



Canadian Disability Policy Alliance

**Alliance Canadienne concernant
les politiques reliées au handicap**

**Improving accessibility of
Family Health Teams for
people with mobility disabilities:**

**Examining rooms with
adjustable tables and lifts**

Mary Ann McColl, PhD, MTS

Queen's University, Centre for Health Services & Policy Research

Susan Davey, MHSc

Health Policy Consultant, Osborne Group

Bill Adair, Executive Director

Peter Athanasopolous & Nathan Hauch, Public Policy & Government Relations

Spinal Cord Injury Ontario

Jess Stapleton, PhD Candidate

McMaster University

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A vision of Canada where people with disabilities enjoy full participation and citizenship, supported by a coherent framework of legislation, regulation and programs.

The **Canadian Disability Policy Alliance** is a national collaboration of disability researchers, community organizations, and federal and provincial policy-makers, aimed at creating and mobilizing knowledge to enhance disability policy in Canada, and to promote equity and opportunity for disabled Canadians. The Alliance is funded by the Social Science and Humanities Research Council for a period of 5 years (2009-14). Our **vision** for Canada is a place where people with disabilities enjoy full participation and citizenship, supported by a coherent framework of **legislation, regulation and programs**. This vision is achieved through:

- **United voices** – of researchers, consumers, policy makers, providers, educators, employers; across jurisdictions, across boundaries, across barriers;
- **Learning collaboratively** – through focused, interactive research cycles;
- Effectively using **tools for change** – producing context-sensitive, policy-relevant evidence to promote effective disability policy.

University Partners:

Mary Ann McColl	Queen’s University (University Lead)
Alice Aiken	Queen’s, Rehabilitation (Health Services Lead)
Lyn Jongbloed	UBC, Occupational Therapy (Employment Lead)
Audrey Kobayashi	Queen’s, Geography (Citizenship Lead)
Vianne Timmons	University of Regina (Education Lead)
Jerome Bickenbach	Queen’s, Philosophy / Law
Mary Law	McMaster University, Rehabilitation Science
Kathleen Norman	Queen’s, Rehabilitation
Hélène OuelletteKuntz	Queen’s, Community Health & Epidemiology
Scott Thompson	University of Regina, Education

Community Partners:

Bill Adair	Spinal Cord Injury Ontario (Community Lead)
Katherine Hum-Antonopoulos	Canadian Hearing Society
Max Beck	Easter Seals Canada
Steven Christianson	Ontario March of Dimes
Gordon Porter	Canadian Association of Community Living

Policy Partners:

Abdou Saouab	HRSDC, Knowledge Planning & Exchange
Ellen Waxman	Assistant Deputy Minister, Ontario Accessibility Directorate

Project Staff:

Lynn Roberts	Queen’s Centre for Health Services & Policy Research
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Improving accessibility of Family Health Teams for people with mobility disabilities

Mary Ann McColl, PhD, MTS, Queen's University, Centre for Health Services & Policy Research
Susan Davey, MHSc, Health Policy Consultant, Osborne Group
Bill Adair, Peter Athanasopolous, Nathan Hauch, Jess Stapleton, Spinal Cord Injury Ontario

ABSTRACT

Despite the recent focus on primary care reform, adults with physical disabilities continue to experience difficulties with access to primary care. The current initiative was launched jointly by the Canadian Disability Policy Alliance, Queen's University Centre for Health Services & Policy Research, the Spinal Cord Injury Ontario, and the Primary Care Team at the Ministry of Health and Long-Term Care, to improve access to Family Health Teams and Nurse Practitioner-led Clinics in Ontario for people with mobility impairments. The specific change we sought was to have at least one examining room in each FHT and NP-led Clinic equipped with an adjustable examining table and/or a ceiling-track lift. Using the Learning Collaborative approach, we contributed to tangible changes in the primary care environment toward increased equity and accessibility for people with disabilities. All 50 of the newest FHTs and 25 Nurse Practitioner-led Clinics (100%) have been advised of their obligations under the Accessibility for Ontarians with Disabilities Act, provided with information about increasing accessibility in their examining rooms, and sensitized to the needs of disabled patients in the practice. Further initiatives to build on the current success are already underway. Over the next year, the remaining 150 FHTs will be afforded the same opportunity to enhance accessibility of their examining space for patients with mobility impairments, and to enhance compliance with AODA standards. In terms of lessons learned in this project, we recommend that:

1. timing of delivery of orientation materials coincides with appropriate budget cycle;
2. visual distinctiveness of distributed materials be enhanced;
3. the Ministry offer bulk purchasing and pricing options to ensure consistency;
4. physicians receive targeted information in terms of their obligations under AODA;

We look forward to continuing to work with the Ministry and Ontario Accessibility Directorate, as well as primary care organizations, to assist with dissemination and application of information regarding disability, access and AODA. As a result of this project, durable links between decision makers, primary care organizations, disability organizations and university researchers have been forged that promise to continue to contribute positively to the accessibility of the primary care environment in Ontario.

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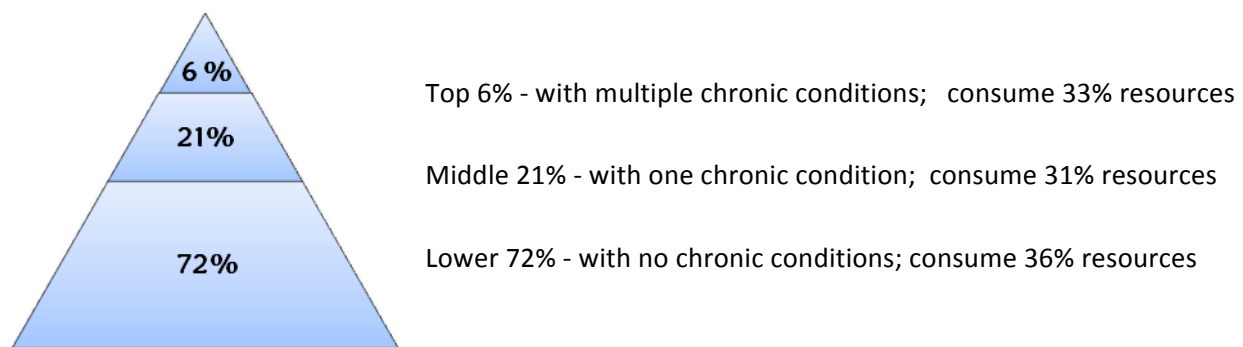
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INTRODUCTION

PEOPLE WITH DISABILITIES IN PRIMARY CARE

Despite the recent focus on primary care reform, adults with physical disabilities continue to experience difficulties with access to primary care. Adults with disabilities are undeniably high users of primary care -- they make an average of six visits per year to the family doctor, versus 2.5 for non-disabled Canadians (McCull & Shortt, 2006; McCull, Aiken, McCull, Sakakibara, & Smith, in press).

People with severe disabilities and chronic conditions constitute a small subset of the typical primary care caseload (Wallace, 2007). They are among the approximately 6% of patients with multiple or severe chronic conditions, who consume about 33% of primary care resources. They require intensive management, including a high degree of coordination among multiple providers and agencies, in addition to frequent contact, coaching and support. This level of service may be intermittent, but when a health problem arises, it is typically complicated.



Disabled adults tend to use family medicine for the same types of health concerns as their non-disabled contemporaries; however, they also have three additional categories of utilization:

- disability-related issues,
- secondary complications of the disability, and
- administrative issues associated with the disability.

For example, an individual with a mobility impairment might need access to family medicine in a given year for any of the following issues:

- Age and gender-related screening for chronic diseases
- Standard disease prevention, monitoring and immunizations
- Normal infectious and acute conditions
- Monitoring of disability status
- Monitoring and treatment of secondary conditions, such as overuse syndromes, fatigue, injuries, bowel, bladder, skin conditions
- Social and mental health issues
- Eligibility for disability benefits, such as pensions, tax credits, insurance claims, other social and welfare benefits
- Caregiver issues and relief
- Referral to specialists, diagnostics and institutional services.

In spite of high utilization, however, disabled adults experience three times as many unmet health care needs as their non-disabled contemporaries (McColl, Jarzynowska & Shortt, 2010). Research substantiates that people with disabilities receive an inferior standard of primary care because they are not properly examined or assessed (Booth & Kendall, 2007; McColl et al., 2008; Wullink, Veldhuijzen, van Schroyenstein Lantman-de Valk, Metsemakers, & Dinant, 2009). Physicians themselves report that patients with disabilities are considerably more time consuming and complex to treat, and given the many challenges, they often don't actually examine them (McColl et al., 2008; Wullink et al., 2009). Unfortunately, those with the most severe needs also experience the greatest number of unmet health needs (McColl, Jarzynowska & Shortt, 2010). Even after controlling for the effects of health and chronic disease, disability still represents a significant source of health need (McColl, Shortt, Gignac, & Lam, 2010). With restrictions in most family practices on the number of issues that can be raised in a single appointment (usually between 1 and 3), it can readily be seen how the number of annual visits would exceed the average, and how people with disabilities might leave the office feeling that their needs had not been met.

DISABILITY

Disability is defined according to the International Classification of Health, Functioning and Disability as *"an umbrella term for impairments, activity limitations and participation restrictions"* (World Health Organization, 2001, p. 3). This definition incorporates two ideas – that disability is associated with a health condition, and that it is manifest as activity limitations and participation restrictions.

Demographic trends show that Canadians are not only growing older, they are also increasing their probability of developing and living with a disability. Disability rates increase with age starting with 3.3% for children aged 0 to 14 years, 10% among adults aged 15 to 64 years, 40% for those over 65, and 53.3% for persons 75 years and over. From a population health perspective, it is expected that the absolute number of persons with disabilities will increase dramatically along with population growth.

ACCESS

The Health Services Access Survey (Statistics Canada, 2003) shows that 12% of Canadians do not have a family doctor, and 18% report access problems such as wait times and difficulty contacting their doctor. These were problems that delayed access to primary care and decreased patient satisfaction. Talbot et al. (2001) found that those most likely to be without a doctor were single, poor, smokers, recent immigrants, and those who were socially isolated. Research has shown repeatedly that where a problem with access exists in the general population, it is considerably more severe in subsets of the population that are most disadvantaged (Brownell, Roos, & Roos, 2001). The literature provides numerous examples of inequities in access to health services for people with disabilities and chronic conditions (Rosenbach, 1995; DeJong, 1997; Rummery, Ellis & Davis, 1999; Turner-Stokes et al., 2000; Anderson & Kitchin, 2000). Groch (1991) found that while many public institutions used the rhetoric of *"responding to the needs of disabled citizens"*, few were actually committed to ensuring access.

The consequences of decreased access to primary care for people with disabilities and chronic conditions include social, psychological, functional and economic disadvantages, in addition to the

obvious health consequences (Neri & Kroll, 2003). There are numerous reasons that primary health care of people with disabilities and chronic illnesses is different from that of the general population:

- They have a thinner margin of health, and the balance of their health is more fragile and easily disturbed;
- They often do not have the same opportunities for health maintenance and prevention, such as physical activity, as their non-disabled counterparts;
- People with chronic conditions and disabilities tend to experience earlier onset of conditions associated with aging, such as cardiac and arthritic changes;
- Functional consequences of illness or injury, such as bed rest, wound healing and chest congestion, are greater for pre-existing conditions;
- Disability or chronic illness may cause prolongation and complications in treatment of illness or injury;
- There are often multiple providers involved, due to the multi-factorial nature of disability and chronic illness (DeJong, 1997).

BARRIERS

Access to primary care has become a highly politicized issue, and the term “access” has been used very broadly. When the popular press refers to access, it typically means wait times, geographic distribution and supply of health human resources. These issues are present for everyone, however there are also four other issues that impede access to health services for people with chronic illnesses and disabilities (McColl, Forster, Shortt, Hunter, Dorland, Godwin & Rosser, 2008):

- Physical barriers, such as door widths, stairs, manoeuvring room, signage;
- Attitudinal barriers, such as unwillingness to provide needed services or make accommodations for people with disabilities;
- Informational barriers, such as lack of knowledge of disability-related considerations, complications and resources;
- Systemic barriers, such as inadequate provisions for disability in health system planning and implementation.

Access may be impeded at six points in attempting to secure service:

- Finding a doctor;
- Getting an appointment;
- Getting into the practice;
- Using the facilities, particularly examining, diagnostic and treatment spaces;
- Obtaining the necessary accommodations; and,
- Receiving a reasonable standard of care.

The most straight-forward reason for difficulties with access are physical barriers – stairs, narrow doorways, obstacles, cramped spaces, clutter, high counters, high racks and shelves, high surfaces and tables. These are arguably also the easiest to remedy, and yet, they remain a significant problem for people with disabilities. Primary care settings are unaware of what to do to make their practices and processes more accessible to people with disabilities (McColl et al., 2008; Sullivan et al., 2006).

Despite receiving the majority of their operating budgets from public funds, physicians' offices have historically been classified as private sector premises, and have thus not been subject to the accessibility requirements of the public sector. They have of course been subject to human rights complaints from patients who are denied access, however it is very unlikely that a patient would bring a human rights complaint against his or her doctor for a number of reasons. It is costly in terms of tangible and intangible resources for people that are typically economically and socially disadvantaged. It would do irreparable damage to the doctor-patient relationship, and with a shortage of family physicians and wait lists to obtain a doctor, a patient would not risk losing his or her doctor.

Physical barriers not only delay or inconvenience attempts at access, but they can actually prevent it. These barriers send a further message that the practice may be inaccessible in more subtle ways. Recent Canadian data shows that while 74% of family doctors said their offices were accessible, only 40% of their patients with mobility disabilities agreed. Twenty-seven percent of patients with disabilities said they were not satisfied with access to their physician's office, and 33% were not satisfied with health care accessibility in general (Shankardass, et al., 2003). Guidelines for access to doctors' offices were published in CMAJ (see Jones & Tamari, 1997), after the authors found only about half of doctors' offices accessible. Recent research in Eastern Ontario showed that only 15% of practices had an accessible examining room with an adjustable table onto which a mobility-impaired patient could transfer (McColl, Shortt, Hunter, Dorland, Godwin, Rosser, & Shaw, 2010).

PURPOSE OF THE PROJECT

The question that arises is how to ensure equitable access to primary care for persons with chronic illnesses or disabilities. The McGuinty government in Ontario came to power in 2006 on a promise of ensuring access to primary care for all Ontarians. It advanced a model of primary health care called the Family Health Team (FHT), with trademark characteristics such as interdisciplinary care, rostering of patients to physicians, and chronic disease management (Rosser, Colwill, Kasperski, & Wilson, 2011).

Despite demonstrated commitment to accessibility by the same government (i.e., the passage of the Accessibility for Ontarians with Disabilities Act (AODA, 2005) the government did not explicitly require Family Health Teams to be accessible to people with disabilities. There were published accessibility standards for family medicine in Canada (Jones & Tamari, 1997), and advice for Family Health Teams regarding space planning (http://www.health.gov.on.ca/transformation/fht/fht_guides.html), but neither were enforced, nor was there any specific program or incentive to assist family physicians to upgrade their office facilities to make them more accessible.

The current initiative was launched jointly by the Canadian Disability Policy Alliance, Queen's University Centre for Health Services & Policy Research, the Spinal Cord Injury Ontario, and the Primary Care Team at the Ontario Ministry of Health and Long-Term Care. The goal was to improve access to Family Health Teams in Ontario for people with mobility impairments. The specific change we sought was to have at

least one examining room in each FHT equipped with an adjustable examining table and/or a ceiling-track lift.

This was a highly focussed initiative with a relatively modest objective. The objective was achievable, politically relevant, timely, important, and consistent with government priorities. The government had made “complex-vulnerable” patients its priority in ensuring access to primary care, and thus were receptive to a focus on disability. In addition, under the recently passed Accessibility for Ontarians with Disabilities Act (Government of Ontario, 2005), regulations would soon require the primary care sector to be accessible to people with disabilities. As of January 2010, the broader public sector was subject to the Customer Service Standard of the AODA, and by January 2012, even the private sector was required to conform.

METHOD

Design

This study employed the Learning Collaborative methodology (described in detail elsewhere: McColl et al., 2012; www.disabilitypolicyalliance.ca). This is one of the signature methodologies of the Canadian Disability Policy Alliance, and is a form of emancipatory research. The Learning Collaborative approach is characterized by the **Plan-Do-Study-Act** cycle, where academic and community partners alternately assume responsibility for the project, as per the particular expertise of each.

1. **PLAN:** The research phase was led by Dr. Mary Ann McColl of the Centre for Health Services & Policy Research at Queen’s University. Based on a comprehensive review of literature on primary care for people with disabilities, and an environmental scan of accessibility of primary care settings in Ontario, a one-page briefing note was prepared to develop the case for the need for improved accessibility in primary care in Ontario, and specifically for the need to improve examining room equipment to permit people with physical disabilities to be properly examined (<http://69.89.31.83/~disabio5/wp-content/uploads/2012/09/Accessible-Exam-Tables-in-Primary-Care1.pdf>).
2. **DO:** The DO phase was led by Susan Davey of The Osborne Group, on behalf of the community partner, SCI Ontario. The MOHLTC provided contact information and permission to approach FHTs on a limited basis specifically for this initiative. The Quality Improvement and Innovation Program (QIIP) also provided assistance. We reached out to 186 Family Health Teams and 25 Nurse Practitioner-led clinics to:
 - Alert them to the requirements of the Accessibility for Ontarians with Disabilities Act as it pertained to Family Health Teams;
 - Draw their attention to the issue of exam room accessibility as a key impediment to customer service;
 - Provide them with tools to assess the overall accessibility of their practice;

- Recommend equipment to enhance accessibility, along with pricing, budget justification and bulk purchasing options.

In consultation with key individuals at the Ontario Ministry of Health and Long-term Care, we received assurances of targeted funding to enhance accessibility of at least one examining suite in each FHT conditional upon availability of funds. The SCIO, with the assistance of the policy consultant, researched and identified high-quality, Canadian-made, cost-effective equipment, and offered the FHTs advice, consultation and information to assist them to make and justify specific requests for an adjustable examining table and/or ceiling track lift.

In addition, a self-assessment tool *Accessibility for Family Health Teams* (<http://69.89.31.83/~disabio5/wp-content/uploads/2012/09/FHT-access-chkfst-24-Jun-111.pdf>) was circulated to all FHTs and NP-led clinics, and discussions of the necessity of AODA compliance have increased the visibility of this issue considerably. We have also interacted with the Family Health Team Advisory Group, the Association of Family Health Teams of Ontario and the Association of Ontario Health Centres to discuss the information needs of primary care practices as regards AODA implementation and compliance. Plans are underway to assist practices with additional information and training.

3. **STUDY:** The follow-up phase was again led by the academic partner to ascertain the degree of uptake of equipment requests in the 151 participating FHTs from Waves 1-3 (137 FHTs) and Wave 4 (14 FHTs). Follow-up phone calls were also intended to offer support and advice about accessibility, and to gather information about the effectiveness of the outreach process. Detailed results of this process are reported elsewhere (McColl et al., 2012; <http://www.disabilitypolicyalliance.ca/wp-content/uploads/2013/02/CJDS-Article-200113.pdf>).
4. **ACT:** On the basis of lessons learned with the Wave 4 FHTs, the initiative was expanded to include the remaining FHTs and NP-led clinics. In April 2011, we provided information to the 30 FHTs in Wave 5 and the 25 NP-led clinics that the MOHLTC had recently approved. These FHTs were in the process of developing their funding requests for submission to the Ministry when we contacted them. Finally, in April 2012, we provided information to the remaining 137 FHTs in Waves 1-3.

Sample

The sampling process for this initiative began with 186 Family Health Teams and 25 Nurse Practitioner-led clinics operating in Ontario, launched between June 2009 and April 2011. Family Health Teams were launched in five Waves: 69 in Wave 1, 31 in Wave 2, 50 in Wave 3, 20 in Wave 4 and 30 in Wave 5. Based on information that was publicly available on the MOHLTC website, as well as confidential contact information provided by the Ministry, we obtained names and phone numbers for the Executive Directors and Medical Leads of all FHT's. In the 3 waves of follow-up described above, we were successful in recruiting 78 FHTs to provide data and feedback on the initiative – 14 from Wave 4 and 59 from Waves 1-3. Contact was also achieved with a representative of the NP-led clinics. Wave 5 FHTs were not contacted as they many were still in temporary premises and had not yet completed their space plans.

Data Collection

Two types of information were collected from participating FHTs as a means of assessing the impact and effectiveness of the current initiative:

- objective information about uptake on procurement of exam room accessibility enhancements; and,
- subjective information about accessibility generally, knowledge of the AODA standard requirements, and the effectiveness of the outreach initiative.

We also sought to understand the experience of the FHTs in considering accessibility and improving exam room access. Data were collected from participating sites by telephone to obtain their feedback on the initiative and their suggestions for improvement. A sample of the interview schedule is included below.

1. Do you have an exam room with an accessible examination table and/or a ceiling track lift?
Yes Tell me about that room (*Prompts: Door width? Maneuvering room? Space for attendant, caregiver, interpreter? Hi-lo exam table? Hoyer or ceiling lift? Other features?*)

No What are the reasons or barriers that prevent you from improving the accessibility of your exam rooms?
2. How do your doctors/other health professionals use that room?
3. What difference has it made for your patients and their families?
4. What difference has it made for your doctors/other health professionals?
5. Do you have more than one FHT location?
Yes Do you have an accessible examination table / ceiling track lift in more than one FHT location?
No
6. Do you remember the materials we sent you last year on Accessibility for Ontarians with Disabilities Act (AODA), specification for the two pieces of equipment, pricing of equipment, budget rationale?
Yes No If No, **proceed to question #7.**
 - a. Did you pursue Ministry funding for an accessible exam table and/or ceiling track lift after hearing from us a year ago?
Yes No If No, **proceed to question #7**
 - b. How helpful was that information? (*Prompt: on a scale of 1 to 5 with 1 being "not helpful at all", 2 "only marginally helpful", 3 "neutral", 4 "somewhat helpful", and 5 "very helpful"?*)

Information on AODA	_____
Specifications for equipment	_____
Pricing of equipment	_____
Budget rationale	_____
7. What plans do you have to increase accessibility of your practice to patients with disabilities? Is there anything we can help you with?

RESULTS AND DISCUSSION

From the 78 FHTs contacted, a total of 63 pieces of equipment were procured by the FHTs (53 tables and 10 lifts). All 25 NP-led clinics had obtained equipment and outfitted their exam rooms.

Funding was generally approved on a cost-sharing basis with the physicians, with the Ministry picking up between 60 and 100% of the cost.

It is worth noting that there were significant discrepancies from region to region in prices for the same piece of equipment. For example, the Hi-Lo Exam Table ranges in price from \$4,900 to \$10,000, and the ceiling track lift ranges from \$3,000 to \$6,327. Further inquiries showed that the source of these inconsistencies lay primarily with suppliers, and the lack of industry price standardization within the province.

Follow-up telephone interviews provided insights as to the responses of the FHTs to this outreach and funding initiative. Following are a number of themes that arose in these interviews:

- The survey showed that the consumer / academic / policy partnership represented by the Canadian Disability Policy Alliance was compelling in terms of credibility and integrity. Practices were inclined to respond positively to the combination of authentic consumer representation, evidence-based policy analysis, and recommendations that were specifically targeted to their political and organizational context.
- Practices appreciated that the equipment recommended would benefit not only their physically disabled patients, but also older and obese patients, and that it was helpful for practitioners, making examination of patients easier.
- Practices were appreciative of the voluntary accessibility self-audit tool, but did not make a priority of enhancing accessibility in light of competing priorities for resources and for meeting start-up and recruitment targets.
- Timing was an important determinant of receptivity to the opportunity to increase accessibility. We attempted to reach FHTs when they were initially planning space, however this period was stressful and uncertain. Capital improvements and equipment retro-fits were more readily incorporated once the FHT was operating in a steady state, rather than when they were starting up.
- The survey showed that follow-up is required to assist FHTs with space planning and implementation of accessibility equipment, as they typically had no experience with universal design or accessibility requirements. They were very appreciative of individual follow-up initiatives and advice.
- Practices noted the need also for other accessibility technology, such as stair-lifts, door-openers, and other devices.

- Some practices did not believe that there was sufficient need within the Family Health Team to make an exam room accessible.
- Practices were distressed by the impending deadline for enforcement of the AODA Customer Service standard, and felt that they lacked resources to assist them to meet this need. Family Health Teams made it clear that they needed training in order to be fully compliant with customer service standards. There may have been an expectation that they should know how to accommodate patients with disabilities, whereas in fact they did not. In addition, there may have been some embarrassment about not knowing, leading to reluctance to ask questions or seek assistance.
- There was resistance on the part of some physicians to share the cost of the equipment. There were expressions of unwillingness to incur any financial responsibility for accessibility. They did not appear to understand their obligation to ensure equal access for people with disabilities under the Human Rights Code or under the AODA. It was interesting to note that although Ontario was always assumed to have adequate human rights protections for people with disabilities (i.e., the provincial and federal human rights codes and the Charter of Rights and Freedoms), none of these was sufficient to ensure access to primary care. It was only when the AODA was passed, with its enforceable minimum standards for access that the primary care sector was persuaded to take notice and enact changes.

CONCLUSION

This initiative has contributed not only to the development of a solid evidence base about primary care for people with disabilities, it has also been highly successful in disseminating evidence and best practices to appropriate decision makers, and forging partnerships between consumers, providers and policy-makers. It has been successful in enacting real, tangible changes in the environment, and promoting equity and accessibility. All 186 FHTs and all 25 of the Nurse Practitioner-led Clinics have been:

- advised of their obligations under the Customer Service Standard of the Accessibility for Ontarians with Disabilities Act;
- provided with information about equipment choices to increase accessibility in their examining rooms;
- offered a voluntary self-assessment tool for evaluating the accessibility of their practice to patients with disabilities;
- sensitized to the needs of disabled patients in the practice.

With regard to actual changes to the primary care environment in Ontario:

- there are now FHTs distributed across the province that have at least one exam room accessible to people with mobility impairments, due to the installation of an adjustable exam table and/or a ceiling track lift. In addition there are 25 NP-Led Clinics that have been approved for funding to make at least one exam room accessible to people with mobility impairments with the installation of an adjustable exam table and/or a ceiling track lift;
- awareness of the needs of primary care patients with mobility disabilities has been substantially increased, as evidenced by the expression of need for AODA orientation and awareness;
- durable links between decision makers, primary care organizations, disability organizations and university researchers have been forged that promise to continue to contribute positively to the accessibility of the primary care environment in Ontario.

In the final analysis, the success of this initiative will be determined by the health and health care of people with mobility disabilities. Such longer-term impacts cannot be ascertained at this point in time.

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