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Research Paper

Predicting barriers to primary care for patients with disabilities: A mixed methods study of practice administrators

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Abstract

Background: People with disabilities continue to be identified as a group who experience disparate health/health care. They are less likely to engage in some health care services. Structural barriers are often identified as one of the reasons for the underutilization of some health care services by people with disabilities. However, to date no study has been conducted to understand why structural barriers persist twenty years after the Americans with Disabilities Act (ADA) became law.

Objectives: We examined the relationship between primary care practice administrators' knowledge of the ADA and the number of accessibility barriers that patients with mobility disabilities might encounter.

Methods: Primary care practice administrators who were members of a medical management organization were surveyed between December 20, 2011, and January 17, 2012. A mixed methods research design was employed. Data were analyzed using a Guttman scale, linear and multiple linear regression.

Results: ADA knowledge questions conformed to a valid Guttman scale. There was a significant inverse relationship between practice administrators' knowledge of the ADA and the number of barriers reported in their clinics. Age of the administrators and buildings built before 1993 were also significant predictors of the number of barriers.

Conclusion: This study helps to identify medical practices that are more likely to have access barriers and have the greatest need for ADA compliance interventions. Results from this study highlight practice administrators' need for specific knowledge of the ADA as it applies to their medical practice. Efforts are needed to improve disability training for health professionals.

Keywords: Americans with Disabilities Act; Patients with disabilities; Structural barriers; Practice administrators

The Americans with Disabilities Act (ADA) became a Federal Civil Rights law in 1990 and prohibits discrimination against people with disabilities. Title II and Title III of the ADA require that health care providers grant: full and equal access to their health care services and facilities to their patients with disabilities or that they make reasonable modifications to policies, practices and procedures so that their health care services are fully available to individuals with disabilities.[1]

Ultimately, the responsibility of ADA compliance within a medical practice rests on 'the practice'. Whether the practice operates in a building owned by the practice or in leased space, ADA compliance within the practice is the legal obligation of 'the practice'.[1] Practice/health care administrators typically have oversight of the budget, equipment purchasing, facility operations and patient flow within their medical practices. Additionally, practice administrators have the responsibility of planning, directing, coordinating and supervising their medical practices. Based on the job description of a practice/health care administrator provided by the US Department of Labor, practice administrators manage personnel, finances (including equipment purchase) and facility operations.[2] Because of this, the practice administrators should be knowledgeable about the ADA to ensure ADA compliance as well as full and equal access to their practices for patients with disabilities.

Although the ADA has been in place for over two decades, people with disabilities continue to be identified as a group who experience disparate health/health care. They are more likely to report barriers to accessing health care,

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a lower quality of care and are less likely to engage in certain preventative services when compared to people without disabilities.[3–7] For example, women with disabilities are less likely to have received a Pap test, breast exam or mammogram than women without disabilities.[3–15] People with disabilities are less likely to have had their teeth cleaned or height checked.[5,6] People with disabilities were significantly more likely to rate their health as poor and to report dissatisfaction with their health care provided.[16]

Several qualitative research studies have been conducted with people with disabilities to identify the causes of health disparities among this vulnerable group.[17–23] Three main categories of barriers (factors) impacting access to health care for people with disabilities emerged through these studies and included structural, financial and personal/cultural barriers (factors). Structural factors that affected patient access were the physical environment including the structural accessibility of the medical office building and the medical practice, accessibility of medical equipment and transportation to medical appointments. Financial factors that impacted patient access included the cost associated with specific providers or services; the cost of prescription, over-the counter medication, supplies, equipment and equipment repairs. Personal-cultural factors that affected patient access to care included the providers' disability specific knowledge, providers' perceptions (or misconceptions) about people with disabilities, respect and sensitivity of providers and staff, providers taking the patient or their caregiver seriously and the willingness of the provider to provide care.[19]

Structural accessibility of medical office buildings, the medical practices and medical equipment were selected from the above factors to be the focus of this study because they are subject to the requirements of the ADA.[1] Structural barriers that limit or impede access to health care practices or health care services include: inadequate disability parking (number of spaces or size of spaces), lack of ramps or ramps with too steep of a grade, narrow doorways, doors that swing inward, heavy doors without automatic opening capabilities, lack of elevators, cramped waiting rooms, exam rooms that are too small to maneuver a wheelchair, scales that cannot accommodate a wheelchair, examination tables that are not height adjustable, inaccessible diagnostic equipment and inaccessible restrooms.[18,21–24] Structural barriers compromise patient safety, health care worker safety and the quality of care that is delivered.[25] They have been identified as a major reason that people with disabilities do not engage in some preventative services.[17–19,21–23,26]

One of the new objectives added to Healthy People 2020 is to reduce the number of people with disabilities who report a delay in receiving preventative care or primary care due to specific barriers.[27,28] An understanding of why structural barriers exist is fundamental to developing strategies to eliminate barriers and improve access to health care for people with disabilities. However, to date, no study has examined why barriers to health care exist, especially structural barriers. The purpose of this study was to determine if primary care practice administrators' knowledge of the ADA was associated with the number of barriers reported in their clinic. We hypothesized that there would be an inverse relationship between ADA knowledge and the number of barriers. In addition to ADA knowledge, we sought to determine if the number of barriers reported in the clinics could be predicted by characteristics of the administrators (age, educational attainment, number of years as a practice administrator, gender, or number of years in their current practice) or characteristics of the practice (number of years the practice had been in operation, if the building was built before 1993, number of providers, number of patients and percent of patients with a disability).

Methods

Participants and data collection

This study employed a convergent, mixed methods research design to collect qualitative and quantitative data from primary care practice administrators who were members of a medical management organization.[29] Primary care clinics were chosen for this study because they are typically the point of entry into the health care system for patients and because health maintenance and preventative care traditionally have been within the scope of care of primary care physicians.[30] Primary care clinics included general practice, family practice, internal medicine and obstetrics/gynecology. Practice administrators/health care administrators were selected for this study because their position usually has oversight of the budget, equipment purchasing, facility operations and patient flow as mentioned previously.[2]

IRB approval was obtained prior to data collection. Primary care practice administrators from a medical management organization were identified through the organization's website. Practice administrators who self-identified as primary care administrators were contacted through the website e-group communication portal. The e-group communication portal allowed for an invitation to participate in an on-line survey to be sent to each administrator's communication portal. In total, 1637 practice administrators were sent a message through the e-group communication system on three separate dates between December 20, 2011, and January 17, 2012. Eighty-six administrators initiated the survey with sixty-three completions (73.3%). The number of administrators who viewed the message and refused to participate or the number of administrators who did not view the message (non-contact) could not be determined because the e-group communication portal system could not track this information. Because of this, it was not possible to calculate an accurate contact, cooperation or response rate; however, it is acknowledged that the response rate was low.