

Data Summary | Health and Screening Disparities for People with Disabilities

Introduction

This summary presents key data on health and screening disparities experienced by people with disabilities in relation to the 29 preventive screenings graded as “A” or “B” by the U.S. Preventive Services Task Force (USPSTF). Where available, data are disaggregated by disability type. Despite the scale and significance of these disparities, national data on disease burden and screening rates among people with disabilities remains limited, impeding progress toward equitable preventive care.

People with disabilities face widespread systemic barriers to screening and health care access. These include inaccessible buildings and equipment, communication difficulties, lack of disability-competent and trauma-informed care, and practitioner bias. These barriers are not confined to one setting, condition, or screening; they affect nearly every aspect of preventive health care and contribute to delayed screening and diagnosis and worse health outcomes.

Closing these gaps requires better data. Evidence-based interventions depend on robust and sustainable data collection systems that track disability status, screening rates, and disease prevalence. Without this structure, people with disabilities will continue to be left behind in public health surveillance and health care.

Demographics

People with disabilities represent a large and growing segment of the U.S. population. More than one in four adults (28.7%) report having a disability (Centers for Disease Control and Prevention [CDC], 2022). Data from the 2019 Behavioral Risk Factor Surveillance System (BRFSS) (Table 1) show that adults with disabilities are more likely to experience social and economic challenges, such as lower educational attainment, reduced employment opportunities, and lower household

incomes compared to those without disabilities (Varadaraj et al., 2021). These differences reflect the disproportionate impact of social determinants of health on people with disabilities, which in turn influences the health disparities they face, including barriers to accessing care. Recognizing these persistent inequities, the National Institute on Minority Health and Health Disparities has officially designated people with disabilities as a health disparity population in 2023, emphasizing the need for targeted strategies to address these systemic challenges.

Table 1 : Disability Demographics

Characteristics	Weighted % (95% CI)	
	No Disability	Any Disability
Age category (years)		
18-29	22.6 (22.3-23.0)	14.9 (14.4-15.3)
30-39	20.0 (19.6-20.3)	11.5 (11.1-11.9)
40-49	16.4 (16.1-16.6)	11.5 (11.1-11.9)
50-64	24.0 (23.7-24.3)	28.6 (28.1-29.1)
65-74	11.1 (11.0-11.3)	17.0 (16.7-17.4)
75+	5.9 (5.8-6.1)	16.6 (16.3-17.0)
Sex at birth		
Male	50.0 (49.6-50.3)	46.3 (45.6-47.0)
Female	50.0 (49.7-50.4)	53.7 (53.0-54.4)
Education		
Less than high school	9.7 (9.5-10.0)	20.7 (20.1-21.3)
High school	26.2 (25.9-26.5)	32.3 (31.6-32.9)
Some college	30.9 (30.5-31.2)	31.7 (31.1-32.2)
College graduate	33.2 (32.9-33.5)	15.4 (15.0-15.8)
Annual household income		
Less than \$25,000	19.2 (18.9-19.6)	44.8 (44.0-45.5)
\$25,000-\$50,000	21.7 (21.4-22.1)	24.6 (24.0-25.3)
Greater than \$50,000	59.1 (58.7-59.5)	30.6 (29.9-31.3)
Employment status		
Employed for wages	56.6 (56.3-57.0)	45.8 (45.0-46.6)
Self-employed	10.8 (10.6-11.1)	9.9 (9.4-10.5)
Out of work	4.4 (4.2-4.5)	11.5 (11.0-12.0)
Homemaker or student	12.4 (12.1-12.7)	13.1 (12.5-13.7)
Retired	15.8 (15.7-16.0)	19.7 (19.4-20.0)

Data Source: Adapted from Varadaraj V, Deal JA, Campanile J, Reed NS, Swenor BK. National Prevalence of Disability and Disability Types Among Adults in the US, 2019. JAMA Netw Open. 2021;4(10):e2130358. doi:10.1001/jamanetworkopen.2021.30358

Methodology

This summary primarily draws from the CDC's Disability and Health Data System (DHDS), which presents an analysis of the BRFSS. The BRFSS is a nationally representative telephone survey of noninstitutionalized adults 18 years and older in all 50 states, the District of Columbia (DC), and three U.S. territories. It collects self-reported data on health conditions, preventive health care, and disability relevant to this summary.

The DHDS includes breakdowns of BRFSS data by disability status and type. In the 2022 BRFSS, a respondent is classified as having a disability if they answer 'Yes' to at least one of the following six questions:

- **Hearing:** Some people who are deaf or have serious difficulty hearing use assistive devices to communicate by phone. Are you deaf or do you have serious difficulty hearing?
- **Vision:** Are you blind or do you have serious difficulty seeing, even when wearing glasses?
- **Cognition:** Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
- **Mobility:** Do you have serious difficulty walking or climbing stairs?
- **Self-care:** Do you have difficulty dressing or bathing?
- **Independent living:** Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

In this summary, BRFSS/DHDS data are the primary source for comparing screening rates and disease prevalence between adults with and without disabilities, including by disability type, when available. These data are supplemented by peer-reviewed literature and national surveys, such as the National Health Interview Survey (NHIS), National Survey on Drug Use and Health (NSDUH), and Medical Monitoring Project (MMP).

Data Limitations and Gaps

While BRFSS/DHDS provide important national data on disability and preventive care, there are several limitations that affect interpretation and comparability across sources.

First, not all USPSTF A- and B-recommended preventive screenings are included in BRFSS, and some that are included may not fully align with current clinical guidance. Additionally, BRFSS relies on self-reported data, which can introduce bias or underreporting, particularly when disaggregating disability status, where stigma, question interpretation, or survey mode may influence responses.

Although BRFSS includes six functional disability types, other national surveys and research studies do not consistently disaggregate results by disability type, limiting the ability to identify variation in screening access and outcomes across groups. Moreover, most of the data available on preventive screenings and health conditions by disability status are cross-sectional rather than longitudinal, which limits the ability to determine causality or the temporal relationship between disability and health outcomes.

BRFSS, and most other national surveys, are limited to noninstitutionalized, community-dwelling adults. As a result, they exclude individuals living in long-term care facilities, group homes, and other institutional or congregate care settings, many of which have higher prevalence of disability, according to an analysis of 2015-2019 American Community Survey data (von Reichert, 2022). This limitation may contribute to underrepresentation of people with disabilities impacting disability status data for screening access and disease burden.

Finally, definitions of disability vary across the research literature cited in this summary. While BRFSS uses a standard six questions about functional limitations, other sources define disability type through other self-report questions, medical diagnosis through CD-10 codes, or program eligibility, such as Social Security Disability Insurance or Medicaid. These differences in definitions should be considered when comparing data across studies.

Health Care Access Disparities

Access to care is a foundational prerequisite for receiving preventive health screenings, yet people with disabilities consistently face barriers to accessing care than people without disabilities. According to the 2022 BRFSS (Table 2), 22.6% of disabled people reported being unable to see a doctor in the past year due to cost, compared to 8% of those without disabilities (CDC, 2022). This disparity is even greater for people with mobility or cognitive disabilities, with 26% in each group reporting cost-related access issues. People with disabilities are also less likely to have health care coverage (88.9%) compared to people without disabilities (91.5%) (CDC, 2022). These overlapping financial and systemic barriers create cumulative disadvantages that interfere with timely access to preventive screenings.

Table 2: Barriers and Costs to Health Care Across Disability Status

Indicator (Year)	Weighted % (95% CI)					
	No Disability	Any Disability	Cognitive Disability	Hearing Disability	Mobility Disability	Vision Disability
Could not see a doctor due to cost in the past 12 months among adults 18 years of age or older (2022)	8.0 (7.8 - 8.2)	22.6 (22.0 - 23.2)	26.0 (25.2 - 26.8)	21.9 (20.2 - 23.7)	26.0 (24.8 - 27.3)	27.3 (25.8 - 28.9)
Health care coverage among adults 18 years of age or older (2022)	91.5 (91.3 - 91.8)	88.9 (88.4 - 89.4)	89.0 (88.3 - 89.5)	88.5 (87.2 - 89.8)	89.1 (88.0 - 90.0)	86.8 (85.5 - 87.9)
Routine check-up in the past year among adults 18 years of age or older (2022)	74.0 (73.7 - 74.4)	74.7 (74.1 - 75.3)	73.7 (72.9 - 74.5)	73.3 (71.5 - 75.1)	80.1 (78.9 - 81.3)	74.9 (73.4 - 76.4)

Data Source: Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. Disability and Health Data System (DHDS) Data. Retrieved June 15, 2025, from <https://dhds.cdc.gov>

Screening-specific Data Cancer (Breast, Cervical, and Colorectal)

Adults with disabilities are significantly more likely to report having cancer (excluding skin cancer) than those without disabilities (9.1% vs. 6.1%), with the highest prevalence among people with mobility

limitations (11%) (CDC, 2022). This disparity is particularly concerning given the consistently lower rates of cancer screening among people with disabilities.

For example, among adults aged 50 and 74, only 71.3% of disabled people reported receiving a mammogram in the past two years, compared to 79.3% of those without disabilities (CDC, 2022). Similarly, people with disabilities between the ages of 21 and 65 are significantly less likely to be up to date on cervical cancer screenings (77.9%) compared to those without disabilities (84.2%) (CDC, 2020). These screening gaps may reflect a range of systemic barriers, including inaccessible mammography machines, lack of appropriate transfer assistance, and practitioner bias.

In contrast, people with disabilities are more likely to be up to date on colorectal cancer screenings (73.5%) compared to those without disabilities (71.7%) (CDC, 2020); however, overall colorectal screening rates remain lower than breast and cervical cancer screening rates, underscoring the need for addressing barriers for everyone.

Additional evidence from a study analyzing data from 2010, 2013, 2015, and 2018 NHIS shows that pre-existing disabilities related to movement difficulties or complex activity limitations are associated with higher prevalence of breast and cervical cancers compared to women without disabilities (Iezzoni et al., 2021). It was discovered that the rate of breast cancer among women without disabilities was 2.2% compared to the rate of breast cancer for those with mobility difficulties (3.5%) and complex activity limitations (3.6%), respectively. For cervical cancer, the rate was 0.6% for women without disabilities and 0.8% and 1% for women with mobility difficulties and complex activity limitations, respectively.

Another study analyzing 2010-2017 NHIS data found increased odds of colorectal cancer among adults with movement difficulties (aOR 1.5; 95% CI 1.2-1.9) and complex activity limitations (aOR 1.9; 95% CI 1.5-2.4) (Iezzoni et al., 2020). These findings reinforce the need for more accessible cancer screening efforts to address disparities in detections and outcomes.

For guidance on improving access to cancer screening for patients with disabilities, see our [Breast and Cervical Cancer Screening Practice](#)

[Considerations](#), which provide practical strategies for practitioners and health systems.

Hypertension

People with disabilities are significantly more likely to report high blood pressure than people without disabilities. According to the 2021 BRFSS, 39.8% of adults with disabilities reported ever having hypertension, compared to 26.2% of those without disabilities. The prevalence is even higher among people with mobility disabilities, with nearly half (48.7%) reporting a hypertension diagnosis (CDC, 2021).

Because hypertension is a major risk factor for heart disease, this disparity raises serious concerns. Among adults with disabilities, 10.4% report ever having heart disease, compared to only 3.7% of those without disabilities (CDC, 2022). These patterns highlight the need for targeted cardiovascular risk reduction efforts, particularly for individuals with mobility limitations who face both elevated risk and known barriers to preventive care.

Diabetes

People with disabilities are more than twice as likely to report ever having diabetes compared to people without disabilities (16.6% vs. 7.9%) (CDC, 2022). Prevalence is especially high among those with mobility disabilities (22.7%) and vision disabilities (21.5%).

Despite the substantial burden of diabetes in this population, national data on screening rates by disability status are lacking. A 2014 study found that only 46.2% of eligible adults overall had received diabetes screening based on the American Diabetes Association's criteria at the time (Kiefer et al., 2015), but disability status was not examined. This represents a critical data gap given the significantly higher diabetes burden among people with disabilities.

HIV and Other Sexually Transmitted Infections

People with disabilities are more likely to have been screened for HIV than those without disabilities (51.3% vs. 41.3%) (CDC, 2022). This contrasts with most other preventive screenings where rates are lower among disabled people. One study suggests this association between disability and higher rates of HIV screenings could be because HIV screening often does not require a physical exam, transfer assistance,

or specialized equipment, removing some of the barriers present in other screenings, like breast and cervical cancer screenings (Pharr & Bungum, 2012).

While national HIV prevalence data disaggregated by disability type are limited, one study that analyzed Medical Monitoring Project data shows that almost half (44.5%) of adults living with HIV reported having at least one disability (Chowdhury et al., 2021). As a cross-sectional study, it cannot establish whether disability preceded HIV infection or resulted from it. Nonetheless, the high co-occurrence reinforces the need to integrate disability accommodations into all aspects of HIV prevention, screening, and care.

Additionally, women with disabilities also face increased risk of other sexually transmitted infections (STIs). A study analyzing 2015-2019 National Survey on Drug Use and Health data found that women with cognitive disabilities had nearly twice the odds of reporting an STI compared to those without disabilities (aOR = 1.9; 95% CI = 1.6-2.2) (Parekh et al., 2023). The study also found that people with sensory disabilities (aOR = 1.5; 95% CI = 1.2-1.9) and two or more disabilities (aOR = 1.8; 95% CI = 1.5-2.1) have higher odds of STIs compared to women without disabilities.

National data on STI screening rates by disability status are sparse; however, a single-institution study shows significantly lower STI screening among adolescents with physical (aOR = 0.26; 95% CI= 0.09-0.72) and intellectual disabilities (aOR = 0.37; 95% CI= 0.21-0.64) (Amir et al., 2025), raising concern about missed preventive opportunities.

Questionnaire Screenings

This section focuses on screenings that rely on standardized, self-report questionnaires, which may introduce unique accessibility barriers for disabled people. These questionnaire screenings include drug use, alcohol use, major depressive disorder, and anxiety disorders.

Substance Use

People with disabilities experience disproportionately high rates of substance and alcohol use disorders. NSDUH data show that adults with disabilities have elevated odds of alcohol use disorders (aOR = 1.8; 95% CI = 1.6-2.0), particularly those with cognitive (aOR = 2.2; 95% CI =

1.9-2.5) or two or more disabilities (aOR = 2.3; 95% CI = 2.0–2.6), compared to people without disabilities (Aram et al., 2023). They also have increased odds of drug use disorder (aOR = 2.7; 95% CI = 2.5-3.0).

While people with disabilities are more likely to report drug use, including prescription drug misuse, compared to people without disabilities, according to the National Alcohol Survey (Reif et al., 2022), patterns of alcohol use vary. For example, the same survey showed that people with disabilities were less likely to report current alcohol use, defined by at least one drink of any kind of alcoholic beverage in the past 12 months, and no more likely to engage in high-intensity drinking, defined by drinking at least eight drinks on a given day in the past 12 months. Data from DHDS also show similar or slightly lower rates of recent binge drinking compared to people without disabilities, with notably lower rates among those with mobility disabilities.

Depression and Anxiety

According to 2022 BRFSS data, people with disabilities are significantly more likely to report poor mental health and a history of depression. For example, 43.6% of adults with disabilities reported ever having depression, compared to only 13.7% of those without disabilities. Among people with cognitive disabilities, the prevalence reached 58.1%. Similarly, 36.6% of adults with disabilities reported 14 or more mentally unhealthy days in the past month, compared to only 9.7% of those without disabilities.

A study analyzing electronic health record (EHR) data from 2019 through 2021 across 11 states suggests that screening tools for depression and anxiety have reduced accuracy when they are embedded into EHRs for performance measurement (Simon et al., 2023). Questionnaire screenings can introduce many barriers for people with disabilities, such as inaccessible formats, repetitive screenings, and stigma. Considering this alongside the prevalence of depression among people with disabilities highlights the importance of assessing patients with disabilities for depression and anxiety in accessible ways.

Table 3: Health Disparities Across Disability Status

Indicator (Year)	Weighted % (95% CI)					
	No Disability	Any Disability	Cognitive Disability	Hearing Disability	Mobility Disability	Vision Disability
Fair or poor self-rated health among adults 18 years of age or older (2022)	8.8 (8.5 - 9.0)	37.7 (37.1 - 38.4)	42.5 (41.6 - 43.3)	34.7 (32.8 - 36.6)	55.7 (54.4 - 57.0)	42.3 (40.6 - 43.9)
14 or more physically unhealthy days in the past 30 days among adults 18 years of age or older (2022)	5.4 (5.2 - 5.6)	28.8 (28.2 - 29.4)	31.9 (31.1 - 32.8)	26.0 (24.4 - 27.7)	48.8 (47.4 - 50.1)	31.3 (29.8 - 33.0)
Binge drinking in the past 30 days among adults 18 years of age or older (2022)	18.2 (17.9 - 18.5)	17.0 (16.4 - 17.5)	18.1 (17.4 - 18.8)	18.7 (17.2 - 20.2)	13.7 (12.7 - 14.8)	16.8 (15.4 - 18.2)
Ever had heart disease among adults 18 years of age or older (2022)	3.7 (3.6 - 3.9)	10.4 (10.0 - 10.7)	11.4 (10.8 - 11.9)	13.2 (11.8 - 14.8)	14.3 (13.5 - 15.1)	14.0 (12.8 - 15.3)
Ever had high blood pressure among adults 18 years of age or older (2021)	26.2 (25.9 - 26.5)	39.8 (39.1 - 40.4)	39.0 (38.1 - 40.0)	41.4 (39.8 - 43.1)	48.7 (47.4 - 50.0)	41.7 (40.1 - 43.4)
Ever had cancer (excluding skin cancer) among adults 18 years of age or older (2022)	6.1 (6.0 - 6.3)	9.1 (8.8 - 9.4)	9.4 (8.9 - 9.9)	10.2 (9.2 - 11.2)	11.0 (10.3 - 11.8)	9.6 (8.7 - 10.6)
Ever had diabetes among adults 18 years of age or older (2022)	7.9 (7.8 - 8.2)	16.6 (16.1 - 17.0)	16.8 (16.1 - 17.4)	16.6 (15.2 - 18.2)	22.7 (21.7 - 23.7)	21.5 (20.0 - 23.1)
Ever had depression among adults 18 years of age or older (2022)	13.7 (13.4 - 14.0)	43.6 (43.0 - 44.3)	58.1 (57.2 - 59.0)	36.7 (34.9 - 38.6)	45.4 (44.0 - 46.7)	39.1 (37.5 - 40.8)
14 or more mentally unhealthy days in the past 30 days among 18 years of age or older (2022)	9.7 (9.4 - 9.9)	36.6 (35.9 - 37.2)	49.2 (48.3 - 50.2)	29.1 (27.3 - 30.9)	37.2 (35.9 - 38.5)	34.1 (32.5 - 35.8)

Data Source: Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. Disability and Health Data System (DHDS) Data. Retrieved June 15, 2025, from <https://dhds.cdc.gov>

Table 4: Screening Rates Across Disability Status

	Weighted % (95% CI)					
	No Disability	Any Disability	Cognitive Disability	Hearing Disability	Mobility Disability	Vision Disability
Ever been tested for HIV among adults 18 to 64 years of age (2022)	41.3 (40.8 - 41.8)	51.3 (50.5 - 52.1)	54.3 (53.2 - 55.3)	53.2 (51.1 - 55.2)	54.6 (52.9 - 56.3)	52.7 (50.8 - 54.7)
Mammogram in the past two years among females 50 to 74 years of age (2022)	79.3 (78.6 - 80.0)	71.3 (70.2 - 72.4)	67.7 (65.7 - 69.7)	72.8 (70.2 - 75.3)	70.5 (69.1 - 71.8)	67.2 (64.7 - 69.7)
Up-to-date cervical cancer screening among females 21 to 65 years of age (2020)	84.2 (83.6 - 84.8)	77.9 (76.5 - 79.2)	77.4 (75.5 - 79.2)	76.2 (72.4 - 79.5)	78.4 (76.2 - 80.5)	76.7 (73.4 - 79.8)
Up-to-date colorectal cancer screening among adults 50 to 75 years of age (2020)	71.7 (71.0 - 72.3)	73.5 (72.5 - 74.5)	71.3 (69.4 - 73.2)	77.2 (75.4 - 78.9)	74.8 (73.6 - 76.0)	69.7 (67.1 - 72.1)

Data Source: Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. Disability and Health Data System (DHDS) Data. Retrieved June 15, 2025, from <https://dhds.cdc.gov>

Cross-cutting Themes and Data Gaps

Several key themes emerge across preventive screenings. First, people with disabilities consistently experience higher prevalence of diseases and conditions, including hypertension, diabetes, depression, breast cancer, and cervical cancer, yet face lower rates of screening for many of these same conditions.

Second, disparities vary by disability type. Individuals with mobility and cognitive disabilities frequently experience the highest disease burden and most pronounced screening gaps, though data are often unavailable for other disability types.

Third, systemic barriers to care access, such as cost, inaccessible facilities and equipment, lack of disability-competent and trauma-informed trained practitioners, stigma, and insufficient accommodations, appear to contribute to delayed or missed screenings. Screenings that are easier to administer (e.g., HIV testing) show higher

rates among people with disabilities suggesting that when accessibility improves, disparities can shrink.

Several data gaps also hinder monitoring and improvement efforts. Many national datasets:

- Do not collect or fail to disaggregate results by disability type.
- Use inconsistent definitions of disability or disability types.
- Exclude institutionalized populations.
- Are inconsistent with current USPSTF recommendations.

These limitations make it challenging to track progress or identify inequities across the full preventive screening spectrum.

Other Existing Data Sources

In addition to national surveillance systems, like BRFSS, there are other sources that could support the identification and monitoring of screening and health disparities among people with disabilities. Some of these sources are publicly available while others require system-level access or data-use agreements. Expanding the use of these sources, particularly at the local and health system level, can help close data gaps, support quality improvement, and inform targeted interventions. These sources include:

- National Health Interview Survey (NHIS)
- National Survey on Drug Use and Health (NSDUH)
- Medical Monitoring Project (MMP)
- Medical Expenditure Panel Survey (MEPS)
- National Health and Nutrition Examination Survey (NHANES)
- National Survey on Health and Disability (NSHD)
- Veterans Health Administration (VHA) Data
- Medicare Current Beneficiary Survey (MCBS)
- National Institutes of Health's All of Us Research Program

- Electronic Health Records (EHR) Networks
- State cancer registries
- Medicare and Medicaid Claims Data, Center for Medicaid and Medicare Services
- State All-Payer Claims Databases
- MarketScan Commercial Claims and Encounters (CCAЕ) by IBM
- Optum Clinformatics DataMart
- Specialized disability organizations and registries

Recommendations for Data Collection and Monitoring

The screening disparities documented in this summary, combined with the data limitations identified above, point to several areas where improved data collection and monitoring could strengthen surveillance efforts and inform targeted interventions.

Standardized Data Collection

As noted in the data limitations section, inconsistent disability definitions across surveys and research studies limit the ability to compare findings and track trends over time. Adopting the BRFSS six-question framework as a standard across all national health surveys would improve data quality and comparability.

Given the limitations in current sample sizes for disability subgroup analysis, ensuring adequate representation of all disability types in national surveys would enable more targeted identification of disparities. The exclusion of institutionalized populations from most national surveys also warrants attention, as these settings serve populations with higher disability prevalence.

Engaging people with disabilities as partners in research design and implementation is essential for improving data quality and relevance. This includes involving disability community members in developing survey instruments, data collection protocols, and interpretation of

findings. Such engagement can help identify accessibility barriers in current data collection methods and ensure that research questions address the priorities and experiences of people with disabilities.

Aligning with Clinical Guidance

Many existing survey instruments do not fully align with current USPSTF recommendations, limiting their utility for monitoring adherence to evidence-based screening guidelines. Some A- and B-rated screenings are not included in major national surveys while others may not reflect current screening intervals or age recommendations.

Expanding Health System Data Utilizations

EHRs and administrative claims databases contain substantial information about health care utilization patterns that could be leveraged to monitor screening disparities. These systems capture diagnosis and procedure codes that can be used to identify both disability status and screening receipt, potentially enabling systematic tracking of screening rates by disability type. Medicare and Medicaid claims data, could provide valuable insights into screening patterns and health care-access barriers without requiring new data collection infrastructure.

These data system improvements would provide a stronger foundation for monitoring health equity and developing evidence-based interventions to address screening disparities among people with disabilities.

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About Screening for All

Screening for All is an initiative funded by the Centers for Disease Control and Prevention (CDC)'s National Center on Birth Defects and Developmental Disabilities (NCBDDD) to address the significant barriers people with disabilities face in accessing preventive health screenings.

Developed by MCD Global Health, this project provides patients and healthcare providers with evidence-based tools and resources to make preventive health screenings accessible to all patients. Questions or comments can be sent to ScreeningForAll@mcd.org. More resources are available at mcd.org/screening-for-all.

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