

## Physical accessibility in primary health care settings: Results from California on-site reviews

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### Abstract

**Background:** People with disabilities report physical barriers in doctors' offices that affect the quality of care. Whether most or few doctors' offices are accessible is not known. We address this gap with data on 2389 primary care provider facilities.

**Objectives:** The analysis seeks to describe overall primary care office physical accessibility and identify (1) in which areas offices meet access criteria, (2) which accessibility criteria are most often not met, and (3) whether there are urban/non-urban differences.

**Methods:** Reviewers rated medical offices using a 55-item instrument that assessed parking, exterior access, building entrance, interior public spaces, doctor's office interior, and the presence of accessible exam equipment. Five health plans that serve California Medicaid patients conducted reviews of providers signed with their plans. Data from the plans were merged, coded, and a descriptive analysis conducted.

**Results:** An accessible weight scale was present in 3.6% and a height adjustable examination table in 8.4% of the sites. Other high prevalence access barriers were in bathrooms and examination rooms. Parking, exterior access, building access, and interior public spaces generally met the access criteria, except for van accessible parking.

**Conclusions:** These findings provide a base for quantitative expectations about accessibility nationwide, and indicate significant barriers exist. They show it is possible to conduct a large number of accessibility site reviews, providing one model to meet the Affordable Care Act requirement for provider accessibility information. Physical access is important as it may affect the quality of care and willingness of patients to engage in preventive care. © 2012 Elsevier Inc. All rights reserved.

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A large and growing literature documents that people with disabilities experience barriers when accessing primary health care. In qualitative interviews, focus groups, and surveys, individuals with disabilities report a number of problems and experiences that prevent their receipt of quality health care or which result in substandard care [1-6]. Among the problems reported are architectural barriers, examination equipment that cannot accommodate

persons with varying physical limitations, inflexible office procedures and organizational processes, negative attitudes, and lack of knowledge among physicians, nurses, and other health care personnel about treating patients with disabilities [1-3,7]. Patients with mobility disabilities report they are seldom weighed [8] and patients who are deaf report examinations with doctors communicating by writing brief notes because no sign language interpreter is present [9]. People with disabilities also report delaying doctor visits because of physical and programmatic hassles, inadequate health insurance coverage, and greater dissatisfaction with care [1,10-12].

The literature on health care access problems encountered by people with disabilities is largely based on data obtained from the patients themselves. There are no national comprehensive data on providers and their access characteristics. Surveys of physicians have found them reluctant to respond, resulting in low response rates and

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small n's [13]. As a consequence, there are no national estimates of the proportion of provider facilities that are architecturally accessible or have accessible medical exam equipment. It is unknown how many and to what extent provider offices are accessible. Lack of access makes it difficult for individuals to engage in health prevention and wellness services, and this may later result in higher cost and/or more serious health problems.

This paper presents a descriptive analysis of a unique set of data, derived from on-site reviews of 2389 primary care provider facilities in California. The analysis seeks to answer the overarching question, what is the extent of primary care office physical accessibility to patients with disabilities? In particular, it asks the following:

1. Which areas of providers' offices meet most of the indicators of accessibility?
2. Which areas are most deficient?
3. Is access different between providers located in urban versus non-urban areas?

### Previous research

Although to date there are no studies with a national sample or a large number of observations, there are studies of physician office access. These studies fall into two groups: those that collected data from medical provider offices via a self-administered survey and those that used an on-site surveyor to rate access. These studies used different data collection tools with differing sets of questions.

In the first group, the studies that survey providers, are Grabois, Nosek, and Rossi [14]; McNeal, Carrothers, and Premo [15]; and the California Foundation for Independent Living Centers (CFILC) in collaboration with Cohen [16] (which surveyed health plans about their accessibility information on providers). These surveys generally had low response rates and a small number of observations in their analyses. The final sample size in the Grabois, Nosek and Rossi study [14] was 62 (28% response rate); it was 501 (26% response rate) in the McNeal, Carrothers, and Premo study [15]; and 10 health plans responded of 28 contacted (36% response rate) in the CFILC and Cohen study [16]. In addition to these surveys, Iezzoni and O'Day [3] "visited and spoke" with approximately 20 persons (physicians, nurses, and office staff) in several medical practices about issues of access. Across these studies, the respondents indicated that approximately 50% of their offices had examination tables that were not accessible to patients with mobility impairments. Restrooms were another area that respondents indicated were not always fully accessible to their patients with disabilities, especially those who used wheelchairs.

In the second group, comprised of studies with on-site observation of accessibility, are Sanchez et al. [17]; Graham and Mann [18]; and Story, Kailes, and Mac Donald

[19]. Graham and Mann [18] report on-site assessments conducted by a rehabilitation engineer of 68 physician offices in South Carolina. The Sanchez et al. study [17], with 40 respondents, is especially interesting because they first conducted a telephone survey with the provider's office manager (or delegate) that asked about elements of access. They followed this with a site visit by a team of surveyors that conducted an on-site assessment of parking, building entrance, examination room, and restroom accessibility. A comparison of the survey report with the on-site report revealed significant discrepancies. The Story et al. [19] publication summarizes in general terms findings from the authors' consultations with more than 20 hospitals and a number of clinics across the United States that were conducted as part of compliance with ADA legal actions involving lack of access. As part of the consultation, information was gathered from interviews with medical center personnel, formal on-site surveys of the facilities, and other key informants familiar with the facility's procedures for accommodating patients with disabilities.

The Graham and Mann study [18] found height adjustable examination tables in 44% of the 68 respondent sites and an accessible scale at only one site. In the Sanchez et al. study [17], 17.5% of sites had a height adjustable examination table (although 38% had reported having one in the survey component). Both studies also found that approximately 60% of bathrooms met accessibility criteria (summing across such indicators as doorways, stall size, sink height, door hardware, and grab bars). Story et al. [19] do not provide quantitative findings; however, accessible examination tables and weight scales are mentioned as problems they observed, along with inadequate space in waiting areas. Graham and Mann [18] used year of construction or most recent renovation in a regression model with accessibility as the dependent variable and found it was the best predictor of level of accessibility (newer buildings or those with recent renovations were more accessible). A comparison of urban and rural settings found no difference in rates of accessibility.

The prior research suggests that on-site observation of accessibility is more reliable than self-administered or telephone surveys of providers. From the prior observation-based studies we have a developing sense of the access elements that are consistently present or absent. However, the sample sizes of these studies are too small to derive confident conclusions about average level of medical provider accessibility, or the presence of such specific access elements as an accessible examination table. Moreover, because the respondent providers in the prior observation studies were not selected at random, but were providers who had agreed to being reviewed, they may represent physicians already more attuned to issues of access. Thus, the need remains for information on provider access obtained from observation of a larger number of sites and a selection process that is more representative of all provider settings.

## Methods

### *Data source and study size*

Starting in 2000, four health plans in California that contract with the State of California to offer Medicaid managed care worked with two disability consultants to develop a 55-item instrument to assess the physical access of health provider facilities. The plans already were required by the State of California to assess medical provider sites for such qualities as procedures for infection control and the training of staff for informed consent procedures. The site reviews are conducted when a doctor first signs up with a plan and every three years thereafter. Starting in 2006, when a health plan conducted the required State of California on-site review of a doctor's office, the disability access tool also was used by the site reviewer. The plans share information where a provider is signed up with more than one plan so that only a single review is conducted. Some plans post selected access information on their website as part of a provider's profile to assist members seeking to select a physician.

Realizing these site reviews offered unique information about provider access characteristics, we asked the plans if we could obtain their data for analysis purposes. The four plans readily agreed, and a fifth plan offered its data on hearing of the project. Thus this analysis reports on a merged dataset created from data collected by five different health plans in California. All five plans provided data from the 55-item tool. However, additional information about the providers was limited and varied from plan to plan because data were not always stored in the same manner. The data we received were stripped of the name and address of the provider, but included city and zip code. We received the data in Excel spreadsheets and cleaned, moved, and merged the data for analysis into SPSS. The unit of analysis is provider site and the data are its physical characteristics. The Institutional Review Board indicated the project did not require review.

The final dataset consists of reviews conducted between January 2006 and September 2010, from 2389 provider sites. There were 192 observations with duplicate state identification numbers (96 pairs) that we excluded from the final dataset because it was unclear whether the duplicate numbers were due to a re-review of a site, or whether other circumstances accounted for unique sites with the same site identification numbers. The observations in this dataset are from providers obliged to submit to the review as a requirement for their association with one or more of the five California Medicaid health plans. Thus, the dataset is not a representative random sample of providers across California, but it includes providers regardless of their level of interest in or awareness of disability accommodation.

The 2389 provider sites in the final dataset represent more than 2389 doctors. Some sites are a single doctor practicing alone; some are small medical practice groups;

and some are large primary practice groups all using the same suite of offices. All providers whose sites are in the dataset are considered primary care providers. Within the sites are doctors who define their practice specialty as internal medicine or family practice, with a small number listing pediatrics or obstetrics/gynecology. Although we do not know the number of doctors, the health plans provided estimates of the numbers of members associated with their plans. The total number of Medicaid enrollees across the five health plans is approximately 2.5 million persons (per communications from the plans). Some of the providers also see non-Medicaid patients; thus, even recognizing that some doctors newly associated with a plan may not have had their site reviewed, the total number of persons served by providers in this dataset is likely in excess of 2.5 million patients in California. Figure 1 shows the counties in which the providers are located and the table within Figure 1 shows the number of provider observations in each county.

### *Measures*

The 55-item accessibility survey used by the health plans rates each access criterion *yes*, *no*, or *not applicable* for accessible parking spaces; exterior ramps, stairs, and walkways; building entrance (including signs and door hardware); interior circulation (including hallways, ramps, and stairs); elevator characteristics (where an elevator is present); entrance to the doctor's office (door weight and hardware); waiting area; restrooms (stall size and layout, grab bars, door hardware, and sink access); examination room (size, door weight and hardware); and medical examination equipment (examination table and weight scale). Of the 53 architectural elements, 41 are from the 1991 ADAAG guidelines [20]. These include the measurement guidelines for door width, ramp run lengths and handrails, parking space ratios, and door handles. Because the 1991 ADAAG guidelines address inpatient hospital facilities, but not specifically outpatient doctors' offices, the tool incorporates the hospital guidelines where appropriate, and the guidelines for commercial settings otherwise. For example, parking, entrances, and restroom criteria were taken from the guidelines for commercial settings. The health plans were concerned about the time required to perform the assessment and so the 55 items are a subset of elements judged to be important for health care service access. The U.S. Department of Justice *Access to Medical Care for Individuals with Mobility Impairments* publication was issued after the tool was already in use [21].

For analysis, we treat the 55 items as equally weighted and group them into four categories: (1) parking and exterior access (12 indicators), (2) building entrance and interior public spaces (21 indicators), (3) interior of provider's office (waiting area, examination rooms, and restrooms—20 indicators), and (4) examination equipment

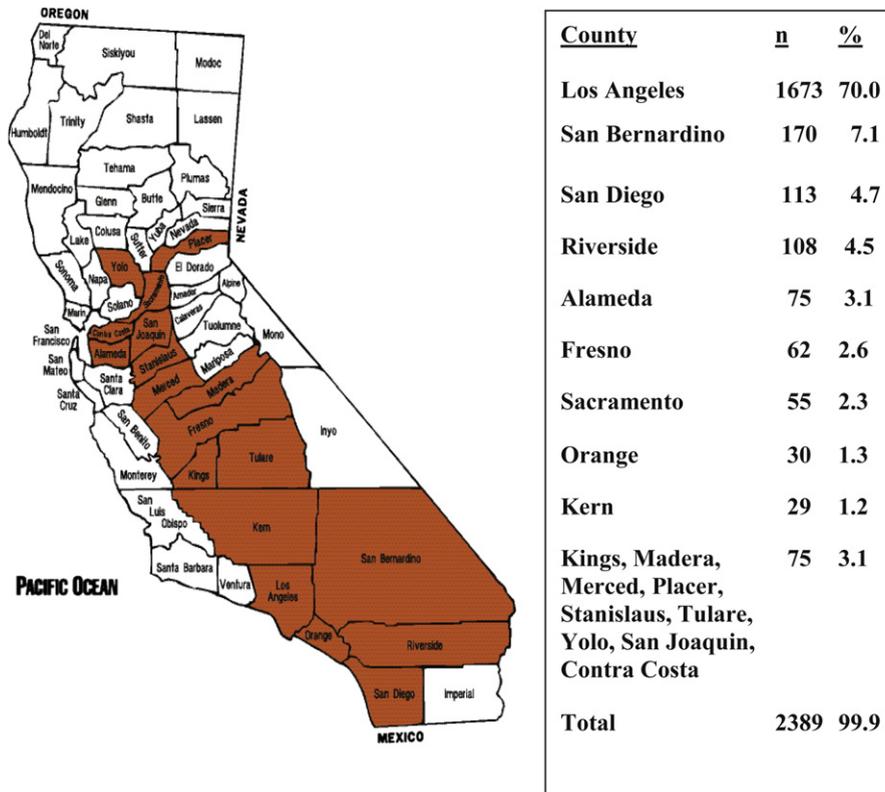


Figure 1. Distribution and geographic location of health care provider sites assessed.

(2 indicators). Within the groupings, 9 of the 12 *parking and exterior access* elements represent an ADAAG guideline; 18 of 21 *building entrance and interior public area* elements are from ADAAG; and 14 of 20 *interior of provider’s office* elements are from ADAAG. Medical equipment is not addressed in the 1991 ADAAG. The 12 architectural assessment items that do not conform to an ADAAG guideline are not as specific as the ADAAG (and may require rater judgment) or address an element that is not part of the ADAAG. For example, criterion 41 states, “There is accessible space beside the toilet so that the wheelchair user can transfer from the wheelchair to the toilet.” This does not specify the space size and requires the rater to judge whether or not the space is accessible in size and placement. Criterion 50 states, “Examination and treatment rooms located on accessible route.” The reviewers were not provided specific measurements to use for assessment and therefore had to use their judgment regarding accessibility. The complete assessment tool can be viewed at the California Department of Health Care Services website [http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/FEB24/ADA%20Tool\\_IEHP\\_LACare\\_HealthNet\\_Molina.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/FEB24/ADA%20Tool_IEHP_LACare_HealthNet_Molina.pdf).

Not all 55-items apply to every site (e.g., the elevator elements do not apply to doctors’ offices in a single story building). To provide a sense of the degree to which a provider site was accessible, we used the total number of criteria that applied to that site as the base and calculated

the percentage of these *applicable* items that conformed to the access criteria. For a small number of provider sites, there was no information on all the elements within a grouping. These missing observation cases are not included in the data displayed in Figures 2-5.

The provider sites were categorized as urban or non-urban using city and zip code and the Census Bureau’s list of urbanized areas based on the 2000 Census [22]. A site was considered a non-urban site if it was in a city of less than 50,000 people that was not contiguous to an urban site. With this criterion, 94.8% (2265) of the providers in the

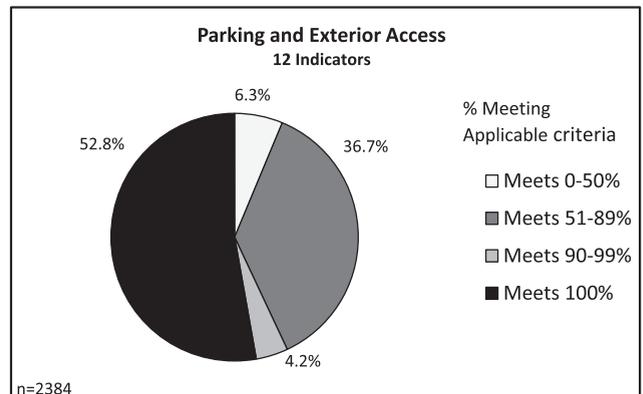


Figure 2. Distribution of health care provider ratings for parking and exterior access—the percentage of providers that meet access criteria.

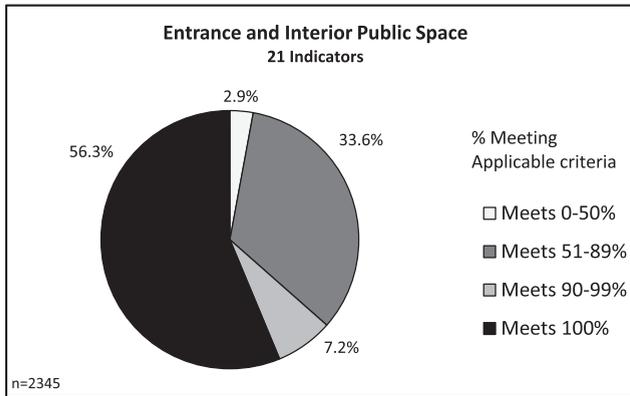


Figure 3. Distribution of health care provider ratings for entrance and interior public spaces—the percentage of providers that meet access criteria.

dataset are located in an urban area, with only 5.2% (124) located in a non-urban area. The table within Figure 1 indicates that most of the sites are in counties with large urban areas (e.g., Los Angeles, San Bernardino, San Diego, Riverside, and Alameda). However, the map also indicates that some providers are located in counties that include the Central Valley agricultural region, the Sierra Nevada Mountains and their foothills, and the Mohave Desert which are more sparsely populated (e.g., Fresno, Kern, and Tulare).

**Data collection**

The data were collected by RNs employed by the different plans, but trained together on the instrument, its intent, and the basis for concerns about disability access. The initial training was conducted by the two disability consultants and a key individual from one of the plans, who is now responsible for all subsequent training. Each plan uses between one to four raters, depending on the number of providers associated with the plan. Where the tool includes a measurement specification, raters conduct the measurement. Inter-rater reliability checks within a plan or across the plans have not been performed.

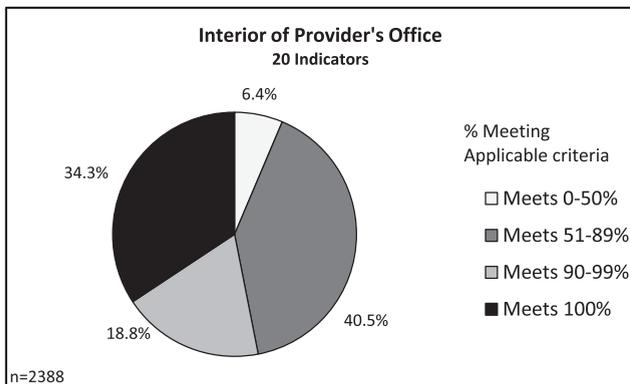


Figure 4. Distribution of health care provider ratings for the interior of the provider's office—the percentage of providers that meet access criteria.

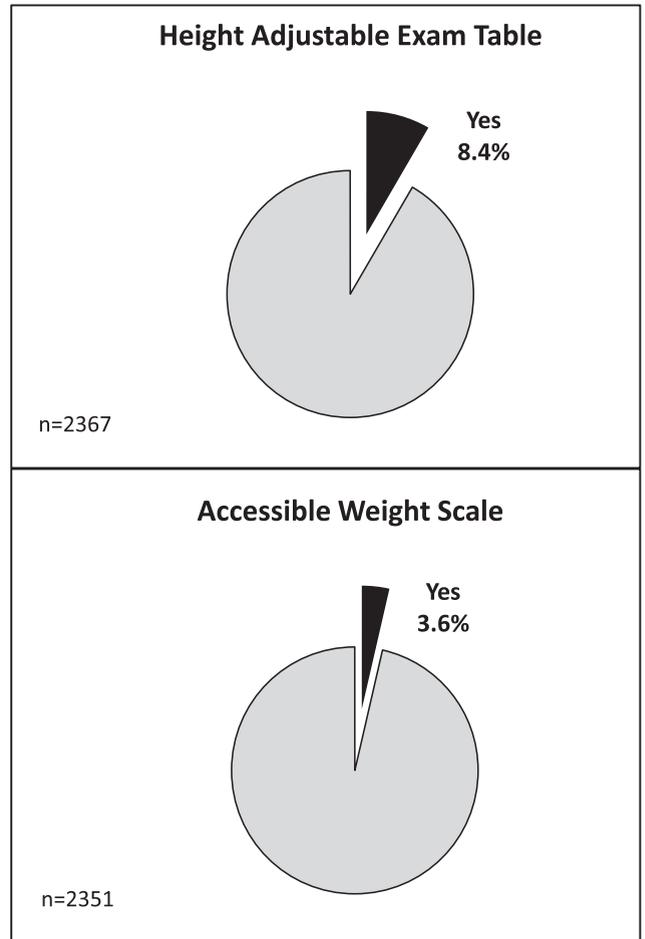


Figure 5. The percentage of health care provider offices with accessible medical examination equipment.

**Results**

Figures 2-5 display the frequency distributions on the accessibility criteria in the four categories: parking and exterior access, building entrance and interior public areas, interior of the provider's office, and accessible examination equipment. The data are summarized using pie charts with the percentage distribution displayed in four groups: 0-50%, 51-89%, 90-99%, and 100%. For the first three categories Table 1 lists the individual criteria met by the largest percentage of sites and the criteria most frequently not met. The pie charts show that the largest percentages of sites meeting all criteria are in "parking and exterior access" and "building entrance and interior public areas." The percentage of providers meeting all access indicators for "interior of the provider's office" or "accessible medical equipment" is noticeably lower.

**Parking and exterior access**

Figure 2 shows that nearly 53% of provider sites met all 12 criteria for parking and exterior access, and another 4.2% meet between 90-99% of the access criteria that apply

Table 1  
Areas of greatest access and largest access deficiencies in medical offices

Parking and exterior access (12 criteria)	Building entrance and interior public areas (21 criteria)	Interior of provider's office (20 criteria)
Areas of greatest access (percent of sites that meet the criteria)		
Required ratio of accessible parking spaces (94.3%)	Entrance door $\geq$ 32 inches clear opening (98.5%)	Examination and treatment rooms on an accessible route (99.5%)
Curb cuts at drives, parking, and drop-offs (96.9%)	If elevators, near major path of travel, usable when building occupied (98.8%)	Door to physician office $\geq$ 32 inches clear opening (96.9%)
Where ramps are present, meets standard for length, landings, width (94.6%-98.8%)	If ramps or stairs, meets standards for length, landings, width, and handrails (88%-96%)	Toilet paper dispensers are accessible (98.1%)
Areas of largest deficiency (percent of sites that do not meet the criteria)		
Presence or ratio of van accessible spaces (34.8%)	Signage on inaccessible entrances directing to accessible entrance (40.1%)	Door hardware: office door (32.6%); restroom door (31.1%); examination room door (36.5%)
Signage for accessible parking not visible (15.7%)	Exterior door hardware (17.5%)	Door weight (20.2%)
Handrails on both sides of ramp $\geq$ 6 feet (19.7%)	If elevator, visible and audible door opening or closing and floor indicators (30.7%)	Restroom: space in single and/or multi-user stall (13.3%-16.6% across four indicators)
	Floor signage on both elevator door jambs (22.1%)	Restroom: space under sink (15.3%); faucet type (18.9%)

to the characteristics of that setting. Nonetheless, 43% of the sites are below 90% in the proportion of the access criteria they meet. In Table 1 the largest areas of deficiency are the number of van accessible spaces and visible signage for the van accessible spaces. Handrails on ramps that are longer than 6 feet is another area of exterior access where many sites do not meet the criteria.

### **Building entrance and interior public areas**

There are 21 indicators within the category of building entrance and interior public areas that include the ADAAG guidelines for the width of the main building door; interior hallways, ramps, and stairs; and elevators for buildings with multiple stories. Figure 3 shows that 56.3% of sites met all 21 indicators with another 7.2% of sites meeting between 90-99% of the criteria that apply to them. Table 1 indicates that the items for which there are the most problems are exterior signage on inaccessible entrances that direct visitors to an accessible entrance and door hardware. Where an elevator is present, signage deficiencies include the absence of audible and visual door opening/closing and floor notifications and signage on both door jambs of the elevator opening on each floor.

### **Interior of the provider's office**

There are 20 indicators within the category of the provider's office. Items within this category address the entrance to the office suite, the waiting area, the interior hallways, examination room size and door weight, and the characteristics of the restroom. There are 11 restroom criteria and they include adequate transfer and turning space, door hardware, grab bars, toilet paper dispenser location, sink height, and faucet handles in both single user restrooms and multi-user restrooms with stalls. Figure 4 indicates that the proportion of sites that meet all of these

indicators is 34.3%; 18.8% meet between 90-99% of the criteria. This is in contrast to the two prior areas of access where more than 50% of the provider sites met all the criteria. Sites meet the accessibility criteria with respect to the examination rooms being located on an accessible route, the examination room door width, and the height of the toilet paper dispensers. However, there are a number of areas where the restrooms are inaccessible: stall size, space under the sink, hardware on the restroom door and toilet stall doors, and faucets.

### **Accessible examination equipment**

The site reviewers looked for the presence of two items of accessible medical examination equipment, a height adjustable examination table with a minimum height of 20 inches and an accessible weight scale. An accessible weight scale was defined as a scale usable by all patients, including those with mobility or activity limitations or who may exceed the standard weight scale limit. As Figure 5 indicates, only 8.4% had a height adjustable examination table and only 3.6% of provider office sites had an accessible weight scale.

### **Urban and non-urban differences**

Significant differences in site accessibility across the 55 access criteria between offices located in urban or non-urban settings were found for four indicators ( $p < .05$ ). The non-urban settings showed the greater access with respect to the door weight of the entrance to the provider's office (an interior door), the clear space for turning in order to use examination room doors, the clear space in the examination room itself, and the presence of a height adjustable examination table. The greatest urban/non-urban discrepancy was in the area of height adjustable examination tables; 17.9% of providers located in a non-urban setting

had a height adjustable examination table compared with 7.8% of provider offices located in an urban setting ( $\chi^2 = 15.34, p < .01$ ). There was no statistically significant difference in the presence of accessible weight scales between providers located in an urban versus a non-urban setting.

## Discussion

This dataset provides information from a significantly larger number of sites than previously published studies of the accessibility characteristics of medical providers' offices. Because the sites reviewed were not identified through a volunteer process, and the data were collected by outside reviewer observation, the sites in the dataset are more likely to be representative of provider sites, generally. Therefore, these data offer a stronger quantitative indication of provider office accessibility to patients with disabilities than prior studies. The findings concur with conclusions from the smaller and earlier studies in general terms; however, there is a different prevalence for key elements of access.

The most important finding is that only 8.4% of provider sites have a height adjustable examination table and only 3.6% of sites have an accessible weight scale. The prior studies had indicated that height adjustable examination tables were present in 17%–44% of offices. Our findings show their presence to be significantly lower. Where there is no height adjustable examination table, interviews from both patients and providers indicate that patients may be examined seated or lifted up onto the examination table [3]. Conditions may be missed if a patient is only examined seated in a wheelchair, as the 2001 lawsuit Metzler et al. versus Kaiser Foundation Health Plan, Inc. et al. made clear [7]. Untrained or unassisted lifting of a patient onto an examination table risks injuring the patient and/or the individual who is doing the lifting [3,17]. Patients also report avoiding going to the doctor because they are fearful of the climb onto the examination table [4]. Height adjustable examination tables are useful to a broad range of patients that includes people with obesity, arthritis, balance difficulties, vision impairments, and a wide range of mobility impairments.

There are no other quantitative estimates of the prevalence of accessible weight scales for comparison purposes. However, these findings confirm the qualitative reports from patients unable to use conventional scales, that they are seldom or never weighed. For most patients, weight is the first thing measured in a medical encounter because weight and weight change is used as an indicator for many health problems.

The findings also show that although the parking arrangements and exterior entrances of most medical buildings are accessible to a patient with a disability, significant barriers continue to exist inside their physician's office.

Only 34.3% of provider offices met all of the interior office access criteria appropriate for their setting. The most problematic barriers are found in the bathrooms. Heavy doors and unusable door knobs, wrong sink heights and faucet handles, the absence of grab bars, and inadequate space for someone using a wheelchair to enter, turn, and open or close a door, or to transfer from wheelchair to toilet are present in many of the medical office restrooms. These characteristics mean that even if a patient can enter a physician's office, the inability to use the bathroom presents a significant barrier to appropriate medical care and diagnostic tests.

We had expected that urban settings would show greater accessibility than non-urban settings, but that is not what we found. One possible explanation, consistent with Graham and Mann [18] may be that the buildings in non-urban settings are newer.

## Caveats

In interpreting these findings, some caveats should be kept in mind. First, although the health plans engaged in similar training of the raters, no assessment of inter-rater reliability was conducted. Because some of the items did require rater judgment, as noted earlier, such an analysis would have been useful. Second, the access instrument was not developed for research purposes, but as a monitoring tool for the health plans. It evolved from a process of negotiation across the four health plans and with the disability advocates with considerations of what was feasible and what was most important to measure. Once completed, the tool was not field tested before being put into use, nor assessed for reliability or validity. Third, the observations are only for providers who take Medicaid patients. Because studies of the health insurance used by adults with disabilities find that they are much more likely than adults without disabilities to be covered by Medicaid or Medicare [10], the data may cover the providers such patients are most likely to see. However, not surveyed are physicians who do not accept Medicaid or who are not associated with one of the five health plans in the counties in Figure 1. These data provide no insight on the accessibility of the offices of these other providers.

Other weaknesses involve data we were unable to acquire. More information about the providers' practices, including the number of physicians in the practice, the number of patients they serve, and the age of the building would have been useful. The exact address also would have allowed us to map population characteristics against the location of accessible offices, but it may have compromised the anonymity of the providers.

Finally, it is important to recognize that the 55-item instrument focuses nearly exclusively on elements of architectural access. Not assessed are other crucial aspects of access identified in the literature. These include the use of Sign Language interpreters; other measures for effective

communication with patients who have hearing, vision, or cognitive impairments; modifications of office procedures to accommodate patients who use medical transport or have other needs; training of physicians and nurses for providing care to patients with disabilities; training of staff regarding attitudes and stereotypes concerning people with disabilities; training in disability cultural competence for interactions with patients with different impairments; and the presence of accessible medical diagnostic equipment beyond examination tables and scales.

### Conclusion and policy applications

We believe these findings provide a solid base for developing expectations about accessibility nationwide. Although these audits were conducted only in California, the barriers observed are unlikely to be unique. In fact, it is possible that architectural access in California is greater than in older cities in the United States where there are larger numbers of older buildings. Without quantitative data about the dimensions of accessibility, it has been difficult to estimate the degree to which access barriers may account for the documented health disparities experienced by people with disabilities. Specific information about the access elements most often *not* present also may help to effectively target efforts to increase access.

This study also shows that it is possible to conduct site reviews of doctors' offices and obtain useful data for a large number of provider sites. As part of its Section 1115 Medicaid Waiver [23], the State of California is now implementing facility site reviews that include a disability accessibility tool as a mandatory component. The state is using a slightly longer instrument built on the one analyzed here. At the federal level, the Affordable Care Act contains two provisions for which the information and data collection experience described in this study are pertinent. Section 4203 requires the U.S. Access Board to develop standards for accessible examination tables, scales, imaging equipment, medical chairs, and other diagnostic medical equipment to support examinations for patients with disabilities to adequately accommodate their disabilities. Section 4302 requires the U.S. Department of Health and Human Services to

[S]urvey health care providers and establish other procedures to assess access to care and treatment for individuals with disabilities and to identify—

- (1) locations where individuals with disabilities access primary, acute (including intensive), and long-term care;
- (2) the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities, including medical diagnostic equipment that meets the minimum technical criteria;
- (3) the number of employees of health care providers trained in disability and patient care of individuals with disabilities.

The data collection method used here provides an approach to consider for meeting the Section 4302 requirements. The findings confirm the utility of the data.

Elimination of the physical and programmatic access barriers that people with disabilities face when they seek medical care has the potential to affect the course of care for acute and chronic conditions and the quality of care received. Intervention may occur sooner and at a lower cost overall if individuals do not delay seeking care because they find the experience exhausting, frustrating, demeaning, or impossible. People with disabilities have a right to the same range of options and providers as other Americans for the treatment of their health conditions and for care aimed at prevention and wellness. Accessible physician offices are a crucial element in making equal treatment a reality.

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### Instrument

The tool used to gather the data can be viewed at: [http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/FEB24/ADA%20Tool\\_IEHP\\_LACare\\_HealthNet\\_Molina.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/FEB24/ADA%20Tool_IEHP_LACare_HealthNet_Molina.pdf).

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