UPMC Rehabilitation Institute

University of Pittsburgh

Opportunities to Improve Access to Care in Physical Medicine and Rehabilitation Outpatient Clinics

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INTRODUCTION

Despite the many successes of the disability rights movement highlighted by the recent 30-year anniversary of the Americans with Disabilities Act (ADA), there is significant evidence that achieving equal access to medical care for people with disabilities remains a persistent and complex challenge. While provider training and cultural competence is often discussed as a means of improving access to equitable care, access to care within the physical medicine and rehabilitation (PM&R) specialty care has not been carefully examined. We assessed access to care in PM&R outpatient clinics both structurally and through qualitative interviews with clinicians and staff.

AIMS

1. Assess **structural** access to care in outpatient clinics based on ADA standards
2. Identify **non-structural** opportunities for improvement (e.g., accommodation identification, scheduling, clinic workflow) through interviews with clinic staff and physicians.

METHODS

The University of Pittsburgh Medical Center IRB and Wolff Center designated and approved this study as Quality Improvement.

1. Modified ADA checklist

Waiting room, restrooms, exam rooms, hallways, doors

Comprised of relevant criteria from

a) "ADA Checklist for Existing Facilities" by New England ADA Center and Institute for Human Centered Design

b) "Access to Medical Care for Individuals with Mobility Disabilities" by Department of Justice and Department of Health and Human Services

Scan the QR Code to explore our checklist

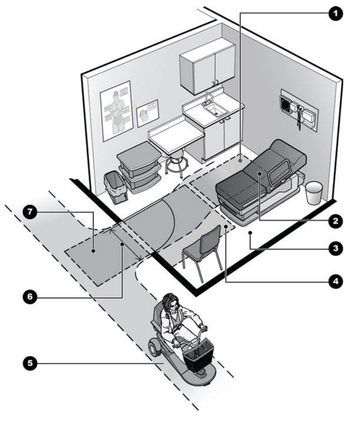
Please type in "AAP 2021" into the required name

2. Semi-structured interviews

Interview at least one individual from each category at all clinic sites:

(1) attending physician, (2) registration staff, and (3) rooming staff / clinician

Figure 1: Accessible examination room



1. Clear floor space (30" X 48" minimum) adjacent to the exam table and adjoining accessible route make it possible to do a side transfer.
2. Adjustable height accessible exam table lowers for transfers.
3. Providing space between table and wall allows staff to assist with patient transfers and positioning.
4. Amount of floor space needed beside and at end of exam table will vary depending on method of patient transfer and lift equipment size.
5. Accessible route connects to other accessible public and common use spaces.
6. Accessible entry door has 32" minimum clear opening width with door open 90 degrees.
7. Maneuvering clearances are needed at the door to the room.

RESULTS

Table 1: Modified ADA Checklist Results by Clinic

Clinic #	Waiting Room	Restrooms	Exam Rooms	Hallways	Doors
1	compliant	non-compliant	non-compliant	compliant	compliant
2	non-compliant	compliant	compliant	compliant	compliant
3	non-compliant	non-compliant	non-compliant	non-compliant	compliant
4	non-compliant	non-compliant	compliant	compliant	compliant
5	non-compliant	non-compliant	compliant	compliant	non-compliant
6	compliant	non-compliant	compliant	compliant	compliant
7	compliant	compliant	compliant	compliant	compliant
8	compliant	compliant	compliant	compliant	compliant
9	non-compliant	compliant	non-compliant	compliant	non-compliant
10	compliant	compliant	non-compliant	compliant	compliant
11	non-compliant	non-compliant	non-compliant	compliant	compliant
12	non-compliant	non-compliant	compliant	compliant	compliant
13	non-compliant	compliant	non-compliant	compliant	compliant

Figure 2: Example pictures of common structural barriers: (A) waiting room chairs placed in front of light and accessible door switches, (B) coat hook installed above the recommended height of 48 cm above the floor, and (C) inaccessible exam tables.

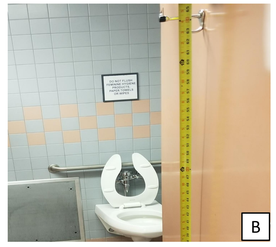


Table 2: Key Themes Based on **Grounded Theory Approach** with Select Quotes from Semi-Structured Interviews with 16 PM&R attendings and 14 front desk staff and rooming clinicians (30 total interviews)

Theme	Quote A	Quote B
Variable resource awareness and availability	"I don't even know if we have a Hoyer lift in clinic. There might be one at the corner."	"I think definitely not Braille, but I think we can print the AVSs in large fonts … I read it to them."
Diverse solutions to similar problems	"Typically, morning of … we are reviewing … if we have to make any special accommodations for anybody throughout the day"	"patient that was deaf… mostly communicated with reading lips. … cutting out a space in the mask and then using the shield …"
Access is not static	"… the beds were not adjustable … they actually moved me from that clinic … so it has not been as much of an issue."	"our doors were not electronic … It took a long time to put a button at the door to open it … because trying to manipulate a wheelchair at the same time as trying to pull the door open…"
Variation in "equal care"	"If a patient is wheelchair dependent and they cannot transport to the bed safely, then we perform their testing while they're in the wheelchair … It affects the testing … but we do our best …"	"I had a specific patient that had a lot of lateral hip pain … I couldn't quite look at it, and it was just because he couldn't transfer out of the wheelchair."

DISCUSSION

- Structurally, nearly half of all clinics lacked even one fully accessible exam room with ~85% of clinics exhibiting at least one opportunity for improvement.
- Accessibility barriers ranged widely from uninformed waiting room chair reorganization in otherwise highly accessible environments to staff injury during transfers.
- Clinic ability to identify and plan for accessibility needs prior to arrival is variable.
- Currently available resources suffer from lack of consistent awareness and utilization.
- Regular changes to accessibility over time were commonly described , often with significant improvement relative to prior situation.

LIMITATIONS

- No patient input.
- Modified ADA checklist <25% of the full ADA checklist, likely decreasing sensitivity of structural accessibility evaluation. Notably, we did not modify any criteria or questions from original published checklists.

CONCLUSIONS

- Access to equitable medical care remains a challenge even in a department where practitioners dedicate their careers and lives toward working with, learning from, and empowering patients with disabilities.
- Dedicated providers & staff with extensive knowledge and decades of experience is inadequate by itself.
- The challenge is complicated by rapid changes over time and the reality that the department does not "own" some of the clinics it uses.
- "Success" will be an ongoing process that requires leadership willing to guide, fund, and champion the effort.

CURRENT & FUTURE DIRECTIONS

- Q 2-month meeting with department chair, attending physicians, residents
- Coordination with the UPMC Disabilities Resource Center
- Current initiatives include:
  - Department funding/effort to address currently identified barriers to access
  - Educational posters (raw photoshop files to be published in the future) for clinic waiting room, hallway, exam room, bathroom (Figure 3)
  - "Accessibility champion" staff member in each clinic who regularly assesses clinic access
  - Effort to develop validated accessibility measurement tool specifically designed for the medical clinic
  - Update to call center scripts to improve identification of accessibility needs
  - Plan to expand via partnerships with other departments

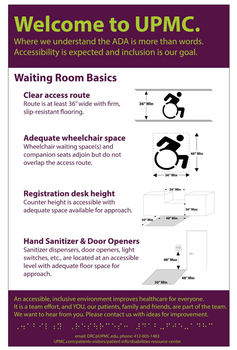


Figure 3: Educational poster

FUNDING

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