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Accessible medical diagnostic equipment in primary care: Assessing its geographic distribution for disability equity

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Key words: disability, accessible medical diagnostic equipment; height adjustable examination tables, accessible weight scales; Medicaid network adequacy

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Abstract

Background. Height adjustable examination tables, accessible weight scales, and lifts for transferring individuals on/off examination equipment enable delivery of equitable health care to persons with mobility impairment. Because most Medicaid-covered patients must utilize a managed care network, network providers with accessible medical diagnostic equipment (MDE) at proximate locations for travel time and distance are necessary. Network density and distribution of accessible MDE has not been studied.

Objective. This descriptive research examined geographic network adequacy by comparing the density of persons with mobility impairments and location of Medicaid managed care practices with accessible MDE in Los Angeles County.

Methods. Medicaid managed care practices with MDE were mapped by ZIP Codes shaded to indicate the number of persons with mobility impairment. Zero-inflated negative binomial regression examined ZIP Code population characteristics as potential predictors of accessible MDE presence. Data sources were: (1) 2013-2016 primary care facility audit of Medicaid managed care network providers in LA County, aggregated by ZIP Code, and (2) LA County ZIP Code characteristics from the 2016 American Community Survey. ArcGIS was used for mapping and MPlus for the regression analysis.

Results. No consistent association between the size of the mobility limited population, demographic characteristics, and presence of accessible MDE was observed or measured by regression. The observed low MDE density suggests network adequacy likely is not achieved in LA County.

Conclusions. Actions by state and federal agencies are necessary to increase accessible MDE and network adequacy by enforcing existing non-discrimination law and Medicaid regulations.

Key words. Disability, accessible medical diagnostic equipment, height adjustable examination table, accessible weight scale, Medicaid network adequacy

Introduction

The importance of accessible medical diagnostic equipment (MDE) for the delivery of quality health care to people with mobility limitations is well documented. [1] The absence of accessible MDE contributes to lower rates than recommended for mammograms, cervical cancer screening and dental care, and higher rates of delayed care and dissatisfaction. [2-7] The population of patients who may benefit from accessible MDE is larger than the 8.4 million persons with mobility impairment (13.7% of disabled people) and can include individuals who are weak or frail, of short stature, or limited by arthritis, obesity, or pregnancy. [8]

The delivery of health care to these patients is facilitated by use of height adjustable examination tables, accessible examination chairs, scales to weigh a seated person, and lifts for transfer from wheelchair to examination table.[1] The equipment facilitates monitoring patient weight and conducting medical examinations with the same thoroughness as that provided other patients. However, only a minority of primary care doctors' offices are equipped with accessible MDE. [9-12]

With Los Angeles County data for primary care practices affiliated with a Medicaid Managed Care Organization (MMCO), this research compared the locations of offices with accessible MDE to the residential locations of persons with mobility impairment. The aim was to assess whether offices with MDE were sufficient in number and spatial location to enable reasonable access to quality care. Understanding the location of accessible MDE is important due to federal Medicaid network adequacy regulations for travel time and distance, for disability non-discrimination, and for compliance with the Americans with Disabilities Act (ADA). These concerns link directly to health disparities wherein receipt of health services is affected by systematic barriers that influence access, quality, and equity of care.

Accessible health care and discrimination

The ADA, Section 504 of the 1973 Rehabilitation Act, and Section 1557 of the Affordable Care Act (ACA) prohibit disability-based discrimination by virtually all health care plans,

services, and programs in the U.S. Health plans and providers can avoid disability-based discrimination by implementing various accommodations including providing accessible MDE.[13] ADA and 504 complaints have prevailed against primary care practices and health services operated by state and local governments with accessible MDE required as part of providing equitable and effective health care to patients.[14] Despite these laws, most primary care physician offices are not equipped with accessible MDE.[10, 15, 16]

Accessible medical diagnostic equipment

In its 2021 report on MDE, the National Council on Disability reviews the evidence linking accessible medical care facilities to health care utilization and quality of health care for people with mobility limitation.[1] As evidence of the impact on quality, people with mobility difficulties reported they were examined in a chair or their wheelchair and seldom weighed when weight measurement or examination on a table would occur for others.[4, 16, 17] Patients not weighed were asked to provide their weight, although research has found patient reports often are inaccurate.[18] Failing to obtain a weight measure is a quality of care issue as weight is used for medication dosage and to monitor health status. In some studies providers reported they would examine a patient in their wheelchair if transferring to an examination table was not easy or possible or required too much time, even though some problems might be missed.[19, 20] Quality and care disparity also may arise when accessible MDE is available in the medical office, but not consistently utilized.[12] By contrast, providers have reported that use of a height adjustable examination table is safer for patients and enables them to examine fragile or mobility-limited patients more thoroughly.[21]

No regular national data collection tracks the presence of accessible MDE in health care delivery settings, but surveys of physicians and practice administrators suggest that between 10%-40% of practice sites have accessible MDE.[12, 15, 19] Four studies that directly observed whether accessible MDE was present found between 10-44% of practices had height adjustable examination tables and 1-11% had accessible scales.[9-11, 22] A survey of primary care practice

79 administrators, who often are responsible for equipment purchase, found that less than half
80 knew accessible MDE existed.[15]

81 Network adequacy and travel to accessible health care

82 The location of health care providers and the ability of patients with disability to travel to
83 providers can constitute barriers to care.[23, 24] Transportation disadvantage and geographic
84 barriers are social determinants of health. They contribute to poor health outcomes or late-stage
85 presentation of medical problems when patients skip, postpone, or miss appointments due to
86 problems with transportation.[25] In a 2017 national survey, 5.8 million people reported delaying
87 health care for lack of transportation.[24] Within this group, people with a functional limitation were
88 2.6 times more likely to report a transport barrier that caused a delay in care. A 2017 Federal
89 Highway Administration survey classified 25.5 million people as having “travel-limiting
90 disabilities.”[26] Compared to persons without travel-limiting disability, these persons were less
91 likely to use a personal vehicle (74.8% vs. 83.9%) and more often used local public transit
92 (4.3% vs. 2.7%). Even when using a personal vehicle, persons with travel-limiting disability were
93 more likely to be passengers (38.9% vs. 16.1%). Trips for medical care were not the most
94 frequent reason for travel, but persons with travel-limiting disability reported double the number
95 of trips for medical care.

96 Disabled enrollees in a MMCO plan can only seek care from providers approved for that
97 plan's network, making the travel mode, time, and distance to accessible care important.
98 Concerned about MCO's ability to deliver contractual benefits within closed provider networks,
99 the Centers for Medicare & Medicaid Services (CMS) spelled out access standards in
100 regulations issued in 2002 and 2016. The Network Adequacy Standards (42 C.F.R. § 438.68)
101 direct states to consider physical accessibility and presence of accessible MDE at the practices
102 within MCO networks, and to develop travel time and distance standards with consideration of
103 geographic locations of network providers and Medicaid enrollees.[27] California’s 2017 network
104 adequacy standards allowed for alternative access standards when the MCO showed it could

not reasonably meet the federal requirement [28] ; its 2018 regulations required providers to be located within 10 miles or 30 minutes from the beneficiary's residence unless unreasonable to do so. [29] In 2020, California approved nearly 15,000 MCO exception requests[30] including exceptions for travel distances of 41-60 miles in LA County. Other exceptions affected diverse rural and urban communities, including lower-income communities of color in urban areas where barriers to accessing health care have been reported. [30, 31]

Methods

Using data from LA County, this descriptive research explored geographic network adequacy by examining the presence of persons with mobility impairments compared to the presence of medical practices with accessible MDE. Four research questions comprised this inquiry: (1) what is the frequency of MCO-affiliated practices with accessible equipment within LA County? (2) does the distribution indicate geographic spread or concentration? (3) are ZIP Codes with larger numbers of persons with mobility impairment served by larger numbers of practices with MDE? and (4) is there an association between the ZIP Code's population characteristics and the presence of accessible MDE? The demographic characteristics are race, ethnicity, age, use of public health insurance, population density of the ZIP Code, and number of persons reporting mobility impairment. We hypothesized that ZIP Codes more densely populated by people with mobility impairments and by older persons would have a greater number of practices with accessible MDE as a response to population need. The other demographic characteristics were selected to represent social determinants of health, with the expectation that ZIP Codes more densely populated by persons of color and participants in public health insurance (an indicator of low income) would show fewer practices with accessible MDE. ZIP Code population density/1000 was included because population and geographic sizes of ZIP Codes vary widely. The total number of MMCO-affiliated practices (regardless of MDE presence) was used as a control, expecting that the greater the number of practices the more likely at least one will have MDE.

Sources of Data

Two sources of data were used: (1) a 2013-2016 facility site review of primary care offices participating in Medicaid Managed Care networks serving LA County and (2) demographic characteristics data for LA County ZIP Codes from the 2016 wave of the American Community Survey. This research was IRB exempt because data had no human subjects.

Physical Accessibility Review Survey (PARS). Primary care practices that join MMCO plans in California are triennially audited using the state's Physical Accessibility Review Survey to rate accessibility for individuals with disability. [32] Trained reviewers observe architectural and equipment features using a survey based on the U.S. Access Board's 2010 ADA Accessibility Guidelines. [33] This research used three dichotomous questions about the presence of height adjustable examination tables, lift equipment, and accessible weight scales (Table 1). The examination table question conforms to the standard issued by the Access Board in the 2017 MDE accessibility standards. [34] The PARS data cover 2096 MMCO-affiliated LA County practices audited during 2013-2016, aggregated into their ZIP Codes. Practices not affiliated with a MMCO are not in the dataset; included practices also may treat patients with private insurance or Medicare. Appendix A has more detail about the survey instrument and data collection.

American Community Survey (ACS). The demographic data from the 2016 American Community Survey for LA County includes ZIP Code population density, race, ethnicity, age, use of public health insurance, and the number of individuals reporting mobility impairment. [35] Mobility impairment, not disability more broadly, was used as accessible MDE is likely most needed by these individuals (wording in Table 1). Age was coded as the percent of the population age 65 or older. Race and ethnicity were coded as separate dichotomous variables. The public health insurance variable includes Medicaid, Medicare, CHIP (Children's Health Insurance Program), Veterans Administration health care, and individual state insurance. [36] The ACS ZIP Code data did not offer a separate variable for Medicaid.

Data Analysis

ZIP Codes are the unit of analysis. The number of practices within the ZIP Code with each piece of accessible MDE are outcome variables. MMCO affiliated practices were observed in 233 of the county's 290 ZIP Codes. ArcGIS ArcMap Version 10.7 was used for mapping. For Figure 1 ZIP Codes were colored from lightest to darkest (shades of blue) to indicate the

number of practices in the ZIP Code with each type of equipment. Diagonal lines (grey) indicate no MMCO participating practices.

The PARS and 2016 ACS datasets were used together to map accessible equipment by population of individuals with mobility impairments. ZIP Codes were shaded to indicate the density of the population with mobility impairment: 0-2000 people (lightest, in beige), 2001-4000 people (darker, in orange), and 4001 or more people (darkest, in brown). Some ZIP Codes belong to an organization (e.g. university) that internally distributes mail. These, indicated by dots, have no ACS population data. The circled number overlaid in each ZIP Code indicates the number of practices with an accessible MDE equipment item. The placement of the number within the ZIP Code does not indicate the exact location of the practices.

M*plus* 8 was used to analyze the relationship between MDE and other demographic characteristics as potential predictors of the presence of accessible MDE using zero-inflated negative binomial regression models. Since outcome variables were count variables both with excessive values of zero and with variances larger than means, zero-inflated negative binomial regression was used.

Study Setting

LA County is the study site because PARS data were available from all county-designated MMCOs for 2013-2016. Thus, all MMCO-affiliated primary care practices likely are represented. LA County extends nearly 70 miles east to west and 100 miles from south to north.[37] The ZIP Codes in the south and southwest areas of the county include the Los Angeles Metropolitan Area, highly urban and crisscrossed by freeways with bus and rail transit. ZIP Code sizes are 3-10 square miles with approximately 24,000 persons per square mile. In the northern border of the county 13 ZIP Codes are 50-250 square miles with population density approximately 300-700 per square mile. This area includes arid terrain, high desert, and forests. The road network is not dense, with fewer transportation options. There are two centrally located adjoining cities of 150,000.

189

Results

In the 233 studied ZIP Codes, the Black and the Hispanic populations averaged 9.17% and 40.33%. Roughly 33% of the population participated in public health insurance. The average for the population over age 65 was almost 14% and for mobility impairment 6%. The mean number of practices per ZIP Code was 8.9 and mean population 36,010 (Appendix B).

Figure 1 displays the presence of practices with a height adjustable examination table, an accessible weight scale, and a patient lift in separate maps; the darker colors indicate greater presence of that type of equipment. Map A shows that in 37.8% of ZIP Codes there was no MMCO participating practice with height adjustable examination tables and in 28.3% of ZIP Codes there was one practice. Map B displays even fewer ZIP Codes with practices equipped with an accessible weight scale; 57.1% of ZIP Codes did not have a MMCO practice with an accessible weight scale and 22.7% had only one practice with an accessible scale. Lift equipment was the least present (Map C) with 74.2% of ZIP Codes without a MMCO practice with lift equipment and 21% of ZIP Codes with only one practice. The ZIP Codes in darkest shade show that only or one two ZIP Codes contained 6-10 practices with accessible MDE. Maps B and C also indicated that for scales and lifts there was sparse presence in both the southern and northern parts of the county. The two darkest shaded ZIP Codes in the northeastern part of the county show 2-5 practices with accessible equipment served a mid-sized city and a large sparsely populated surrounding area.

Figure 2 shows the geographic match of practices with a height adjustable examination table to the population potentially in need of such equipment. The numerical distribution of practices with a height adjustable examination table is below the map. Regardless of the size of the population of individuals with mobility limitations, the map indicated no observable pattern, with most ZIP Codes containing zero or one practice with a height adjustable examination table. A single ZIP code, on the eastern border of Los Angeles County, was an outlier with 10 practices with height adjustable examination tables. Noteworthy was how few practices had an

accessible examination table across the many square miles of the northern part of the county despite the indication of a sizeable number of people for whom such equipment would be of benefit. Numerous ZIP Codes in the dense southern part of the county had few to no practices with accessible equipment, although the smaller distance between ZIP Codes could provide greater potential to meet the network adequacy standard. By observation, there were few differences between the number of practices with accessible tables in ZIP Codes estimated to have 4,000 persons with mobility impairments compared to ZIP Codes where the population size was 0-2,000 persons.

The Figure 3 map shows that over half of the ZIP Codes did not have a single practice with an accessible weight scale. The observed geographic distribution showed greater presence of accessible scales near the center of the City of Los Angeles, with one ZIP Code containing 10 practices and another 5 practices with an accessible weight scale. Moving north on the map, the presence of accessible scales appeared to decrease. The areas containing larger numbers of persons with mobility impairments (darkest shade) showed little difference in the number of practices with accessible weight scales compared to the ZIP Codes where those numbers were smaller.

Figure 4 shows that the presence of lifts was extremely small and spread over a wide area. Nearly three quarters of ZIP Codes had zero MMCO-affiliated practices with lift equipment. In the northern part of the county only one ZIP Code contained practices with lift equipment. Even in the central and southern regions of the county there was often only one ZIP Code with a practice with lift equipment. Out of 233 ZIP Codes, only eleven contained more than one medical practice with a lift. The map shading does not suggest that lift equipment was especially located in the ZIP Codes with larger numbers of residents with mobility impairments.

The statistical summary of the ZIP Code profile data (Appendix B) found the average number of practices with accessible examination tables, accessible scales, and lift equipment

241 was 1.34 (*SD* = 1.64), 0.77 (*SD*= 1.21), 0.33 (*SD* = 0.69) respectively, confirming the skewed
242 distributions displayed in Figures 2,3,4, with standard deviations larger than the means.
243 Table 2 displays zero-inflated negative binomial regression model results, with the
244 population characteristics as predictors for examination tables, weight scales, and lifts. The
245 number of practices providing exam tables was negatively associated with the percentage of the
246 population over 65 and population density while positively associated with the total number of
247 practices in the ZIP Code. The number of practices providing lifts was only positively associated
248 with the total number of practices. The number of practices providing scales was positively
249 associated with the percentage using public insurance and the total number of practices. The
250 percent of the Black and Hispanic populations, and the percent with mobility impairment, were
251 not significantly associated with the numbers of practices providing examination tables, lifts, or
252 scales.
253

Discussion

This study mapped the geographical locations of accessible examination tables, weight scales, and patient lifts in LA County and quantitatively explored potential population predictors. The maps illustrated a very low presence of accessible MDE in MMCO-affiliated practices with many ZIP Codes having no practices with accessible equipment of any kind. Although low, more practices had height adjustable examination tables than accessible weight scales and lift equipment. These findings are consistent with previous studies. [9, 15] Lack of accessible MDE may pose a greater challenge in northern LA County than in the southern areas because people there may face the need to travel longer distances to reach a facility with accessible MDE. The need to travel more than 30 minutes for primary care, even if this meets a network adequacy exception, likely results in delayed or postponed care for some people. [24, 26] Persons who cannot drive themselves will need to rely on another's availability, a scheduled medical transport, paratransit, or where feasible, public transit. Each option may pose time or schedule limitations that present a barrier to medical care.

The maps and quantitative findings revealed that even when accessible equipment was present, its geographic placement did not appear to be an intentional response to federal or state policy, population need, patient demographics, travel time or distance considerations, or other concerns for disabled Medicaid participants. Areas with larger population density, older populations, and populations with mobility impairment were not afforded greater consistent access to accessible MDE. However, a larger number of MMCO practices increased the likely presence of MDE in at least one practice in a ZIP Code. Some MMCOs have purchased accessible MDE for some of their affiliated medical practices, and this may explain the high outliers and positive association of scales with public health insurance. [38] The non-significant findings on association between Black and Hispanic populations with numbers of practices with accessible MDE raises concerns about equitable access to health care services for some racial groups. The 2015 Los Angeles County Health Survey reports the Black population had the

highest percentage of adults with disability (33.5%) compared to other racial/ethnic groups [39]. The findings suggest deeper examination of the intersection of Black population disability rates and provider disability accessibility is needed.

The maps offer a visual assessment of probable compliance with the required travel time and distance network standards per Medicaid and ADA non-discrimination mandates. [27, 30] Network adequacy standards create an expectation that a reasonable number of primary care providers in a network will have accessible MDE. The minor role of population density as a predictor of MDE tests this assumption, with Figures 2, 3, and 4 further suggesting that LA County may not be meeting the state's network adequacy standards. With the granted exceptions the standards may fail to achieve their intent. Patients may face a significant challenge to find and utilize a medical practice with accessible MDE.

Study Limitations

One study limitation is that the PARS data obtained from MMCOs did not include practices' addresses, sizes, patient capacities, or number of pieces of accessible MDE within each practice. This limited our ability to assess other factors that could influence the presence of accessible MDE. The audit instrument and process were developed by MMCOs for their needs without testing for data reliability and quality; this is a limitation for research application. The data cover only MMCO-affiliated practices, not all primary care practices in LA County. Because of state variation, we cannot generalize about equipment presence to MMCO practices in other states with other policies. However, this mandatory auditing methodology is generalizable and offers a model for developing a national database. Our data are older than 6 years; the current equipment rate might be greater. However, the increase between a 2006-2009 measurement and this dataset was just under 10%.[9] To our knowledge, no other large observation-based dataset exists.

Policy recommendations

These findings suggest policy actions that may advance healthcare equity for people with disability. First, the findings highlight a disconnect between data collected by MMCOs and resulting action. MMCOs are not required to use the accessible equipment data as an indicator of disability non-discrimination in health care services or to inform network adequacy. Thus, well-established disability rights law and policy are disregarded, and the purpose and effectiveness of network adequacy standards is undermined. States should require that MMCOs collect, use, and submit to the state data on the presence of accessible equipment in network adequacy determinations.

Second, to address the paucity of primary care offices with accessible MDE, DOJ and HHS should revise their ADA regulations and require health care providers subject to their jurisdiction to acquire accessible equipment that meets the Access Board's MDE Standards. [34] Regulations should spell out how many of each type of accessible equipment are required based on practice and patient characteristics. The regulations could induce MMCOs to tie provider reimbursements to benchmarks for accessible MDE. Further, MMCOs could leverage their purchasing power to lower provider equipment costs or offer grants for acquisition of accessible MDE. Another strategy is to increase provider knowledge about accessible MDE and its importance when treating patients with disability. Other studies have identified lack of knowledge as a key factor. [12, 19] The Accreditation Council on Graduate Medical Education (ACGME) should require all federally funded medical residency programs to include disability competency training that addresses the use of accessible MDE as integral to equitable health care.

Finally, all MMCOs should be required to conduct *on-site* accessibility reviews using a nationally standardized and tested survey instrument that notes accessible MDE and practice address and characteristics. This would improve the utility of the data for compliance and

facilitate further research on the intersection of accessible MDE with local disability, demographic, and transportation characteristics.

Conclusions

This is the first study to analyze the presence of accessible MDE from a geographical perspective and link findings to Medicaid MCO network adequacy for patients with disability. There was no evidence of intentional geographic placement of accessible MDE as a response to the patient population. The geographical locations of accessible MDE revealed a substantial need to increase its presence in MMCO-affiliated practices in urban and non-urban areas and especially in areas with higher numbers of people with mobility impairment. A stronger match between the residential locations of people with mobility limitation and location of accessible MDE will increase the receipt of equitable primary and preventive care.

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Figure legends

Figure 1. Presence of accessible equipment in MMCO-affiliated primary care practices by ZIP Code

Figure 2. Height adjustable examination tables and individuals with mobility limitations by ZIP Code

Figure 3. Accessible weight scales and individuals with mobility limitations by ZIP Code

Figure 4. Patient lifts and individuals with mobility limitations by ZIP Code

Table 1. Wording of survey questions identifying medical diagnostic equipment and mobility impairment

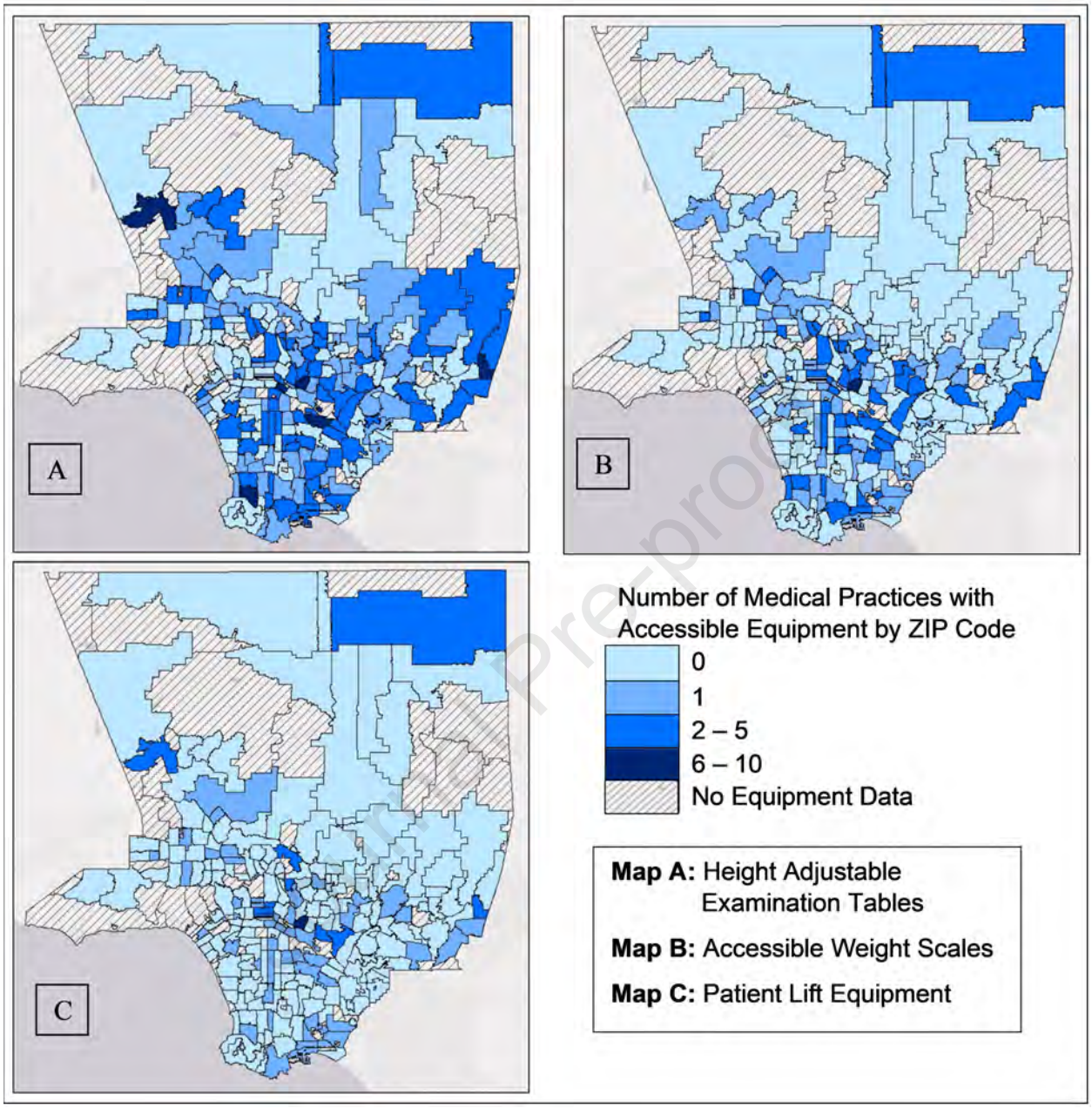
Physical Accessibility Review Survey Exam Equipment Questions (N=2096)		Yes
Q 81	Is there a height adjustable exam table that lowers between 17 inches and 19 inches from the floor to the top of the cushion?	14.9%
Q 84	Is a lift available to assist staff with transfers (portable, overhead, or ceiling mounted)?	3.6%
Q 86	Is a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient?	8.6%
American Community Survey 2016 Mobility Impairment Question Used for Maps		Yes- LA County
Q 17b	Does this person have serious difficulty walking or climbing stairs?	5.9%

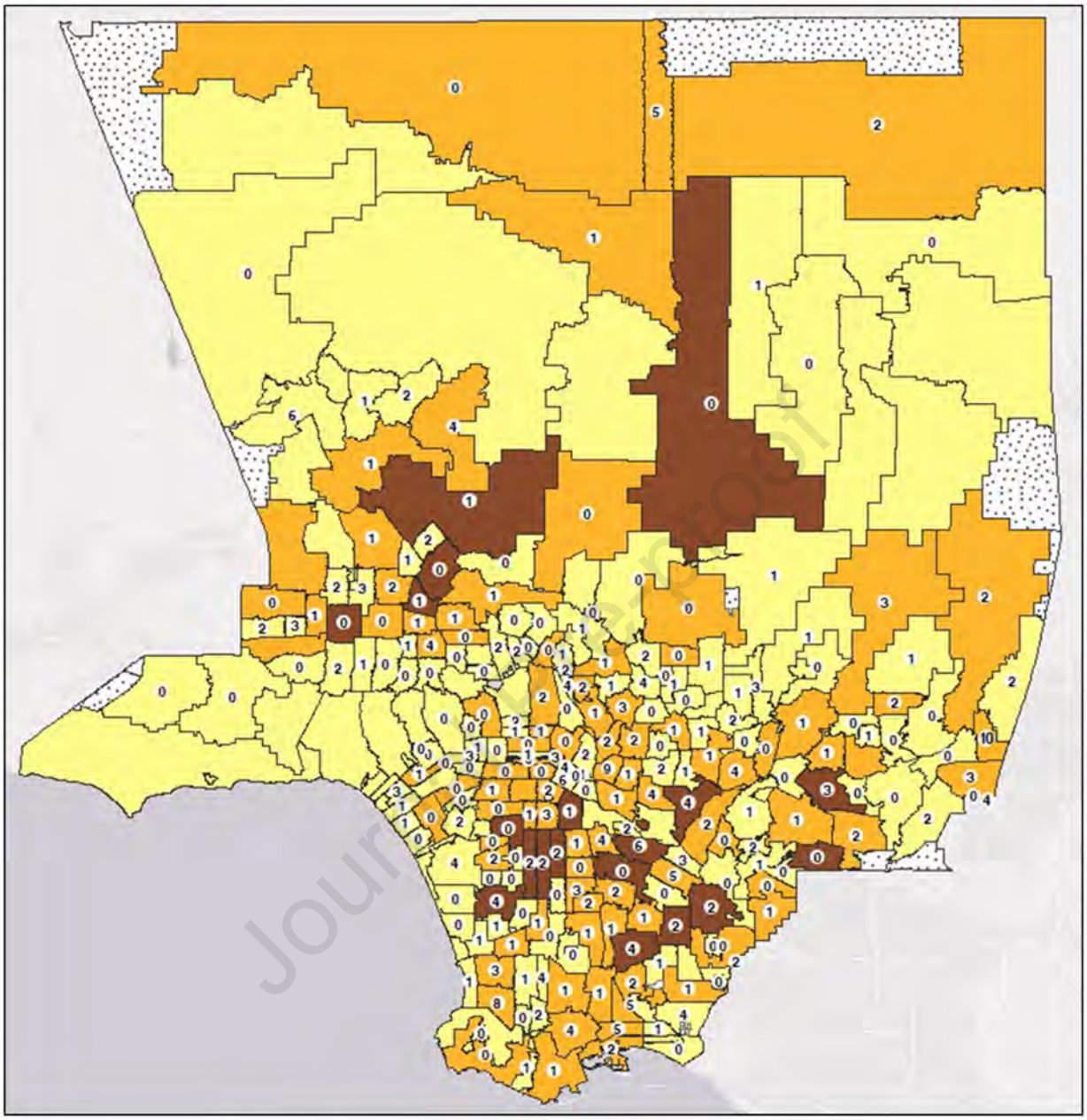
Note: All questions are answered Yes or No.

Table 2. Zero-inflated negative binomial regression of predictors for accessible medical diagnostic equipment, Los Angeles County

	Exam tables b (SE)	Scales b (SE)	Lifts b (SE)
Percent of the Black Population	-0.001 (0.007)	-0.008 (0.009)	-0.008 (0.014)
Percent of the Hispanic Population	-0.001 (0.004)	0.004 (0.006)	-0.005 (0.008)
Percent of the Population with Public Health Insurance	0.001 (0.011)	0.037* (0.015)	0.033 (0.021)
Percent of the Population over the age of 65	-0.061* (0.024)	-0.039 (0.049)	-0.016 (0.042)
Percent of the Population with mobility impairment	-0.021 (0.052)	-0.051 (0.074)	-0.029 (0.098)
Population density/1000	-0.026** (0.010)	-0.005 (0.011)	0.006 (0.015)
Total number of practices per ZIP Code	0.066*** (0.006)	0.049*** (0.008)	0.063*** (0.011)

*p<.05 **p<.01 ***p<.001



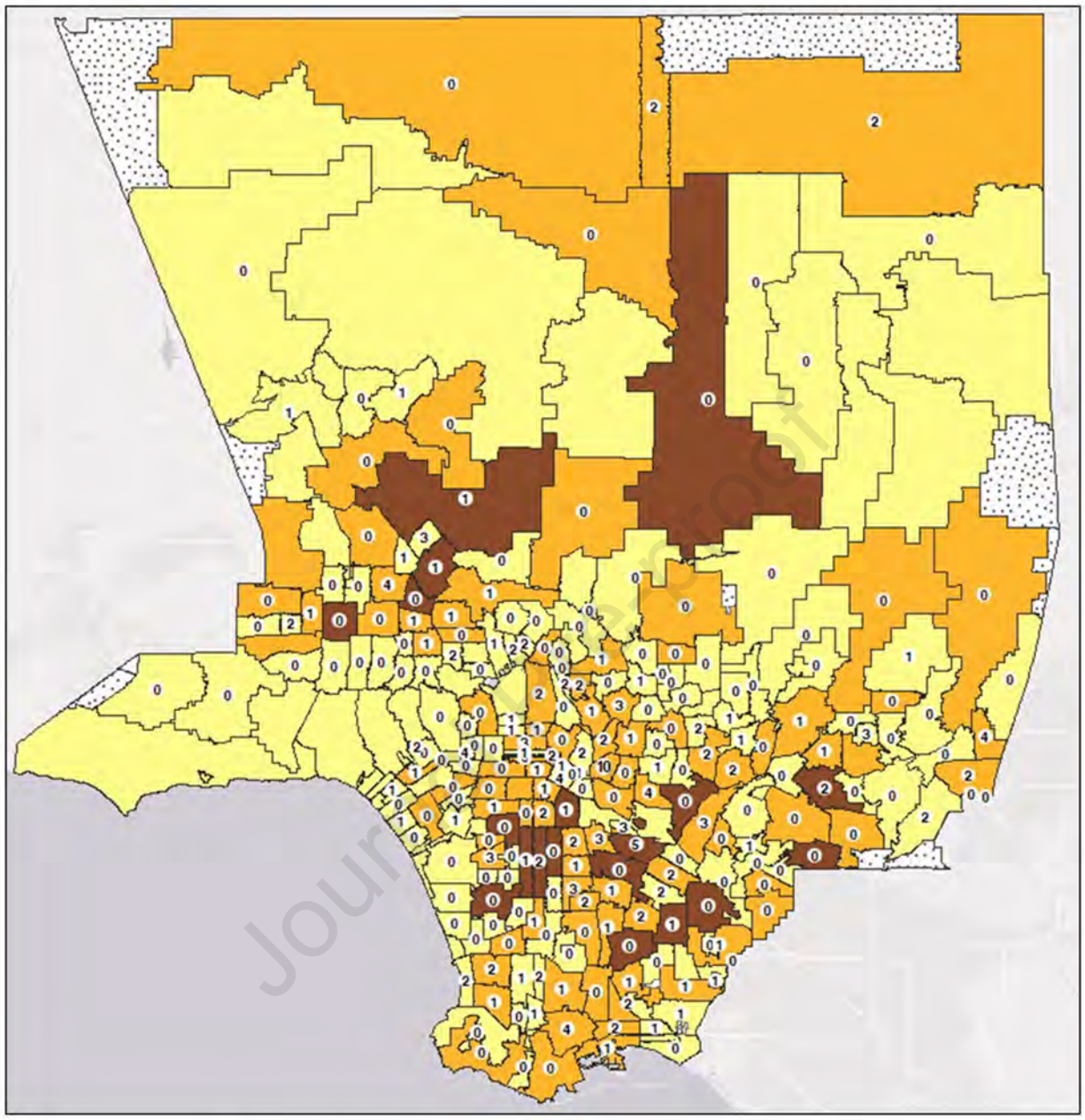


Number of people with mobility limitations by ZIP Code:

0 - 2,000
2,001 – 4,000
4,001 and above
No population data

Medicaid MCO Primary Care Practices with a Height Adjustable Exam Table by ZIP Code

Count of practices	0	1	2	3	4	5	6	7	8	9	10	Total
Count of ZIP Codes	88	66	40	14	15	4	3	0	1	1	1	233
Percent of total ZIP Codes (%)	37.8	28.3	17.2	6.0	6.4	1.7	1.3	0.0	0.4	0.4	0.4	100.0

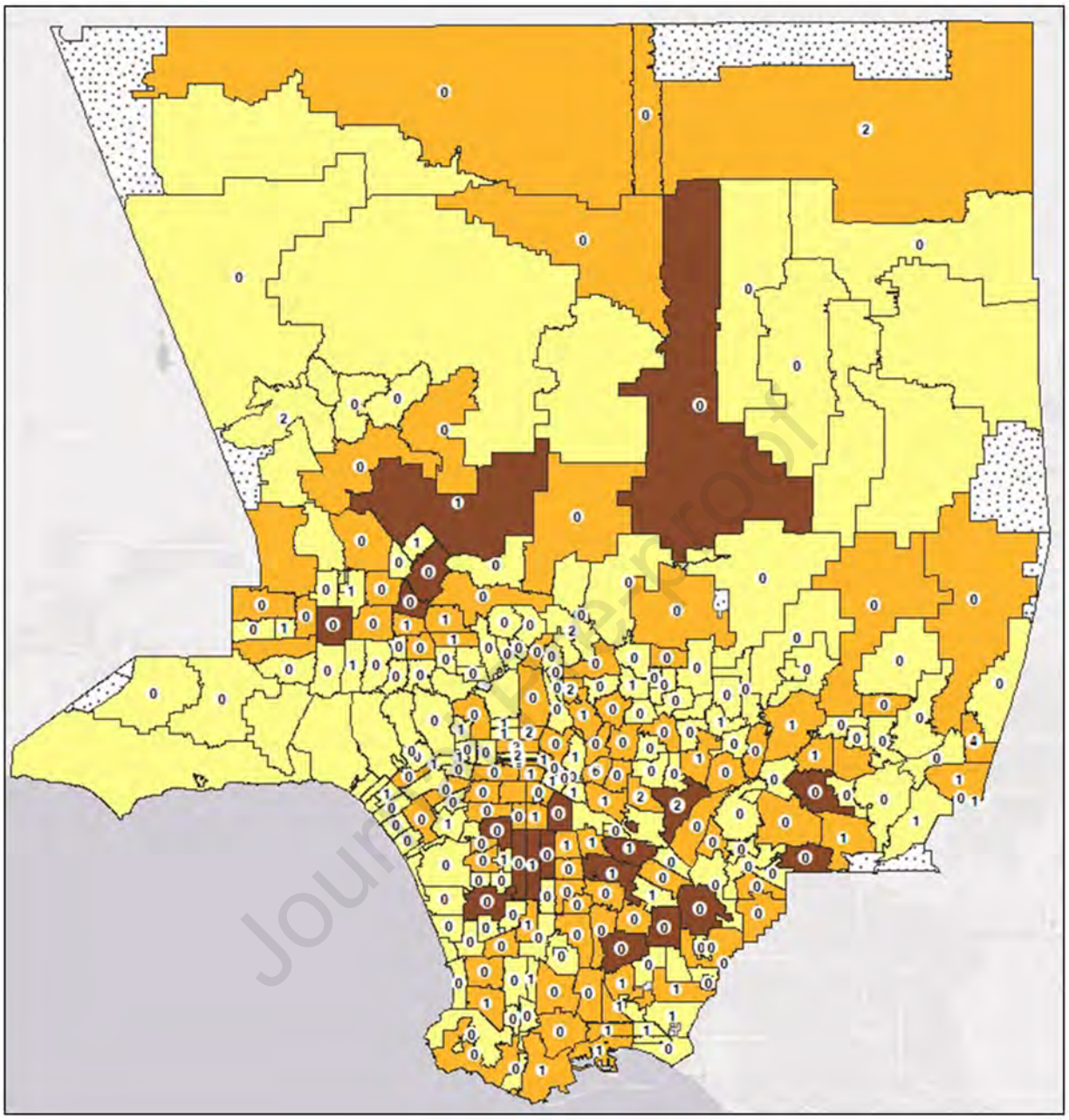


Number of people with mobility limitations by ZIP Code:

0 - 2,000
2,001 – 4,000
4,001 and above
No population data

Medicaid MCO Primary Care Practices with an Accessible Weight Scale by ZIP Code

Count of practices	0	1	2	3	4	5	6	7	8	9	10	Total
Count of ZIP Codes	133	53	30	9	6	1	0	0	0	0	1	233
Percent (%)	57.1	22.7	12.9	3.9	2.6	0.4	0.0	0.0	0.0	0.0	0.4	100.0



Number of people with mobility limitations by ZIP Code:

0 - 2,000
2,001 – 4,000
4,001 and above
No population data

Medicaid MCO Primary Care Practices with Lift Equipment by ZIP Code

Count of practices	0	1	2	3	4	5	6	7	8	9	10	Total
Count of ZIP Codes	173	49	9	0	1	0	1	0	0	0	0	233
Percent (%)	74.2	21.0	3.9	0.0	0.4	0.0	0.4	0.0	0.0	0.0	0.0	100.0