2025 REGIONAL Community Health Needs Assessment

FOR SOUTHEASTERN PENNSYLVANIA

Disability

Disability affects the lives of millions of people in the United States, shaping not only health outcomes but also experiences with care, independence, and community participation. According to the Centers for Disease Control and Prevention (CDC), "a disability is any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities and interact with the world around them." As of 2025, approximately one in four adults—an estimated 67 million people—live with some form of disability. In the five-county southeastern Pennsylvania (SEPA) region, about 14 percent of residents are currently living with a disability. Understanding the diverse needs, barriers, and strengths of this population is critical to advancing equity and ensuring that services are inclusive, accessible, and empowering. This report draws on both survey and qualitative findings to paint a fuller picture of life with a disability in SEPA—capturing challenges in care access, mental health, daily life, social connection, and the importance of advocacy and community support.

A survey was developed to assess the health needs of people living with disabilities in the SEPA region (see online Appendix for results and a copy of the survey itself). This survey retained core questions included in the 2022 rCHNA disability survey, with the addition of several evidence-based items addressing quality of life, experiences with microaggressions, trust in health care providers, and feelings of isolation. The original questions explored respondents' disabilities, general health status, health care access, health behaviors, non-medical needs, employment status, use of technology and assistive devices, community participation, resource needs, and demographic characteristics.

A committee composed of representatives from Bryn Mawr Rehab Hospital, GSPP Rehabilitation, Jefferson Moss-Magee Rehabilitation - Center City and Jefferson Moss-Magee Rehabilitation - Elkins Park, and St. Mary Rehabilitation Hospital reviewed and approved the final survey instrument. The survey was fielded online in two waves: August–September 2024 and again in April 2025 to support focus group recruitment. The survey link was distributed through committee-generated contact lists, which included partner organizations, community programs, and support groups across the region. Committee members also shared the link through their own networks of current and former patients. All survey participants who provided an email address received a $10 gift card as a thank-you.

Descriptive analysis was conducted on 140 unique submissions. Where appropriate, open-ended responses were coded by the project team to identify key themes. For "check all that apply" questions, percentages may exceed 100 percent due to multiple selections.

In addition to the survey, two focus groups and four individual interviews were conducted to explore topics such as access to care, experiences with clinicians, community assets and barriers, and the isolation and loneliness associated with having a disability.

Human Subjects Protection

The focus group protocol was reviewed and approved by Advarra Institutional Review Board (IRB). All participants provided informed consent, and procedures followed institutional and federal guidelines to ensure the protection of human subjects.

Survey Results

RESPONDENT CHARACTERISTICS

The table at right summarizes the demographic characteristics of respondents. Respondents who are over 40, white, or had earned bachelor or graduate degrees made up a majority of the sample. Given this sample profile, it is important to note that the findings may not generalize to the larger community of adults with disabilities when interpreting survey results.

Characteristics		**N**	**%**
Gender	Man	75	48%
	Woman	75	48%
	Nonbinary	2	1%
	Transgender Man	1	<1%
	Prefer Not to Answer	3	2%
Age	18-24	5	3%
	25-44	31	20%
	45-64	81	52%
	>65	38	24%
	Prefer Not To Answer	1	1%
Race/Ethnicity	American-Indian/Alaskan Native	1	<1%
	Asian	9	5%
	Black/African-American	22	13%
	Hispanic/Latine	7	4%
	Native Hawaiian/Pacific Islander	1	<1%
	White	116	70%
	Some other race	2	1%
	Prefer Not To Answer	5	3%
Education	High school degree or equivalent	18	12%
	Some college	19	12%
	Associate degree	14	9%
	Bachelor degree	46	29%
	Graduate degree	53	34%
	Prefer Not To Answer	6	4%
Sexual Orientation	Straight	134	85%
	Gay or lesbian	10	6%
	Bisexual	6	4%
	Not Sure	2	1%
	Pansexual	1	<1%
	Prefer Not To Answer	6	4%

Additionally:

- Almost half the sample is **currently not working (43%), 24 percent are retired, 16 percent are working full-time and 10 percent are working part-time**. The remaining 7% include students, people who volunteer, care givers and those able to work but unable to find employment. About half of those working part-time do so because earning more puts them at risk for losing disability or attendant care benefits.
- **About 85 percent are residents of the five-county SEPA region (Bucks: 13%, Chester: 7%, Delaware: 9%, Montgomery: 26%, Philadelphia: 30%)**, with an additional 10 percent from other parts of Pennsylvania, collar counties in New Jersey and Delaware. The remainder are largely from outside the Greater Philadelphia region.

Disabilities and Limitations

- Most respondents **(92%) reported their disability as permanent**.
- Using the Center for Disease Control's standardized disability questions:
  - 9% are deaf or have serious difficulty hearing.
  - 12% are blind or have serious difficulty seeing even with glasses.
  - 41% have serious difficulty concentrating, remembering or making decisions because of physical, mental or emotional conditions.
  - 64% have serious difficulty walking or climbing stairs.
  - 44% have difficulty bathing or dressing.
  - 53% have difficulty doing errands alone because of a physical, mental or emotional condition.
- For those reporting more than one health condition or disability:
  - **24%** report **chronic pain**.
  - **19%** report **chronic disease**.
  - **12%** have **trouble speaking**.
  - **11%** report being **neurodivergent** including being on the autism spectrum, having ADHD, dyslexia, dyspraxia or Tourette syndrome.
- More than half of respondents **(68%) reported having their disability or condition for over five years**.
- About a quarter of participants **(26%) indicated that their mobility is impacted** by their condition. **Another 27%** reported difficulty with interactions such as making friends, being around others and communicating with others.
- Of those respondents who indicated that they **require personal assistance for life activities (92% of the total sample)**, 50% indicated that unpaid family and friends provide this care.
- **49% of the sample reported needing help for certain activities but not being able to get it.** These included daily activities such as self-care, mobility-related or physical activity, social interactions, and therapy or other health care.

Current Health

- Most prevalent **health conditions** were as follows:
  - **47% reported falling** within the past 12 months.
  - **17% reported having diabetes or high blood sugar.**
  - **13% reported having been diagnosed with asthma.**
  - **37% had been diagnosed with high blood pressure or hypertension.**
  - **54% reported being diagnosed with a mental health condition.**
- **About half of the sample reported good (35%) or very good health (12%).** An additional 35% reported fair health.

Accessing Health Services

- When asked about health services that had been utilized in the past 12 months, the most frequently selected options were **primary care (27%) and dental care (18%)**. About 11% of respondents reported using emergency care and about 15% reported use of psychological and/or counseling services.
- Of the almost 60% of respondents who indicated that they could not get the medical care that they needed in the past 12 months, the most frequently selected barriers were: **participants could not get an appointment, could not find a clinician who understood my condition, have difficulty identifying a doctor or clinic or had too much difficulty getting to the doctor's office or clinic**.
- Almost all participants who indicated they **take medication (98%) were able to regularly get the medication they needed (96%)**.
- Of the nearly 50% of respondents whose insurance status impacted their ability to get care, **the most frequently selected barriers included insurance did not pay for what was needed, could not afford care needed, could not find clinician that accepted insurance**. Of those reporting insurance barriers only **2% indicated they had no insurance at all**.
- About two- thirds of participants **(66%) reported that they have used telehealth services** in the past 12 months, and a majority of these respondents found **services beneficial (96%)**.
  - Those who had not used telehealth services indicated that they either did not have a need for such services or preferred in-person care.
  - While many found the services **convenient** (especially for particular types of appointments), others expressed **preference for in-person appointments or cited challenges related to technology and limitations of what could be done virtually**.
- The majority of participants **(82%) reported using a portal, website or app to see health information, communicate with their health team or make an appointment** in the past 12 months, and a majority of these respondents found **services beneficial (93%)**.
  - Those who had not used telehealth services indicated that they prefer to speak to someone on the phone or had difficulty with digital access.

Disability-Related Resources

- **27% of respondents reported needing special equipment or assistive devices**, with factors such as cost, insurance-related issues, and lack of knowledge posing barriers to acquisition. Needed equipment included:
  - Lifts, chairs, or other mechanized assists (7%)
  - Stair access supports (5%)
  - Railings, bars, or other non-mechanized assists (6%)
  - Vehicle big enough for a wheelchair, cart, or scooter (5%)
- Nearly half **(43%) reported that they currently participate in support groups**, with an additional 22% indicating that they are not currently participating but would be interested. A variety of resources were not widely used, but some respondents indicated interest in using:
  - Transportation support (28%)
  - Peer mentors (19%)
  - Support for caregivers (relief support or respite) (15%)
  - Care navigation (15%)
  - Complementary therapy (8%)
  - Adaptive sports programs (7%)

Non-Medical Needs

- With respect to housing, the biggest challenges were related to **home access and safety**:
  - **About a quarter of respondents (24%) with a physical disability indicated that they cannot enter or leave their home without assistance from someone else.**
  - **Almost 30% indicated that their current housing does not meet their needs.** Most commonly shared issues included those related to accessibility, safety, need for repairs, and cost.
- **Twenty-three percent of respondents shared that their primary means of transportation does not meet their current needs.** Most cited reasons included cost, need for assistance or equipment, and lack of reliability or convenience of transportation mode.
- **More than a quarter of the sample expressed significant financial needs:**
  - Almost 20% reported that there was a time in the last 12 months when they were **not able to pay mortgage, rent, or utility bills**. **Forty-four percent** of participants reported that **housing costs were somewhat or very difficult in the past year**.
  - Approximately **38% experienced food insecurity and 47% were often or sometimes worried about food insecurity**.
  - Twenty-seven percent needed the **services of an attorney but were not being able to afford one**.

Lifestyle

- While 33% of respondents shared that they exercise at least 30 minutes three or more days per week, **28% indicated that they never participate in such activity**. Most frequent barriers to physical activity were: not having the physical capability to participate in exercise, inability to afford a gym membership or no places near their home to exercise and lack of knowledge of exercises appropriate for their condition.
- **A majority of respondents (81%) reported eating at least one serving of fruits and vegetables in a typical day.**
- **Substance use was not prevalent in the sample:** 92% indicated that they do not currently use tobacco; 95% stated that they either do not use or do not feel that drug use impacts their daily life; and 86% stated that they either do not use or do not feel that alcohol use impacts their daily life.
- The survey asked about typical social interactions and activities:
  - A majority of respondents indicated that they **socialize with close friends, relatives, or neighbors (82%) and feel there are people they are close to (88%)**.
  - **Over a third (36%) indicated that they do not feel that their daily life is full of things that are interesting to them.**

Quality of Life and Connection

- More than **two-thirds of respondents (67%) rank quality of life as ‘so-so’**, neither good or bad.
- Despite almost 80% of participants indicating they regularly socialize, more than half of participants experience some form of isolation often or some of time including:
  - **Twenty-two percent of participants feel they often lack companionship** and 32% lack companionship some of the time.
  - **Thirty percent of participants report often feeling left out** and an additional 33% feel left out some of time.
  - **Twenty-eight percent of participants feel isolated from others often** and another 33% feel isolated some of the time.

Experience with Disability Microaggressions

Microaggression	% Applicable	% Impacted
People feel they need to do something to help me because I have a disability.	91%	62%
People express admiration for me or describe me as inspirational simply because I live with a disability.	91%	67%
People express pity for me because I have a disability.	88%	35%
People do not expect me to have a job or volunteer activities because I have a disability.	85%	31%
People offer me unsolicited, unwanted, or unneeded help because I have a disa-bility.	88%	38%
People are unwilling to accept I have a disability because I appear able-bodied.	79%	31%
People minimize my disability or suggest it could be worse.	90%	44%
People act as if accommodations for my disability are unnecessary.	89%	36%

While the survey provided valuable insight into trends in access, resource use, and unmet needs across the SEPA disability community, the lived experiences behind the numbers reveal even deeper truths. To better understand how people with disabilities navigate daily life, interact with health and social systems, and define quality of life, two focus groups and four in-depth interviews were conducted.

These conversations explored issues such as mental health, caregiving, social connection, systemic trust, and self-advocacy—shedding light on the emotional, relational, and structural dimensions of living with a disability. Participants’ voices brought richness and nuance to the data, elevating the themes from statistics to stories.

Access to Care

Access to care encompasses a broad range of experiences that shape whether, and how, people with disabilities are able to get the healthcare and support they need. Participants described numerous barriers, from delayed appointments to inaccessible clinic environments. One person shared that post-pandemic delays were widespread: **“There’s always a long wait for any doctor nowadays,”** especially for specialists and therapies. Even when appointments happened, the facilities were sometimes unprepared. One participant recalled arriving in respiratory distress only to learn the provider **“didn’t have oxygen or anything in his office,”** and he was sent home with no help.

Transportation and logistical hurdles were major subthemes. **“I need rides, I can’t drive myself now… that can be really difficult to coordinate,”** one woman explained, describing how unreliable paratransit and agency transport often caused her to miss care altogether. Financial barriers also emerged as key obstacles—especially costs not covered by insurance. One man noted, **“The cost of home care… it’s just one of those things that’s often not covered,”** leaving people to pay out of pocket for essential support. Others shared stories of navigating confusing insurance denials or delays for treatments they needed.

Communication was another critical piece of access. A participant with a neurological condition explained, **“It’s gonna take me a longer time to process what you’re saying, and I’m not leaving until I understand.”** Without time, clarity, or written instructions, even having an appointment didn’t guarantee appropriate care. True access meant being treated as someone who deserved to fully understand and participate in care decisions.

Alongside these barriers, some participants shared moments of supportive, well-designed care. One person compared experiences at two therapy sites: at the hospital, he received attentive, concierge-like service—**“staff met me with a wheelchair and escorted me”**—but not at the same health system’s affiliate site. This highlighted how responsive systems can make care accessible, while inattentive ones leave patients struggling.

Participants also emphasized **respect** as a vital part of access. Disrespect or dismissiveness—especially tied to invisible disabilities—eroded the quality of care. **“Sometimes I feel like they assume I can’t read or write,”** one woman said, highlighting how stereotyping can undercut a patient’s credibility. Others described being talked over or not accommodated in exams, leading to frustration and missed information.

Power in decision-making was closely tied to access. Many participants felt they had to push hard to be heard. **“If I don’t question them, who will? It’s my health,”** one said. This advocacy was sometimes misunderstood as being “difficult,” but participants saw it as necessary to ensure their needs were met. One woman described how she has to educate every new provider about her condition: **“Why don’t you all know about aphasia? If I say I have aphasia, I need you to speak slowly.”** These acts of advocacy—even switching providers or dictating how a visit should go—were about claiming a rightful voice in their care.

Experiences of **discrimination in care** further complicated access. A wheelchair user described a snowy day when **“they plowed all the snow into the handicap spot,”** leaving her unable to reach her doctor’s office. Her complaint was ignored. Others described being denied care or questioned unfairly due to disability-related insurance or visible conditions. These stories revealed how both policy-level and interpersonal discrimination shape whether patients receive equitable treatment.

At the broader systems level, **trust and mistrust** shaped how participants approached access. Many described healthcare and insurance systems as adversarial. **“You look at the [denial] letter… and go, ‘Were they even on the same phone call I was on?’”** one participant asked. Still, some found pockets of trust in individual providers who took time and advocated for them.

Transitions from pediatric to adult care added another layer of complexity. **“Moving from the school age, transitioning into adulthood becomes this vast scope of unknown things,”** a mother said, describing how her son lost the coordinated services he relied on. While adult systems often expect individuals to be independent, they frequently fail to provide the necessary guidance to support that independence. Simply turning 18 does not automatically equip young people—or their families—with the tools to navigate complex adult systems. Without intentional transition planning and continued support, families are left feeling overwhelmed and unsure of how to move forward.

Outside of clinical settings, participants also pointed to **broader health-related barriers** in their lives. Unsafe housing, poor public infrastructure, and limited access to food or community services made it hard to stay healthy. **“If you don’t have a car to get to the food pantries... obviously the people in need of these supports can’t get them,”** one said. These environmental and economic factors directly influenced health and reinforced the need for community-level changes.

Still, many highlighted the value of **community supports** that worked. **“There have been a lot of resources available,”** one person said, referring to local nonprofits and peer groups. Accessible transportation, wellness activities, and advocacy organizations were often described as game-changers. **“There’s a lot of peer support out there if you look,”** another noted.

Finally, **health and digital literacy** challenges were cited as modern barriers to care. From navigating telehealth to deciphering insurance forms, many participants felt overwhelmed. One man shared, **“I see now, because everything is connected to the phone... I need a phone.”** For others, peer support and self-teaching helped bridge the gap, but they emphasized the need for better tech training and more accessible provider communication.

In sum, participants’ stories made clear that access to care is about much more than scheduling appointments—it’s about transportation, respect, power, discrimination, trust, and navigating complex systems. Where supports were in place, care felt possible. But too often, the fight for access was exhausting and unjust, underscoring the urgent need for more inclusive, responsive systems.

Solutions for Access to Care

Participants identified several key strategies to improve access to care for people with disabilities. First, they emphasized the need for more **disability-competent providers**—clinicians who understand various conditions, communicate clearly, and are equipped to accommodate different needs. Ongoing provider training in accessibility and respectful care was strongly recommended. Second, **transportation support** emerged as critical. Suggestions included expanding paratransit services, offering travel vouchers, and developing shuttle programs for medical and social needs.

Third, participants advocated for **simplified insurance processes** and stronger care coordination, including patient navigators who can assist with scheduling, referrals, and insurance appeals. Lastly, participants called for **more integrated telehealth and digital access tools**—paired with training and support to ensure that technology enhances rather than hinders access. These practical solutions reflect a desire not only for medical services, but for systems that recognize and respond to the full scope of disability-related barriers.

The Experience of Being Disabled: Emotional, Social, and Support Dimensions

Living with a disability deeply impacts emotional and social well-being, not just physical health. Participants spoke openly about how their mental health was affected by both their conditions and the systems they had to navigate. Many experienced **depression, anxiety, and chronic stress**, often triggered by loss of independence, pain, or the emotional toll of feeling misunderstood or devalued in daily life and healthcare settings. **"I am statutorily blind, and that has also affected my mental health,"** one participant said, explaining how the progressive loss of vision slowly closed off the world she once knew. Others spoke about how physical limitations chipped away at their identity: **"After a while, you get into a funk because you can't do what you used to."** These expressions of grief and frustration were common, especially from those who had recently experienced a major shift in health or ability.

The emotional toll wasn't limited to the disability itself—it was **compounded by negative experiences with healthcare providers, insurance companies, and public systems**. Several participants described being dismissed or misunderstood by doctors, which triggered anxiety and made them dread appointments. Others linked their mental health struggles to systemic barriers like job insecurity or housing instability. One woman noted that the stress of nearly losing her job due to health-related absences **"kept me up at night and worsened my health overall."** These reflections show how navigating a difficult or disrespectful system can intensify mental health issues, creating a cycle that affects both physical and emotional well-being.

Despite these struggles, there were signs of **resilience and growth**. A participant with aphasia described how she used to beat herself up when her speech faltered: **"I used to get so… it would just depress me more."** Over time, she shifted to a more compassionate inner dialogue: **"Now I've learned to be gentler with myself."** Others shared that seeking therapy or joining a support group helped them cope and reconnect with others. For many, mental health care wasn't just helpful—it was transformative. **"I finally felt understood,"** one said about joining a group. Participants also emphasized the need for integrated mental health services, such as being referred to counseling automatically after a diagnosis or trauma. As one person put it, **"Mental health is very important, especially when you have [a disability],"** advocating for it to be treated as an essential part of care, not an afterthought.

Closely tied to mental health was the theme of **isolation and loneliness**. Participants described how social disconnection was both a cause and effect of their health challenges. Many shared that they no longer had strong support networks; illness had chipped away at their social lives. **"I don't work anymore… your communication isn't like it was,"** one woman said, describing how losing the routine and relationships of work left her adrift. Others noted that friends gradually stopped inviting them to events, assuming they couldn't attend. Over time, this erosion of contact created a sense of being forgotten.

Importantly, isolation wasn't always about physical solitude—it often stemmed from **feeling misunderstood or "othered."** One woman explained that having multiple disabilities made people treat her as fundamentally different: **"My long span of having many disabilities… I personally experienced a lot of isolation."** Others shared that even when they were with others, they felt emotionally alone, especially if their communication needs weren't respected. A participant with a speech impairment described the frustration of people trying to finish her sentences: **"They don't understand the frustration when I don't want you to feed the words for me."** These seemingly small moments created a disconnect that added to her loneliness.

Physical barriers played a role too. Several participants said they avoided social outings because of the effort required to get there—transportation challenges, poor infrastructure, or inaccessible buildings. **"Even though I'm grateful for public transportation, it's a challenge… I don't want to socialize sometimes because it's such an ordeal to get out,"** one person shared. Others who had relocated for care or housing reported being surrounded by strangers, unable to build new connections.

Yet again, **peer support emerged as a lifeline**. Whether through Zoom groups, community centers, or faith communities, participants found comfort in shared experience. **"It's nice to hear you're not alone in this… we're part of the world,"** one person said during a focus group session. This moment of recognition—of mutual understanding—served as a powerful antidote to isolation. People described how support groups, even if virtual, helped them feel included and valued. Others took proactive steps to build community, like forming informal networks with neighbors or becoming peer mentors.

Independent living and relationship support emerged as a fragile balance. Participants wanted autonomy but often lacked help with everyday tasks—transportation, housework, companionship. One person reflected, **"God knows I would love to have more help… even to the point of, oh my gosh, having the dude who does my lawn."** Those without a partner or family nearby faced steeper challenges. Pride and shame were emotional barriers to asking for help, particularly among men. Some built informal networks—neighbors, church friends—to fill the gap, showing resilience and creativity in maintaining independence.

Caregiver support and burden was another side of this conversation. Participants deeply valued family caregivers but were also keenly aware of the strain. **"My mom has been amazing, but I feel like it's taken a toll on her,"** one person said. Others were caregivers themselves while managing their own disabilities, leading to compounded stress. Financial strain, lack of respite options, and emotional fatigue were common, and many worried about the future if caregivers became unavailable.

Finally, **advocacy and self-advocacy** stood out as powerful tools for navigating all of these challenges. Participants described filing complaints, organizing support groups, joining hospital advisory boards, and founding nonprofits. **"I am always wearing my advocate hat,"** one participant said, illustrating how advocacy became a way of life—protecting their own rights while improving conditions for others. These acts, large and small, fostered a sense of agency and purpose, even in the face of overwhelming systems.

In sum, the emotional and social dimensions of disability are as significant as the medical ones. Mental health support, connection, autonomy, caregiver balance, and advocacy all shape how people live and thrive with disability—and when those elements are missing, they carry heavy costs.

Solutions for Connection

Solutions for Connection revolves around ideas and initiatives to reduce loneliness and build community among people with disabilities. After many participants shared their struggles with isolation, this theme captured the hopeful turn: what can we do about it? Participants had a chance to brainstorm and endorse various solutions – some they've experienced working, and others they wish to see implemented.

One overwhelmingly supported solution was **increasing the availability of support groups and peer gatherings**. **"I like the idea... more support groups publicly available. I think that's a great idea,"** one participant said, jumping off another's suggestion. There was a consensus that support groups (whether for specific conditions or more general disability social groups) help people connect, share experiences, and feel less alone. Participants discussed how these could be made more accessible – for instance, held in community centers or libraries (public, neutral places), possibly facilitated by a counselor or volunteer, and better advertised so people know about them. **"A lot of people either don't know or don't have access to those groups,"** the participant continued, noting that awareness is key. The idea of doctors or clinics referring patients to local support groups was floated; essentially, integrating social support into the care plan. The group clearly felt that structured settings where disabled individuals can meet each other are invaluable. Several people had personal anecdotes: one mentioned a stroke survivors group that "saved" her from deep depression, another talked about a virtual group for young adults with disabilities that became her friend circle. These examples reinforced the point – **organized peer support** is a lifeline, and expanding it would directly combat loneliness.

Technology as a tool for connection came up as well. Even though earlier there was frustration over technology, here participants noted its positive side. **Zoom gatherings** were cited: **"We do weekly support groups on Zoom... there's lots of folks from anywhere who join in,"** one participant mentioned. This was seen as a great solution for those who can't easily leave home or who live far apart. People can bond online and perhaps occasionally meet in person when possible. Social media groups specific to disability interests were also mentioned (with caveats about sometimes misinformation, but for socializing they can be good). One participant said he found a Facebook group for people with his rare disease and now has friends across the country from it – even traveling to meet one in person. Participants agreed that **digital connection** is a powerful solution, as long as people are comfortable with the technology (looping back to digital literacy and accessibility efforts).

Another major idea was **community events and activities designed to be inclusive**. Participants thought communities should create more opportunities for people with and without disabilities to socialize in a comfortable way. One person suggested a monthly game night or movie night at the local recreation center that specifically welcomes individuals with disabilities (providing needed accommodations but also open to all, to encourage integration). **"I think it was number 3 who threw out... more support groups...,"** another said, building on earlier comments, **"but also maybe like social events – like mixers where people can just hang out."** They imagined things like an adaptive sports day, art classes adapted for various abilities, or disability-friendly festivals. The key is these events would be well-publicized and normalized, not just one-off special occasions. Some noted that organizations do exist that host such events (like Easterseals, Centers for Independent Living, etc.), but they wished for more funding and frequency for these.

Participants also touched on **transportation solutions** as a prerequisite for connection. All the events in the world don't help if people can't get there. So, some suggested expanding shuttle services or volunteer driver programs for those with mobility issues to attend social gatherings. One person said her community started a free shuttle that **"goes to different parts of town that are important."** Such transit options, possibly funded by local government or nonprofits, were seen as enabling solutions for connection.

Interestingly, a participant with significant mobility limitations said that even just **phone calls** make a difference: **"They do have activities here… they've led me down the path of prayer,"** he said about his assisted facility residence, **"and we pray a lot. We also have folks who call to check on us."** This highlighted those simple interventions, like a scheduled call from a volunteer or staff just to chat or say hello, can brighten someone's day and make them feel cared about. Another participant mentioned "friendly visitor" programs where volunteers visit homebound older adults or individuals with disabilities regularly — she thought expanding those programs would be beneficial.

A few participants brought up the idea of **buddy systems or peer mentoring**. For example, pairing someone who's newly disabled with a peer who's been living with disability for a while – not only to provide practical advice but also friendship. One man said when he first became a wheelchair user, an older gentleman who also used a wheelchair took him under his wing through a local program, and that bond was crucial to his adjustment. They remained friends beyond the formal mentoring period. Standardizing such buddy programs (maybe through hospitals or community organizations) was seen as a great way to ensure no one falls through the cracks after a life change.

Advocacy and community education were mentioned as long-term solutions to change attitudes that cause isolation. For instance, teaching school kids about disability inclusion, or having community workshops to "demystify" disabilities, so that the general public is more comfortable interacting with and including people with disabilities. Over time this type of programming and education could reduce the social barriers and make organic connections more likely. While this is more preventative and cultural, the participants did see value in it.

Finally, it was noted that **the conversation we were having right now is part of the solution**. By coming together in this survey/focus group and sharing, they were already lessening isolation. One participant said, **"These conversations… give us an opportunity to differentiate care from quality care… and to be heard."** This comment highlighted the value of creating space for disabled individuals to define what quality care means beyond basic services. Through collective discussion, participants could identify shared priorities, articulate what a meaningful quality of life looks like, and feel a sense of connection and validation by being heard within a supportive group setting.

In conclusion, the **Solutions for Connection** theme was uplifting because it focused on positive action. Participants clearly believe that loneliness is not an inevitable fate – there are concrete steps to be taken. They championed **support groups, inclusive events, better transportation, buddy systems, and leveraging technology** as ways to bring people together. Importantly, those with firsthand experience in some of these solutions vouched for their effectiveness: **"We're not alone, and we're trying to fit in… it helps to hear each other,"** as one said. The collective wish was for these types of programs to be more widespread, consistent, and integrated into community offerings. There was a sense of empowerment: having identified solutions, participants seemed motivated to pursue them or at least to voice that these changes are needed. In a way, this theme tied the narrative together on a hopeful note – yes, there are many challenges, but also many ways to foster connection, and the participants are eager to see those ways expanded.

Intersectionality

Intersectionality in this context refers to how disability intersects with other identities or social factors (such as race, gender, socioeconomic status, incarceration history, etc.) to shape a person's experience. Although fewer participants spoke directly about this theme, those who did provided insightful examples of how their disability experience is compounded by other aspects of who they are.

One participant highlighted the importance of **cultural and linguistic background** in her healthcare. She struggled for years to find mental health providers who could understand her context – a woman of color and an immigrant. Eventually, she succeeded: **"I managed to find some providers from my particular background – so this would be women from minority backgrounds or from immigrant backgrounds."** This made a tremendous difference to her comfort level in care. **"There's a lot that I can tell them that they intuitively understand,"** she explained, **"[I don't have] to explain too much."** In other words, sharing gender and cultural identities with her providers meant she didn't have to constantly translate or justify her experiences; they "got it." Her story shows how **race/ethnicity and gender** intersect with disability in care settings – when these are aligned, the care feels more supportive, and when they're not, patients may feel misunderstood. It was an important reminder that a one-size-fits-all approach in healthcare can leave people from minoritized backgrounds feeling lost or alienated, whereas a provider who shares aspects of their identity can alleviate that burden.

Another powerful example of intersectionality came from participants who had been involved with the **criminal justice system**. One gentleman shared his experience of being incarcerated while managing mental health challenges. **"I was like in [prison] with a bunch of men, and I just didn't socialize that much,"** he admitted. It was only when he **"became a peer support and then the block tutor for the special needs unit"** that he found a sense of community. In helping other inmates with disabilities, he connected deeply: **"I could relate with those guys because I am them."** Here, his identity as a formerly incarcerated person and as someone with a disability converged. He felt "othered" both as a person with a disability in society and as an ex-prisoner, but in that role as peer mentor, those pieces of his identity combined to give him purpose and belonging. After being incarcerated for 20 years, reentering society was extremely challenging for him – he mentioned feeling "empty" coming home to a changed city and struggling with everyday technology, such as self-checkout machines. In addition to dealing with his health and disability, he bore the label of "ex-offender," which carries its own stigma. When two store employees laughed at him for not knowing how to use a self-checkout kiosk and joked, **"old head, you been locked up?"** it illustrated the prejudice he faced. That intersection of **disability and incarceration history** made his transition doubly hard: he had to catch up with societal changes and find people who would accept him. His story emphasizes that for some, disability can't be separated from contexts like incarceration – the two interlock to influence their challenges and needs.

Participants also touched on **mental health stigma and sexual orientation** as intersecting factors. One man described feeling judged in the past when seeking help for depression because some providers – or even friends – would say dismissive things like **"we all get sad, come on."** That lack of understanding was partly due, he felt, to a cultural stigma around mental illness. One participant shared, "I identify with the LGBT community," and reflected on past healthcare experiences where certain questions from providers made him "feel weird." Although he did not specify the questions, it can be inferred that they may have been phrased insensitively or based on assumptions about his sexual orientation, contributing to discomfort and a sense of exclusion in the care setting. **"That was in the past... typically now I don't experience that,"** he noted, implying that healthcare has become more aware of LGBTQ+ concerns over time, but it was clearly an issue he remembered. This shows an intersection of **disability, mental health, and LGBTQ+ identity** – any one of those can invite bias, and together they can complicate finding supportive care. For him, knowing that element of his identity might affect a provider's attitude was an extra worry layered on top of managing her health.

Interestingly, one participant reflected on intersectionality from a position of relative privilege. He introduced himself by acknowledging, **"I have my privilege, you know, as a white male,"** and yet he described a particular kind of fear. Despite his privilege, he said, **"I'm scared of doctors in a way... I don't want to ask for maybe a certain medication, or I don't want to admit... that I'm having a problem."** This reluctance to show vulnerability, which he partly attributed to being a man in our society ("a macho thing"), intersected with his mental health needs. Fortunately, he found a psychiatrist who was "very open" and supportive, and **"that experience with that particular person has been wonderful."** His perspective is telling: even someone who does not face racial or economic disadvantage still experiences a kind of intersectional barrier – in this case, the societal expectations of masculinity affecting how he engages with healthcare. It underlines that intersectionality isn't only about marginalization; it's about **how all facets of identity interact**. For him, being male made it harder to admit he needed help (due to stigma around men and mental health), and being disabled made that help necessary – a tricky combination he had to navigate.

In summary, the **Intersectionality** theme illuminated that people with disabilities are not monolithic – their other identities significantly shape their experiences. Whether it's finding refuge in a provider who shares your culture, or struggling with societal reintegration after prison, or ensuring a safe space as an LGBTQ+ individual, these additional layers can either buffer or intensify the challenges of living with a disability. Participants' narratives here call for a more nuanced understanding in services: cultural competence in healthcare, support systems for those with disability and a criminal record, sensitivity to gender and sexual orientation in treatment, and acknowledgment that disability intersects with issues of race, class, and beyond. Recognizing these intersections is key to addressing the full person, not just their disability in isolation.

General Population Perspectives

The **general population perspectives** theme captures insights from community members—caregivers, advocates, and concerned residents—who may not identify as disabled but are aware of disability-related issues. These comments emerged from a broader series of community conversations about health and well-being, offering an important outside-looking-in viewpoint that often validated and reinforced the voices of people with disabilities.

Across the board, general population participants expressed empathy and concern, especially for older adults who lose mobility and face financial strain. **"Many people lose their driver's license when they are older,"** one participant said, noting the lack of affordable alternatives: **"They need a person to take care of them, and some people don't have the money to pay for that [help]."** Others pointed to community efforts—like meal delivery services—as examples of what's working but acknowledged that services for medical transport or social needs remain insufficient.

A recurring theme was the **invisibility of the disability community**. One passionate advocate who tried for years to improve a local adaptive fitness center said, **"The disability community to this day, in my opinion, is left out… the voiceless hidden community."** His frustration with bureaucratic inaction showed how even non-disabled allies are aware of systemic neglect—and are sometimes stonewalled when trying to help.

Many echoed the need for **expanded services and inclusion across all ages**. **"People with disabilities are definitely suffering the most… from the youth all the way up to our seniors,"** one person observed. Another shared pride in witnessing inclusive community behavior: when a blind woman attended a local event, **"everybody was so attentive… her needs were met.**" That moment stood out as rare and commendable, subtly highlighting that such inclusion is not yet the norm.

General population voices also revealed awareness of **technical and systemic challenges**—from poorly run paratransit programs to the financial burdens of caregiving. One participant described how unpredictable ride services leave people stranded: **"You never know when your rides are coming… if they're late, they don't even know they're late."**

In sum, general population community members served as powerful allies in these discussions. They saw and echoed many of the barriers described by discussion participants with disabilities—transportation, affordability, social exclusion—and added their own frustrations and hopes. Their perspectives highlight that disability access is not just a personal issue; it's a community one. They called for improved services, infrastructure, and inclusion, expressing solidarity and a willingness to act. Their voices added strength to the overall message: people with disabilities should be seen, heard, and supported—by everyone.

Together, the survey and qualitative data presented above highlight the complex and multifaceted experience of living with a disability in southeastern Pennsylvania. While many participants expressed resilience and described meaningful support systems—ranging from peer groups to trusted providers—there were also clear and persistent barriers: inaccessible services, financial hardship, social isolation, and deep mistrust in institutions. Emotional and mental health impacts were intertwined with structural challenges, and personal stories of exclusion often paralleled broader systemic failures. Yet participants also offered solutions—calls for more inclusive community programming, better caregiver support, integrated mental health care, and expanded opportunities for connection and advocacy. The findings underscore the urgency of addressing disability not just as a clinical condition but as a social and policy issue requiring comprehensive, person-centered strategies. This report aims to inform that work—by ensuring that the voices and needs of people with disabilities are central to planning, policy, and community health initiatives across the region.