviors (e.g., physical inactivity and poor nutritional intake). One of the major priorities in health promotion for people with disabilities is to prevent secondary conditions. (3)

People with disabilities are often concerned about secondary conditions. Secondary conditions describe conditions that were related to a primary disability or had a substantially higher prevalence in people with disabilities compared with the general population. Associated conditions are certain aspects or features of the disability and are a direct result of the primary disability. (3)

Health Behavior and Information Seeking

Communication networks, such as online bloggers and social influencers share information across disability communities. Word of mouth communication with testimonials offer the greatest opportunities for promotion.

Persons with disabilities often face a plethora of medical, behavioral and other appointments. Health information is driven by access and health insurance. Depending on an individual's personal finances, insurance coverage and availability and accessibility of health care services, health outcomes may vary.

The Internet is a particularly valuable health information resource for people with physical disabilities due to the challenges of traditional information sources (e.g., physician office). Compared to other Internet users, users who have a disability are more likely to search online health information and their medical treatment decisions are more likely to be influenced by the information. Specifically, 86 percent of Internet users who are disabled have sought health information online and 75 percent of them have integrated the health information into their medical treatment decisions. (5)

Trusted Sources and Influencers

- Family and friends, many who may serve as caregivers, are reliable and trusted sources of information. People with disabilities and their family and caregiving networks represent a large group of consumers whose identity goes beyond medical condition when making purchasing decisions and seeking health information.
- Disability service organizations. Organizations that represent and advocate for individuals with disabilities are key sources of information. Programs and local efforts that are endorsed by or co-presented with disability-specific organizations offer authenticity and expertise in inclusion.
- The medical community and personal providers—particularly those involved in long-term care for individuals with disability are particularly

influential and trusted sources of information. They should also be encouraged to help their patients.

Media Habits

Innovation has driven how persons with disabilities have grown to consume media. Technology has improved opportunities for engaging on social media, allowing individuals to participate in online communities, share experiences and talk about approaches and brands that work (and don't work). Even though technology use has increased for certain groups, it is important to keep in mind that there is still a digital divide with people that have vision loss or intellectual disabilities.

It is also important to remember that for some people with a disability, they do not primarily define themselves and align their habits with their disability. Therefore, a 46-year-old highly educated African American woman in a wheelchair who works full time in corporate America may identify more with her gender and ethnicity than her mobility.

It is also important to keep in mind that while

Barriers and Benefits

Barriers to National DPP Recruitment and Enrollment

- **Medical barriers.** Many people with disabilities adhere to specific medical programs that include diet, exercise and medication. Adding a new program and new approaches to healthier living may seem to conflict with other programs in place.
- **Accessibility and accommodations.** Individuals with disabilities often require accommodations to ensure their full participation. This may include sign language interpreters, larger print materials, elevators or first-floor meeting spaces, scales that accommodate wheelchairs, among others. People with vision, hearing mobility and intellectual disabilities must be considered to ensure inclusivity and accessibility. Structural barriers that limit or impede access to health care practices or health care services include: inaccessible parking (number of spaces or size of spaces), lack of ramps or ramps with too steep of a grade, narrow doorways, heavy doors or entrances without automatic opening capabilities, lack of elevators, waiting rooms and exam rooms that cannot accommodate a wheelchair, scales that are not for wheelchair, accessible examination tables that are not height adjustable, inaccessible diagnostic equipment and inaccessible restrooms. (6) For example, a person can be highly responsive to a health promotion intervention (i.e., strong personal interest and motivation) but not have an accessible fitness facility near his or her home. (3)

Benefits of National DPP Lifestyle Change Programs

- The program is empowering and offers participants an opportunity to be in charge of their health—something that for some with a disability is a welcome experience. This fosters an increased feeling of independence.
- The program is an effective and often fun way to prevent type 2 diabetes among people with disabilities in your community.
- With an organized and structured program, you are able to guide people with disabilities in living healthier and reducing the rates of diabetes.
- A proven program with a lifestyle coach offers participants a go-to source for accurate, tested and proven information and practices that work.
- The program provides a group setting along with customized education that allows participants the opportunity to share experiences, rely on their community for support while facing their own challenges on the road to healthier living to prevent type 2 diabetes. The group setting provides the environment for the sharing of different ideas and perspectives from others in the program and motivation for individual success.

Proven Promotion Strategies

- **Focus on family and caregivers.** Caregivers are important influencers for people with disabilities. Caregivers can also be recipients of information related to diabetes prevention.
- **Partner with trusted community organizations.** Organizations that have a history and strong reputation for advocating for people with disabilities will serve as helpful program organizers, promoters, recruiters and leaders.
- **Don't forget health care providers.** People with disabilities rely on their health care teams for their long-term care. Get health care providers on board to help promote and recruit for the program. These teams may include rehabilitation

professionals, physical therapists, nutritionists and others who provide regular care.

- **Ensure accessibility and provide accommodations.** Full participation is your goal. Be sure to be inclusive, think ahead to address accessibility and accommodations. Use environments that are accessible, make sure you have needed assistive technology and communicate information effectively. Remember that you don't have to be the expert on inclusion. You can partner with disability service organizations for support.
- **Provide well-trained and specially-trained lifestyle coaches.** To ensure people with disabilities feel welcomed and are invited to fully participate in succeed in the program, ensure you're your lifestyle coach is able to address environmental, physical, programmatic and attitudinal barriers.
- **Use respectful and inclusive language in your communications.** Most often, this means using person-first terminology. In other words, leading with the individual rather than the disability, as in saying "a person with a disability" instead of "a disabled person." It's important to recognize this is not a universal preference. Certain groups may prefer the opposite to person-first language (known as identify-first language). Engage disability organizations to understand the most respectful and effective ways to communicate. Don't use negative terminology such as "confined to a wheelchair," "handicapped" or "the disabled."
- **Develop appropriate materials for people with disabilities.** To ensure people with disabilities can utilize your resources, use appropriate graphics, colors, font and formatting.
- **Follow 9 guidelines to ensure new and existing program initiatives and activities are appropriate and accessible for people with disability.** Use the Guidelines for Disability Inclusion to support the implementation of your program within the community and fully address the needs of the people with disabilities. (Link: http://committoinclusion.org/9-guidelines-for-disability-inclusion/)

Questions for Consideration

Understanding people with disabilities in your community

- What are the demographics of people with disabilities in your community?

Demographics	Statistic/Data
Population Percentage	
Median Age	
Gender	
Country of Origin	
Language (spoken)	
Population with Prediabetes	
Economic Status	

- What are the cultural and language nuances for people with disabilities in your community?
- Within your community, are there particularly active or large groups that represent people with disabilities?

Health Care and Health Information Seeking Behaviors

- Where specifically does your local group of people with disabilities go for health care?
- How accessible is health care within the community, especially for people with disabilities?
- Are the health information seeking behaviors the same or different for the local group of people with disabilities compared to other populations within the community? If different, how?
- Who are the trusted sources for health information for people with disabilities? Are they different or the same as other trusted sources?

Trusted Sources

- Who are the trusted thought leaders in your local community?
    - Community Based Organizations?
    - Faith Communities?
    - Health Care Providers?
    - Vocal advocates?
- Who has access to these groups? With whom do you need to collaborate?
- How can you utilize these trusted sources to help you with marketing and promoting your lifestyle change program?

Media Habits

- Which media channels, including social and digital media, are most popular and/or preferred among people with disabilities in your community?
- What relationships do you have with these media outlets? Who do you need to reach out to?
- What infrastructure does your organization have to utilize popular social and digital channels? What do you need to strengthen?

Messages

- Are your messages delivered in accessible formats?
- Do you have images that include people with disabilities?
- Are you working with community organizations or groups that will be able to assist with message development for your marketing materials?

Barriers and Benefits to Lifestyle Change Programs

- What are the specific barriers in your community?
- How will you work to mitigate these and with whom?
- What are the benefits of the lifestyle change program that are meaningful to your audience? How can you work these benefits into your marketing materials?
- What does your lifestyle change program offer the community that other prevention programs or events don't or can't?

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