Introduction:

- The Americans with Disabilities Act (ADA) became a Federal Civil Rights law in 1990 and prohibits discrimination against people with disabilities.
- People with disabilities continue to be identified as a group who experience disparate health care.
- They are more likely to report barriers to accessing health care, a lower quality of care, and are less likely to engage in certain preventive services when compared to people without disabilities [1-4].
- Three main categories of barriers to accessing health care emerged through these studies and included structural, financial, and personal/cultural barriers.
- Of interest to this study are structural barriers including:
  - inadequate disability parking (number of spaces or size of spaces),
  - lack of ramps or ramps too steep of a grade,
  - narrow doorways,
  - lack of elevators, cramped waiting and exam rooms,
  - scales that cannot accommodate a wheelchair,
  - examination tables that are not height adjustable,
  - inaccessible diagnostic equipment
- The purpose of this study was to determine if the number of barriers reported in the clinics could be predicted by characteristics of the administrators or characteristics of the practice.

Methods:

- Survey
  - Developed using ADA construction guidelines, the ADA’s Access to Medical Care for Individuals with Mobility Disabilities, the Adaptive Environment Center’s Checklist for Existing Facilities, and published literature
- Primary Care Practice Administrators
  - Primary Care - Typically the point of entry into the health care system for patients and because health maintenance and disease prevention traditionally has been within the scope of care of primary care physicians
  - Practice Administrators - oversight of the budget, equipment purchasing, facility operations and patient flow
- Southern Nevada
  - Contacted by telephone
  - MGMA
  - Contacted through MGMA website
  - Total = 81 administrators

Results:

- Southern Nevada practice administrators reported significantly fewer barriers than MGMA administrators.
- There was no significant difference in total ADA knowledge scores between groups.
- Total ADA knowledge scores were found to be a significant predictor of the total number of barriers using linear regression (p = 0.01).
- Multiple linear regression analyses were conducted using characteristics of the administrator and of the practice.
  - A final model (p = 0.01) was achieved that explained 36% of the variability in the total number of barriers.
  - Significant independent variables were: group, ADA knowledge, building built before 1993, age of administrator and number of patients as significant independent variables.

\[
\text{# barriers} = 9.57 - 2.57(a) + 1.24(b) - .26(c) - .08(d) - 9.490E-6(e)
\]

(a = group, b = building, c = ADA knowledge, d = age, e = number of patients, group = 1 for Southern Nevada, group = 0 for MGMA, building = 1 for built before 1993, and building = 0 for built after 1993).

Discussion:

- Southern Nevada practices had a significantly lower number of access barriers
  - Southern Nevada practices were more likely to be built after 1993
  - Southern Nevada practice administrators were surveyed via telephone, MGMA practice administrators answered an on-line survey.
- Greater the administrators’ knowledge of the ADA, the lower the number of barriers reported in their clinics.
- More experienced administrators reported few barriers in their clinics.
- As the number of patients increased, the number of barriers was reduced.
- Economics of scale, more patients, providers = low cost per piece of equipment
- Buildings built before 1993 had higher number of barriers compared to buildings built after 1993.

Conclusion:

To increase accessibility to health care, interventions should focus on practices located in buildings built before 1993, practices with administrators who are younger and have limited experience as administrators, administrators with low levels of ADA knowledge and practices with smaller number of patients.

References: