An assessment of the structural & equipment accessibility of primary care offices

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Background

People with disabilities encounter barriers to access when attempting to receive medical care at primary care offices. Common barriers include structural issues, lack of accessible equipment, lack of transportation, financial concerns, and difficulty attending/maintaining focus during appointments [1-6].

Persons with a disability who encounter a structural barrier are 2.5 times more likely to experience delayed or no medical care than persons without a disability who encounter the same structures [2]. The Centers for Medicaid and Medicare released a 2017 report highlighting further issues [6].

There is no other dataset with national data on the accessibility of primary care offices, nor with as many observations. A previous iteration of this data (2010) found that lack of accessible medical equipment was the area of least accessibility [7].

Objectives

1. Identify and display the general level of accessibility among primary care offices
2. Investigate factors associated with high levels of exam room accessibility in these offices

Methods

Auditors from 5 managed health care plans evaluated disability access of 3991 primary care offices in California between 2014-2016. Sites were rated using an 86-item instrument based on the 2010 ADA Standards for Accessible Design [8]. The items in the initial instrument were reduced to 44 in order to isolate questions that most universally addressed barriers to access. These 44 were reorganized into five subcategories and the total score:

- Parking (8 items)
- Building Entrance (9 items)
- Interior Route (11 items)
- Toilet Room (11 items)
- Exam Room, including accessible exam equipment (5 items)
- Total, which is the overall score of all these items (44 items)

Sites were then ranked on a scale of 1-3 in each subcategory and the Total. Sites where 50% or less of the guidelines were followed were considered “low” accessibility; 51-88% were considered “medium”; and above 89% were considered “high.”

This data was then examined for those offices ranked as “high-scoring” in the Exam Room subcategory for medical equipment to see if they had high access in other subcategories.

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Methods, cont.

Step 1

Data from 3991 primary care sites in California were acquired from five Medicaid managed care plans.

Step 2

These data were entered into SPSS, including each office’s answer to the 86 items of the survey.

Step 3

Data were cleaned to remove duplicate site IDs. The instrument items were assessed for consistency.

Step 4

The 86 items were reduced to 44 items for the purposes of this study.

Step 5

These 44 items were broken into subcategories: Parking, Building Entrance, Interior Route, Toilet Room, and Exam Room.

Step 6

Each site was ranked on accessibility from 1 to 3 (lowest-highest) in each subcategory.

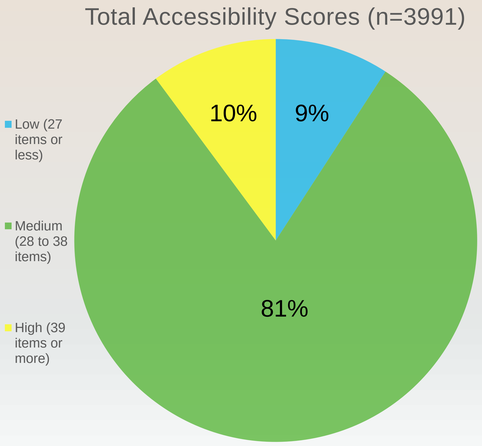
Step 7

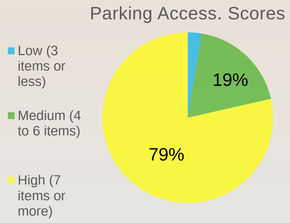
Sites with highest levels of Exam Room accessibility were analyzed for access in other subcategories.

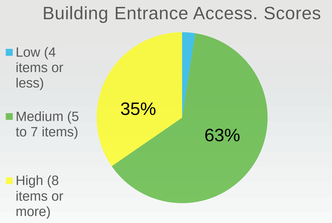
Step 8

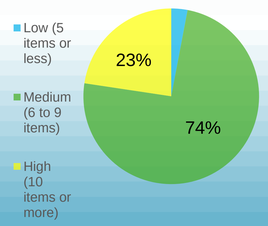
Tests of significance were conducted using Chi-Square and Cramer’s V.

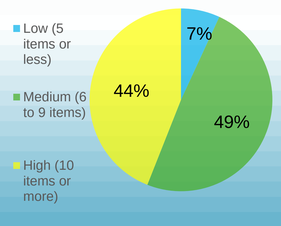
Results

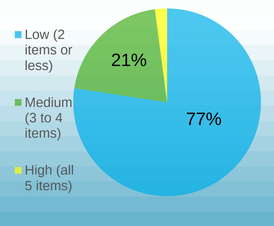






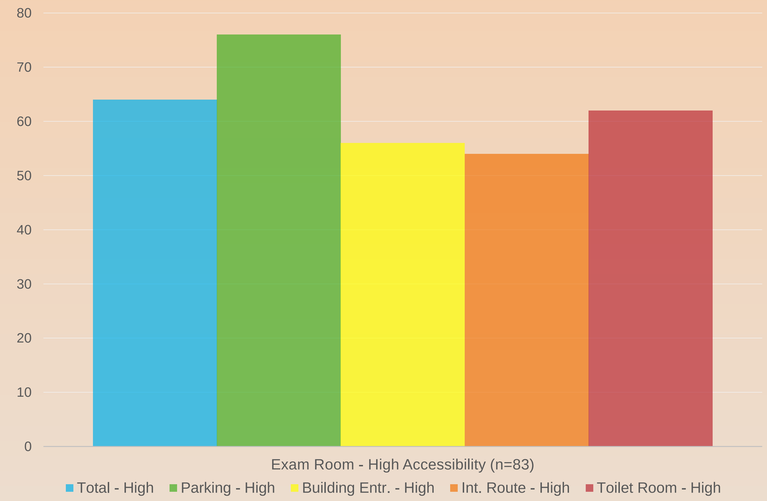






Results, cont.

As Exam Room is the subcategory with the lowest compliance to accessibility guidelines, the 83 sites with perfect Exam Room scores were analyzed for association with other subcategories.



Overall, these sites are more likely to be high-scoring across all 5 subcategories. No high-scoring exam rooms had low-scoring parking. A Spearman’s Rank Order correlation found no significant correlation between the subcategories. All $p<.05$ for these tables, and Cramer’s V values ranged from 0.067 to 0.328.

Discussion

Results overall show that primary care offices are meeting most, or between 63-87%, of federal accessibility guidelines. It appears that major problematic areas for accessibility are Exam Rooms and Toilet Rooms. Possibilities for this outcome include higher costs for equipment (as opposed to structural/architectural changes), difficulty accommodating interior room layouts, and the office’s perception of need.

It also appears that medical offices that do procure accessible medical equipment are overall more likely to be structurally accessible, due possibly to high funding or commitment to accessibility.

References

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