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RESEARCH ARTICLE

Disability and Experiences of Health Care in Lucas County, Ohio

Eric D. Salvati[1]; Rebecca Monteleone[2]

[1]University of Toledo, Toledo, OH
[2]Disability Studies Program, University of Toledo, Toledo, OH

Corresponding Author: Eric Salvati, 1945 West Central Avenue, Toledo, OH 43606, 561-699-0732, Eric.Salvati@rockets.utoledo.edu
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ABSTRACT

Introduction: Americans with disabilities face a number of barriers to accessing appropriate, respectful, and timely health care, but there remains limited research collecting their perspectives and lived experiences. This paper presents the results of an exploratory mixed-methods study conducted in Lucas County, Ohio, arguing that patient perspectives are crucial for identifying and addressing inequities in health care access.

Methods: We conducted an online survey with 42 respondents self-identifying as having a disability who live and/or receive health care in Lucas County, Ohio. We deployed a mixed-methods approach including both 5-point Likert scales and open-ended qualitative responses across 4 categories: scheduling, access to care, communication, and quality of care, along with basic demographic information.

Results: Findings addressed 3 major themes, attitudes, access, and infrastructure, as well as 9 subthemes. While most respondents reported positive clinical experiences overall, a substantial minority shared a number of barriers. Regarding attitudes, respondents experienced diagnostic overshadowing, invalidation, and self-blame for poor clinical encounters, as well as positive experiences when clinicians approached with respect for their requests and experiences. Respondents also reported inaccessible medical equipment, communication methods, and policies and practices that hindered their access to care. On the macro level, respondents spoke to issues with insurance and timely access to qualified providers.

Conclusion: Patient perspectives can yield new insights that can and should be applied across health care settings, including integration into curricula and trainings. There is a need for both adaptations to clinical settings and practices, such as the integration of accessible medical equipment, as well as changes that enable easier navigation of health care systems and development pipelines for qualified, disability-conscious practitioners.

Keywords: Disability; Health care; Lucas County; Mixed methods; Inequities; Experiences

INTRODUCTION

Americans with disabilities, which account for nearly a quarter of the population, face disparities in access to quality health care.[1] There has been substantial debate about the terminology used to refer to disability, which has been written about extensively elsewhere.[2,3] In this article, we use identity-first (disabled people) and person-first (people with disabilities) language interchangeably. Previous research, though sparse, has shown significant issues in accessing quality health care, including both attitudinal and logistical barriers. According to a recent study by Lagu and colleagues[4] about physician perspectives on patients with disabilities, the most common barriers to health care include physically inaccessible infrastructures, issues with communication, a lack of provider knowledge about disability, limited time to see patients, stigmatizing attitudes about disability, and lack of knowledge about the Americans with Disabilities Act (ADA).

Most physicians do not use or do not have access to accessible equipment for routine care of patients with disabilities.[4] Further, a lack of awareness, accessibility, or sufficient resources can lead to poor experiences for patients with disabilities. Glasby reported that people with developmental disabilities, for example, found the hospital to be

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traumatic, reporting untrained staff and inadequate services.[5] Tuffrey-Wijine and colleagues, in their UK-based study on health care delivery for people with intellectual disabilities, found that approximately one-third of health care workers reported poor communication and failure to complete a full assessment, with a small subset reporting that this resulted in poorer health outcomes for the patient.[6] Overall, this research points to systemic health care barriers for people with disabilities.

METHODS

In this paper, we present the of a mixed-methods survey collecting experiences of adults with disabilities who are living or receiving health care in Lucas County, Ohio. Lucas County, Ohio, is located in northwest Ohio and, as of 2024, is home to approximately 425 000 people. More than half of those live in the city of Toledo.[7] Lucas County is located within what is colloquially known as the "Rust Belt," having previously been a hub of industrial activity prior to an economic downturn. Ross and Bateman note that the rate of disability is higher than average in the Rust Belt cities of Ohio (such as Toledo, Akron, and Youngstown), and that there is a correlation between disability and low educational attainment in these areas.[8]

Demographically, 73% of residents identify as White, 20% as Black, 8% as Hispanic or Latino, 4% identified as 2 or more races, 2% as Asian, and less than 1% as American Indian/Alaska Native or Native Hawaiian/Pacific Islander. Ninety-one percent of Lucas County residents have a high school diploma, and 29% have a bachelor's degree or higher. Sixty-three percent of the population over 16 years of age is currently in the civilian labor force, and 18% live below the poverty line. The poverty rate is nearly 25% in the city limits of Toledo.[7]

Nearly 12% of the population in Lucas County under 65 years of age has a disability. That number is 14% for Toledo, placing it among the metro areas with the highest disability prevalence in the country.[7,8] Eight percent of Lucas County residents under 65 years of age do not have health insurance. Gaining an understanding of the experiences of people with disabilities who receive health care in Lucas County could not only improve service delivery and health equity in this region but could also provide insights that serve regions with similar demographic and infrastructural characteristics.

To solicit perspectives from health care recipients with disabilities in Lucas County, we developed an anonymous online survey, drawing on existing literature. To ensure the usability and significance of our survey, we tested the survey with 4 people with lived disability experience and expertise in accessibility, incorporating their feedback into subsequent drafts. We deployed a mixed-methods approach including both 5-point Likert scales and open-ended qualitative responses across 4 categories: scheduling, access to care, communication, and quality of care, along with basic demographic information. Participants were recruited via email and through social media invitations to disability-focused organizations in Lucas County, Ohio, as well as from the research team's professional networks. Participants had to be English-speaking adults (18 years of age and over) and identify as disabled or having a disability. Respondents did not need to live in Lucas County but must have received health care within the county limits. The survey included branching options to accommodate self-consent and guardian consent/participant assent for those who had a legally authorized representative.

Responses were collected from January to March 2023. Likert responses were analyzed based on frequency of responses. Qualitative responses were analyzed using inductive thematic analysis.[9] Initially, researchers developed separate codebooks, analyzing and coding 50% of responses independently to ensure intercoder reliability. Upon comparing, we found a 77.5% agreement in initial codes, which is significant for inductive coding. We then engaged in iterative discussions to develop these codes into 3 major themes, attitudes, access, and infrastructure, as well as 9 subthemes.

RESULTS

A total of 42 individuals responded to the survey. Of those 42 respondents, the majority (n=31) identified as female, with 5 identifying as male, 4 as non-binary, and 1 as other. Two respondents identified as transgender. Among the respondents, 15 were aged 18 to 24 years, 8 were aged 25 to 34 years, 8 were aged 35 to 44 years, 5 were aged 45 to 54 years, 4 were aged 55 to 64 years, and 1 was aged 65 years or over. Respondents overwhelmingly identified as White (n=35), with only 3 identifying as Asian, 2 as African American/Black, 1 as Hispanic/Latinx, and 1 as other.

Participants could select multiple disability categories when completing demographic information. The most selected categories were physical disability (n=24), mental/emotional disability (n=24), intellectual/cognitive disability (n=19), visual disability (n=6), speech/verbal disability (n=4), and hearing disability (n=3). Full demographic information can be found in the Appendix.

Participants completed 16 Likert-type responses regarding their agreement with statements across the 4 categories. The frequency analysis of these responses revealed notable trends in health care experiences in Lucas County in patients with disabilities. In general, respondents reported positive experiences, with 85.7% of respondents feeling included in decision-making processes with their care team, and 92.8% reporting their facilities to be physically accessible. However, many reported attitudinal barriers. For example, 38% of respondents indicated that their provider/care team did not have sufficient knowledge about their disability, and 16.7% felt they experienced unfair treatment because of their disability. Table 1 contains a full summary of quantitative responses.

Attitudes

In addition to Likert statements, respondents completed 6 open-ended responses. These responses were analyzed via inductive thematic analysis, yielding 3 themes and 9 subthemes. The first major theme addressed attitudes among both clinicians and respondents. For many, establishing trust with a health care provider was a key component of facilitating an open, safe outlet to express questions or medical concerns. Where trust was missing, often due to perceived judgement or lack of understanding, respondents reported compromised care. Additionally,

Table 1. Participant Health Care Experiences in Lucas County, Ohio

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
I found no difficulties in the scheduling process of my appointment.	31%	42.9%	19%	7.1%
The scheduling process was difficult, confusing, or challenging.	4.8%	16.7%	40.5%	38.1%
I was able to easily travel to my appointment.	40.5%	47.6%	7.1%	4.8%
Lobbies and entryways were accessible to me.	47.6%	47.6%	4.8%	NR
The exam equipment (such as exam tables or weighing scales) used during my care was accessible.	41.5%	48.8%	7.3%	2.4%
I felt the overall environment of the service to be physically accessible for my disability.	45.2%	47.6%	7.1%	NR[a]
My provider/team were very approachable and helpful during my visit.	35.7%	52.4%	9.5%	2.4%
I was provided with ASL or other language interpreters (if needed).	19.2%	46.2%	15.4%	19.2%
My provider/team answered all my questions in easy-to-understand language.	38.1%	59.5%	NR	2.4%
I felt included in the decision-making process with my care provider/team.	45.2%	40.5%	4.8%	9.5%
All directions were clear and easy for me to understand.	31.7%	56.1%	9.8%	2.4%
My provider/team had sufficient knowledge about my disability.	28.6%	33.3%	26.2%	11.9%
I received what felt like full and accurate treatment for my care.	33.3%	42.9%	11.9%	11.9%
I experienced unfair treatment because of my disability.	2.4%	14.3%	33.3%	50%
I received inadequate treatment due to a lack of understanding about my disability.	9.8%	12.2%	26.8%	51.2%

Abbreviation: NR, no participant response.

respondents spoke about their perceptions of themselves, often blaming themselves for poor clinical encounters. In the attitudes theme, 3 subthemes developed: (1) self-blame, (2) discrimination and diagnostic overshadowing, and (3) open-minded attitude.

Self-Blame

Some respondents blamed themselves for receiving poor care. For example, when a person feels nervous interacting with health care professionals, they may try to rush through the encounter, providing fewer descriptive details and experiencing overall greater dissatisfaction with care outcomes. When asked to describe current barriers to care, one respondent commented, "Difficultly expressing my needs and them being fulfilled. Unable to (tell) them how I wanted my treatment or questions because I'm a people pleaser." Another respondent cited "my own ego" as a barrier to care.

Health care professionals may be able to preempt this self-blame, offering assurance to their patients with disabilities, and thus allowing improved trust, more descriptive details, and better establishment of a health care relationship.

Discrimination and Diagnostic Overshadowing

Some respondents reported obstacles when seeking to have their medical concerns validated. Some shared feeling confused and self-conscious when their experiences and emotions were not legitimized by their clinicians. They sometimes found that when they brought up new symptoms, clinicians assumed symptoms all stemmed from their pre-existing disability, a phenomenon known as diagnostic overshadowing.[10] For example, when asked if they have ever experienced unfair treatment because of their disability, one respondent commented:

> Because one of my disabilities is chronic anxiety (for which I am on medication), when I see specialists to try to treat my chronic nausea and vomiting, 3 recent doctors have told me I am faking it or that it is solely anxiety and one even told me to get out and not come back unless I get on an antidepressant.

Table 2 shows 16.7% of the respondents agreed or strongly agreed that they have received unfair treatment on the basis of their disability.

Qualitatively, respondents expressed feeling their concerns were being dismissed, which may be related to the provider's limited knowledge/specialty knowledge about their disability. For example, one respondent reported:

> Not at my recent appointment, but oftentimes as someone with anxiety and chronic physical illness, male doctors especially refuse to treat me for my physical illnesses because they feel that it is caused by my anxiety and refuse to look any further despite already being treated for my anxiety. People are very rude and talk down to me.

Another similarly stated:

> As soon as a doctor sees my autoimmune disorder, they immediately blame everything on it. As soon as my last therapist saw my psychiatric diagnosis, they said that they would have to find someone else (for me) because they have had issues with the same diagnosis in the past.

Table 3 shows 22% of respondents either agreed or strongly agreed that these attitudes and lack of knowledge led to inadequate treatment. When asked if they felt their provider had sufficient knowledge about their disability, nearly 40% of respondents replied that they either disagreed (26.8%) or strongly disagreed (12.2%). One respondent expressed that

Table 2. I experienced unfair treatment because of my disability.

Strongly Agreed	Agreed	Disagreed	Strongly Disagreed	Total
2.4%	14.3%	33.3%	50%	100%

Table 3. I received inadequate treatment due to a lack of understanding about my disability.

Strongly Agreed	Agreed	Disagreed	Strongly Disagreed	Total
9.8%	12.2%	26.8%	51.2%	100%

they have experienced, “Drs [sic] not educated about invisible disabilities,” referring to conditions that are not immediately visually apparent, such as chronic illness or learning disability, while another stated “my concerns about problems my disability was causing were kind of written off and not taken seriously.” People with disabilities who seek care face attitudinal barriers that downplay their concerns, as well as barriers produced by a lack of knowledge about their specific conditions. This could ultimately result in poor delivery of care where patients with disabilities are delegitimized or dismissed as too complex or time-consuming.

Open-Minded Attitude

Conversely, some respondents shared that their health care team’s attitudes significantly improved their comfort and care experience. For example, when asked to describe an experience of excellent care, one respondent wrote, “I asked my practitioner not to weigh me/tell me my weight as that is very triggering to me. It’s noted in my chart at the practice, and they are very considerate of that.” Having practitioners who are responsive and provide an open-minded attitude to patient requests allowed respondents to feel more comfortable trusting health care providers with sensitive information. Notably, most respondents reported their care teams as helpful and approachable, even if they encountered care impediments (Table 4).

As demonstrated in previous sections, while most respondents in the survey felt their providers were approachable and helpful (as shown in Table 4), a notable number of respondents may still feel uneasy describing their health care concerns with less approachable, dismissive care professionals. Patients have the right to choose a health care professional that listens and is receptive to their concerns, highlighting a need for open-minded practitioners.

Access

The second major theme addressed accessibility and willingness to accommodate patients. Most respondents found their appointments accessible. However, some expressed issues ranging from physical equipment to lack of human support during appointments. In the access theme, 4 related subthemes developed: (1) failures in scheduling, (2) equipment barriers, (3) human support, and (4) communication.

Failures in Scheduling

Some respondents pointed out that procedures and processes often pose barriers to success. For example, one respondent noted that the encouraged method of scheduling an appointment (online) was not compatible with their assistive technology, stating, “The online scheduling is not able to be read on a screen reader, so I must call to schedule.” Another respondent discussed how standard scheduling procedures produced barriers, sharing:

> If there is a need to reschedule from the health care provider's side, they like to call my cell phone and leave a message. I am still Deaf. I've asked, if possible, to email, text, or call me on the videophone.

Over 20% of respondents found difficulties during their scheduling process (Table 5).

Lack of accessible scheduling procedures may prevent people with disabilities from interacting with health care professionals at all. Failure to make this process more inclusive only places more delays and limitations on patients seeking care. An emphasis should be put on facilitating a more seamless, accessible system for patients to make appointments.

Equipment Barriers

Some respondents reported clinic equipment to be inaccessible. One respondent pointed to the constraints of scales without sufficient handrails or supports, stating:

> I wish my OB/GYN had something other than the equivalent of a household scale. My primary care at least has an assist rail so I can get a guess at my weight. I would like to see wheelchair scales in all offices someday. I would then know my actual true weight instead of an educated guess when I'm standing as I am partial ambulatory. I can get on exam tables with help because I have some use of my legs, but adjustable tables would be much easier. My primary care usually lets me just sit in a chair.

Most respondents found the exam equipment to be accessible; however, roughly 10% reported otherwise (Table 6). This was confirmed by qualitative responses. As one respondent wrote, "I would like to see accessible scales and better parking. The biggest generation is now becoming seniors...”

Limited accessible equipment in health care facilities places a constraint on thorough patient evaluations. Failure to address this element in health care delivery will contribute to insufficient diagnostic evaluation and compromised care.

Table 4. My provider/team were very approachable and helpful during my visit.

Strongly Agreed	Agreed	Disagreed	Strongly Disagreed	Total
35.7%	52.4%	9.5%	2.4%	100%

Table 5. The scheduling process was difficult, confusing, or challenging.

Strongly Agreed	Agreed	Disagreed	Strongly Disagreed	Total
4.8%	16.7%	40.5%	38.1%	100%

Table 6. The exam equipment (such as exam tables or weighing scales) used during my care was accessible.

Strongly Agreed	Agreed	Disagreed	Strongly Disagreed	Total
41.5%	48.8%	7.3%	2.4%	100%

Human Support

Some respondents discussed relying on additional human support, such as support people or caregivers, when navigating health care settings. However, some clinics had policies that disallowed additional people in the exam room, often due to lingering practices from the height of the COVID-19 pandemic. When asked about their last experience with excellent care one respondent wrote, "Before [the] pandemic doctors allowed in my caregivers[.] Now it's not allowed making so my care sucks."

Of a total of 42 survey respondents, 14% (n=6) reported having a legal guardian, who is often responsible for making health care decisions. Even for people with disabilities who are legally their own guardians, a support person or caregiver can provide crucial assistance in clinical settings. Caregivers and legal guardians are necessary accommodations for some patients with disabilities and can facilitate a more complete understanding of physician recommendations. It is imperative to recognize that accommodation is not just physical or technological but includes access to human support and assistance.

Communication

Respondents also cited communication issues with health care providers as a barrier to care (Table 7). Some respondents described their appointment experience as feeling "incomplete" when they were not fully acknowledged or communicated with effectively. One respondent commented, "It was confusing to understand what I was supposed to do or say because they did not make instructions clear."

One respondent wrote:

> I am HoH [hard-of-hearing] and at times I had to have things repeated due to intake wearing mask (I could not read lips and muffled speech), lack of eye contact (so I could get visual clues), etc. I did not ask for an interpreter, but the intake kept forgetting I asked them to look at me while speaking so I could hear better (I do wear hearing aids, but I also have an auditory processing disorder...so I need several forms of input to help me decode what is being said). The team beyond intake was much better with communicating in a manner that made things easier for me.

Additionally, respondents reported difficulty navigating medical facilities due to a lack of accessible signage or directions. One commented, for example, on having difficulty navigating to bathrooms. Implementing multiple modes of communication, such as verbal and written directions, frequent checks for understanding, and accessible assistance in wayfinding, can ensure all patients receive the same standard of care.

Infrastructure

The third major theme addressed meso level and macro level infrastructural issues found within medical systems. Even if clinical experience is inclusive and accessible, people with disabilities are still marginalized within systems that privilege nondisabled experiences. For example, many people with disabilities face issues with insurance that limit care options. Within the infrastructure theme, we developed 2 associated subthemes: (1) limited number of providers, (2) cost and insurance barriers.

Limited Number of Qualified Providers

Twenty-six percent of respondents reported scheduling difficulties. While, as discussed in the previous theme, some scheduling issues were due to inaccessible systems, some expressed having difficulty obtaining an appointment due to the limited number of suitable providers. For example, when asked to describe any inaccessible aspects of the scheduling process, one respondent wrote, "Wait times – especially to see someone qualified to see me." Another stated, "Well the doctor's office requires you leave messages they call back sometimes hard [to] get appointments because the doctor sees so many people." A third responded, "Long scheduling wait times."

Delays in care can result in unnecessary pain and suffering and can even be life threatening. For those requiring specialized care, wait times can be significant. This emphasizes a need to remedy the limited number of health care providers who are qualified to see patients with disabilities.

Cost and Insurance Barriers

Nearly a quarter of respondents felt their care was inadequate or incomplete (Table 8).

Further, asked if they were ever denied care or unable to receive care at any of their visits due to cost and insurance barriers, 12% reported "yes." One respondent stated, "My managed care plan wasn't contracted with [the] doctor[.] I had to pay a copay for Medicaid portion, so it made me have to go to another location for testing [when it] was urgent and delayed care." Insurance authorizations are a hurdle for patients and health care providers alike. While the majority of respondents felt content with their care, those facing insurance and cost barriers reveal a disparity that can compromise the efficiency and quality of care delivered.

DISCUSSION

This project surveyed adults with disabilities living or receiving care in Lucas County, Ohio, about their experiences in medical settings. Such insights add to the small pool of research capturing the lived experiences of people with disabilities in health care settings. Additionally, conducting this research in Lucas County, which is a medical desert with a higher-than-average population with disabilities, may offer insights to communities facing similar socioeconomic, geographic, and political conditions.

We identified 3 major themes: attitudes, access, and infrastructure. Each highlights a different set of barriers survey respondents faced during their medical visits. Attitudes refer to barriers arising from the manner in which both clinicians and respondents interpreted themselves and their disabilities. Some respondents described experiencing diagnostic overshadowing and blamed themselves for not being able to express their medical concerns fully with a health care provider. This finding resonates with other research, such as Yi and colleagues who, when looking at health care provider perspectives in South Korea, found that persons with disabilities were described as "difficult," "suffering," and "burdensome."[11] Respondents in our case similarly reported feeling their concerns were not legitimized by a medical professional, such as through experiences of diagnostic overshadowing. However, other respondents reported experiencing positive health care outcomes when their providers used an open-minded, patient-centered approach to their care. It is vital that health care professionals recognize the importance of incorporating an attitude rooted in mutual respect and dignity when delivering care. This approach can allow patients to fully express their medical concerns and allow physicians and providers to grasp a complete understanding of their patients.

The second theme, access, found that disabled people in Lucas County, Ohio, face barriers to care due to inaccessible infrastructure and communication. Some patients felt their care was limited by failures in scheduling, equipment, and policies. Similarly, Mudrick and colleagues, in a 2012 analysis of medical facilities in California, found that only 3.6% of the 2389 primary care facilities they reviewed had accessible scales and only 8.4% had height adjustable examination tables.[12] In our findings, respondents reported limitations with equipment and technology prior to and during their visit. They also noted inaccessibility with other resources, such as having a support person accompany them during medical visits. Ensuring equitably accessible medical equipment such as adaptive scales and examination tables is vital for all patients. Further, providers should incorporate patient feedback to develop more inclusive policies and practices. Health care professionals should be thorough, respectful, and uphold a patient's crucial right to human dignity.

The third theme, infrastructure, addressed how meso level and macro level dimensions of the US health care system, such as cost and geographic availability of services, influenced individual experiences. Some respondents described cost and insurance barriers as aspects affecting their care. According to the US census for Lucas County, Ohio, 6.9% of individuals with disabilities under 65 years of age are uninsured, compared to 5.6%, the national average.[7,13] Often, patients face difficult choices between affording daily necessities and receiving quality health care. Additionally, respondents noted a lack of available qualified providers as impeding their access to care. The Association of American Medical Colleges (AAMC) notes "the United States could see an estimated shortage of between 37 800 and 124 000 physicians by 2034, including shortfalls in both primary and specialty care."[14] With the current physician shortage impacting the US, patients, especially those with disabilities, are compromised in their ability to access reliable and specialized health care.

Our findings provide insights that lead to several recommendations. As health care appointments continue to shorten, it is important to recognize that some patients may need more time within a visit or more encounters with a provider to comfortably share their medical concerns.[15] To address diagnostic overshadowing and stigma, we believe implementing more disability education into health care training and more intentionally incorporating experts with lived experience of disability in medical

Table 7. All directions were clear and easy for me to understand.

Strongly Agreed	Agreed	Disagreed	Strongly Disagreed	Total
31.7%	56.1%	9.8%	2.4%	100%

Table 8. I received what felt like full and accurate treatment for my care.

Strongly Agreed	Agreed	Disagreed	Strongly Disagreed	Total
33.3%	42.9%	11.9%	11.9%	100%

education could begin to address these concerns at their root. To reduce access burdens, health care facilities should consider implementing accessible features such as those recommended by respondents, including text message appointment reminders, wheelchair accessible scales, clear face masks, plain language signage, and policies that allow human support. Developing an advisory committee made up of with disabilities would allow health care practitioners to remain responsive and adaptive to the localized, specific needs of the communities they serve. Ultimately, we endorse creating health care curricula and administrative practices that incorporate disabled experiences and perspectives. Programs built with this priority in mind will not only help subsidize the shortage of qualified providers but also will resolve some of the disparity gaps faced by those with disabilities in health care.

While this research had some distinct strengths, including a mixed-methods approach that enabled respondents to provide more holistic accounts of their experiences, we note several limitations. Generalizability is limited by our small sample size and our intentionally restricted geographic reach. While we consider our approach appropriate for an exploratory study, future research across a broader geography and a larger, more demographically representative sample could verify these findings. Additionally, participation could be limited due to our online recruitment methods. Americans with disabilities are less likely, on average, to have access to the internet and internet-enabled devices than their nondisabled counterparts.[16] Notably, Fong and Swick report how this digital divide correlates with other characteristics that contribute to health care disparities, such as socioeconomic status and more difficulty finding and maintaining employment.[16] Providing multiple modes of access could have increased the demographic reach of this research, yielding potentially rich data for comparison.

PUBLIC HEALTH IMPLICATIONS

Americans with disabilities are on an unequal footing in their access to quality health care. Our research, collecting perspectives from people with disabilities receiving care in Lucas County, Ohio, contributes to the small pool of research focusing on patient perspectives as a means to identify and address these inequities. We found that many respondents with disabilities feel the current health care system in Lucas County is falling short of providing them with quality care. Respondents spoke to disconnected communication and attitudes between patients and practitioners, restrictive policies, lack of accessible facility equipment, cost and insurance barriers, and limited access to knowledgeable practitioners. Failure to address these issues will only perpetuate stigma, restrict access, make individuals with disabilities uncomfortable confiding in practitioners, leading to continued poor health care outcomes.

People with disabilities have the most exposure with the medical field but receive the least support and inclusion.[17] Given our findings, there is an evident need to further research the health care experiences among Americans with disabilities. Further, conducting a similar mixed-methods study for local health care providers could allow for beneficial comparative analysis. This would ideally foster a better understanding of the divide between those with disabilities and their health care teams, leading to more accessible, inclusive, and equitable care.

AUTHOR CONTRIBUTIONS

Eric Salvati: conceptualization (lead); investigation; analysis (lead); writing–original draft preparation. Rebecca Monteleone: supervision; conceptualization (supporting); analysis (supporting); validation; writing–review and editing.

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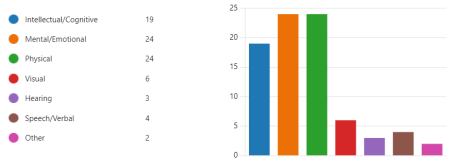
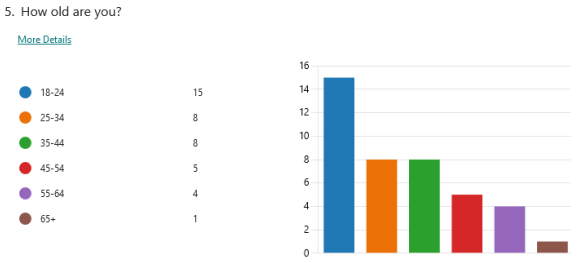
APPENDIX – Demographic Information

Figure 1. Disability Identity



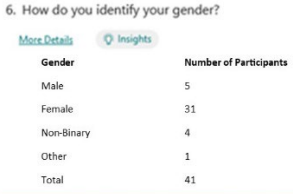
Survey respondent selected disability identity (select all that apply)

Figure 2. Age



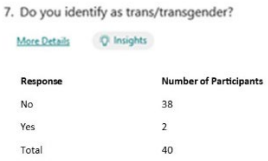
Survey respondent selected age group. The y-axis represents the total respondents for selected value

Figure 3. Gender Identity



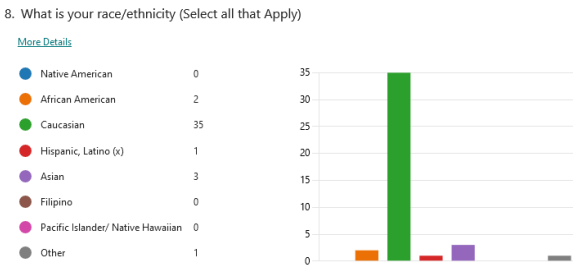
Survey respondent selected gender identity

Figure 4. Trans/Transgender Identity



Survey respondent selected identity as trans/transgender

Figure 5. Race/Ethnicity



Survey respondent selected race/ethnicity (select all that apply). The y-axis represents total respondents for selected value