



Chronic Health Conditions Among People with Disabilities

Living in the Mountain West

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Chronic health conditions (CHCs) account for a large portion of healthcare spending across the United States and commonly require navigation of complicated healthcare services to receive effective care (CDC, 2022). CHCs include a wide array of conditions such as asthma, arthritis, coronary heart disease, and depression (CDC, 2022). While previous research has suggested that people with disabilities (PWD) are more likely to have multiple CHCs (Gulley et al., 2011), there is need to: (a) better understand the current trends of CHCs among people with disabilities, and (b) understand how trends vary by geographic areas of the United States to help inform policy and practice efforts. The current whitepaper summarizes findings from analyses among PWD living in the Mountain West (MW) region of the United States using the Behavioral Risk Factor Surveillance System (BRFSS). The following questions are addressed:

- 1. Among people with disabilities living in the Mountain West, what is the prevalence of chronic health conditions?*
- 2. Among people with disabilities living in the Mountain West, what are the most reported chronic health conditions?*

How do we answer these questions?

We used the 2022 release of the BRFSS from the Centers for Disease Control and Prevention (CDC). PWD were identified using a set of six questions related to hearing, vision, cognition, mobility, self-care, and independent living. We examined the estimated frequency of CHCs among PWD across the MW using sampling weights from the BRFSS to calculate a weighted prevalence of CHCs. We defined a person as having a CHC if they reported ever having been diagnosed with any of the 11 chronic conditions collected by the BRFSS: arthritis, asthma, skin cancer, melanoma or any other type of cancer, chronic obstructive pulmonary disease (COPD), depression, diabetes, heart disease, kidney disease, obesity, stroke. Asthma was excluded in respondents who reported only having asthma as a child and not as an adult. Gestational diabetes was excluded. Obesity was calculated from participants' self-reported current height and weight,

with obesity defined as a body mass index (BMI) of 30 kg/m² or higher. The current analyses selected cases in the geographic region defined by the U.S. Census Bureau as the Mountain West: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming.

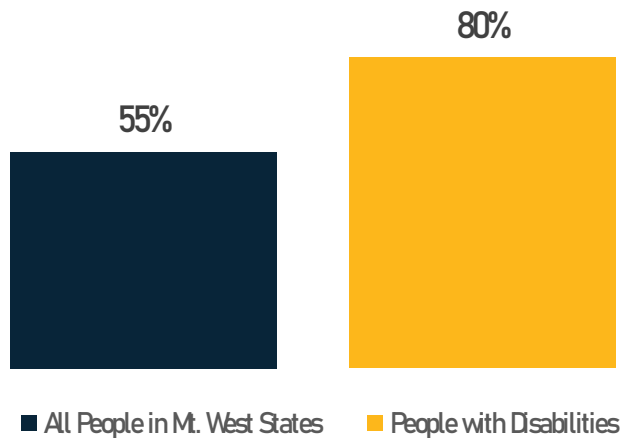
What did we learn?

Among people with disabilities living in the Mountain West, what is the prevalence of chronic health conditions?

The proportion of people with CHCs in the MW is higher among PWD than all people living in the MW. Inspection of each state reveals that the differences remain consistent across all states within the MW. Accordingly, Figure 1 displays aggregate results of all states in the region. To illustrate the similarity across states, Montana state had the highest proportion of CHCs among PWD with 83.1%; Nevada state had the lowest proportion at 77.1%.

Figure 1

The proportion of people with chronic health conditions in the Mountain West is higher among **people with disabilities** than among **all people in all Mountain West states**.

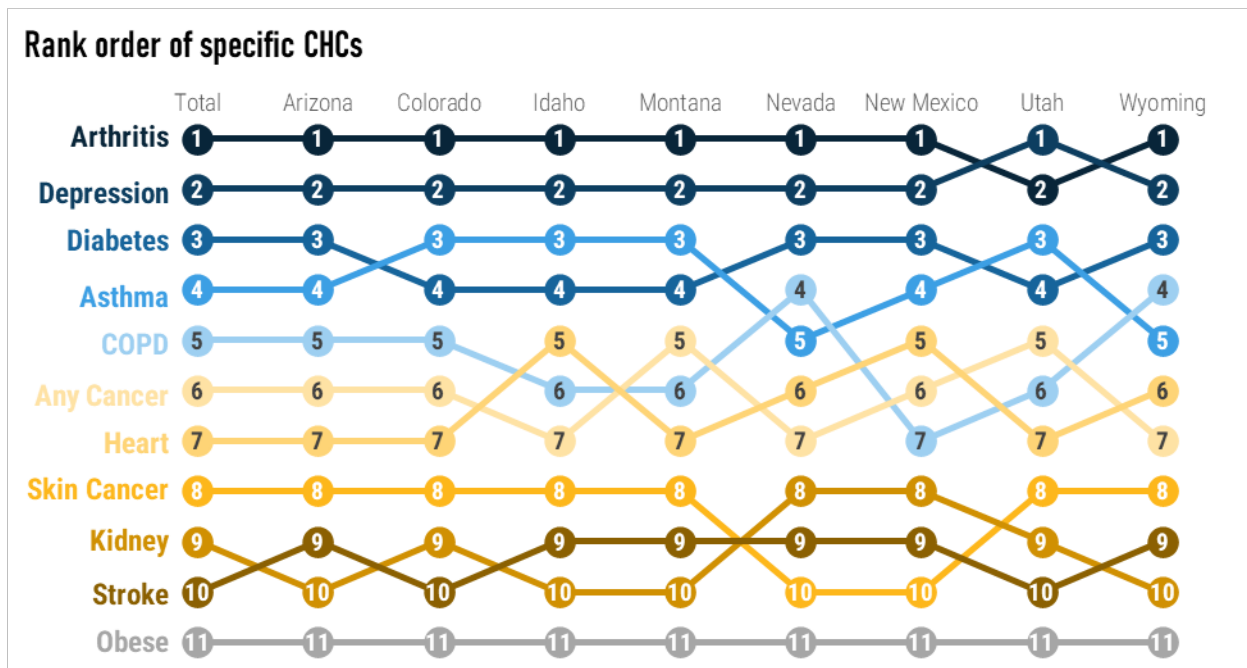


Among people with disabilities living in the Mountain West, what are the most reported chronic health conditions?

The most frequently reported chronic health conditions among PWD in the MW as a whole, and in each individual state are compared in (Figure 2). Arthritis and depression are the most common

CHC across all states, except Utah, where their rank order is swapped with depression in the number one spot. Obesity consistently ranked as the least prevalent CHC.

Figure 2



Note: “Arthritis” includes arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; “Depression” includes depression, major depression, dysthymia, or minor depression; “COPD” includes chronic obstructive pulmonary disease, emphysema or chronic bronchitis; “Any cancer” includes melanoma or any other types of cancer; “Heart” includes heart attack (also called a myocardial infarction) and angina or coronary heart disease; “Skin cancer” does not include melanoma; “Kidney” does not include kidney stones, bladder infection or incontinence.

A more nuanced look at the prevalence of each of the individual types of CHCs (See Figure 3) revealed that the proportion of people with disabilities in the MW who have a specific chronic health condition is nearly double the total population of people in the MW. For example, our analyses found that depression, which had the largest difference between the general population and PWD in the MW, was present in 21% of the general population, while 39% of PWD in the MW are estimated to experience depression.

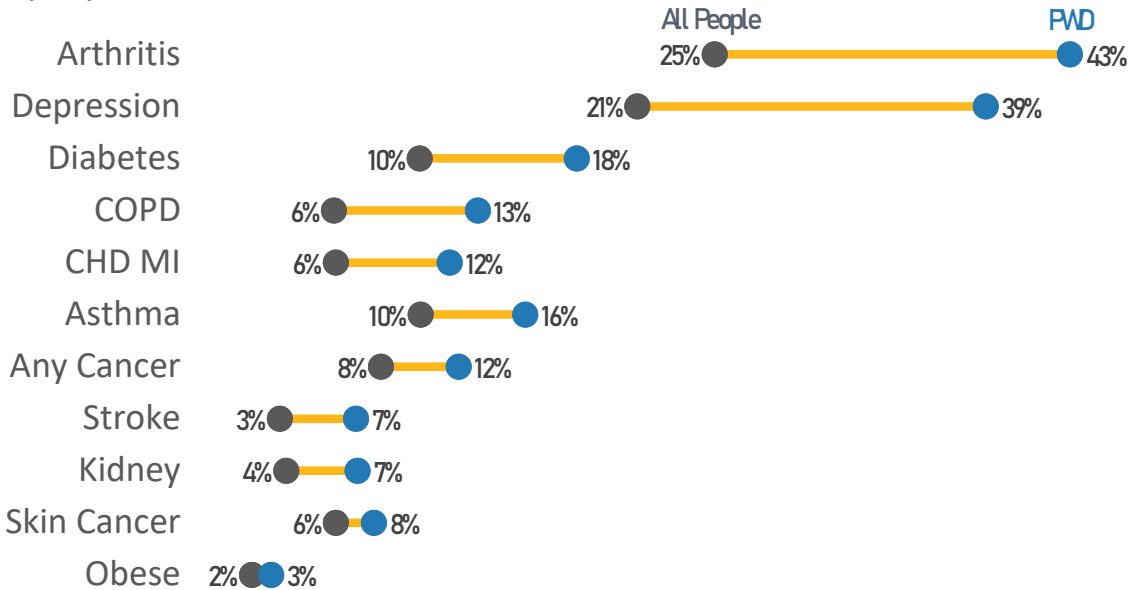
Why does this matter?

Improving healthcare for PWD that also experience CHCs is crucial to helping improve quality of life for PWD. Each of the CHCs reported on in the current whitepaper can be improved through access to high quality healthcare that includes both medical and psychological interventions. For instance, evidence-based psychological interventions have been demonstrated to help improve quality of life for individuals experiencing CHCs, especially when access to medical interventions may be lacking. Policy makers and providers could benefit from taking tiered approaches to treatment access that value both front-line medical interventions and supplementing with

psychological supports that can be accessed remotely. As PWD are more likely to experience these CHCs than people without disabilities, an emphasis on accessibility and universal design of these services is crucial.

Figure 3

The porportion of **people with disabilities** who have specific chronic health conditions is nearly double compared to all people in the Mountain West.



Note: Chronic health conditions are ordered from the largest to the smallest estimated gap between people with disabilities and the total population in Mountain West states.

References

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